



Idaho Healthcare Coalition

Meeting Agenda

February 14, 2018 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: 773079

Attendee URL: <https://rap.dhw.idaho.gov/meeting/24999296/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone URL:

<pulsesecure://?method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=24999296&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 12/13/2017 and 01/10/2018 meeting notes - <i>Lisa Hettinger, IHC Co-Chair</i> ACTION ITEM(s)
1:35 p.m.	Update - Farley Policy Center Report - <i>Gina Westcott, SW Hub Administrative Director, Division of Behavioral Health, IDHW</i>
1:55 p.m.	IHDE Update - <i>Brad Erickson, Executive Director, IHDE</i>
2:05 p.m.	Mercer update - <i>Katie Falls, Mercer</i>
2:15 p.m.	CHEMS Learning Collaborative Report - <i>Wayne Denny, Chief, Bureau of Emergency Medical Services & Preparedness, Division of Public Health, IDHW</i>
2:35 p.m.	Briljent Cohort Two Report - <i>Nancy Kamp, Training Lead, Health Management Associates</i>
2:45 p.m.	Break
3:00 p.m.	Report on PCMH Transformation Workshop - <i>Kym Schreiber, IDHW, Mary Ann Herny, Instructional Design Lead, Briljent</i>
3:20 p.m.	SHIP Transformation Process Discussion - <i>Lisa Hettinger, IHC Co-Chair</i>
4:00 p.m.	SHIP Operations and Advisory Group reports/ Updates - Please see written report (SHIP Operations and IHC Workgroup reports): <ul style="list-style-type: none">• Presentations, Staffing, Contracts, and RFPs status - <i>Cynthia York, IDHW</i>• Regional Collaboratives Update - <i>Madeline Russell, IDHW</i>• Telehealth, Community EMS, Community Health Workers - <i>Madeline Russell, IDHW</i>• Data Governance Workgroup - <i>Dr. Andrew Baron, Terry Reilly and Janica Hardin, Saint Alphonsus, Workgroup Chairs</i>• Multi-Payer Workgroup - <i>Norm Varin, PacificSource, Workgroup Chair</i>• Behavioral Health/Primary Care Integration Workgroup - <i>Ross Edmunds, IDHW and Dr. Charles Novak, Workgroup Co-Chairs</i>• Population Health Workgroup - <i>Elke Shaw-Tulloch, IDHW & Carol Moehrle, Public Health Idaho North Central District, Workgroup Chairs</i>• IMHC Workgroup – <i>Dr. Scott Dunn, Family Health Center and Matt Wimmer, IDHW Workgroup Chairs</i>
4:15 p.m.	Additional business & next steps - <i>Lisa Hettinger, 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 (IHC)
February 14, 2018
Action Items

■ Action Item 1 – December IHC Meeting Minutes

IHC members will be asked to adopt the minutes from the December 13, 2017 IHC meeting.

Motion: I, _____ move to accept the minutes of the December 13, 2017, Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.

■ Action Item 2 – January IHC Meeting Minutes

IHC members will be asked to adopt the minutes from the January 10, 2018 IHC meeting.

Motion: I, _____ move to accept the minutes of the January 10, 2018 Idaho Healthcare Coalition (IHC) meeting as prepared.

Second: _____

Motion Carried.



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT: IHC December Minutes

DATE: December 13, 2017

ATTENDEES: Rachel Blanton in for Dr. Andrew Baron, Russ Barron, Kathy Brashear, Pam Catt-Oliason, Dustin Raney in for Melissa Christian, Russell Duke, Gina Westcott in for Ross Edmunds, Dr. Ted Epperly, Janica Hardin, Lisa Hettinger, Yvonne Ketchum, Deena LaJoie, Dr. David Peterman, Susie Pouliot, Dr. Kevin Rich, Neva Santos, Elke Shaw-Tulloch, Mary Sheridan, Larry Tisdale, Jennifer Wheeler, Beth Criet in for Matt Wimmer, Cynthia York, Nikole Zogg

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

Teleconference: Michelle Anderson, Keith Davis, Dr. James Lederer, Maggie Mann, Casey Meza, Carol Moehrle, Geri Rachow, Dr. Rhonda Robinson-Beale, Karen Vauk, Lora Whalen

Members Absent: Norm Varin, Dr. Scott Dunn, Lee Heider, Dr. Mark Horrocks, Dr. Glenn Jefferson, Amy Mart, Nicole McKay, Daniel Ordyna, Dr. David Pate, Tammy Perkins, Dr. Boyd Southwick, Fred Wood

IDHW Staff Ann Watkins, Kymberlee Schreiber, Stacey St. Amand, Madeline Russell, Madeline Priest, James Hague, McKenzie Hansen, Alexis Marcovitz

STATUS: Draft 12/13/17

Summary of Motions/Decisions:

Motion:

Kathy Brashear moved that the IHC accept the previous month's meeting minutes with the discussed edits. Kevin Rich seconded the motion.

Outcome:

Passed

Lisa Hettinger moved that the IHC accept the Graduate Medical Education 10-year Strategic Plan as presented. Kathy Brashear seconded.

Passed

Jennifer Wheeler moved that the IHC adopt the SHIP Cohort Three application as presented. Elke Shaw-Tulloch seconded the motion.

Passed

Mary Sheridan moved that the IHC accept the Operational Plan for Award Year 4 as presented by Katie Falls from Mercer. Larry Tisdale seconded the motion.

Passed

Elke Shaw-Tulloch moved that the IHC adopt the Population Health Workgroup Charter as presented. Neva Santos seconded the motion.

Passed

Agenda Topics:

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

- ◆ Dr. Epperly welcomed everyone to the meeting and took role. Dr. Epperly started the meeting sharing two stories: the first about family and the second about health; he wished everyone the gift of health and family this holiday season.

Graduate Medical Education, 10-Year Strategic Plan - Dr. Ted Epperly, IHC Chair

- ◆ Dr. Epperly presented an overview of the 10-year strategic plan for graduate medical education in Idaho.
- ◆ Idaho is the second lowest state with active physicians per 100,00 population. Twenty-seven percent of the Idaho physician work force is over the age of 60 and will be retiring within the next decade.
- ◆ Idaho currently has only nine medical graduate programs. With this new plan the goal is to grow the number of programs to 21. Over the decade of the plan more physicians will be trained in Idaho to grow our physician work force.

Introduce Cohort Three-Kym Schreiber SHIP PCMH Project Manager

- ◆ Kym Schreiber presented the introduction to Cohort Three and a brief update on the evaluation and selection processes:
- ◆ Cohort Three had 58 total applications; the organizational capitation was suspended based on the total number of applications. Fifty-four sites were selected for Cohort Three.
- ◆ Ms. Schreiber presented proposed next steps:

- Brilljent will conduct a readiness assessment
- Brilljent clinic agreement initiation with Cohort Three
- Project MOUs between Cohort Three and IDHW
- IHDE agreement initiation
- Cohort Three kick-off webinar
- Cohort Three Learning Collaborative

AY4 Operational Plan and Dashboard-Katie Falls, Mercer

- ◆ Katie Falls presented the Operational Plan for Award Year 4. Ms. Falls informed the group that Idaho did not receive its requested no cost extension. Since the notification of the no cost extension was received two weeks before the operational plan due date of December 1, 2017, the Operational Plan is now due January 1, 2018.
- ◆ The Goals for Award Year 4 include:
 - Goal 1-165 SHIP cohort clinics.
 - Goal 2 and 5- Increased IHDE capacity and enhanced clinic trainings.
 - Goal 3- Linkages to new Medicaid payment models.
 - Goal 4- Integration of CHW and CHEMS in delivery system.
 - Goal 6-Development of new Medicaid payment models.
 - Goal 7- Two data collection and analysis cycles, cost avoidance financial analysis report.
 - Each goal is also working toward sustainability planning.
- ◆ The Sustainability Plan is broken down into two deliverables:
 - Part 1: End-state vision, state accomplishments, and change in environment – due in April 2018.
 - Part 2: Assess the status of key elements of Idaho’s model and prepare a detailed plan for sustaining its major SHIP incentives to achieve its end-state vision – due in July 2018.

CQM Measures Clarification- Janica Hardin, Data Governance Workgroup Co-Chair

- ◆ Janica Hardin presented clarification on the clinical quality measures catalog presented at the previous month’s meeting. The last four measure descriptions are now enhanced to match exactly the NQF measure standards.
- ◆ For the Colorectal Cancer Screening measure, the age range was previously stated as 50-80 years of age but will now state 50-75. This is in alignment with the NQF definition.
- ◆ The Breast Cancer Screening measure has a two year look back period. Ms. Hardin stated that this is a denominator. While the measure states 50-74 years of age, the denominator inclusion criteria is operationally 52-74 years of age.

Population Health Workgroup Charter-Elke Shaw-Tulloch, Population Health Workgroup, Co-Chair

- ◆ Elke Shaw-Tulloch presented an update on the Population Health Workgroup Project Charter. There have been some staffing changes within the PHW: Carol Moehrle is the new co-chair and Madeline Russell is the new SHIP staff member.
- ◆ The new business alignment workgroup role now reads, “Identify opportunities for public health and primary care integration within the regions that can positively impact SHIP success,” and “Develop population health measures and baseline values.”
- ◆ The first deliverable was added to read “assist the Division of Public Health in the creation of the SHIP Model Test Grant required population health improvement plan.”
- ◆ Within the charter there is now a section that shows completed activities.

Follow-up on BHI Stakeholder Convening: Farley Health Policy Center- *Gina Westcott, SW Hub Administrative Director, Division of Behavioral Health*

- ◆ Gina Westcott presented an update from the Farley Health Policy Center convening. The focus of the meeting was to begin developing a common vision for behavioral health integration.
- ◆ Payment reform was a central focus of the convening along with workforce issues and communication.
- ◆ The next BHI subcommittee will meet on January 9th, 2018.

PHD and Regional Collaborative Updates- *Public Health District SHIP Managers*

- ◆ Steve Holloway presented an update on Region 1. This region has found success in ongoing collaboration with community members and SHIP clinics. Mr. Holloway provided an update with successes and challenges in establishing CHEMS within their district.
- ◆ Kayla Sprenger presented an update on Region 2. Accomplishments for the region include linking Cohort One clinics with Cohort Two clinics to provide mentoring partnerships.
- ◆ Rachel Blanton presented on Region 3. Accomplishments from the region include embedding behavioral health in local schools as a demonstration.
- ◆ Melissa Dille presented on Region 4. This region has found success in the Caregiver Integration Project.
- ◆ Rob Petroch presented on Region 5. Mr. Petroch stated his region has had success in ongoing collaboration.
- ◆ Rhonda D'Amico presented on Region 6. Ms. D'Amico gave an update of the Regional Suicide Prevention Symposium.
- ◆ James Corbett presented an update on Region 7. Clinics in this region have found success in empowering clinics to look outside themselves for solutions.
- ◆ Common challenges among all regions are the lack of data, consistency of RC attendance, and sustainability once grant funding ends.
- ◆ Slides from the PHD Presentations will be posted on the IHC webpage

Additional business and next steps- *Ted Epperly, IHC Chair*

- ◆ Madeline Russell presented the health clinics participating in round 2 of telehealth funding. There were eight clinics and one CHEMS agency that were awarded grants.
- ◆ Dr. Epperly closed the meeting wishing everyone the gifts of health and family for the holiday season.
- ◆ Meeting adjourned at **4:35 PM**



Idaho Healthcare Coalition

Meeting Minutes:

SUBJECT:	IHC January Minutes	DATE:	January 10 2018
ATTENDEES:	Russ Barron, Norm Varin, Pam Catt-Oliason, Melissa Christian, Keith Davis, Russ Duke, Ross Edmunds, Dr. Ted Epperly, Lisa Hettinger, Deena LaJoie, Dr. James Lederer, Dr. Kevin Rich, Dieuke Dizney-Spencer in for Mary Sheridan, Larry Tisdale, Matt Wimmer, Cynthia York, Rachel Blanton in for Nikole Zogg	LOCATION:	700 W State Street, 1 st Floor East Conference Room
Teleconference:	Michelle Anderson, Dr. Andrew Barron, Kathy Brashear, Yvonne Ketchum, Maggie Mann, Kayla Springers in for Carole Moehrle, Sandy Stevenson in for Dr. David Pate, Dr. David Peterman, Susie Pouliot, Geri Rackow, Dr. Rhonda Robinson-Beale, Neva Santos, Elke Shaw-Tulloch, Lora Whalen, Jennifer Wheeler,		
Members	Dr. Richard Bell, Dr. Scott Dunn,		
Absent:	Janica Hardin, Lee Heider, Dr. Mark Horrocks, Dr. Glenn Jefferson, Amy Mart, Nicole McKay, Casey Meza, Daniel Ordyna, Tammy Perkins, Dr. Boyd Southwick, Karen Vauk, Dr. Fred Wood		
IDHW Staff	Casey Moyer, Ann Watkins, Burke Jensen, Kym Schreiber, Madeline Russell, Stacey St. Amand, Jill Cooke, Madeline Priest, Alexis Marcovitz		
Guests:	Scott Banken, Katie Falls, Greg Kunz, and Robbie Jackson		
STATUS:	Draft 1/20/18		

Summary of Motions/Decisions:

Motion:

Russ Barron moved to recommend that the governor appoint Melody Bowyer to the IHC representing South Central Public Health. Geri Rackow seconded the motion.

Outcome:

Passed

Norm Varin moved to recommend that the governor appoint Dr. Kelly McGrath to the IHC representing the Multi-Payer Workgroup. Dr. James Lederer seconded the motion. **Passed**

Patt Catt-Oliason moved to recommend that the governor appoint Drew Hobby to the IHC representing Blue Cross to replace Dr. Rhonda Robinson-Beale. Kevin Rich seconded the motion. **Passed**

Lisa Hettinger moved to support the submission of the Payer Financial and Enrollment Metrics Report as presented by Scott Banken from Mercer. Russ Barron seconded the motion. **Passed**

Agenda Topics:

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

- ◆ Dr. Epperly welcomed everyone and opened the meeting with a quote from Zig Ziglar, “Our favorite attitude should be gratitude.” Following role call Dr. Epperly introduced new members to the IHC and moved that the group accept the new members. The motion to accept minutes from December’s meeting was held until February pending edits.

Report on ONC Conference – Casey Moyer and Burke Jensen, DHW

- ◆ Casey Moyer presented an update on the ONC conference. It was a meeting of western states to discuss how federal rules and policies are being interpreted and applied; it also offered technical assistance with transformation goals.
- ◆ Mr. Moyer spoke to the difficulties with healthcare technology and its importance to payment reform.
- ◆ A key focus of this convening was exploring how some states are successfully incorporating social determinates of health and what types of data elements they are using to help with their payment reform efforts. Idaho is in the process using high-tech funding to connect with Medicaid clinics.
- ◆ There is a mandatory ONC convening in Washington D.C. in February. There will be update of this meeting at the March IHC meeting.

Data Quality Improvement Process Update – Burke Jensen, DHW

- ◆ Buke Jensen presented the improvement process for data quality. The current analytic dashboard is reporting on 44 clinics across 11 organizations. There are six different EMR’s from which data is being collected.
- ◆ Mr. Jensen stated that there are still data gaps between episodic and longitudinal CCDs.

Mercer Update– Katie Falls, Mercer

- ◆ Katie Falls presented an update from Mercer. Ms. Falls stated that the Operational Plan has been submitted and is awaiting approval and the release of funds from CMMI.

- ◆ Ms. Falls stated that there is a sustainability plan to be submitted to CMMI that will consist of two deliverables: the first part is due at the end of April, the second is due at the end of July and is a road map on how to sustain the SHIP model.

Annual SHIP Payer Financial and Enrollment Metrics report –*Scott Banken, CPA Principal, Mercer*

- ◆ Scott Banken presented the Goal 6 Metric report. Goal 6 is to move away from Fee for Service (FFS) payments to value-based payments. This is an attempt to achieve a long-term, sustainable impact on healthcare in Idaho.
- ◆ The multi-payer approach includes payers’ needs to design and implement payment models that fit their organizations’ goals and that are most effective for their beneficiaries and providers. There are four categories of APM framework:
 - FFS-no link to quality and value
 - FFS-link to quality and value
 - Methodologies built on FFS architecture
 - Population-based payment
- ◆ Payments were still primarily FFS in 2015 and 2016. This shows that providers are hesitant to accept quality-based payments with risk due to lack of beneficiaries assigned to each provider.

IHDE Update – *Brad Erickson, Executive Director, IHDE*

- ◆ Brad Erickson presented an update from IHDE. As of December 31, 2017, the organizations with bidirectional connections include:
 - Cohort One: 37 of 55 SHIP clinics are connected.
 - Cohort Two: 32 of 56 SHIP clinics are connected.
 - Cohort Three: Work in progress to connect 53 clinics.
- ◆ Mr. Erickson stated the IHDE is focusing on stability, performance improvement, and platform flexibility. A 3-5-year strategic plan is underway with financial, sales/marketing, and technology being key areas.

Live Better Idaho Presentation/Demonstration – *Greg Kunz, Deputy Administrator and Robbie Jackson, Project Coordinator, Division of Welfare, Self-Reliance Programs*

- ◆ Greg Kunz gave an overview of the vision of the Live Better Idaho website. The primary vision of the site is to connect people with services in Idaho.
- ◆ Robbie Jackson demonstrated how any service can be found in just three clicks. Ms. Jackson spoke to how the site was designed to be action oriented and easily accessible.
- ◆ An average of 5,000 individuals access the site each month; Live Better Idaho’s goal is to grow that number.

Continue PCMH transformation – *Kym Schreiber, Project Manager, DHW, Ted Epperly, IHC Chair, Lisa Hettinger, IHC Co-Chair*

- ◆ Kym Schreiber presented the group with information about the PCMP sustainability workshop that will be taking place January 11 and 12, 2018. The workshop will be facilitated by Brilljent. The goal is to look at where the State of Idaho is in regard to healthcare transformation and the direction the state would like to go.
- ◆ The workshop will focus on the challenges and opportunities for PCMP and form a common understanding of sustainability and what it will look like once the SHIP grant has ended.
- ◆ Ms. Schreiber stated that a report will be developed to prioritize action items from the workshop; it will be brought back the IHC for review and further discussion.

Additional business and Next Steps, *Dr. Ted Epperly IHC Co-Chair*

- ◆ Casey Moyer informed the group that the meeting-sharing software will be changing from Juno to WebEx at the next meeting.
- ◆ There being no further business, the meeting was adjourned at 4:13 PM.



Aligning and Advancing

Integrated Behavioral Health

Across the State of Idaho

A Stakeholder's Report DECEMBER 2017





Emma Gilchrist, MPH
Lina Brou, MPH
Stephanie Kirchner, MSPH, RD
Stephanie Gold, MD
Jonathan Muther, PhD
Shale Wong, MD, MSPH

Eugene S. Farley, Jr. Health Policy Center
University of Colorado School of Medicine

December 2017



Acknowledgements

The authors gratefully acknowledge the Behavioral Health Integration Stakeholder Convening participants for their time and expertise, Gina Westcott and Katie Ayad for their support in planning the convening and sharing data, and the Robert Wood Johnson Foundation for their financial support through a grant to the Farley Health Policy Center.

Suggested citation

Gilchrist EC, Brou L, Kirchner SR, Gold SB, Muther J, Wong SL. *Aligning and Advancing Integrated Behavioral Health Across Idaho: A Stakeholder's Report*. December 2017.



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Background

Idaho is redesigning its healthcare system with a state innovation model grant from the Center for Medicare and Medicaid Innovation. The goals of Idaho's State Healthcare Innovation Plan (SHIP) are to improve Idahoans' health by strengthening primary and preventive care through the patient centered medical home (PCMH), and evolve from a fee-for-service, volume-based payment system of care to a value-based payment system that rewards improved health outcomes [1].

Whole person, patient-centered care requires meeting both physical and behavioral health needs. The separation of physical and behavioral health is costly and results in poorer health outcomes. With PCMH transformation efforts underway with SHIP and previously in the Medical Home Collaborative, there are opportunities to better integrate behavioral health.

The Farley Health Policy Center advances policy to integrate systems that address the wholeness of a person, their physical, behavioral and social health in the context of family, home, community and the healthcare system. The FHPC works with states to understand achievable policy actions to improve the integration of behavioral health across health and healthcare systems. With support from the Robert Wood Johnson Foundation, the FHPC partnered with the Idaho Department of Health and Welfare-Division of Behavioral Health to provide assistance to advance integration of behavioral health in Idaho. Through a series of conversations to better understand current efforts and needs, the FHPC and Division of Behavioral Health began planning for a stakeholder convening with the aim to align a statewide vision for integrated care and to identify action steps for moving forward collectively.

The Division of Behavioral Health organized the participant invitee list, starting with stakeholders from the Idaho Healthcare Coalition and the State Healthcare Innovation Plan (SHIP) Behavioral Health Integration Workgroup. To gather input from stakeholders and prepare for the convening, invited participants received an online survey to help develop the proposed vision, define current barriers and assets to integrating behavioral health, and values to guide effective integration. Respondents were also asked to review and provide additions to a list of stakeholders in Idaho working on integrating care. Survey responses were synthesized and presented in aggregate at the convening. Findings shaped the goals for the day and guided content for the discussions.

Data from Medicaid's fee-for-service claims database and from Optum's Idaho Behavioral Health Plan (fiscal year 2016) were analyzed to establish a baseline understanding of behavioral health services in Idaho and to inform the convening's discussion. Behavioral health diagnoses for analysis included mental health disorders and substance use disorders. See Appendix A for data analysis methods. These data were presented at the convening, providing a broad overview of the epidemiology of behavioral health among Idaho's Medicaid population to inform how integration efforts may be directed to those in need of behavioral health services.



The stakeholder convening was held on Thursday, November 9, 2017 in Boise, Idaho. The convening agenda and list of participants are found in Appendix B and C. In addition to the participant survey and behavioral health data, presentations included cost and clinical outcomes of integrated care and best practices for operationalizing integration. Breakout sessions focused on community and state strengths and gaps; prioritization of activities; and building relationships among participants for future work to advance behavioral health integration across Idaho.

This report describes the survey and claims data collected and analyzed, as well as the discussion and action items prioritized during the convening.

Vision and Values

The following vision statement and values were written and tailored to reflect the specific input collected from Idaho state leadership and convening participants:

Vision: All Idahoans are able to receive affordable and quality care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values:

- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services across the state, including rural and frontier areas.
- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Providers sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and providers should remain open to innovation and collaboration to best meet the needs of patients and families.

Behavioral Health Data

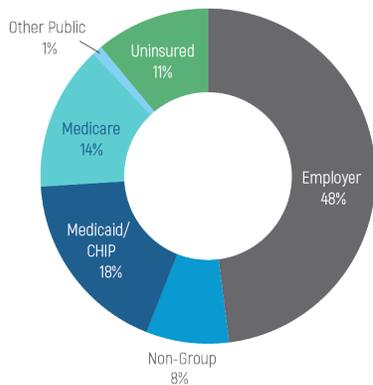
In 2015, more than 43 million Americans experienced a mental health issue, 20.8 million experienced a substance use disorder, and 8.1 million experienced both [2]. Within the healthcare delivery system in 2014, there were 65.9 million visits to physician offices and 5 million emergency department visits for patients with a primary diagnosis of a mental health disorder [4, 5]. Additionally, there has been a staggering increase in the age-adjusted rate of suicide, up 24% from 1999 to 2014 [3].



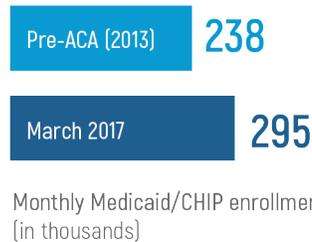
At the state level, 20% of Idahoans experienced a mental health issue which is slightly higher than the national prevalence of 18% [4]. With regard to substance use, 8.1% of Idaho’s adult population reported substance dependence or abuse, equivalent to the national prevalence in 2014-15 [4]. Over a third (37%) of adults in Idaho self-reported having poor mental health status. Thirty-three percent of Idaho’s overall population is low-income [5], a well-documented risk factor for behavioral health issues and a barrier for healthcare access.

Insurance coverage is an important marker of behavioral healthcare access. Figure 1 shows the distribution of health insurance coverage in Idaho for 2015; 48% of the population was covered by employer-based insurance, 18% Medicaid, 14% Medicare, 11% uninsured, 8% non-group, and 1% other public insurance. From 2013 to 2015, the uninsured rate for Idaho decreased from 15% to 11%, corresponding with the implementation of the Patient Protection and Affordable Care Act (ACA). Medicaid/CHIP enrollment also increased in Idaho since the implementation of the ACA.

In 2015, 18% of people in Idaho were covered by Medicaid/CHIP



Since implementation of the Affordable Care Act (ACA), Medicaid/CHIP enrollment has increased in Idaho



The uninsured rate in Idaho has decreased

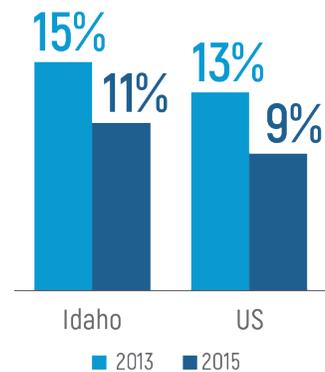


Figure 1. Health Insurance Trends in Idaho [5]

Medicaid’s Role in Behavioral Health

As the single largest payer in the United States for behavioral health services, including both mental health and substance use services, Medicaid plays a critical role in the integration of behavioral health. In 2009, Medicaid accounted for 26% of behavioral health spending in the United States [6].

While one in five Medicaid beneficiaries had behavioral health diagnoses, they accounted for almost half of total Medicaid expenditures in 2011, with more than \$131 billion spent on their total cost of care [6].

Medicaid – State of Behavioral Health in Idaho

In fiscal year 2016, 277,657 Idahoans were enrolled in Medicaid (22.1% of the total state population). Medicaid spending totaled \$2.1 billion in 2016, and 1 in 6 dollars spent overall in



the health system was in Medicaid. According to the Kaiser Family Foundation, 16% of the state general fund spending in Idaho is for Medicaid and 46% of all federal funds received by Idaho are for Medicaid. Almost all (93%) of Medicaid beneficiaries in Idaho are in primary care case management [5]. Behavioral health services are carved-out in a managed care plan managed by Optum, the Idaho Behavioral Health Plan. This plan does not include inpatient behavioral health services.

For FY 2016, within fee-for-service (FFS) claims, 108,185 (39%) Medicaid members had either primary or secondary behavioral health diagnoses. Among Medicaid managed care enrollees in the Idaho Behavioral Health Plan (IBHP), 49,970 (17%) had primary or secondary behavioral health diagnoses. With an average of 301,458 IBHP members with a Medicaid benefit, only 29,507 Medicaid members utilized IBHP behavioral health managed care services. This means fewer than 10% of IBHP members with a Medicaid benefit utilized behavioral health managed care services. Thus, there is a significant opportunity to address this discrepancy between need for behavioral health services and access to behavioral health care. Nearly eight percent (7.7%) of members with a primary or secondary behavioral health diagnosis in the FFS model were diagnosed with serious mental illness (SMI), defined as having bipolar disorder, schizophrenia, or other psychotic disorders; while for the managed care model, 16% of members were diagnosed with a SMI as either their primary or secondary diagnosis. The need for both physical and behavioral health services for those with diagnosed SMI requires acute attention to access and coordination of care.

Regarding expenditures, \$387 million was spent in FY16 on FFS members with behavioral health diagnoses, which accounts for 27.6% of total FFS costs. Figure 2 describes the services that make up the cost of claims for these Medicaid members. Nearly half are outpatient services (including 12.3% for home health; 6.4% for office-based; 8.2% for school-based; and 0.4% for emergency services); 19% to pharmacy; 12% each to residential and intermediate treatment; 9% to inpatient services; and 1% to other costs including medical equipment, labs, and radiology.

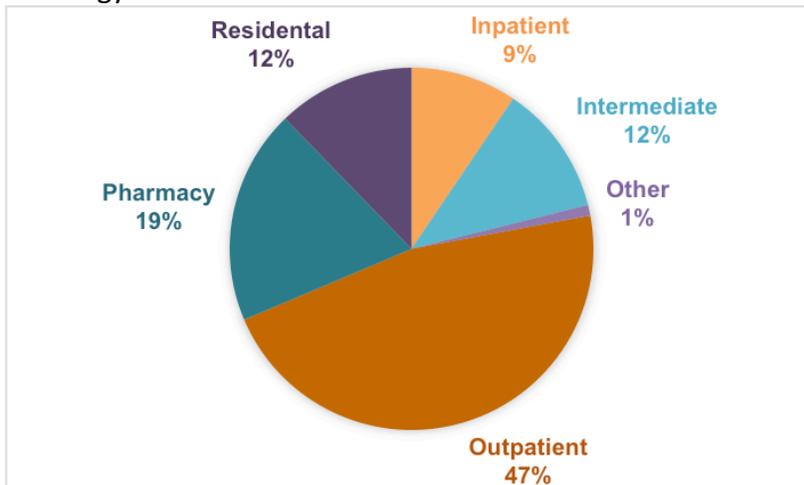


Figure 2. Sites of Service for FFS Behavioral Health Claims, FY16.



Figure 3 shows the annual cost per member by region and stratified by FFS and managed care organization (MCO) claims, and by severity of disease defined as SMI or non-SMI (MCO denotes the Idaho Behavioral Health Plan). Because the data used for this analysis comes from two different de-identified sources, the number of members that overlap between FFS and MCO data is unclear. This figure is intended to demonstrate cost variation by region and severity of illness rather than direct comparison between FFS and MCO data.

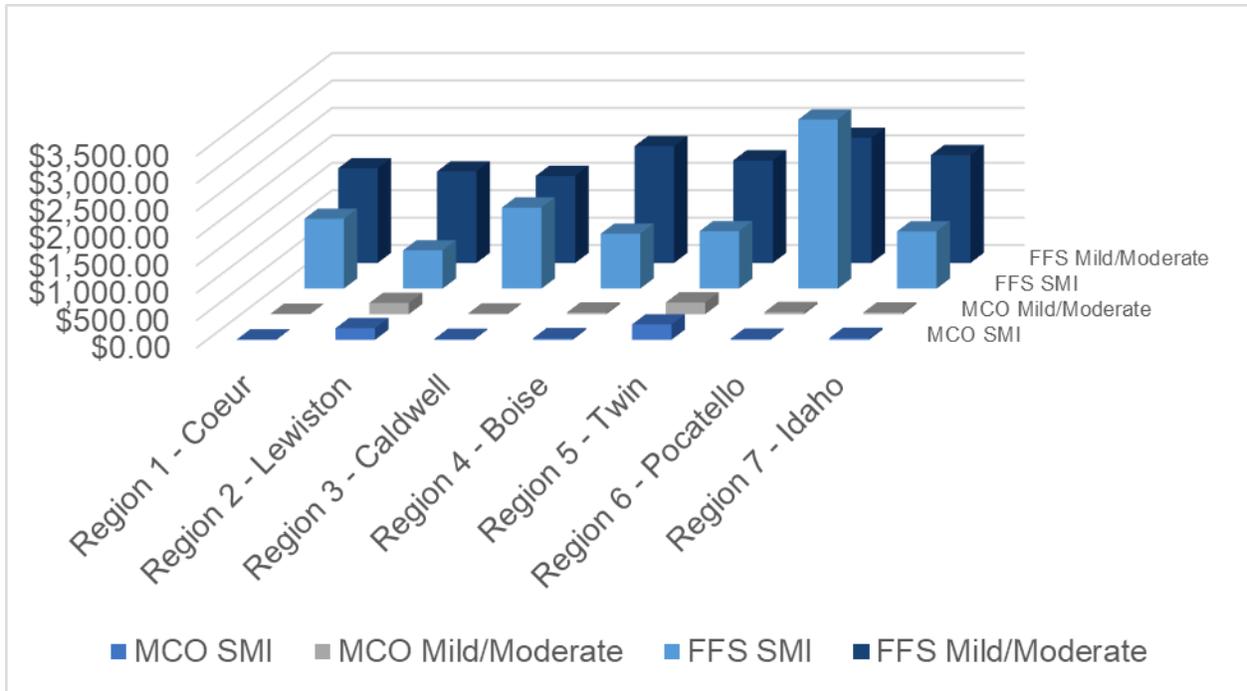


Figure 3. Annual Cost per Member by Region

Collating data from multiple, fragmented sources creates challenges for data management and analysis. Integration of systems to align data collection and measures is essential in addition to integration of payment and delivery systems.

For more detailed results of these analyses, refer to Appendix D for additional tables and figures. See the Tools and Resource section of this report for a link to an interactive, online map of behavioral health data in Idaho

Barriers and Assets to Integrating Behavioral Health

Efforts to better integrate care are happening across the nation and across Idaho. The transformation of care delivery to address both physical and behavioral health conditions is supported by a variety of assets and innovations in Idaho, while simultaneously hindered by existing barriers including fragmentation of payment models. The barriers and assets to



integrating behavioral health identified by convening participants are listed below, organized by domain.

Organizing the movement

Barriers: A driving force to hold this stakeholder convening was the identified challenge that although there are multiple entities in the state of Idaho focusing on increased access to behavioral health services, many are currently working in isolation, without a shared understanding of common goals or current work. Influential partners often do not know how to connect and align their efforts, resulting in redundancies and potentially missed opportunities, both at a community and policy level. This convening allowed for some of those communication gaps to be identified and acknowledged, with a commitment to improved collaboration moving forward.

Assets: Idaho's SHIP has provided tremendous opportunity to transform care, including behavioral health. SHIP has provided recognition of the importance of integrated behavioral health as well as the structure to advance transformation. Additionally, stakeholder engagement and commitment to meeting behavioral health needs through better integrated care is an asset. While there is an issue of efforts and organizations working in isolation in areas, there are also many great community partnerships across disciplines and public and private entities. A complete list of stakeholders identified through the online survey, at the convening, and by the Division of Behavioral Health can be found in Appendix E. Stakeholders include primary care and behavioral health providers and educators, healthcare systems, and agencies and organizations such as the Idaho Department of Health and Welfare and the Idaho Primary Care Association. Participants identified the fact that policy and decision makers are aware of the need to improve behavioral health care, and are poised for change, is an asset.

Workforce, education, and training

Barrier: There is widespread agreement both nationally and in Idaho that the current clinical workforce lacks sufficient diversity, appropriate geographic distribution, and opportunity for inter-professional education and development. There is an immediate need to create and support professional development programs to enable psychologists, social workers, counselors, nurses, physician assistants, physicians, and others to work in integrated settings with a clear understanding of roles and competencies. Stakeholders identified the shortage of behavioral health providers, low pay for primary care and behavioral health providers, and difficulty engaging with primary care providers as challenges to advancing integrated care.

Assets: Academic training programs, like the Family Medicine Residency of Idaho, Boise VA Medical Center primary care psychology postdoctoral program, Boise VA nurse practitioner residency program, and University of Washington-Boise internal medicine residency, provide exposure to and incorporate behavioral health into general medical settings. Local training programs help grow a workforce more likely to stay within the state and prepared to work in integrated settings. A new asset identified by stakeholders is the Idaho Integrated Behavioral Health Network, a newly developed learning collaborative designed to support the growth of



integrated behavioral health programs and to assist in team-based care management of co-morbid medical and behavioral health conditions in primary or specialty care clinics. The learning collaborative develops networking and clinical training opportunities for behavioral health providers and advocates for best practices of integrated care.[7]

Financing

Barriers: Both nationally and locally in Idaho, achieving integration is slowed by financial arrangements that separate out mental and physical health benefits, payments, and services. Fractured payment systems have made it difficult to build and sustain primary care practices with integrated behavioral health providers. There are ongoing efforts with payers in Idaho to better understand the value of behavioral health integration and institute changes in payment models to create an environment where primary care can financially sustain behavioral health services; however, this remains a significant challenge.

Within the current FFS model, there is a lack of sufficient billing codes to support integration. Though convening participants expressed optimism that new codes may become available as soon as 2018, currently participants believe that there are limited billing codes available to support behavioral health services in primary care.

Assets: Although financing was the top barrier identified by convening participants, a few innovations in payment support for integrated behavioral health were highlighted, including new, albeit limited, insurance payment for tele-psychology, Optum's support of newer integrated codes as mentioned above, development of Regional Care Organizations, and Medicaid Healthy Connections tiered payments which include behavioral health integration as an option qualifying for a higher payment tier.

Technology

Barriers: Even in places where technology can enable the exchange of behavioral health data, it is not being used to its full capacity. Extreme privacy practices around behavioral health are often driven by misunderstandings, inconsistent legal interpretations, lack of education of clinical and administrative staff, and conservative legal interpretations by provider organizations, all leading to the inability to coordinate and integrate care.[8] Again, Idaho mirrors these nationally identified challenges. Regulations related to data sharing about behavioral health services have been interpreted in multiple ways, and many providers expressed that they do not have clear guidance on how and with whom it is appropriate to share behavioral health notes, diagnoses, and treatment plans.

Assets: One of the main goals of the SHIP is to improve care coordination through the use of EHRs and health data connections among patient-centered medical homes (PCMHs) and across the medical neighborhood. The Idaho Health Data Exchange (IHDE) provides a platform for data sharing, and together with SHIP, has been connecting more practices across the state. While challenges with behavioral health data sharing remain, IHDE has been requested to provide educational support, and demystify and offer guidance for sharing data.



Care delivery

Barriers: Primary care practices are integrating behavioral health to help overcome barriers due to lack of access and the stigma of seeking and receiving behavioral health care. Some providers acknowledge feeling overwhelmed with the practice transformation necessary for team-based, integrated care. Practices identified the need for technical assistance and resources to help operationalize integrated care. Other challenges include needing support for referrals and transitions of care when integrating within a practice is not feasible.

Assets: There are many efforts across the state to integrate behavioral health into primary care. Stakeholders recognized the work of integration leaders: Family Medicine Residency of Idaho, Terry Reilly and other FQHCs, St. Luke's Health Partnerships, Saint Alphonsus, and Lifeways. Additionally, many endorsed that efforts through SHIP and earlier in the Medical Home Collaborative have spread the PCMH model, laying a foundation of advanced primary care with more capacity for integration. Other efforts to improve behavioral health in Idaho include the work of organizations in the non-profit community such as the Suicide Prevention Action Network of Idaho, Idaho Voices for Children, mental illness intensive care programs, mental health crisis centers, and peer support programs.

Population and community health

Barriers: Integrating behavioral health care is a strategy to meet behavioral health needs and support the health of broad and discrete populations. Coordinating systems for data collection around clear adult and pediatric behavioral health measures and having defined metrics and benchmarks for achieving improved and equitable care are challenges for all states, including Idaho. Disparities in access to care in frontier and rural areas, as well as the lack of Medicaid expansion and the resulting coverage gap were identified as significant barriers.

Assets: Stakeholders recognized the role of agencies and organizations in addressing behavioral health needs, convening stakeholders, and leading innovative partnerships to advance integrated behavioral health to improve population health. Among those highlighted, the Department of Health and Welfare Divisions of Behavioral Health, Medicaid, and Public Health, Regional Behavioral Health Boards, and the Public Health Districts were named. Additionally, a recent grant awarded to Idaho Voices for Children focuses on consumer advocacy for transformation as a strategy to develop and incorporate a permanent consumer voice and community home for health systems change.

Opportunities to Advance Integration

After indexing current barriers and assets, convening participants identified short term (3-6 months) opportunities to advance integrated care in Idaho. These opportunities were discussed in small groups and reported out to all participants. Each individual then voted on their top two priorities for action from the collated list of reported suggestions. The following synthesis highlights opportunities identified as priority action areas.



Organizing the movement

Having a shared language among all stakeholders is an important precursor for change. Currently, different stakeholders use different definitions and have different understandings of integrated care. Without a shared definition, creating unified strategies for payment reform, workforce, education, and care delivery to achieve and scale integrated care can be challenging.

- Create a shared definition for integrated behavioral health in Idaho. Leverage existing definitions (i.e., AHRQ Lexicon for Integrating Behavioral Health and Primary Care) and expand or adapt to reach consensus on a shared definition for Idaho's efforts to integrate care, including the role of integration in hospitals and primary care working in specialty mental health.
- Use SHIP efforts as a platform to disseminate educational materials to begin using a shared definition.

Achieving and advancing integrated care requires committed stakeholders to champion the cause. Convening participants demonstrated the dedication, passion, and expertise to advance the work of integrating care.

- Build collaboration with this stakeholder group and SHIP Behavioral Health Integration Workgroup to continue multi-stakeholder conversations and act on recommendations.
- Assess stakeholder engagement and recruit missing stakeholder groups to fill any gaps to ensure sufficient representation from primary care, patients and community members, universities, and training programs in addition to local and state public health and government agencies.

Workforce, education, and training

Efforts to train the existing workforce and educate the upcoming workforce are critical to Idaho's integrated care efforts.

Current workforce:

- Educate primary care providers on the value of integrated care and the scope of health conditions behavioral health providers can address, including mental health diagnoses, substance use disorders, and health behavior change.
- Provide assistance to primary care providers to understand the type of behavioral health provider needed to meet their patients' behavioral health needs. Encourage behavioral health providers to follow up with primary care providers on psychiatry referrals to assess whether appropriate for specialty mental health, or if the patients' needs could be met in the primary care office with an integrated behavioral health provider.
- Partner with Optum to train behavioral health providers to understand the broader healthcare continuum and role of integrated services.
- Build learning communities among providers to share best practices and tactics for overcoming challenges. Explore the mentorship program within SHIP and peer-to-peer mentoring with Idaho Integrated Behavioral Health Network as opportunities to grow learning communities.



- Conduct a workforce assessment to describe the current behavioral health workforce. Assess behavioral health needs to understand where workforce distributions (across regions and settings) may be needed as a means to better address the gap between identified behavioral needs and access to services.
- Assess where current integrated care providers are educated and trained to inform opportunities for recruitment and training the future workforce to provide integrated care.

Future workforce

- Within the WWAMI states (Washington, Wyoming, Alaska, Montana, and Idaho), advocate for PCMH training to include behavioral health.
- Support the state legislature's current consideration of increased funding for residencies and training sites for behavioral health professionals. Explore better reimbursement for trainees.
- Assess Idaho's medical and behavioral health training programs and advocate for tracks or education pathways to prepare an integrated care workforce. Learn about current efforts underway to include team-based care in accreditation standards and align support.
- Create partnerships with the VA Center of Excellence and leverage the innovations emerging from the training sites.

Financing

Financing is often identified as the biggest barrier to delivering integrated care. While efforts to fully reform the payment system to support integrated care delivery are needed to scale efforts, participants identified the following actions to achieve iterative, short-term success in financing integrated care.

- Provide opportunities for payer-led education for providers on available billing codes for integrated care, how to better utilize existing funding in the system, and current value-based payment models.
- Convene payers to align incentives and measures for integrated care.
- Inform payers of the business case for integrated care and assist practices in developing their specific case to present to payers.
- Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.

Technology

There is a need for information to be shared across provider types and settings to support integrated care. Although the infrastructure may exist to advance data sharing, efforts to improve understanding of what is allowable is needed.

- Partner with Idaho Health Data Exchange to educate providers on data sharing, including the state statute on psychotherapy versus progress notes.
- Assess how telehealth dollars are being spent and how resources can be maximized.



- Leverage Project ECHO as a platform to spread telehealth.
- Advocate for reimbursement of telehealth provided by non-prescribing behavioral health providers.

Care delivery

There are many practices and health systems across the state restructuring their care delivery to provide integrated care. Building on these innovative practices provides an opportunity to scale efforts.

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care, including on successful business models, how to use data, and competencies for integrated practices and providers.
- Educate providers to use data to understand and assess behavioral health needs within their patient population. If access to the necessary data is lacking, work with state agencies and payers to increase access to current data.
- Explore opportunities to leverage practice efforts to obtain PCMH recognition to focus on behavioral health.
- Develop care compacts between specialty mental health and primary care to establish shared understanding of roles for meeting behavioral health needs, referral standards, and plans for information exchange. Have regular meetings to facilitate collaboration and build a robust bi-directional referral system.

Population and community health

Integrating behavioral health and primary care increases access to behavioral health services at a population level. Additional efforts to integrate across other sectors (such as schools and the justice system), partner with community organizations, and incorporate the patient and community voice in planning can further meet behavioral health needs in the state.

- Educate patients and families to understand the benefits of integrated care.
- Explore opportunities to integrate behavioral health in other settings including schools, correctional facilities, and hospitals.
- Involve patients and families in stakeholder convenings and other planning efforts to advance integrated care.
- Partner with community organizations to understand and meet behavioral health needs. Leverage current opportunities, like Idaho Voices for Children's grant from the Robert Wood Johnson Foundation, to address gaps in behavioral health access and integrate care.



Next Steps

Of the short-term opportunities listed above, the following areas for actions emerged as the top priorities:



Organizing the movement

Create and use a shared definition of integrated care

- Create a shared definition of integrated behavioral health to be used across integration efforts in Idaho.



Workforce, education, and training

Train the current workforce and improve the pipeline for integrated care

- Educate primary care providers on the value of integrated care, the scope of health conditions behavioral health providers can address; and how to identify the type of behavioral health provider needed to meet their patients' behavioral health needs.
- Build learning communities among practices and providers to share best practices and tactics for overcoming challenges.
- Assess Idaho medical and behavioral health training programs and advocate for tracks and education pathway to prepare an integrated care workforce. Learn about current efforts underway to meet accreditations standards and align support.



Financing

Optimize payment for integrated services within the current system

- Provide opportunities for payer-led education for providers on current billable codes for integrated care, how to better utilize existing funding in the system, and understand payers' value-based payment.
- Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.



Care delivery

Support practice transformation with resources and expertise

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care.



Tools and Resources

Idaho Behavioral Health Mapping Tool

The Farley Center created an interactive mapping tool to better understand behavioral health in Idaho. The map compiles population health outcomes, behavioral health services utilization, and access data from the Divisions of Medicaid, Public Health and Behavioral Health within the Idaho Department of Health and Welfare. Users can map the variables that they would like to compare by region, including the location of providers and services, prevalence of diagnoses, population demographics, and behavioral health outcomes.

Idaho Mapping Tool: <https://arcg.is/KuXGi>

Eight Core Competencies for Behavioral Health Providers Working in Primary Care

This resource details competencies for onsite behavioral health providers as members of the primary care team in highly integrated practices. Make Health Whole is a communications platform dedicated to advancing whole-person, integrated health. Additional resources will be added to the site in 2018.

<https://makehealthwhole.org/>

The Integration Playbook

The Playbook is a guide to integrating behavioral health in primary care and other ambulatory care settings. The Playbook's implementation framework is meaningful to organizations at any stage of integration development and of any size. More resources on integrated behavioral health can be found on the AHRQ Academy Portal.

<https://integrationacademy.ahrq.gov/playbook/about-playbook>

Advancing Care Together by Integrating Behavioral Health and Primary Care

Journal of the American Board of Family Medicine – Supplement

This journal supplement draws lessons and evidence from 19 integrated behavioral health and primary care practices. The articles can be extracted according to a reader's particular interest, but taken together contribute to an emerging picture of complexity, challenge, success, and struggle during the journey to integrate primary care and behavioral health. They are about the "how" of integrated behavioral health and primary care.

http://www.jabfm.org/content/28/Supplement_1

From Our Practice to Yours: Key Messages from the Journey to Integrated Behavioral Health

Innovators integrating behavioral health and primary care share key messages and insight from their practical experiences for use by other practice leaders to accelerate their practice transformation to integrated care.

<http://www.jabfm.org/content/30/1/25.full>

Outcomes of Integrated Behavioral Health with Primary Care

This article presents quantitative and qualitative data from patients with depression receiving care in integrated primary care practices.

<http://www.jabfm.org/content/30/2/130.full>



Creating a Culture of Whole Health

This report provides actionable recommendations to begin to scale and spread the integration of behavioral health from more than 70 key informants, focus group participants, and a working meeting of national leaders.

<http://farleyhealthpolicycenter.org/cultureofwholehealth/>



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Appendix A. Behavioral Health Data Analysis Methods

The Farley Health Policy Center received data from three divisions within the Idaho Department of Health and Welfare: the Division of Medicaid, Division of Public Health, and the Division of Behavioral Health. The following is a list of specific data sources from each department:

- Division of Medicaid
 - Idaho Medicaid FFS claims data, FY16
 - Optum’s Idaho Behavioral Health Plan managed care encounter data, FY16
- Division of Public Health
 - Idaho Vital Statistics, Bureau of Vital Records and Health Statistics
 - Birth and Mortality Rates, 2015
 - Pregnancy Risk Assessment Tracking System, 2015
 - Idaho Behavioral Risk Factor Surveillance System 2013, 2015
- Division of Behavioral Health
 - Geographic Data on
 - State Mental Health Hospitals
 - State-Funded Behavioral Health Facilities

For the FFS claims and Idaho Behavioral Health Plan encounter data analyses, the diagnoses, prescription classes and place of service codes used are defined using standard classification methods. The Agency for Healthcare Quality’s Healthcare Cost and Utilization Project Clinical Classifications Software (CCS) was used to categorize diagnostic codes from primary or secondary diagnosis listed on the Medicaid claim [9]. The following CCS codes were used to classify behavioral health diagnoses:

HCUP CCS Categories	
'650'	Adjustment disorders
'651'	Anxiety disorders
'652'	Attention-deficit conduct and disruptive behavior disorders
'653'	Delirium dementia and amnesic and other cognitive disorders
'654'	Developmental disorders
'655'	Disorders usually diagnosed in infancy childhood or adolescence
'656'	Impulse control disorders NEC
'657'	Mood disorders
'658'	Personality disorders
'659'	Schizophrenia and other psychotic disorders
'660'	Alcohol-related disorders
'661'	Substance-related disorders
'662'	Suicide and intentional self-inflicted injury
'663'	Screening and history of mental health and substance abuse codes
'670'	Miscellaneous mental health disorders



Prescriptions for Behavioral Health conditions were classified using First Databank's Hierarchical Specific Therapeutic Class Code (HIC-3), which is a component of the National Drug Data File [10]. The treatment setting for claims are classified using the Centers for Medicare and Medicaid's Place of Service Codes for Professional Claims [11].

For the data from the Division of Medicaid, unique member counts were calculated from encounter and claims data and aggregated by Idaho Public Health Districts [12] prior to receipt by FHPC. Descriptive analyses were conducted to describe Medicaid members or the number of services. Fee-for-service claims and Optum's managed care organization (MCO) encounter data were analyzed separately. Because Medicaid beneficiaries can be enrolled in both the fee-for-service and Optum's Idaho Behavioral Health Plan, aggregate-level data cannot differentiate whether an individual was counted in both models; therefore, descriptive statistics are not directly comparable.

While Medicaid utilization and cost data are vital components to understanding behavioral health services, particularly in rural areas where Medicaid is the only payer for behavioral health, our analyses are limited in understanding of trends and distribution of behavioral health in the non-Medicaid population. Although some information can be extrapolated to generalize trends, additional payer data and integrated data collection would provide a more comprehensive picture.

For the Division of Public Health data, descriptive statistics were calculated and aggregated to the Public Health Districts. Geographic data from the Division of Behavioral Health was collected, geocoded and mapped into ArcGIS® software by Esri (Copyright © Esri [13]). These data were used to create the mapping tool for Idaho Behavioral Health data.



Appendix B. Idaho Behavioral Health Stakeholder Convening Agenda



Behavioral Health Integration Stakeholder Convening

Thursday, November 9 | 9:30am-2:30pm | Boise, ID

Convening purpose:

To define a common vision for behavioral health integration in Idaho

Desired outcomes:

- Shared understanding of current practices, efforts and initiatives across the state to integrate behavioral health
- Stakeholder input on the values and priorities that shape an integrated behavioral health system
- Established agreement and variation of the assets and barriers to integrating behavioral health
- Stronger relationships between stakeholders working on these issues across the state
- Delineated next steps that bring stakeholders together

Vision, developed from survey responses:

All Idahoans may seek and receive affordable care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values, identified from survey responses:

- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services.
- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Clinicians sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and clinicians should remain open to innovation and collaboration to best meet the needs of patients and families.

Agenda:

9:30am	Welcome and introductions	Gina Westcott
9:45am	What we've learned: Survey results and behavioral health data	Shale Wong, MD, MSPH Lina Brou, MPH
10:45am	Break	
11am	Breakout session: Strengths, gaps, and building relationships	
12pm	Networking lunch	
1pm	Operationalizing integration	Jonathan Muther, PhD Stephanie Kirchner, MSPH, RD
2pm	Integrating together	Shale Wong, MD, MSPH



Appendix C. Stakeholder Convening Participants

Name	Title	Agency
Dr. Rhonda Robinson Beale	SVP-Medical Director	Blue Cross
Sarah Woodley	CEO	Business Psychology Associates
Orla Kennedy	Administrator	Community Catalyst
Jeff Crouch	Regional Director	DHW
Gina Westcott	Hub Administrator	DHW-Behavioral Health
Ross Edmunds	Administrator	DHW-Behavioral Health
Cindy Brock	ACC-Healthy Connections	DHW-Medicaid
David Welsh	Contract Monitor	DHW-Medicaid
Heather Clark	Quality Improvement Specialist	DHW-Medicaid
Mat Wimmer	Administrator	DHW-Medicaid
Burke Jensen	Contract Monitor	DHW-Office of Health Policy
Cynthia York	Administrator	DHW-Office of Health Policy
Kym Schreiber	Contract Manager	DHW-Office of Health Policy
Elke Shaw-Tulloch	Administrator	DHW-Public Health
Dr. John Tanner	Family Advocate	Family Advocate
Dr. Martha Tanner	Family Advocate	Family Advocate
Tori Torgrimson	BH Programs Manager	Family Health Services
Dr. Winslow Gerrish	Chief Psychologist	Family Medicine Residency of Idaho
Dr. Lynn McArthur	Clinical Psychologist	Health West
Lina Brou, MPH	Lead Policy Analyst	Farley Health Policy Center
Emma Gilchrist, MPH	Deputy Director	Farley Health Policy Center
Stephanie Gold, MD	Assistant Professor	Farley Health Policy Center
Stephanie Kirchner, MSPH, RD	Practice Transformation Prgm Manager	Farley Health Policy Center
Jonathan Muther, PhD	Clinical Integration Advisor	Farley Health Policy Center
Shale Wong, MD,MSPH	Director	Farley Health Policy Center
Neva Santos	Executive Director	Idaho Academy of Physicians
Christine Tiddens	Policy Director	Idaho Asset Building Network
Marilyn Sword	Advocate	Idaho Caregiver Alliance
Toni Lawson	Administrator	Idaho Hospital Association
Nicole Pearson	Program Manager	Idaho Primary Care Association
Susan Ault	Director of Care Improvement	Idaho Primary Care Association
Ceci Thunes	Health Policy Specialist	Jannus-Idaho Voices for Children
Claudia Meiwald	Hospital Administrator	Kootnei Behavioral Health
Dennis Baughman	Clinical Director	Lifeways
Ray Millar	COO	Lifeways
Janice Fulkerson	Director of Contracting	Northpoint Recovery
Jennifer Freeman	CFO	Northpoint Recovery
Dr. Tom Young	CEO	Nview Health
Bevin Modrak	Clinical Program Manager	Optum Idaho
Dr. Ronald Larson	Medical Director	Optum Idaho
Georganne Benjamin	Executive Director	Optum Idaho



Jann Stockwell	Sr. Communications Specialist	Optum Idaho
Sara Bartles	Client Relations/Compliance Dir.	Optum Idaho
Sunny Reed	Behavioral Health Case Manager	Pacific Source
Marty Cappe	SHIP PHD3 Support	PHD 3
Rachel Blanton	SHIP Manager	Public Health District 3
Melissa Dilley	PHD 4 SHIP Manager	Public Health District 4
Linda Rowe	Idaho State Director	Qualis Health
Jennifer Yturriondobeitia	BH Programs Manager	St. Lukes Health Partners
Melissa Mezo	Clinical Director	Terry Reilly Health Services
India King	Associate Director	Veterans Administration



Appendix D. Additional Behavioral Health Data Results

In the fee-for-service data, 42% of FFS members had pharmacy claims for BH medications. 19.1% of all pharmacy expenditures go to BH prescriptions, which totals \$74.3 million. The following figure describes the distribution of behavioral health prescriptions:

Figure A2. Distribution of BH prescriptions for FFS members

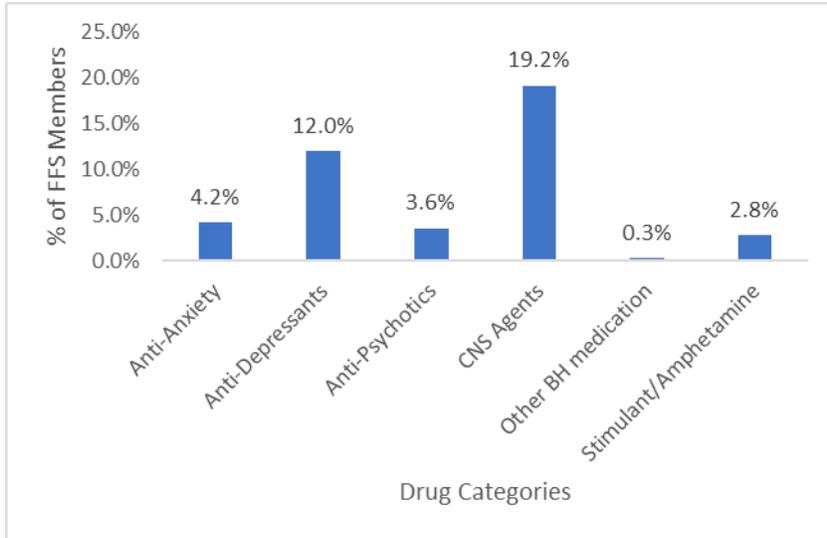
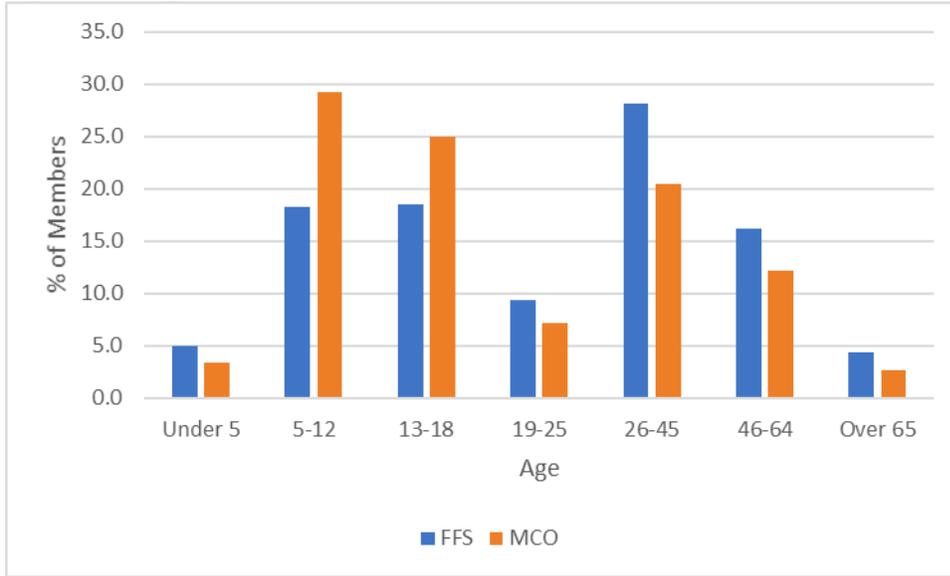


Figure A3 shows the age distribution of the 49,970 members who were enrolled in the Optum Idaho Behavioral Health Plan (MCO) and 108,185 members within FFS in FY16. This figure shows that the MCO members who receive outpatient services under the Idaho Behavioral Health Plan tend to be less than 18 years of age. Given that MCO members may also receive inpatient and pharmacy services within the FFS delivery model, the difference in distributions should be interpreted with caution.

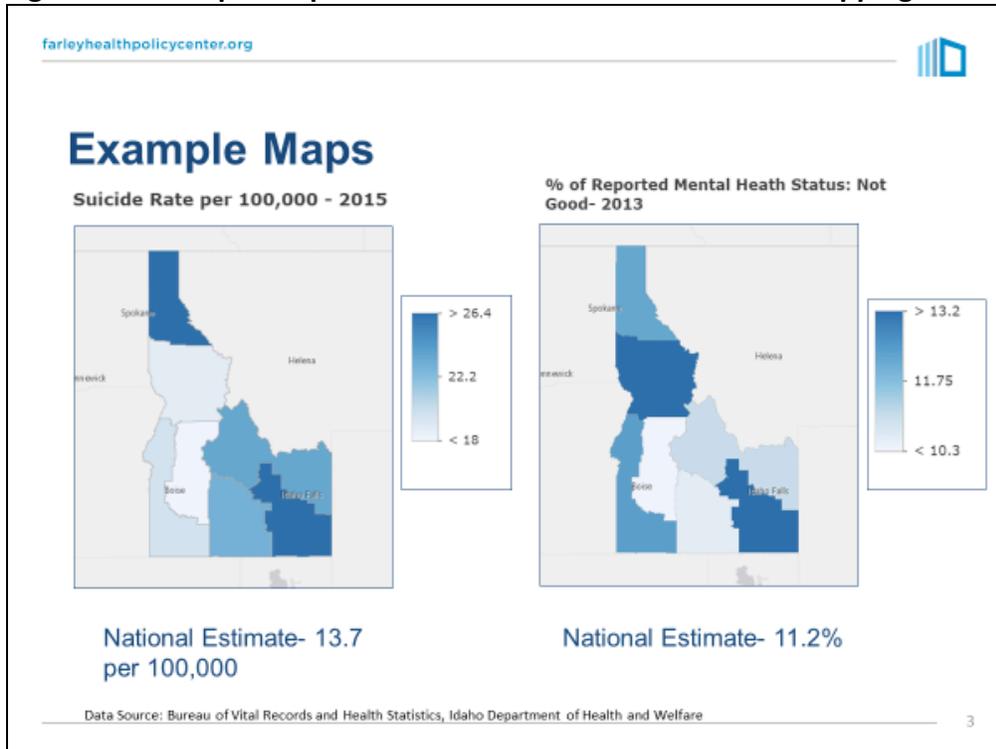


Figure A3. Age Distribution of FFS and Idaho Behavioral Health Plan Members



See the Tools and Resources section for information on an interactive mapping tool that compiles data from three divisions within the Idaho Department of Health and Welfare. Figure A4 displays example maps using the data collected from the Division of Public Health.

Figure A4. Example Maps from the Idaho Behavioral Health Mapping Tool





Appendix E. Behavioral Health Integration Stakeholders

A list of behavioral health integration stakeholders identified by convening participants:

Blue Cross of Idaho
Boise State University
BPA Health
Business Psychology Associates (now known as BPA)
CASA
Clearwater Medical Lewiston
Consortium for Idahoans with Disabilities
Dept of Health and Welfare-Behavioral Health
Dept of Health and Welfare-Medicaid
Dept of Health and Welfare-Office of Health Policy
Dept of Health and Welfare-Office of Suicide Prevention
Dept of Health and Welfare-Public Health
El Centro de Comunidad y Justicia
Empower Idaho
Family Health Services in Twin Falls
Family Medicine Residency of Idaho
Farley Health Policy Center
Head Start
Health Management Associates
Health West Pocatello
Heritage Health
Human Supports of Idaho
Idaho Academy of Family Physicians
Idaho Academy of Physicians
Idaho Association of Counties
Idaho Commission on Aging
Idaho Federation of Families for Children's Mental Health
Idaho Healthcare Coalition
Idaho Hospital Association
Idaho Integrated Behavioral Health Network
Idaho Primary Care Association
Idaho Psychological Association
Idaho Voices for Children
Journey Mental Health
Kootenai Health Network
Kootenai Residency
Kootenai Behavioral Health
Lifeways
Nampa Schools



National Alliance on Mental Illness - Upper Valley Idaho
Northpoint Recovery
Northwest Telehealth Resource Center
Optum Idaho
Pacific Source
Pioneer/Pathways
Public Health Districts
Public Health Executive Directors
Regence
Regional Behavioral Health Boards
Regional Health Collaboratives
SAGE Health Care
Saint Alphonsus Behavioral Health
Shoshone Medical Clinic / Shone Family Medical Center
Suicide Prevention Action Network of Idaho
St. Luke's Health Partners / St. Luke's Health Systems
Terry Reilly Health Services
University of Idaho
Valley Family Health Care (FQHCs)
Valley Medical Lewiston
Veteran's Administration / VA Medical Center
Warm Springs Counseling
Women's and Children's Alliance in Boise

IHDE Update

Idaho Healthcare Coalition Meeting

February 14, 2018

Brad Erickson, Executive Director



1

Highlights, Focus and Activities

Highlights:

- ✓ Built ~ 180 Clinic Connections; 32 Key Deliverables Completed
- ✓ Strong Financials \$4M Revenue, >\$600K Net Income, ~\$800K cash
- ✓ Strong team in place; continuing to build

SHIP & Healthy
Connections
Support

Operations and
Technology
Infrastructure

Customer
Engagement

Build a High
Performing
Team

Strategic and
Sustainability
Planning



2

SHIP and Healthy Connections Support

Bi-Directional Connections:

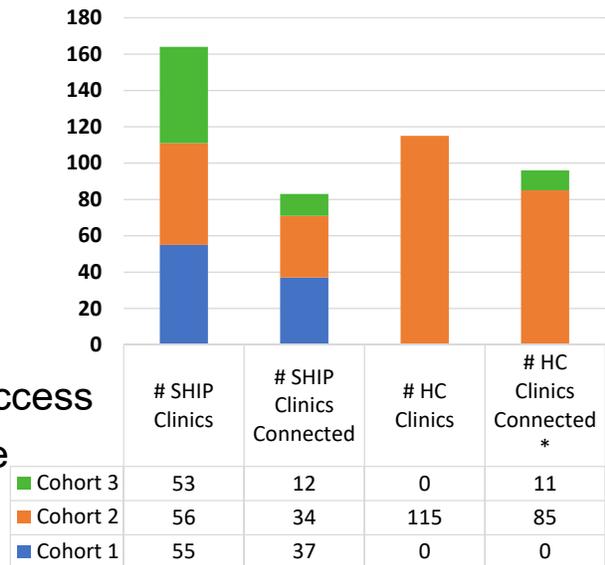
- Cohort 1: 37 of 55 thus far
- Cohort 2: 34 of 56
- Cohort 3: 12 of 53
- Healthy Connections: 96
- ❖ 20 Organizations on Hold

Other SHIP Support:

- EMR Vendor Negotiation Success
- All 32 Key Deliverables Done
- Data Quality Improvement
 - Data reporting accuracy
 - Data analyst support



SHIP Cohort Information 1/31/18



*Count specific to Cohort

Operations and Infrastructure

Current Platform

- System down 9/20 4:30PM – 9/26 2:00AM) ~5.5 days, 123 hrs
- System now stabilized, performance level on target
- Over \$350K of financial remedies negotiated with vendor (Orion) vs. contracted remedies due of ~\$20K

Platform Upgrade

- Planning and configuration in progress
- Improved stability, data access, analytics tools
- Lower cost, more control over build process
- Target go-live June 2019

Other Operations Items

- Security & Privacy Risk Assessment ~ March 2018
- Customer Service ticketing system (Zoho) live 1/15

Customer Engagement - Survey Results

- Online survey (11/13-11/27/17), Interviews with 12 of respondents
- Population: 4,600+ users contacted; 310 qualified responses (7%)

Overall Satisfaction

- 69% = “Mostly” (51%) + “Completely” (18%)
- 85% Satisfied or Higher

Performance

- 90% IHDE provides answers in a timely manner
- 51% impacted by IHDE downtime, but still high scores

Access

- 90% access IHDE directly via portal
- 39% access IHDE >2 times per day
- 23% access IHDE >2 times/week

Customer Engagement & Sales & Marketing

Customer Engagement

- ✓ 30 of 30 Clinics visits completed
- ✓ 10 of 10 Hospital visits completed
- ✓ 14 prospective customer visits
- ✓ Two “quick” handouts created for clinic visits

Key SHIP Deliverables Completed

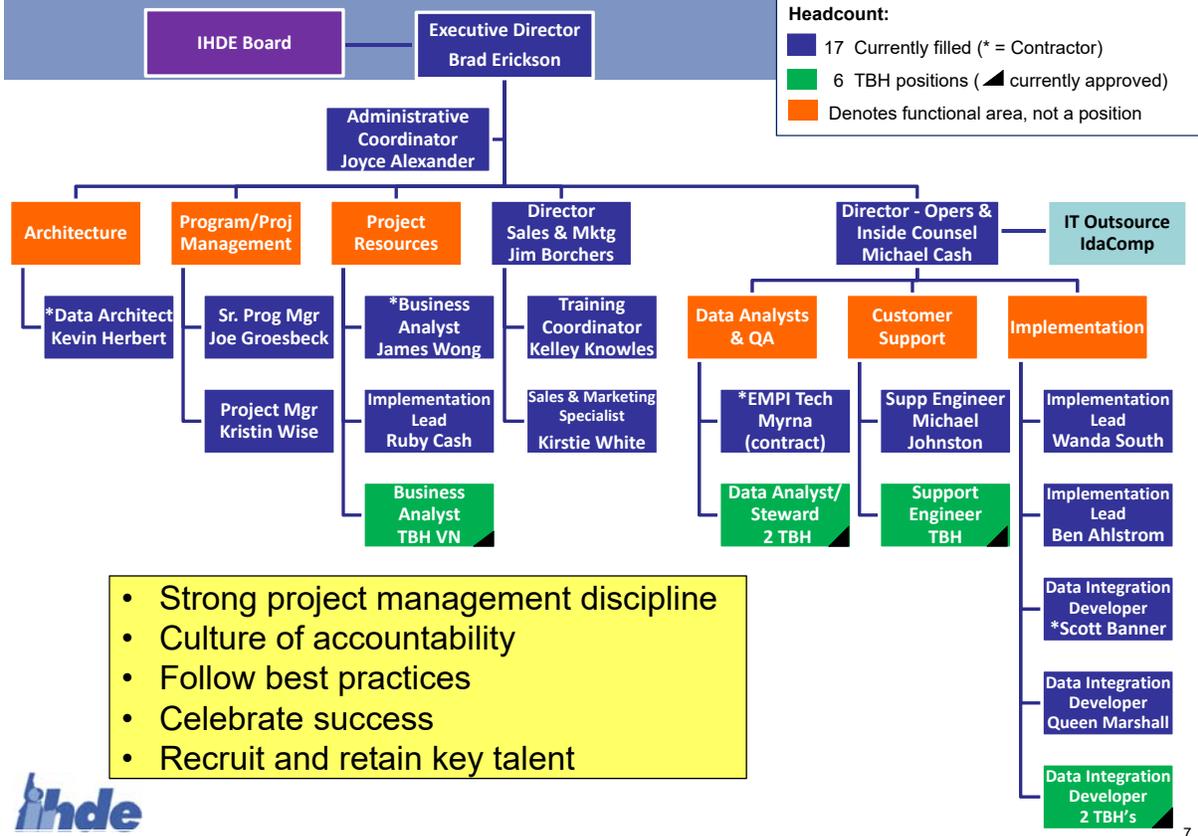
- ✓ Hospital Engagement Plan
- ✓ Participant Licensing Plan
- ✓ Tech Platform Communications Plan
- ✓ IDHW VN Access/Licensing Plan (submitted)

Driving Better Capabilities

- ✓ Training Coordinator hired
- ✓ Neighboring HIE's and National and Western Region HIE engagement

Building a High Performing team

rev: 2/1/18



- Strong project management discipline
- Culture of accountability
- Follow best practices
- Celebrate success
- Recruit and retain key talent



Planning for the Future – Strategic Plan & Sustainability



Next Steps and Addressing Challenges

- Complete SHIP Cohort builds; Healthy Connections builds
- Capitalize on new sales opportunities
- Complete Strategic and Long-term Sustainability Plan
- Finalize 2018 Success Metrics with Board
- Continue to drive platform upgrade
- Continue customer engagement activities/visits – drive understanding of value proposition and use cases
- Continue to build relationships with partners
- Continue to build high performing team (recruit key positions)
- Continue to drive lower cost model - lessen reliance on contractors over time



SHIP COHORT 2 CLINICS – UPDATE BY PCMH TRANSFORMATION TEAM

Of the 55 clinics in Cohort 2:

- 27 are PCMH recognized
 - 9 already recognized coming into the cohort
 - 18 achieved recognition during the cohort year
- 28 clinics will continue to work towards PCMH transformation with the support of PHD SHIP QI Staff, following a transformation roadmap developed by the PCMH Coach and PHD SHIP QI Staff

1



PCMH
TRANSFORMATION TEAM

SHIP COHORT 2 CLINICS – UPDATE *(continued)*

Successes and lessons learned:

- Continued to grow successful working relationships between the PCMH coaches, the PHD QI SHIP Staff and SHIP managers; in addition to the growth in confidence and competency of the PHD QI staff
- PHD SHIP QI staff worked with sites to develop an agenda in preparation for each coaching call
- Sites used the PCMH trackers and regularly shared updates with PHD SHIP QI staff and PCMH coaches
- Much more focused on the gap assessment for 2017 standards, setting up good action plans for structures and processes needed for 2017 work; still need to focus on change management
- Clinic teams were better organized with PCMH planning teams, used white boards in their meeting rooms, and had PCMH transformation or action plan on the board

2



PCMH
TRANSFORMATION TEAM

SHIP COHORT 2 CLINICS – UPDATE *(continued)*

Mentorship:

- Much more involvement with clinic teams as teachers, mentors, and sharing best practices
 - June Learning Collaborate featured Cohort 1 and 2 sites presenting; Coeur D’Alene Pediatrics and St. Mary’s
 - Mentorship program launched and successfully involved Cohort 1 and 2 teams as mentors on various topics
 - Community Health Workers – Genesis, St. Mary’s
 - Behavioral Health (BH) Integration – Health West, Family Health Services, St. Luke’s, Shoshone
 - Care Management Strategies and Care Plans – St. Mary’s, Clearwater Valley, Terry Reilly
 - Strategies for Creating a Culture of PCMH – Family Health Center and Kaniksu

3



PCMH
TRANSFORMATION TEAM

SHIP COHORT 2 CLINICS – UPDATE *(continued)*

PCMH Coaching Evaluation:

- Good response from Cohort 2 clinics to coaching evaluation
- Questions on trust, expertise, and PCMH knowledge of the coaches were 100% positive response
- Typical topic areas discussed that were most helpful were across the PCMH standard topics - team based care, care management, BH integration, efficiencies and access, etc.
- Recommendations for improvement
 - Working with same coach in the district gave consistency, understanding and good working relationships for the PHD QI staff and the coach
 - Having site visit earlier and coaching calls after that site visit
 - Collect clinic profile before coaching starts to give more background to the coach
- Most valuable interaction
 - Site visits was highest - face to face interactions build trusting relationships, but also coaching calls and learning collaborative were mentioned

4



PCMH
TRANSFORMATION TEAM

SHIP COHORT 3 CLINICS PCMH TRANSFORMATION , TRAINING & TECHNICAL ASSISTANCE

Goals:

1. Build knowledge and action plans for the 6 standards of the NCQA PCMH program as a means to reach PCMH transformation through approved NCQA recognition or other certification programs
2. For clinics just starting the process, the team will focus on the “must pass elements” and “critical factors” for recognition
3. For clinics that have already reached PCMH recognition, the team will focus on enhancing those clinics/practices for best practices

5



PCMH
TRANSFORMATION
TEAM

SHIP COHORT 3 CLINICS PCMH TRANSFORMATION , TRAINING & TECHNICAL ASSISTANCE *(continued)*

Plan:

- Kick Off Webinar with SHIP on 2/1 – Getting Clinics started
- PCMH self-assessment and introduction to PCMH coaches and PHD SHIP QI Staff
- Transformation Plans – goals and actions
- Six coaching sessions - begin in March
- Site visits – conducted in April and May
- Six content-specific webinars
 - Webinar #1 Session on 2/21 – 2017 NCQA PCMH Redesign
- Learning Collaborative – 6/27 & 6/28
- Document progress towards PCMH transformation in redesigned PCMH Transformation Portal
- PCMH coaches and PHD QI staff continue to work together on this overall plan
- Five mentorship webinars for clinics from Cohorts 1, 2, and 3

6



PCMH
TRANSFORMATION
TEAM

Patient Centered Medical Home Sustainability Workshop

January 11-12, 2018

Mary Ann Herny
Kymberlee Schreiber



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PCMH
TRANSFORMATION TEAM

Workshop Goals

- Assess where we are and where we want to be
- Identify key challenges and opportunities
- Define “sustainability”
- Select key areas of focus for 2018



Participant Attendees

Participant	Organization
Laura Arjona	Blue Cross of Idaho
Jeff Crouch	IDHW
Dr. Keith Davis	Shoshone Family Medical Center
Dr. Allen Dobson	Community Care of North Carolina
Dr. Ted Epperly	Family Medicine Residency of Idaho
Katie Falls	Mercer
Meg Hall	IDHW – Medicaid Healthy Connections
Jayne Josephsen	Boise State University
Charity Kennedy	PacificSource
Ashley Knight	PacificSource
Janet Reis	Boise State University
Linda Rowe	Qualis Health
Madeline Russell	IDHW-SHIP
Dr. John Schott	St Luke’s Health Partners
Kymerlee Schreiber	IDHW – SHIP
Dr. Jeanene Smith	Health Management Associates
Ann Watkins	IDHW – SHIP
Dr. Karl Watts	Saint Alphonsus Medical Group
Cynthia York	IDHW – SHIP
Nikole Zogg	Southwest District Health

Observers
Jimmy Hague, Boise State Univ.
Burke Jensen, IDHW - SHIP
Janice Lung, University of Idaho
Casey Moyer, IDHW - SHIP
Joey Vasquez, IDHW - Medicaid
Shenghan Xu, University of Idaho
Julie Wall, IDHW - Medicaid

Facilitation Support
Nick Blake, Brilljent
Grace Chandler, Brilljent
Lisa Gouin, eHealthcare Consulting
Mary Ann Herny, Brijent
Dawn Juker, University of Idaho
Chelsea Stevenson, Univ. of Idaho
Molly Volk, University of Idaho

Opening Remarks and a Challenge

Dr. Ted Epperly

- In five years, Idaho's PCMH initiative has gone from infancy to adolescence to adulthood. This energy and enthusiasm is key to continuing transformation.
- We need to get it right on three levels: at the state policy level, at the regional and community levels, and at the practice level (which is team-based and patient-centered) to create a platform for a truly integrated healthcare system.
- Dr. Epperly challenged the group to think about going beyond simple maintenance as they considered sustainability.



Our Approach



Where Are We?

- The SHIP program goal was to transform 165 clinics to Patient Centered Medical Homes, and there are now 163 clinics currently participating.
- As of 1/11/2018 there are approximately 81 recognized PCMH clinics in the State of Idaho.
- Approximately 70 clinics are bi-directionally connected to IHDE.
- Partnerships and collaborations have been developed which will be useful over the long term in promoting sustainability.
- Key concerns were focused on funding and resource availability beyond the SHIP grant.

Trends and Themes

- 
- Consistency
 - Interoperability/compatibility
 - Continuity of the current infrastructure for practice support
 - Development of the business model

Challenges and Opportunities

Ranked Scores

Ranked on the basis of:

- Benefit to patients
- Benefits to providers
- Impact on sustainability
- Complexity of implementation

Score	Challenge/Opportunity
152	Address training and education/communication
151	Identify stakeholders and align goals and direction
143	Capitalize on existing work in value-based reimbursement
141	Build on current SHIP infrastructure
138	Share data to make better decisions
133	Integrate medical health neighborhoods
130	Procure data to document change in patient health and costs of care
128	Adequate resources to make access to data available real-time across all stakeholders
128	Address funding challenges
127	Use and build on existing SHIP business model
126	Develop shared metrics and reporting
123	Statewide connections to information/HIE
115	Create policy that supports collective direction and state requirements
79	Address varying EMR platforms
73	Address competitive market driving variability

Definition of Sustainability

Sustainability

Sustainability is continuously advancing a transformation model in the healthcare system in Idaho that provides high value care to improve population health delivered in a coordinated fashion close to patients' homes.

Strategic Intent Statement



Idaho aims to double the number of PCMH recognized practices by January 2024 by partnering with payers and other stakeholders in expanding value-based reimbursement supported through state leadership and broadening resources at the regional level.

Summary of the Group's Decisions

Idaho aims to double the number of PCMH recognized practices* by January 2024 by partnering with payers and other stakeholders in expanding value-based reimbursement supported through state leadership and broadening resources at the regional level.

To accomplish this, we will identify key stakeholders and work with them to:

1. Build on the current SHIP infrastructure and business model

2. Build on our work in value-based reimbursement

3. Build alignment in direction, goals, metrics and policy

4. Build our ability to educate and communicate with practices and consumers

** As of 1/11/2018, the time at which the intent statement was developed, there were approximately 81 recognized PCMH practices in the State of Idaho.*

What's Next

- Initiative ideas and plans will be reviewed by IDHW leadership and SHIP Operations
- The recommendations will be brought to the IHC for evaluation and the IHC may delegate further review of a recommendation by a particular workgroup.
- IDHW and/or SHIP may also determine to move forward with any recommendation based on its feasibility, required resources, and implementation timeline.

Thank You!



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PCMH
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SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition February 14, 2018

SHIP OPERATIONS:

SHIP Contracting/Request for Proposal (RFP) Status:

- **Report Items:**
 - CMMI requests for release of funds were approved for: 1) Goal 1 Sustainability Workshop Stakeholder Travel and 2) ONC SIM State Convening SHIP Staff and Stakeholder Travel
 - The non-competing continuation application for Award Year Four Budget was approved on 1/31/2018. The following documents were submitted as part of the non-competing continuation application: 424, 424A, 424B 424LL, 425 FFR, AY4 Project Abstract, AY3 Q3 Progress Report, AY4 Operational Plan, AY4 Budget Narrative and accompanying supplemental details; AY4 Budget Spreadsheet and requests for release of funds for: 1) PCMH TA contractor, PHDs 1-7sub-grants, ISU CHW sub-grant, U of I Project Echo contract, HMA telehealth TA contract, HTS contract, Viann Electronics contract, U of I State Evaluator contract and Mercer project management and financial analysis contract.

SHIP Administrative Reporting:

- **Report Items:**
 - Three Virtual PCMH applications were approved for processing in Award Year 4. A subsequent recruitment will take place during the summer.
 - Cohort Three PCMH kick off webinar took place on February 1, 2018.
 - The Goal 1 Sustainability Workshop was held on January 11 -12th, 2018.

Regional Collaboratives (RC):

- **Report Items:**
 - **District 1:** No RC membership meeting was held in December 2017. On 11/9/17 SHIP Manager met with RC Chair regarding the strategic plan. 11/19/17 SHIP Manager met with RC Chair regarding the strategic plan.
 - **District 2:** 12/19/2017: RC2 Meeting, Agenda had updates to the group on newly selected cohort 3 clinics and what can be expected in the last year of the SHIP grant.
 - **District 3:** RC meeting (12/5): bimonthly meeting; Oral health workgroup (12/7): discuss proposed pilot project and share updates from the IOHN; Senior workgroup (12/12): discuss partnership with CHEMS and proposal to train coders on Medicaid Wellness Exams
 - **District 4:** CHC Meeting - 12.5.17, Executive Leadership Meeting - 12.20.17
 - **District 5:** The SCHC did not meet in December. The next scheduled Executive Committee meeting is January 19, 2018.
 - **District 6:** No RC meetings in December 2017.
 - **District 7:** No Meetings held this month.
- **Issues and topics discussed:**
 - **District 1:** The above meeting between the SHIP Manager and RC Chair involved going over the RC strategic plan and updating progress of the RC.

- **District 2:** Agenda had updates to the group on newly selected cohort 3 clinics and what can be expected in the last year of the SHIP grant.
- **District 3:** The SWHC met on 12/5. The first agenda item included discussion of workgroup updates for the Behavioral Health Integration Workgroup, the Oral Health Workgroup, the Senior Workgroup, the ED Utilization Workgroup, and the Care Coordination Grant. The group also discussed key focus areas for the upcoming year including data, CHWs/CHEMS reimbursement, ED utilization, and behavioral health. The SWHC intends to coordinate with the CHC with the launch of the RCO in Regions 3 and 4. Lastly, the group discussed opportunities to further promote the virtual PCMH.
- **District 4:** CHC Executive Leadership Meeting on 12.20.17 - The CHC Executive Leadership team reflected on the SHIP Networking event that was held on December 6th as part of the SHIP Caregiver Integration Project. Dr. Rich with FMRI was very happy with the event and the networking that took place. We also participated in a follow-up discussion on the Pathways Community HUB model after the CHC meeting that took place on 12.5.17, reviewing the support and interest of CHC members. There are a lot of questions that need to be answered before we can move forward with implementation but we see this as an exciting challenge for 2018. As mentioned above, we continued to discuss basic needs in the community, including transportation, oral health and children's mental health. Our next steps including flushing out the Pathways idea around a specific target population, potentially focusing on low-income elementary school children and their families. Our discussion will resume in February and will include new stakeholders interested in the Pathways model. QI Specialists. Kim Thurston and Tara Fouts, will also be preparing a presentation to highlight the work that was done with all Cohort 2 clinics in Region 4.
- **District 5:** The collaborative did not meet this month.
- **District 6:** While no RC meetings were held, PHD6 SHIP staff have dedicated some time to planning for Cohort 3, including the fact that we will need a second QI Specialist. Eleven new clinics were selected for SHIP participation in our region, bringing the total number of SHIP selected clinics in Region 6 to 26. We are very pleased that our region continues to express high interest in the PCMH model of care but have concerns about recruiting, hiring, and training a qualified person for additional TA to clinics.
- **District 7:** Next RC meeting will be held in March to include new cohort 3 clinics. PCMH transformation will be main topic

- **Action Items:**

- **District 1:** None
- **District 2:** None
- **District 3:** The SWHC would like to explore sustainability support for CHEMS and CHWs. Additional information on what is successful in Idaho and similar states would be useful. In addition, including this as a future agenda item at an IHC meeting would be beneficial.
- **District 4:** None
- **District 5:** None
- **District 6:** None
- **District 7:** Sustainability Plan-To help coordinate potential sustainability of local regional collaboratives.

- **Next steps:**

- **District 1:** Look at sustainability of the RC and PCMH progress in the region, Evaluate possible role of our RC in the future Choice advisory board with Medicaid.
- **District 2:** None
- **District 3:** Next steps for the SWHC include working to learn more about opportunities for sustainability for CHEMS and CHWs. In addition, in February the RC will discuss needed support for cohort 3 and continued PCMH transformation. The SWHC will continue to work with partners including local schools, behavioral health, dental, emergency departments, foundations, and the health department to enhance the medical-health neighborhood.
- **District 4:** Next CHC meeting is scheduled for 2.6.18

ADVISORY GROUP REPORTS:



Telehealth SHIP Subcommittee:

Report Items:

- University of Idaho, Project ECHO hired a project manager that will start 2/12/2018.
- Physician Champion, Dr. Palmer, reviewed the ECHO curriculums on Opioid Addiction and Treatment. He is continuing to develop the Idaho ECHO clinic, and has identified the list of experts to teach the didactic sessions.
- Health Management Associates, our telehealth technical assistance contractor, is developing a series of learning collaborative webinars for our telehealth cohort clinics. Their first webinar will be conducted the end of March and will go over how telehealth clinics can work with vendors, and the utilization of their vendor assessment tool.
- The telehealth reimbursement matrix has been sent out for feedback from payers. We anticipate having the completed matrix by February 28, 2018.

Next Steps

- Continue to support Round 1 telehealth clinics through our technical assistance contractor and IDHW.
- Work with University of Idaho to promote Project ECHO to SHIP cohort clinics and within other health systems in Idaho, recruitment of spoke learners should be completed by February 23, 2018.
- Working with Round 2 telehealth clinics and our technical assistance contractor to establish round 2 site visits and future telehealth learning collaboratives for all telehealth clinics.



Community Health Workers:

Report Items:

- The Spring 2017 CHW training currently has 20 students participating in the course.
- The ISU Fall 2017 CHW course evaluation was provided to IDHW, the largest gains in competency scores between the beginning and end-of-course self-assessment included:
 - Ability to discuss the different screenings for cancer, with patients
 - Ability to distinguish between the risk factors for, and signs or symptoms of a heart attack and stroke

- Awareness of tools that could help the CHW build community capacity to advocate for better conditions for health and wellness
- The CHW feels prepared to explain health insurance plans to patients in simple terms
- Awareness of the resources within Idaho to help individuals who are considering harming themselves or others
- The in-person course is under development, ISU has identified a fast-tracked course, April 2018, here in the Treasure Valley to be the most ideal platform.
- Collaboration with the Diabetes, Heart Disease, and Stroke Prevention program, and the CHW association to deliver a daylong CHW in-person learning collaborative.
- Twelve Health Specific Modules have been created they are:

Behavioral Health/Substance Abuse	Oral Health
Breast Health and Breast Cancer Screening	Prediabetes and Diabetes
Cervical Cancer and Cervical Cancer Screening	Family Caregiving
Colorectal Health and Colorectal Cancer Screening	Tobacco Cessation
Cardiovascular Health and Screening	COPD
Heart Failure	Medication Adherence

Next Steps:

- Quarter four data (October 1, 2017 – December 31, 2017) is in the process of being collected.
- Considering resources for translating the CHW course materials, health specific modules and curriculum, into Spanish, and offering a Spanish course in Fall 2018.
- Identified four additional HSMs as priority for development during the last year of the SHIP grant. These include; Opioid addiction and Treatment (unless sufficiently covered in Behavioral Health/Substance Abuse HSM), Blood Pressure and Hypertension, Dementia and Alzheimer’s, Prenatal Care, and Prostate Health and Cancer Screening (if Opioid HMS isn’t chosen).

WORKGROUP REPORTS:



Community Health EMS:

- **Report Items:**
- Last statewide CHEMS workgroup meeting was held January 24, 2018
- The next statewide CHEMS workgroup meeting will be held February 2018 from 10:00-11:00 AM MST
- The internal CHEMS workgroup continues to meet every Monday
- **Collective Workgroup Activities:**
 - EMT/AEMT Certificate Program: Development and Online Delivery Implementation
 - Curriculum development, implementation, and delivery will not hit original target date but the internal workgroup remains dedicated to its completion
 - Next meeting with CWI will be held February 14, 2018
 - ISU Community Paramedic Certificate Program
 - 3rd and final cohort has commenced

- Learning Collaborative:
 - The in person Learning Collaborative took place Wednesday, January 17, 2018
 - Overall, the survey results concluded that the Learning Collaborative was useful, met the objectives, and will be beneficial for CHEMS program development
- Upcoming Webinar – Economic Modeling
 - Presenter – Dr. Shenghan Xu
 - Date not yet identified
- Data Collection
 - The internal workgroup will revisit metrics and previously developed data collection tools to identify if there is a need to revise current data collection methods
- Regional Mentorship
 - The internal workgroup has identified agencies/providers across the state who have expressed interest in participating in regional mentorship development and regional mentorship representation in their respective regions
- **Next Steps:**
- Project Charter, Deliverable 3 – in progress
 - EMT/AEMT Curriculum Development
 - Development and implementation are still underway
- Project Charter, Deliverable 4 – in progress
 - Continue to define, develop, and implement peer mentorship throughout the state
- Project Charter, Deliverable 6 – 100% complete
 - Both webinars and Learning Collaborative have been completed



Idaho Medical Home Collaborative:

- **Report Item:**
 - The IMHC did not meet last month.



Data Governance:

- **Report Item:** The Data Governance Workgroup met on January 8, 2018.
 - Workgroup members discussed the CMMI Success Measures report and Burke Jensen gave a progress update on Goals 2 and 5.
 - The workgroup reviewed two of the four most recent measures added to the CQM catalog;
 - *NQF 2372 – Breast Cancer Screening*
 - *NQF 1392 – Well Child Visits in the First 15 months; and*
 - The workgroup requested a updated CQM catalog with a parenthetical statement indicating the breast cancer screening was required every two years
 - The workgroup questioned the required number of well child visits for NQF 1392. Further research indicated this CQM has 7 different numerators, with the most challenging numerator being 6 or more well child visits.

- Idaho Health Data Exchange (IHDE) gave a clinic connection update. 37 Cohort 1 and 32 Cohort 2 clinics have been connected. Stability and performance issues have improved greatly in recent months.
- IHDE also discussed the data quality improvement process being done by the Data Quality Specialist and provided an overview of the current data gaps and efforts to fill those data gaps and increase data quality.
- HealthTech Solutions (HTS) gave an update on the data analytics.

- **Next Steps:**

- The next SHIP Data Governance Workgroup meeting is scheduled for February 12, 2018.
- Since time did not allow for discussion in the January meeting, a review of the Data Governance Workgroup Charter and CMMI Insights on Idaho's HIT Project will be covered in February's meeting.



Multi-Payer:

- **Report Item:**

- The MPW met January 9, 2018. Outcomes of the meeting include:
 - Dr. Peterman stepped down as co-chair. Dr. Kelly McGrath was elected as the new co-chair.
 - Nicole McKay, Office of the Attorney General from the Department of Health and Welfare reviewed antitrust compliance.
 - Scott Banken, CPA, Senior Associate with Mercer presented the SHIP Payer Financial and Enrollment Metrics report. Results of the report indicate payments were still primarily Fee for Service (FFS) in 2015 and 2016, however, the trend does show slow movement to Advanced Payment Models (APMs). The payers in the room indicated that most of the movement to APMs took place in 2017. The MPW recommended the report be presented to the IHC on 1/10/18.
 - Madeline Russell, SHIP Project Manager presented an update on the telehealth reimbursement matrix the MPW members had agreed to update. She is requesting they complete the matrix by 2/9/18.
 - Brad Erickson, Idaho Health Data Exchange (IHDE) Executive Director presented information on the progress the IHDE has made with the SHIP Clinics:
 - Cohort 1 - 33 of 55 SHIP clinics were connected
 - Cohort 2 - 32 of 56 SHIP clinics connected and 85 other Healthy Connection clinics connected.
 - Cohort 3 - Plan to connect 53 SHIP clinics
 - The importance of having self-funded groups as a driving force in the move to paying for value and improved health outcomes was discussed.
 - Casey Moyer provided an update on the recent ONC convening in Seattle. Mr. Moyer informed the group that health IT interoperability is a struggle with all states, and is a key factor to enhancing payment models. There will be another update after the February ONC convening.

- **Next Steps:**

- The next MPW meeting will be held from 3:00 to 4:30 on March 6, 2018 in room 6A at the Department of Health and Welfare, 450 West State Street.

BHI

Behavioral Health:

Report Items:

- The BHI Sub-Committee met on Tuesday, January 9, 2018 from 9:00-11:00. The focus of the meeting was to review and discuss the Idaho BHI Convening Report that was developed based on the Thursday, November 9, 2017 in collaboration with the Eugene S. Farley, Jr. Health Policy Center at the University of Colorado School of Medicine. After reviewing the report the workgroup determined that next steps would include a process to operational the recommendations. This process will begin at the March 6th meeting of the BHI Sub-Committee.
- The IIBHN in collaboration with Optum Idaho has created a series of training opportunities around the state to educate specialty behavioral health providers about behavioral health integration in primary care and the importance of cross collaboration. The first training was held in Coeur d'Alene on February 6th. Other sessions will be conducted throughout February and March.
- The IIBHN continues to work on the development of a Behavioral Health Integration conference to be held on April 16th and 17th. They have secured several sponsors for the event so that participants will only be charged a nominal fee to participate in the conference. The guest speaker list is quite impressive.
- The next BHI Sub-Committee meeting will be held on March 6th from 9:00-11:00 at 450 W. State Street, 7th floor conference room.

PHW

Population Health:

- **Report Item:**
- The PHW met February 7, 2018 from 3:00 – 4:30. This was their 23rd meeting.
- Kym Schreiber on behalf of a small workgroup discussed the status of the clinic inventory. The list provides an overview of many initiatives that are being conducted in local clinics, and in particular the SHIP cohort clinics. The inventory will be updated with the cohort 3 clinics in the next couple of weeks, be geocoded so it can update the GIS map, placed on the SHIP website and sent as a database to the health districts and others.
- Rafe Hewett, Idaho Immunization Program Manager, provided an update on the immunization data being provided to SHIP. Rafe continues to work with Burke Jensen to have this data be part of the dashboard that will be provided by HealthTech, the SHIP data analytics contractor. Rafe will add cohort 3 clinics to his data pull. In October 2017, Rafe provided individual clinic level data, regional level data, and statewide level data to the SHIP project.
- Get Healthy Idaho: Measuring and Improving Population Health was completed and the final report was shared. It is available in hard copy (in limited supplies) and available at the following location: <http://healthandwelfare.idaho.gov/Portals/0/Health/Get%20Healthy%20Idaho.vers2018.pdf>

- The Get Healthy Idaho website (<http://gethealthy.dhw.idaho.gov/>) continues to be updated. Soon this will be the one-stop shop for public and population health data.
- James Aydelotte, presented on the type of publications his Bureau of Vital Records and Health Statistics produces as well as the location (<http://healthandwelfare.idaho.gov/Health/VitalRecordsHealthStatistics/HealthStatistics/tabid/102/Default.aspx>). The reports range from types of reports (vital statistics, Behavioral Risk Factor Surveillance System analysis, Pregnancy Risk Assessment Tracking System) to various topics in form of fact sheets and reports such as chronic disease, induced termination, general health, etc. Eventually, these reports will be migrated to the gethealthy.dhw.idaho.gov website.
- The group received an update on all components of the virtual PCMH: CEMS, CHW, Telehealth and Project ECHO. These specific updates will be provided to the IHC by their respective workgroup reports.
- Workgroup members provided reports of activities. Five of the seven local public health district directors attended the meeting in person.

Next Steps:

- The next meeting of the PHW is March 7th from 3:00-4:30.