



# Idaho Healthcare Coalition

## Meeting Agenda

January 9, 2019 2:00PM – 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

Join from PC, Mac, Linux, iOS or Android:

<https://zoom.us/j/463737800>

2:00 p.m.	Opening remarks; roll call; introduce any new members, guests, any new IDHW staff; agenda review; and approval of meeting minutes – <i>Dr. Ted Epperly, IHC Chair</i> <b>ACTION ITEM</b>
2:10 p.m.	Final Financial Analysis Report – <i>Katie Falls, Mercer</i> <b>ACTION ITEM</b>
2:25 p.m.	SET Report – <i>Janet Reis, Dawn Juker, &amp; Janice Lung, Boise State University</i>
3:05 p.m.	IHDE Strategic Plan & Next Steps – <i>Brad Erickson, IHDE</i>
3:15 p.m.	Break
3:25 p.m.	The Big Rocks - <i>Dr. Ted Epperly, Chair</i>
3:50 p.m.	PCMH Report – <i>Grace Chandler, Briljent &amp; Nancy Jaeckels-Kamp, HMA</i>
4:10 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"><li>• Presentations, Staffing, Contracts, and RFPs status – Casey Moyer, IDHW</li><li>• Regional Collaboratives Update - Ann Watkins, IDHW</li><li>• Telehealth, Community Health EMS, Community Health Workers - Ann Watkins, IDHW</li><li>• Data Governance Workgroup - Dr. Andrew Baron, Terry Reilly and Janica Hardin, Saint Alphonsus, Workgroup Co-Chairs</li><li>• Multi-Payer Workgroup - Norm Varin, PacificSource and Dr. Kelly McGrath, Workgroup Chairs</li><li>• Behavioral Health/Primary Care Integration Workgroup - Ross Edmunds, IDHW and Dr. Charles Novak, Workgroup Co-Chairs</li><li>• Population Health Workgroup - Elke Shaw-Tulloch, IDHW &amp; Nikki Zogg, Southwest Public Health District, Workgroup Co-Chairs</li><li>• IMHC Workgroup – Dr. Scott Dunn, Family Health Center and Matt Wimmer, IDHW Workgroup Co-Chairs</li></ul>
4:20 p.m.	IHC Wrap Up & Celebration – <i>Dr. Ted Epperly &amp; Lisa Hettinger</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-health neighborhood.

**Goal 3:** Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical-health 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) January 9, 2019

## **Action Items**

- Action Item 1 – December IHC Meeting Minutes

IHC members will be asked to adopt the minutes from the December 12, 2018 IHC meeting:

Motion: I, \_\_\_\_\_ move to accept the minutes of the December 12, 2018, Idaho Healthcare Coalition (IHC) meeting as prepared.

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

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- Action Item 2 – Final Financial Analysis

IHC members will be asked to support and adopt the Final Financial Analysis as presented by Scott Banken and Katie Falls from Mercer.

Motion: I, \_\_\_\_\_ move that the IHC support and adopt the Final Financial Analysis as presented by Scott Banken and Katie Falls.

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

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# Idaho Healthcare Coalition

## Meeting Minutes:

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**SUBJECT:** IHC December Minutes      **DATE:** December 12, 2018

**ATTENDEES:** Kathy Brashear, Russell Duke,      **LOCATION:** 700 W State Street, 1<sup>st</sup>  
Ross Edmunds, Dr. Ted  
Epperly, Lisa Hettinger, Deena  
LaJoie, Jedd Smith as proxy  
for Dr. James Lederer, Casey  
Moyer, Dr. David Pate, Dr.  
Kevin Rich, Dr. Rhonda  
Robinson-Beale, Neva Santos,  
Elke Shaw-Tulloch, Mary  
Sheridan, Norm Varin, Jennifer  
Wheeler, Beth Kriete as proxy  
for Matt Wimmer

**Teleconference:** Michelle Anderson, Russ  
Barron, Melody Bowyer, Pam  
Catt-Oliason, Janica Hardin,  
Yvonne Ketchum-Ward,  
Maggie Mann, Carol Moehrle,  
Susie Pouliot, Geri Rackow,  
Lora Whalen, Rachel Blanton  
as proxy for Nikole Zogg

**Members Absent:** Dr. Andrew Baron, Dr. Richard  
Bell, Melissa Christian, Dr.  
Keith Davis, Dr. Scott Dunn,  
Lee Heider, Drew Hobby, Dr.  
Mark Horrocks, Dr. Glenn  
Jefferson, Amy Mart, Dr. Kelly  
McGrath, Nicole McKay,  
Casey Meza, Daniel Ordyna,  
Tammy Perkins, Dr. David  
Peterman, Dr. Boyd  
Southwick, Larry Tisdale,  
Karen Vauk, Dr. Fred Wood

**IDHW Staff** Kevin Grant, Meagan Graves,  
Burke Jensen, Madeline  
Russell, Kym Schreiber,  
Stacey St.Amand, Ann  
Watkins, Cynthia York

**STATUS:** Draft 12/14/2018

## Summary of Motions/Decisions:

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**Motion:**

Neva Santos moved that the IHC accept the November 14, 2018 IHC meeting minutes as presented.  
Jennifer Wheeler seconded the motion.

**Outcome:**

**Passed**

## Agenda Topics:

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

- ◆ Dr. Epperly welcomed everyone to the meeting and took roll. He opened the meeting with a quote, “If you want to touch the past touch a rock. If you want to touch the present, touch a flower. If you want to touch the future, touch a life.” ~ Anonymous.
- ◆ The IHC moved to accept the minutes of the November 14, 2018 IHC meeting as prepared.

**Regional Collaborative Panel – Madeline Russell, SHIP Operations & PHD SHIP Managers**

- ◆ Representatives of the regional collaboratives attended virtually (Russ Duke attended in-person) to present their successes and lessons learned and review their transition plans. A hand-out of their post-SHIP missions and goals is contained in the IHC packet including sustainability highlights.
  - **District 7 - James Corbett:** successes included PCMH transformation, medical-health neighborhood development and community health data outcomes; QI specialists started from the outset to collect data – improved clinics’ capabilities for NCQA recognition. Barriers included distance, multiple initiative fatigue, getting IHDE connected and different payment structures.
  - **District 6 - Rhonda D’Amico:** successes included having a confident QI specialist to promote growth and development models; establishing trusting relationships with clinics; and a grant opportunity on suicide prevention. By 1/31/2019 clinics will have access to tools and resources to advance PCMH recognition; by 2/1/2019 the PHD will hire a program manager of suicide prevention (32 hrs./wk.).
  - **District 4 - Russ Duke:** successes included having had a large, consistent membership group to coordinate partnerships, best practices, and resources; held the first annual meeting of the Idaho Integrated Behavioral Health Network (IIBHN) in April 2018; and a grant opportunity on the caregiver integration project. The greatest challenge has been sustainability. Looked at adopting Pathways Community Health Model; Collaboratives 3 and 4 met to discuss combining resources and chartering together.
  - **District 3 - Rachel Blanton:** successes included working with a diverse group of people and creating relationships that will endure beyond SHIP funding; and the Idaho Care Network moving forward with support of several local organizations. Challenges included initiative fatigue and struggling with data, waiting too long to develop own measures.
  - **District 2 - Kayla Sprenger:** successes included development of relationships and best practices for clinics; use of mentorship for newer clinics. Lessons learned/barriers included being able to collect accurate and timely data to measure changes in clinics and sustainability.
  - **District 1 - Steve Holloway:** successes included holding forums for collaboration and kick-off meetings that set the stage for each cohort year; PCMH meetings held five or six

times a year; 'lunch and learn' meetings held with clinic staffs. Barriers included staff turnover at clinics and sustainability.

- ◆ Following the presentations, there was an extended discussion of the medical-health neighborhood-specific initiatives and what could be sustained without funding.
- ◆ Dr. Epperly requested that each district furnish a list of activities that they anticipate continuing that can be done absent SHIP funding.

### **Healthcare Transformation Council of Idaho (HTCI) Final Planning Update – Dr. Ted Epperly and Dr. David Pate**

The first meeting of the HTCI will be held on February 21, 2019. The charter, business case and member list will be reviewed at that meeting.

- Drs. Epperly and Pate met with Governor-elect Little on December 4th.
- The governor-elect is mindful that there are issues around healthcare and gave a continuing commitment to make gubernatorial appointments to the HTCI.
- There is support for the OHPI request.
- His presence was requested at the first meeting.
- It was also requested that he make an executive order by the end of January 2019.
- The governor-elect asked about integrating data and connecting systems and how IHDE would integrate with HTCI.
- ◆ A matrix was presented that contained feedback from the workgroup survey (November 2018), the IHC survey (March 2018) and the PCMH sustainability workshop (January 2018). The matrix is contained in the IHC packet.
- ◆ Lisa Hettinger reminded members that letters of support were needed as soon as possible. The letters are to be sent with the budget request to JFAC.

### **Dashboard Update – Katie Falls, Principal, Mercer**

- ◆ Ms. Falls discussed the most recent SHIP success measures on the Project Management Dashboard:
  - A decrease in the count of nationally accredited SHIP clinics occurred due to process scheduling issues either at the clinic level or with NCQA.
  - The state AY3 target for individuals receiving care through value-based purchasing and alternative payment models is 550,000. The actual count is 922,561 which is equal to 83% of the Idaho population.
  - The number of Idahoans who enroll in a primary care practice selected for a SHIP cohort that have an EHR connected HIE has increased by 38,000 since last quarter. The metric reflects a decreasing trend because the quarterly target (denominator) increased by a higher number.

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

- ◆ The IHDE is on track to connect 152 of 166 clinics (to some degree or another) by January 31, 2019. To date, they have connected nine hospital systems (representing 19 individual hospitals).
- ◆ Since December 12, 2018 they have trained 188 new users.
- ◆ Brad was invited back to January 2019 IHC meeting to present the final connection outcome report as well as share the outcome of the organizational strategic planning currently underway.

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

- ◆ The last meeting of the IHC will be held January 9, 2019.
- ◆ There being no further business, the meeting was adjourned at 4:26pm.

HEALTH WEALTH CAREER

# IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN PROJECTED FINANCIAL RESULTS

REQUIRED REPORT FOR  
GRANT CMS-1G1-14-001

JANUARY 8, 2018

MAKE TOMORROW, TODAY



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# 1

## EXECUTIVE SUMMARY

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to improve the health of all residents of Idaho by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care.

To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Model Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze and measure financial results for the State's population health in an effort to determine the impact of changes occurring through the SHIP on the State's healthcare costs and an estimated return on investment (ROI) for the Center for Medicare and Medicaid Innovation (CMMI). This report is to fulfill the requirement of reporting ROI for grant CMS-1G1-14-001.

It is important to note that Mercer measured results at a statewide level. While the SHIP likely influenced the results, the State's payers and providers are implementing a number of other delivery and payment strategies with the goal of improving health outcomes and lowering costs. Thus, the dynamic environment in which the SHIP is being implemented limits the ability to determine the impact of the changes in healthcare costs that can be attributed solely to the SHIP. However, based on national research that shows decreased cost trends resulting from the PCMH model, the SHIP is believed to be a significant contributor to the impacts identified through this analysis.

The Idaho Department of Health and Welfare (IDHW) projects spending roughly \$35.0 million of the Model Testing grant, and there is still more work to do to complete the transition to the PCMH model in Idaho. Annual reported expenditures increased from 2015 to 2018 by \$874 million. However, the analysis shows projected cost avoidance to be \$213.6 million or 1.2% of reported annual expenditures, to show an ROI of 510.2% overall for the CMMI model test grant. For government business, Medicare and Medicaid together showed cost avoidance of \$122.6 million for an overall ROI of 250.2%. These results exceed the estimated cost avoidance submitted with the grant application of \$89 million over 3 years representing 0.5% of annual expenditures.

### LIMITATIONS OF ANALYSIS

In preparing this document, Mercer has used and relied upon data supplied by commercial, Medicare and Medicaid payers in Idaho and CMS Office of the Actuary(OACT). The participating

payers and CMS OACT are responsible for the validity and completeness of this supplied data and information. Mercer reviewed the data and information for consistency and reasonableness. In Mercer's opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this analysis may need to be revised accordingly. All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Since projections of cost avoidance relied heavily on projections of data for trend and for completing 2018 actual results, Mercer recommends revisiting the 2018 calculations of cost avoidance and ROI after actual data is available.

# 2

## INTRODUCTION

Idaho's SHIP is designed to improve the health of all residents of Idaho by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the PCMH model of care.

To support testing Idaho's SHIP, Idaho applied for and received a federal SIM Model Test grant. The four-year grant was comprised of an initial year of preparing to implement the model and referenced as Award Year (AY) 1. The following three years of the grant are to test the model's impact, including the financial impact on Idaho's healthcare system. The "Model Test Years" correspond to AYs 2 through 4.

While the PCMH model was selected to be tested through the SHIP, there are other important delivery and payment approaches being implemented by payers with the common goal of improved health outcomes and lower costs. The largest commercial payers in the State have all implemented alternatives to fee-for-service (FFS) payments to incentivize and reward quality and improved health outcomes. These payment models include:

- Pay-for-Performance
- Enhanced Pay-for-Performance
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments
- Episode-Based Payments

In addition to the PCMH model, commercial payers are testing alternative payment models. Examples include accountable care organizations with many of the State's acute care hospitals, total cost of care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits. Payers are also aligning their product portfolios so that payment methodologies and value-based reimbursement are more aligned

with product designs that guide members to providers delivering high quality care. They are also working to expand value-based programs in an effort to align reimbursements, empower providers with data, focus on overall health, and establish shared decision making between patients and their physicians. Together, payers and providers are developing the infrastructure to support partnerships to be successful in new payment arrangements and align payment systems with benefits, network design, and consumer engagement.

Medicaid, Idaho's largest public payer, is expanding the payment reform model in Idaho by incentivizing participation in the PCMH model. Medicaid is encouraging value-based purchasing through the development of accountable Regional Care Organizations where physicians, providers and hospitals join together to create a regional system of care. Through both models, healthcare providers are rewarded for delivering better care instead of being paid for providing more care regardless of outcomes.

The combined efforts of Idaho's commercial payers, Medicaid, Medicare, and the SHIP to implement delivery and payment models that incentivize and reward quality care will continue to have a significant impact on improving the health of residents of Idaho beyond the end of the grant testing period. In addition, as demonstrated through this financial analysis, there is evidence these combined efforts are bending the cost curve of the State's healthcare system.

# 3

## BACKGROUND

As part of the SIM grant, IDHW, together with the Idaho Healthcare Coalition, engaged Mercer to analyze financial metrics for the State’s population health in an effort to determine the impact of healthcare cost changes occurring through the SHIP. This financial analysis also fulfills a grant requirement as the Centers for Medicare and Medicaid Services (CMS) Innovation seeks to understand the financial impact of healthcare delivery and payment models being tested across the nation.

Idaho’s SHIP model testing is occurring within a dynamic health system environment. As such, this analysis is limited in that the impact of the SHIP PCMH model on utilization and costs cannot be isolated. Furthermore, while the population health metrics selected for this analysis are those that are most expected to be impacted by the PCMH model, it is expected these metrics are also impacted by other payer models being implemented in Idaho. Regardless of these inherent limitations, national research supports the assumption that the PCMH model is a significant contributor to the findings of this financial analysis.

### GRANT YEAR VERSUS CALENDAR YEAR

The grant period runs from February 1, 2015 through January 31, 2019 and is divided into award years as described above and shown in Table 1 below. For ease of data collection and participation from the payers, Mercer is collecting and calculating data on a calendar year (CY) basis without adjusting for the lagging grant month. Therefore, although the Model Test years begin on February 1 and end on January 31, CY projections were not adjusted for the lagging month.

**TABLE 1: REFERENCES TO TIME PERIODS**

FINANCIAL ANALYSIS YEAR DATA/ GRANT YEAR	GRANT AY	MODEL TEST YEAR
CY 2015 / February 1, 2015 through January 31, 2016	AY 1	Baseline (Year 0)
CY 2016 / February 1, 2016 through January 31, 2017	AY 2	Year 1
CY 2017 / February 1, 2017 through January 31, 2018	AY 3	Year 2
CY 2018 / February 1, 2018 through January 31, 2019	AY 4	End of Model Test (Year 3)

In 2013, as part of the grant applications, and again in 2015, Mercer projected cost mitigation through trend reductions from the implementation of the PCMH model over the Model Test period. The areas expected to be impacted by the PCMH model were generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general

primary care savings. The cost savings assumptions were based on research from similar PCMH impact studies. Cost increases associated with new PCMH operations being implemented were also built into the model.

Table 2 below identifies the cost mitigation assumptions.

**TABLE 2: COST TARGETS, MILESTONES AND SAVINGS FOR PUBLIC/  
PRIVATE POPULATIONS COMBINED**

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Early Deliveries (in weeks 37–39 of gestation)	5% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1%–4% of total NICU admissions (\$40 thousand – \$70 thousand/admit) are preventable with later deliveries	0.56% reduction in inpatient hospital utilization for Medicaid child per year <sup>1</sup>
Generic Drug Use	Generic fill rate of 85%	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%–1.0% Medicaid, 0.5%–1.0% commercial)	0.17% reduction in prescription unit costs for Medicaid and commercial per year over 3 years <sup>2</sup>
Hospital Readmissions	5%–10% reduction	20% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for commercial <sup>3</sup>

<sup>1</sup> Ohio Perinatal Quality Collaborative 39-Weeks Delivery Charter Project (2008) <https://opqc.net/node/157>

<sup>2</sup> Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at [http://www.pccpc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pccpc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

<sup>3</sup> Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at [http://www.pccpc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pccpc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Acute Care Hospitalizations	1%–5% reduction	PCMHs reduce with IMPACT <sup>4</sup> & Intensive Outpatient Care Programs training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for commercial <sup>5</sup>
Non-Emergent Emergency Department (ED) Use	5%–10% reduction in total ED use	10%–30% of ED visits are non-emergent	1.0% reduction in ED utilization for all payers <sup>6</sup>
General Primary Care Savings	Reduction in utilization	Savings typical when moving to a care management setting	0.5% reduction for Medicare and Medicaid for Specialists, Physical therapy, Occupational therapy and Radiology; 0.25% in Durable Medical Equipment (DME) for Medicaid Duals, 0.25% for Medicare Duals <sup>7</sup>

As part of the model testing grant application, Mercer built a comparison model of care using medical expense data supplied by IDHW for 2013 and 2014 incurred expenses, the CMS for 2012 and 2013 incurred expenses, three of the four largest commercial payers for 2014, and Mercer’s proprietary commercial claims database. Mercer also used commercial payers’ public filings, as available from 2013 and 2014. Costs were trended forward using trend rates based on the U.S. Consumer Price Index (CPI) for medical care services to align reporting periods, yielding a baseline

<sup>4</sup> IMPACT is an evidence-based depression care program developed by the University of Washington. Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered free thanks to the generous support of the John A. Hartford Foundation.

<sup>5</sup> Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=86](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86)

<sup>6</sup> Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. JAMA Internal Medicine, Report Abstract published online, September 9, 2013 viewable at <http://archinte.jamanetwork.com/article.aspx?articleid=1735895>

<sup>7</sup> Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=86](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86)

for comparison of CY 2015 as the Baseline. Trend assumptions for each Model Test year were derived from the National Health Expenditure projections from the CMS OACT and from Mercer's proprietary commercial claims database. The results showed a projected cost savings of \$89 million over the model testing period, representing 0.5% of annual expenditures.

# 4

## METHODOLOGY FOR DETERMINING COSTS AVOIDED

To collect the data for the analysis, commercial, Medicare, and Medicaid payers were surveyed annually using consistent category of services classifications and definitions included in Appendix A. For all four years of the test, Mercer collected self-reported, summarized data from three of the four largest commercial payers in the state along with Medicaid and Medicare. Medicare data for dual-eligible and Medicare Part C members for CY 2015 and 2016 were provided by Noridian Government Solutions, the Idaho Medicare carrier. Commercial data was weighted and summarized to avoid disclosing any proprietary cost data that may jeopardize any reporting commercial payer’s competitive advantages.

A baseline was created for calendar year 2015 to project what would have happened had the SHIP not been implemented. The 2015 baseline projection used in the original estimate for CMMI was based on 2012 through 2014 data. Mercer found CY 2013 and CY 2014 data were significantly different for all payers compared to 2015 actual data. As a result, Mercer rebased the projected cost avoidance starting from actual 2015 per member per month (PMPM) data by collecting 2015 data from Medicare and Medicaid and from the commercial payers through their public filings. Mercer re-projected the 2015 baseline again using updated trend assumptions from the OACT in 2017.

To allow for sufficient runout of claims, Mercer collected annual data for 2016 and 2017 beginning in July of the following years, and data from January through July of 2018 with runout through October, in November of 2018.

Mercer compiled the reported data and calculated PMPM costs by demographically similar member groupings by payer types. The groupings by payer are listed in Table 3 below. The PMPMs were compared to the 2015 projected baseline data to measure annual PMPM trends to remove the effect of shifts in membership.

**TABLE 3: PAYER GROUPINGS**

MEDICAID	COMMERCIAL	MEDICARE
Adults	Group	Dual Eligible
Children	Individual	Fee For Service/Non-Dual (Parts A and B)
Dual Eligible		Medicare Advantage
Disabled/Elderly		

Since 2018 only included seven months of data, Mercer calculated completion factors to project the complete 2018 year. The completion factors were based on available quarterly insurance filings for all reporting payers in Idaho to allow for seasonality and further runout of 2018 claims.

Mercer trended the baseline PMPMs from 2015 using trend data from OACT National Health Expenditure (NHE) tables available on the CMS website.<sup>8</sup> Mercer assigned and grouped the category of services found in the data request to align with NHE tables to identify the trends to use in projecting PMPMs had the SHIP not been implemented. Actual trends from 2016 and projected trends from 2017 and 2018 were used.

PMPMs were then multiplied by the actual member month counts reported to calculate total costs. The total actual costs were then compared to the projected costs using the NHE trends to determine costs avoided by category of service by year.

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<sup>8</sup> NHE tables can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip>

# 5

## FINANCIAL ANALYSIS AND KEY OBSERVATIONS

Medicaid actual PMPM growth was highest for Aged/Disabled (17.7%) and Dual Eligible (12.1%) members while Other Adults (non-dual, non-disabled) actually decreased by 5.8% over the testing period. The commercial individual population showed the highest PMPM growth of all participant categories at an astounding 41.1% while commercial family trends only grew by 3.5% over the testing period. Medicare growths were more consistent, ranging from 10.2% to 15.0%.

**TABLE 4: ACTUAL PMPMS**

PARTICIPANTS	2015	2016	2017	PROJECTED 2018 *
<b>MEDICAID</b>				
Children	\$262.18	\$265.87	\$271.51	\$287.43
Dual Eligible	\$1,392.94	\$1,405.23	\$1,437.51	\$1,561.03
Aged/Disabled (non-dual)	\$2,145.39	\$2,207.54	\$2,265.95	\$2,525.92
Other Adult	\$422.70	\$410.47	\$407.09	\$398.13
<b>COMMERCIAL</b>				
Individual	\$403.38	\$530.14	\$558.63	\$569.21
Family	\$375.52	\$347.91	\$381.42	\$388.52
<b>MEDICARE</b>				
Dual Eligible	\$756.49	\$876.43	\$790.41	\$870.19
FFS	\$412.54	\$425.64	\$432.23	\$454.50
Medicare Advantage	\$756.23	\$849.44	\$818.63	\$856.71

\*2018 Data projected for all of 2018 using actual results through July 31, 2018 with runout through October 31, 2018

To project what would have happened without the intervention of the model test, NHE trends were used to project PMPMs forward from the 2015 baseline. The results are shown in Table 5. All growth rates were between 11.3% and 17.0% over the testing period. Note that NHE trend data included projected trends for 2017 and 2018 and does not take into account shifts in membership.

**TABLE 5: PROJECTED PMPMS FROM NHE TRENDS**

PARTICIPANTS	2015	2016	2017	2018
<b>MEDICAID</b>				
Children	\$262.18	\$274.32	\$284.44	\$302.47
Dual Eligible	\$1,392.94	\$1,442.64	\$1,470.78	\$1,551.16
Aged/Disabled (non-dual)	\$2,145.39	\$2,242.23	\$2,321.20	\$2,466.04
Other Adult	\$422.70	\$440.53	\$457.38	\$485.23
<b>COMMERCIAL</b>				
Individual	\$403.38	\$427.21	\$449.46	\$472.04
Group	\$375.52	\$397.62	\$418.25	\$439.40
<b>MEDICARE</b>				
Dual Eligible	\$756.49	\$772.63	\$802.05	\$844.46
FFS	\$412.54	\$422.02	\$437.56	\$459.32
Medicare Advantage	\$756.23	\$774.43	\$806.24	\$851.32

Multiplying the member month totals by the differences in the PMPMs in Tables 4 and 5 results in projected cost avoidance. The rate changes shown in Table 6 include all categories of service and not just those identified by the savings assumptions used in Mercer’s original projection. There is no direct correlation that can be drawn from this analysis between the changes in these cost categories and the PCMH model. However, based on research from similar PMCH impact studies, the PCMH model likely had some influence on these results<sup>9</sup>.

**TABLE 6: PROJECTED COST AVOIDANCE IN MILLIONS**

PARTICIPANTS	2016	2017	2018	TOTAL
<b>MEDICAID</b>				
Children	\$22.1	\$33.9	\$36.7	\$92.7
Dual Eligible	\$12.0	\$11.0	\$(3.3)	\$19.7
Aged/Disabled (non-dual)	\$7.4	\$12.0	\$(12.9)	\$6.5
Other Adult	\$18.8	\$33.9	\$54.9	\$107.6

<sup>9</sup> Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at [http://www.pcpcc.org/sites/default/files/media/benefits\\_of\\_implementing\\_the\\_primary\\_care\\_pcmh.pdf](http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf)

PARTICIPANTS	2016	2017	2018	TOTAL
<b>COMMERCIAL</b>				
Individual	\$(129.8)	\$(140.2)	\$(130.3)	\$(400.3)
Group	\$186.3	\$125.4	\$179.6	\$491.3
<b>MEDICARE</b>				
Dual Eligible	\$(47.1)	\$5.3	\$(11.6)	\$(53.4)
FFS	\$(7.2)	\$11.2	\$10.4	\$14.4
Medicare Advantage	\$(52.7)	\$(8.7)	\$(3.5)	\$(64.9)
Total	\$9.8	\$83.7	\$120.1	\$213.6

Changes in membership due to environmental factors such as the increase in Medicaid Adult Other population, the Medicare FFS population and commercial individual population and decreases in commercial group population likely played a role in the fluctuations in PMPMs. Reported member months are shown in Table 7.

**TABLE 7: REPORTED MEMBER MONTHS**

PARTICIPANTS	2015	2016	2017	2018
<b>MEDICAID</b>				
Children	2,514,224	2,614,066	2,618,276	2,441,124
Dual Eligible	309,047	320,435	330,005	333,189
Aged/Disabled (non-dual)	205,855	212,392	217,537	214,805
Other Adult	582,021	626,637	673,363	630,237
<b>COMMERCIAL</b>				
Individual	1,222,091	1,261,180	1,284,680	1,340,765
Group	4,560,579	3,748,770	3,405,951	3,528,652
<b>MEDICARE</b>				
Dual Eligible	419,706	453,841	454,408	449,487
FFS	1,926,669	1,994,524	2,101,690	2,161,231
Medicare Advantage	624,663	702,649	700,803	649,087
Total	12,364,855	11,934,495	11,786,713	11,748,576

# 6

## CONCLUSION

Idaho's SHIP model testing is occurring within a dynamic health system environment, therefore, the results of this analysis cannot be directly attributed to the impact of the SHIP PCMH model on utilization and costs. These metrics are also impacted by other payer models being implemented in the State, changes occurring in membership enrollment, and changes in members' utilization of services.

While reported costs increased from 2015 to 2018 by \$874.0 million, the cost trend of 14.9% was lower than NHE projected trends which indicates a level of cost avoidance. When combining the actual CY 2016 results reported for three of the four largest commercial payers, Medicare and Medicaid show overall costs running lower than projected by \$213.0 million.

The cost avoidance assumptions for hospital, emergency department, specialty care, lab, and diagnostic imaging all showed overall rate improvements, showing a total cost savings of \$676.3 million. However, commercial and Medicare payers did not realize the projected cost avoidance for generic drug usage, as pharmacy costs were an astounding \$496.0 million more than projected by NHE trends.

IDHW projects to spend roughly \$35.0 million of the Model Testing grant, and the transition to the PCMH model in Idaho is not complete. However, noting there is no direct correlation between the cost avoidance estimates and the SHIP model test, the cost avoidance total of \$213.6 million shows an ROI of 510.2% overall for the grant, representing 1.2% of reported annual expenditures. For government business, Medicare and Medicaid together showed cost avoidance of \$122.6 million for an overall ROI of 250.2% for the grant.

Since projections of cost avoidance relied heavily on projections of data for trend and for completing 2018 actual results, Mercer recommends revisiting the 2018 calculations of cost avoidance and ROI after actual data is available.

# APPENDIX A

## DATA REQUEST

### Example of Data Request Template Sent to Payers on March 2, 2017

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the grant Idaho received. Therefore, we are sending you the exact same template sent in 2015 and request that you send us updated results for calendar year 2016. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

For those whose current agreement needs updating, I've also attached the standard Mercer Client Confidentiality Agreement for review by you and your legal teams to ensure your data is protected and kept private. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

We'd like to start receiving data on **March 31, 2017** to meet the CMMI reporting requirements due at the end of April. If you're unable to meet that date, please let me know when you think you can get the template completed. We appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

**TABLE 8: EXAMPLE OF CY 201X**

	MEDICAID/CHIP				PRIVATE/ OTHER		MEDICARE		
	Adult	Child	Dual Eligible (Only)	Disabled/ Elderly (Without Duals)	Individual	Group	Dual Eligible	FFS/ Non- Duals (Parts A and B)	Medicare Advantage Part C
Member Months									
Inpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Emergency Department	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Urgent Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Outpatient Hospital	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Primary Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Specialty Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Diagnostic Imaging/X-Ray	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laboratory Services	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DME	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Dialysis Procedures	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Professional Other (e.g., PT, OT)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Skilled Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Home Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Custodial Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ICF/MR	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HCBS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

	MEDICAID/CHIP				PRIVATE/ OTHER		MEDICARE		
	Adult	Child	Dual Eligible (Only)	Disabled/ Elderly (Without Duals)	Individual	Group	Dual Eligible	FFS/ Non- Duals (Parts A and B)	Medicare Advantage Part C
Behavioral Health	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Prescription Drugs (Outpatient)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

## CATEGORY OF SERVICE CLASSIFICATIONS

Use the following logic in order to classify claims and expenses.

<b>EMERGENCY DEPARTMENT</b>	
	837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
	837P or CMS1500: Procedure codes 99281-99285, G0380-G0384, G0390
<b>URGENT CARE</b>	
	837I or UB04: Revenue code 0456
	837P or CMS1500: Procedure codes S9083, S9088 and/or Place of Service code = 20
<b>DIALYSIS</b>	
	837I or UB04: Revenue codes 082x–088x
	837P or CMS1500: Place of Service = 65 or Rendering Provider Type = ESRD Treatment or Dialysis Facility
<b>INPATIENT HOSPITAL</b>	
	837I or UB04
	Bill Type: 011x or 012x
	BH is to be split out into the BH bucket by revenue codes: 0114, 0116, 0124, 0126, 0134, 0136, 0144, 0146, 0154, 0156, 0204
<b>OUTPATIENT HOSPITAL (EXCLUDES ER)</b>	
	837I or UB04
	Bill Type: 013x or 083x
<b>SNF</b>	
	837I or UB04: Bill Type 02xx
<b>PROFESSIONAL PRIMARY CARE</b>	
	837P or CMS1500: Rendering Provider Type: Family Practice, General Practice, Internal Medicine, Pediatrics, Preventive Medicine, Geriatrics
	<a href="http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf">http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf</a>

<b>PROFESSIONAL SPECIALTY CARE</b>	
	837P or CMS1500: Rendering Provider Type: Allergy & Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology
	<a href="http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf">http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf</a> Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties Only CMS Specialty Codes 01–99 are to be included
<b>PROFESSIONAL OTHER</b>	
	837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care
<b>DIAGNOSTIC IMAGING/X-RAY</b>	
	837P or CMS1500: Procedure Codes 70000–79999
<b>LAB SERVICES</b>	
	837P or CMS1500: Procedure Codes 80000–89999
<b>DME</b>	
	<a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html</a>
	DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data
<b>HH</b>	
	837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989
	837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161
	POS = 05 or Provider Type = Home Health Agency
<b>CUSTODIAL CARE</b>	
	837P or CMS1500: POS = 13, 14, 32, or 33 or Procedure Code: 99324–99339
<b>ICF/MR</b>	
	837I or UB04: Bill Type 065x or 066x and Diagnosis codes 317.x-319.x for MR
<b>BH</b>	
	837P or CMS1500: Primary diagnosis codes 290–319 (excluding ICF claims)
	837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204

<b>HCBS SERVICES FROM WAIVER APPLICATION</b>	
	Residential Habilitation
	Respite
	Supported Employment
	Community Support Services
	Financial Management Services
	Support Broker Services
	Adult Day Health
	Behavior Consultation/Crisis Management
	Chore Services
	Environmental Accessibility Adaptations
	Home Delivered Meals
	Non-Medical Transportation
	Personal Emergency Response System
	Skilled Nursing
	Specialized Medical Equipment and Supplies
<b>PRESCRIPTION DRUGS</b>	
	NCPDP or presence of NDC code
<b>OTHER</b>	
	All other claims that don't fall into the above COS

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Statewide Healthcare  
Innovation Plan

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State-Level Evaluation  
Team (SET) Presentation

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001

1

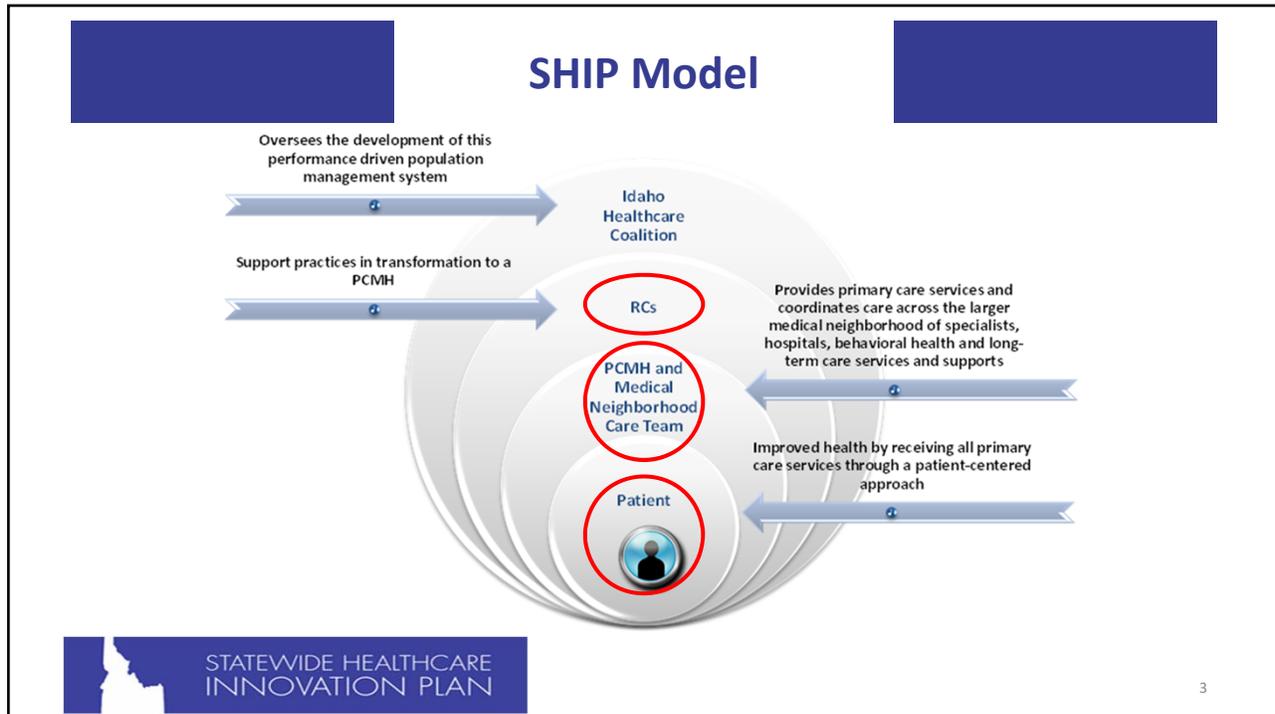
## Framework for Presentation

- SHIP Goal 1 – Patient Centered Medical Home (PCMH) transformation
- SHIP Goals 2 & 5 – Health Information Technology EHR connections/data analytics
- SHIP Goals 3 & 4 – Regional Collaboratives and Virtual PCMH
- Brief recommendations for ongoing healthcare transformation in Idaho

\*Goals 6 (payment mechanisms) & 7 (sustainability) covered by Mercer

\*\*As part of Goal 4, the Project ECHO Telehealth evaluation is discussed in the IHC summary report included in the 1/9/2019 IHC agenda attachments.

2



## Methodological Approach - Goal 1

The Idaho SET evaluation is a descriptive, qualitative effort providing a baseline for Idaho's Patient Centered Medical Home (PCMH) transformation. It discusses:

- 1) what patients want {Idaho only SIM State to talk with patients}
- 2) what clinics need in additional support
- 3) what patients and their healthcare team can do together to move to a value based payment system

4

## SET Evaluation Details

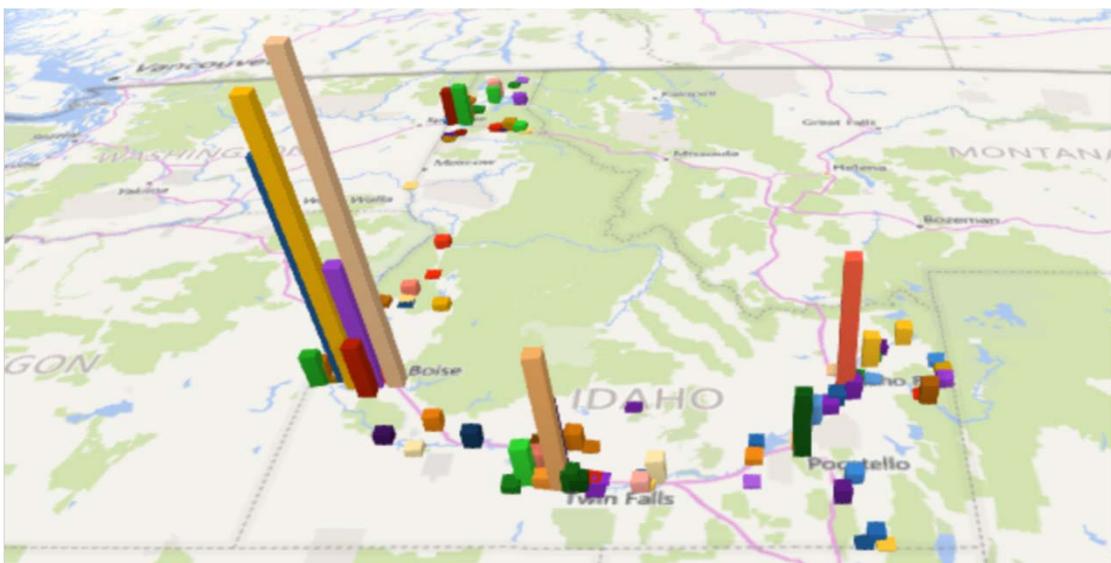
All participants giving feedback are volunteers

Coding and other methodological details discussed in 100+ page appendix in final SET report (to be completed by the end of the grant period)

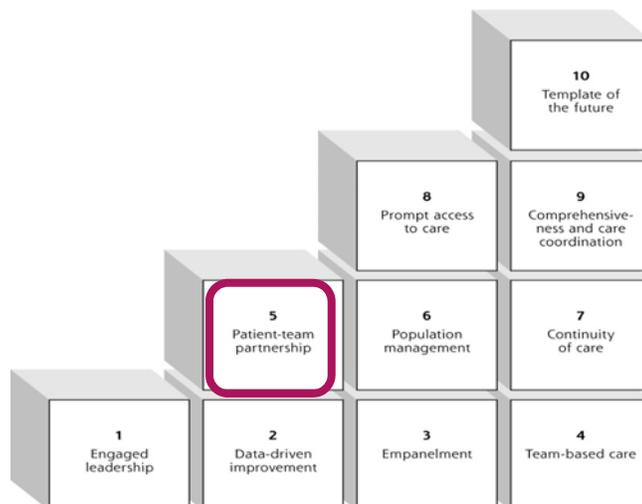
Very few statistically significant relationships observed between type of county (urban, rural and frontier) or type of clinic (community health center, independently owned, hospital owned, or rural health center)

5

## 1,143 Patients Interviewed 92 SHIP Cohort Clinics



## PCMH Building Blocks



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## SHIP Goal 1

### Patient-Centeredness measured with 7 open ended questions for 1143 patients

- Patients' expectation of their own responsibilities for their personal health
- Care received from their healthcare team in the past year
- Patient's definition of primary care healthcare team's responsibilities for patient care
- Additional resources and/or help needed by patient to better take care of their health
- Patient's plans to change their health behavior in the next 6 months
- Role of their primary care healthcare team in helping with those changes
- Patient's own personal barriers to better self-care

8

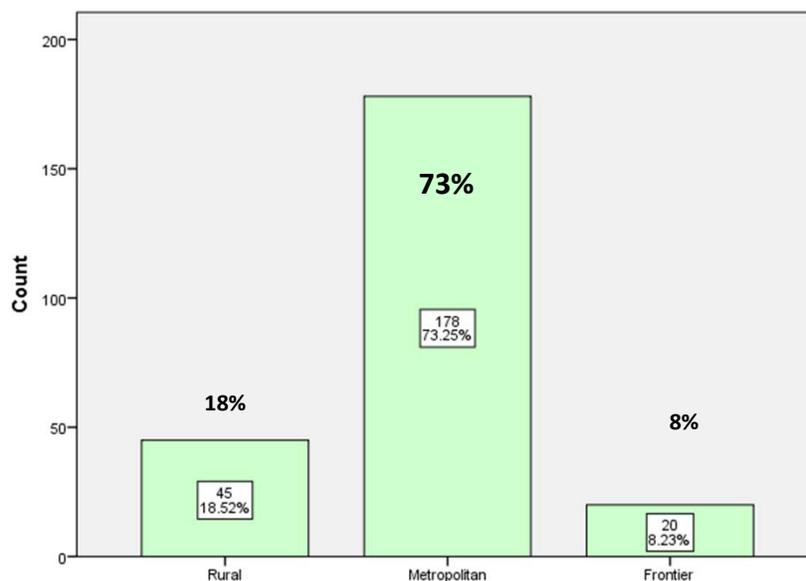
## Patient Exercise Profile

Ready to Exercise: Patients defined as defining regular exercise as personal responsibility for health, **AND**, planning to improve exercise in next 6 months

- Profile gives information on what motivates patients to follow through on their own definition of health and personal responsibilities
- Profile is basis for expanding patient- team partnership within boundaries of what primary healthcare clinics can, and, cannot do themselves
- Profile starts to identify elements of medical health neighborhood that have potential to contribute to improved health

9

### Ready to Exercise, Living in Rural, Metropolitan and Frontier Counties (243 patient from 16 SHIP PCMH clinics around Idaho)

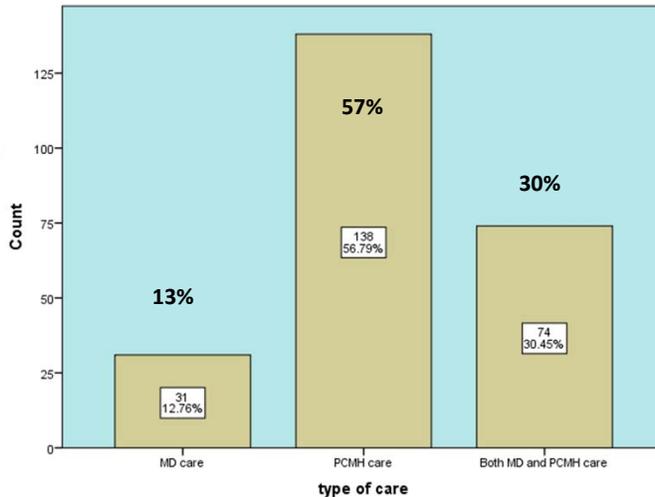


10

## Ready to Exercise, Type of Primary Health Care they want (243 patients)

Chi-Square Tests			
Value	df	Asymptotic Significance (2-sided)	
Pearson Chi-Square	7.758 <sup>a</sup>	2	.021
Likelihood Ratio	7.863	2	.020
Linear-by-Linear Association	3.201	1	.074
N of Valid Cases	229		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 16.51.



10 codes for Patient Centered Medical Home Care

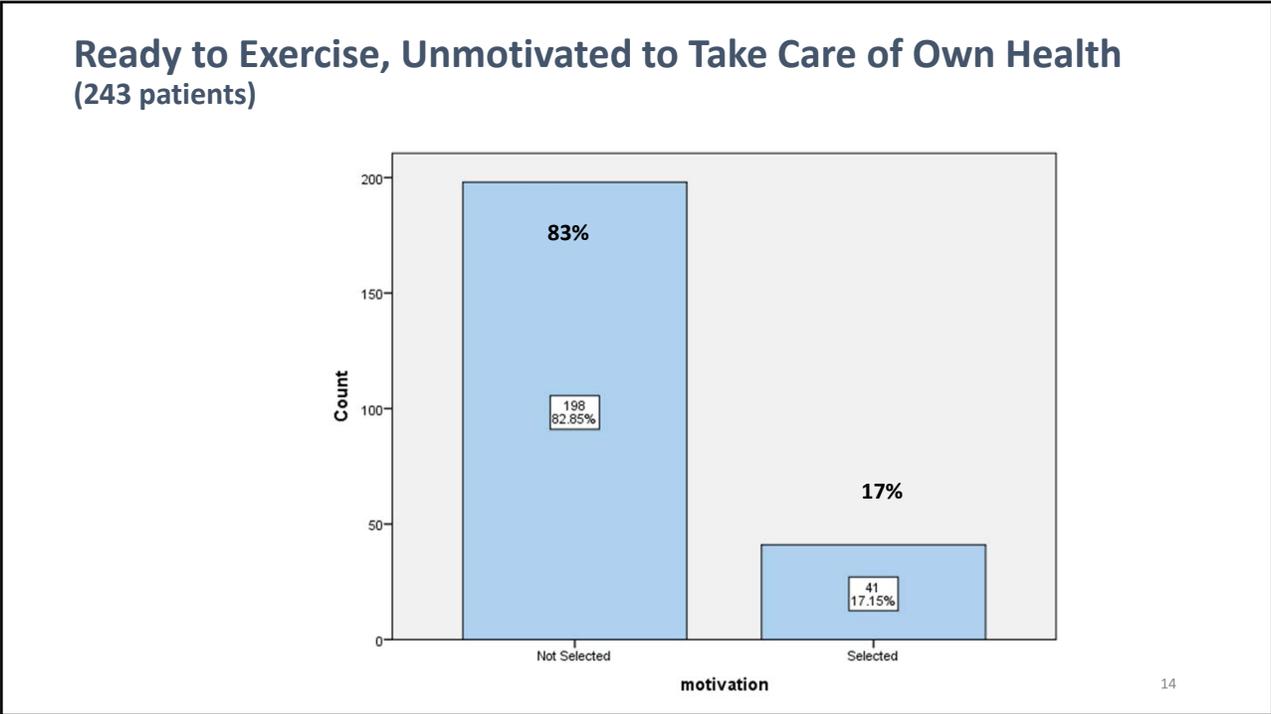
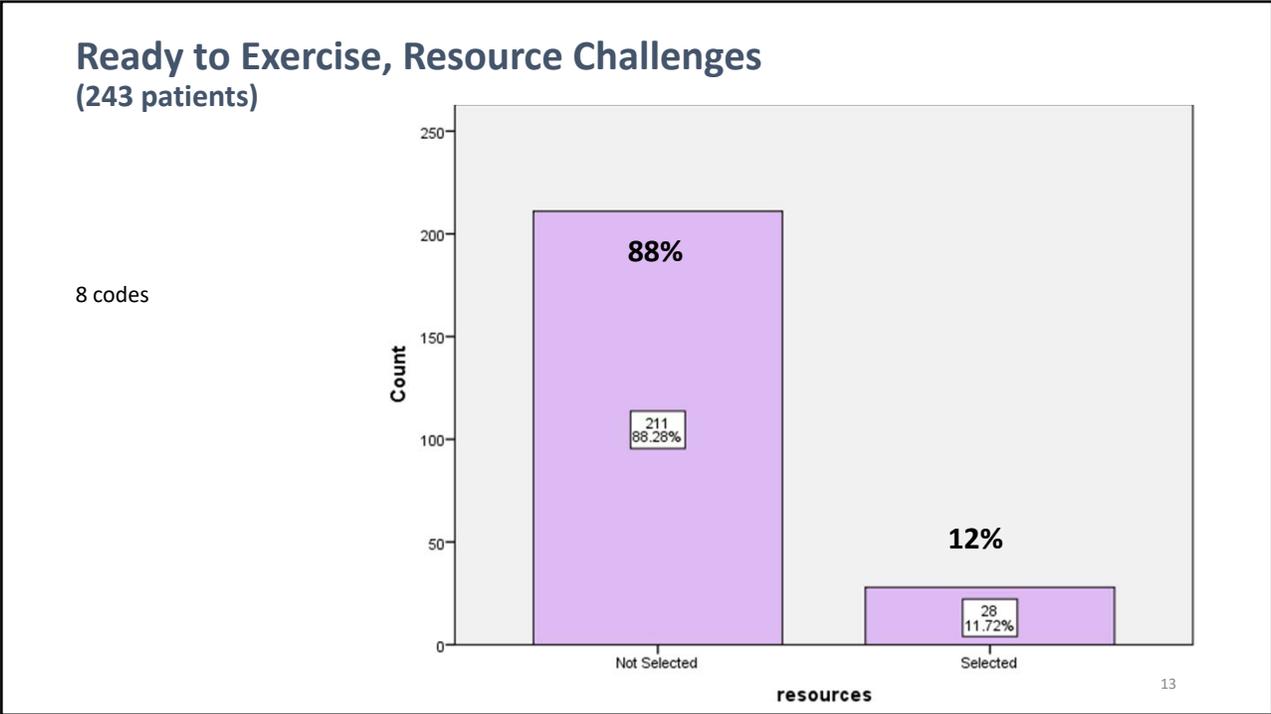
5 codes for MD/basic primary care

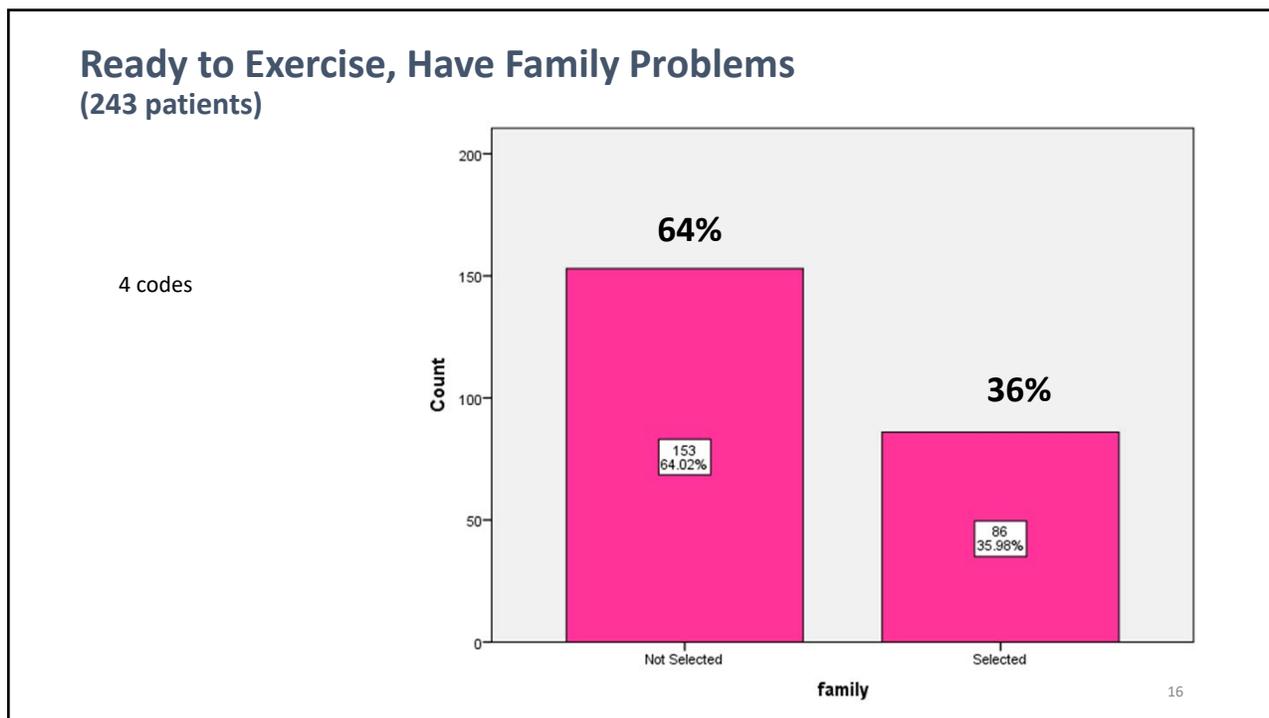
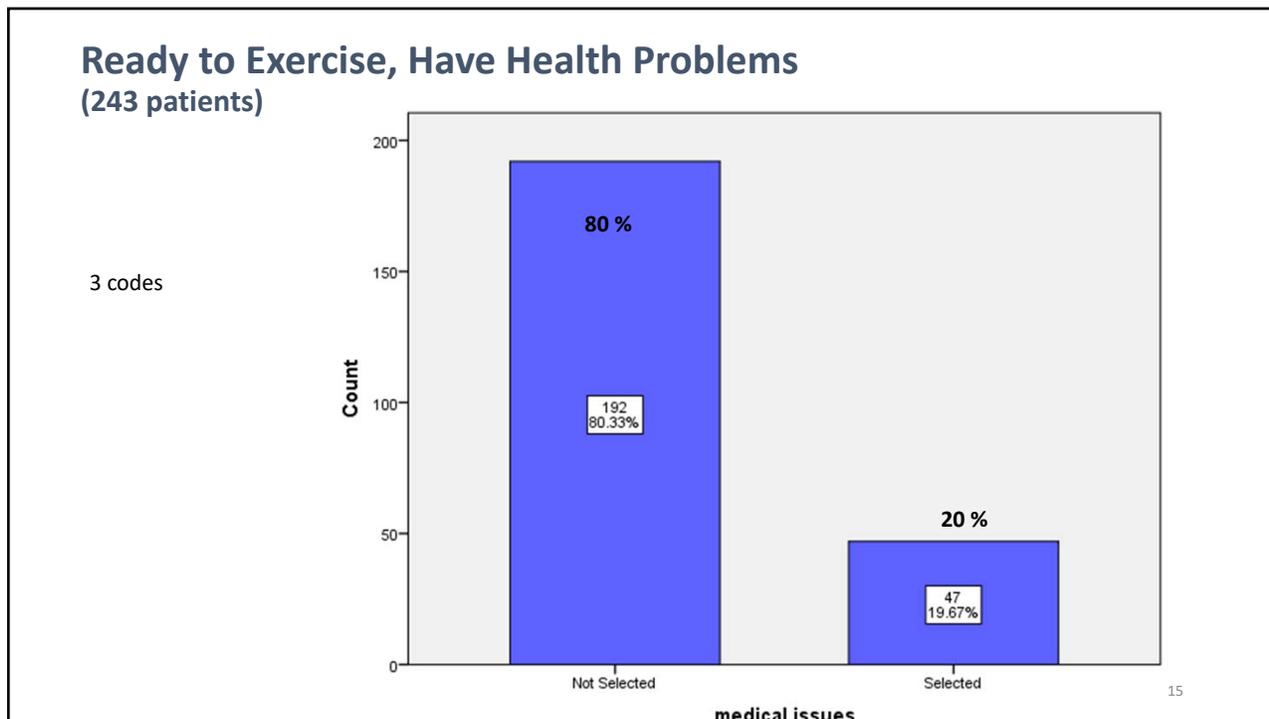
11

## Ready to Exercise and Role of Social Determinants of Health

23 Social Determinants  
listed by Patients





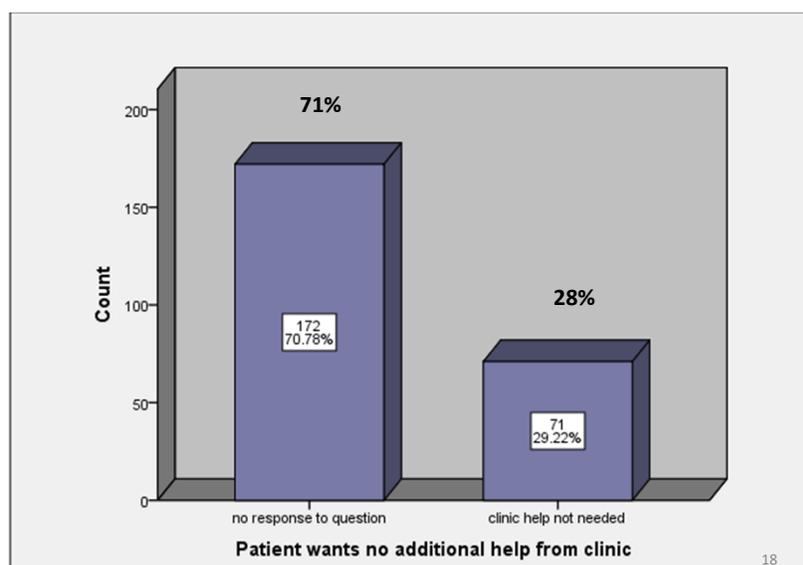


## Patient 6-Month Change Feedback

Patient's Assessment of Primary Healthcare Clinic's Role in helping achieve changes in 6 months in a patient's health

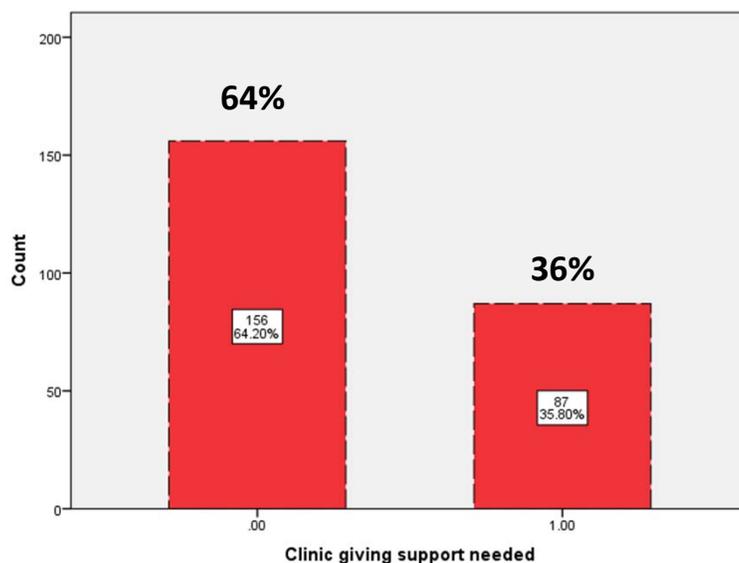
17

### Ready to Exercise, No Additional Help Wanted from Clinic (243 patients)



18

## Ready to Exercise, Clinic Giving Patient Help They Need (243 patients)



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## Additional Resources/Help Needed by Patient to Better Take Care of Their Health

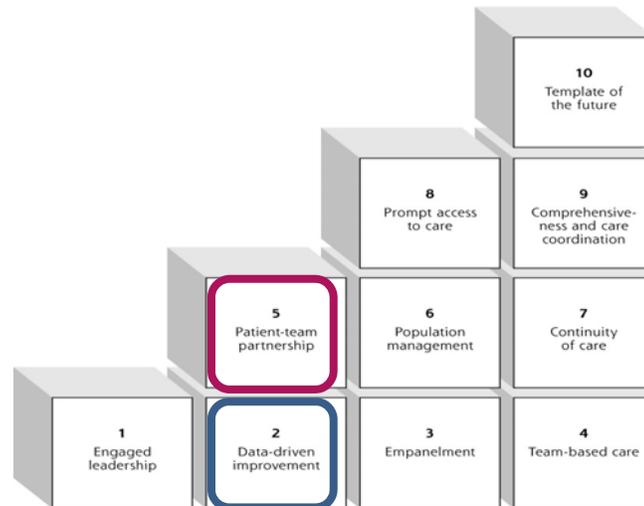
148 interviewees suggested specific additional services they would like to receive.

The top three:

- Increased explanation of care recommendations and more communication with their healthcare team (32%)
- Counseling on nutrition (18%)
- Care coordination (18%)

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## PCMH Building Blocks



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## SHIP Goal 2

### Accomplishments:

- Establishment of connectivity of 152 (92%) of SHIP clinics by 1/31/2019

### Hurdles to address in future HIT transformation efforts:

- Maintenance fees
- Electronic Health Record System's capacity for connection with Idaho Health Data Exchange
- Details of Memos of understanding and Business agreements
- Maintaining confidentiality of Protected Health Information

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## SHIP Goal 5

### Timeline and Evaluation Observations

### Example of Rapid Cycle Evaluation

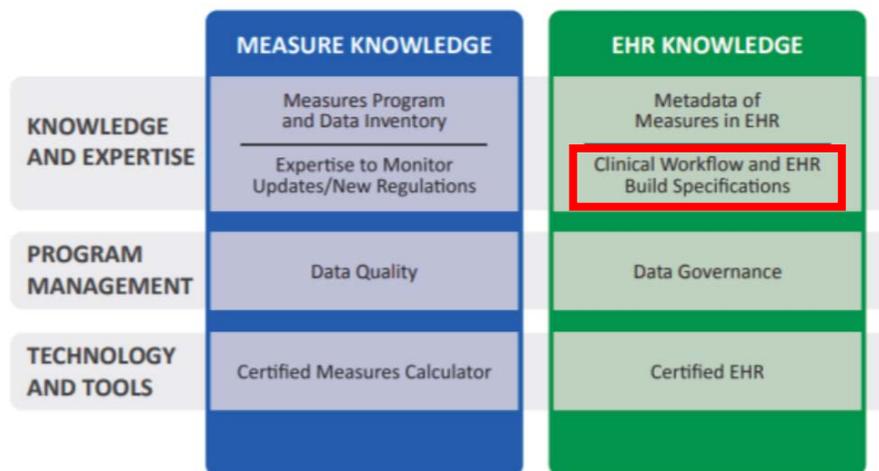
- Challenges with analytics dashboard as well as results of data gap analyses reported regularly to the SHIP Data Governance Workgroup (DGW) beginning 8/2017 identify training opportunities for clinics.
  - Identified imperative for practices to understand data quality and data governance
- 11/2017 update to DGW on data quality issues
- IDHW, IHDE, HTS and other parties review data quality issues 9/2017-3/2018
- Technical Assistance approved with ONC consultant beginning 3/2018 with IDHW, IHDE and SET
- 7/30/2018 DGW announced data quality pivot
- 8/2018 SET Use Case in PHDs 6 & 7 underscored the importance of small, rural clinic staff being knowledgeable in Measure Knowledge and EHR Knowledge Domains
  - Majority of staff had beginner's understanding of Excel, data management, and clinical quality measures

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## Goal 5

### Health Information Technology

#### HIT Curriculum Development: Measure Knowledge and EHR Knowledge Domains



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## Goal 5

### Health Information Technology

Curriculum Development:

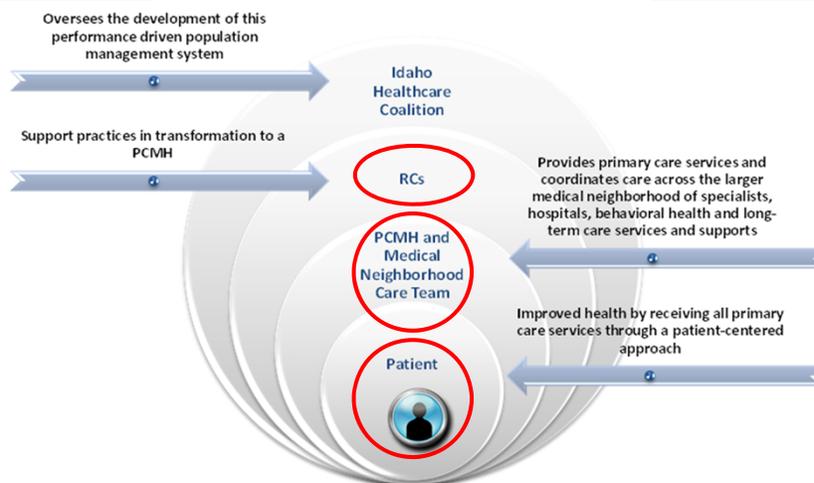
**Measure Knowledge Issues** for Clinic staff addressed in Health Information Training Curriculum being developed by BSU Health informatics team and HMA consultant

- **Data entry:** understanding the necessity of correct placement of information in Electronic Health Record and using correct type of information
- **Measure definition and specification:** understanding the necessity of matching clinical definition of measure with measure specification, and, measure definition available in version of EHR

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## SHIP Model

### Goals 3 & 4



STATEWIDE HEALTHCARE  
INNOVATION PLAN

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## Goal 3

### Regional Collaboratives

- Medical Health Neighborhood as “community”
  - Address social determinants of health
- Regional Collaborative as “convener”
  - Members value participation, engagement, collaboration
  - Stories of impact across Idaho
- Hope for continuation of “a group like this.”
  - Need for organizational infrastructure
- \*Results echoed in coding project by BSU graduate Research Assistant

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## Goal 4

### Virtual PCMH: Community Health Workers

- Impact patient engagement
- Address social determinants of health
- Contribute uniquely to health care team, clinic, and community
- Other SIM states
  - formalized Community Health Worker role, and certification
  - state-level governance and oversight
  - continually engage stakeholders to grow and govern this role
  - continue to explore avenues for funding this role

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## Goal 4

### Virtual PCMH Community Health EMS (CHEMS)

- Demonstrated value
  - Unreliable financing and other barriers
  - Motivated EMS agencies and fire departments
- 
- \*Results align with CHEMS White Paper developed by SET team members e.g. BSU Nursing Faculty member and U of I Business Department Head (included in the final SET report)

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## Next Steps

### Goal 1

Support clinics on how to expand patient- team partnership through patient-centered services

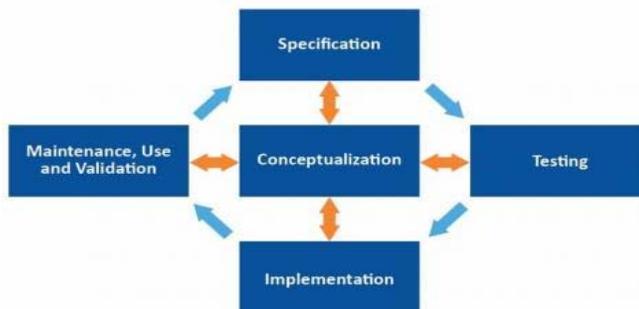
- a) team based care,
- b) care coordination,
- c) quality improvement, &
- d) patient engagement



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## Next Steps Goals 2 & 5

Support educational efforts for clinic staff and health science university students on understanding electronic Clinical Quality Measures' lifecycle



<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/BlueprintVer14.pdf>

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## Next Steps Goals 3 & 4

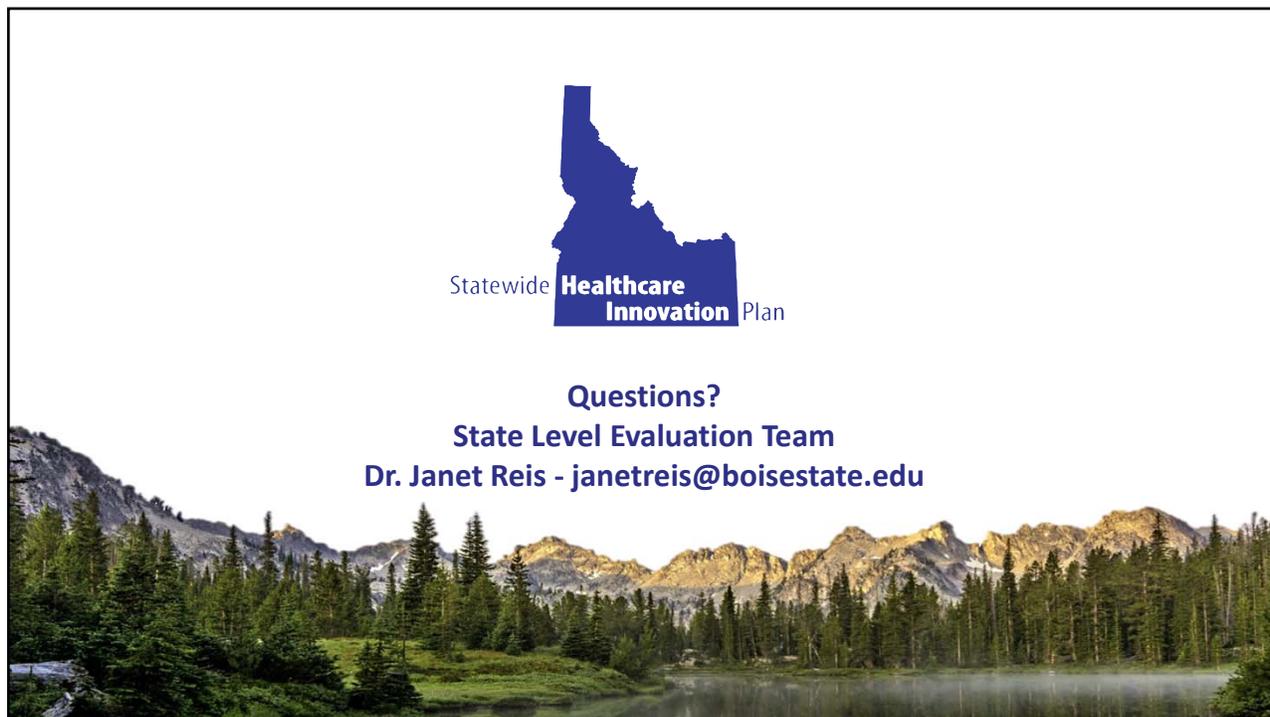
Maintain momentum generated during SHIP

Engage stakeholders at all levels

Introduce state-level initiatives to formalize and govern the roles and credentialing of CHWs and CHEMS

Build infrastructure to support the work of the medical health neighborhoods, regional collaboratives, community health workers and community health EMS.

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Statewide **Healthcare  
Innovation** Plan

**Questions?**  
**State Level Evaluation Team**  
**Dr. Janet Reis - [janetreis@boisestate.edu](mailto:janetreis@boisestate.edu)**



Statewide **Healthcare  
Innovation** Plan

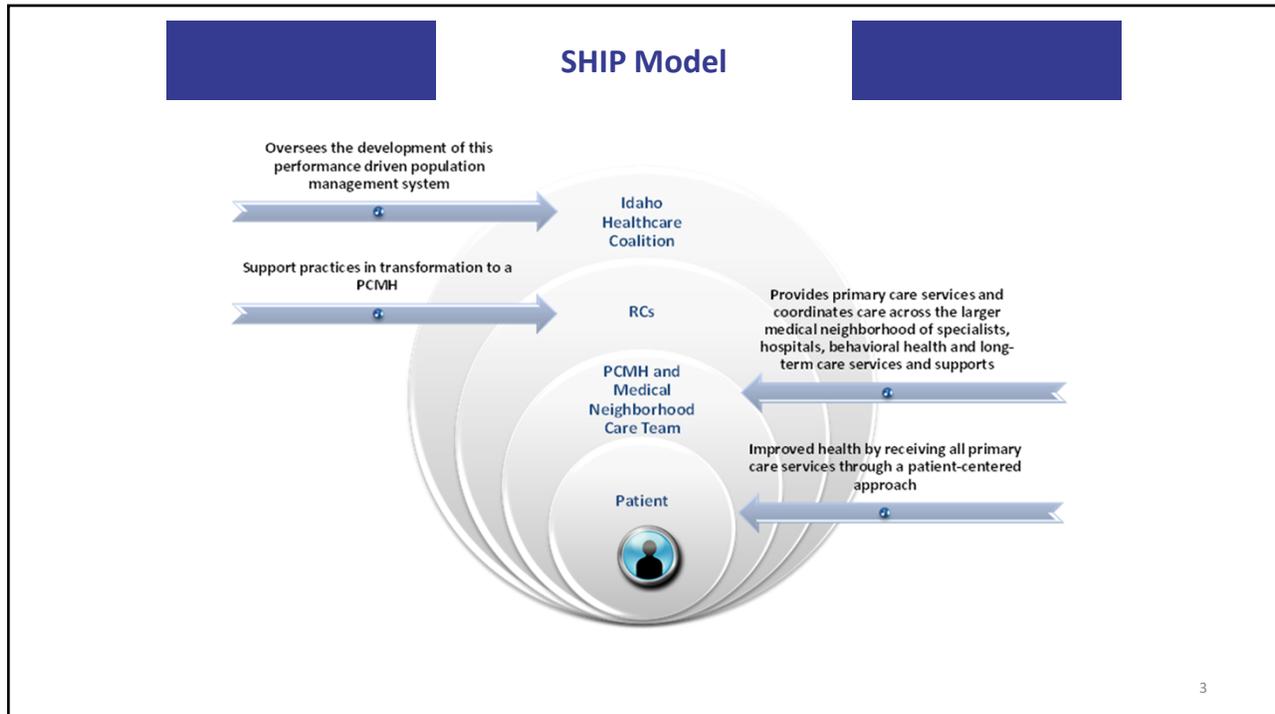
Summary of the State-Level Evaluation of the  
Statewide Healthcare Innovation Plan (SHIP)  
University of Idaho  
Boise State University

1

**Idaho's State-level  
Evaluation of SHIP**

- University of Idaho and Boise State University began a collaborative effort May 2016 for evaluation of Idaho's SHIP
- University effort compliments the Federal level evaluation of State Innovation Model States conducted by the Research Triangle Institute (RTI)

2



### Essential Methodological Issues

The Idaho SET evaluation is a DESCRIPTIVE, QUALITATIVE effort providing a baseline for Idaho's Patient Centered Medical Home (PCMH) transformation and discusses:

- 1) what patients want
- 2) what clinics need in additional support and
- 3) what patients and their healthcare team can do together to move to a value based payment system

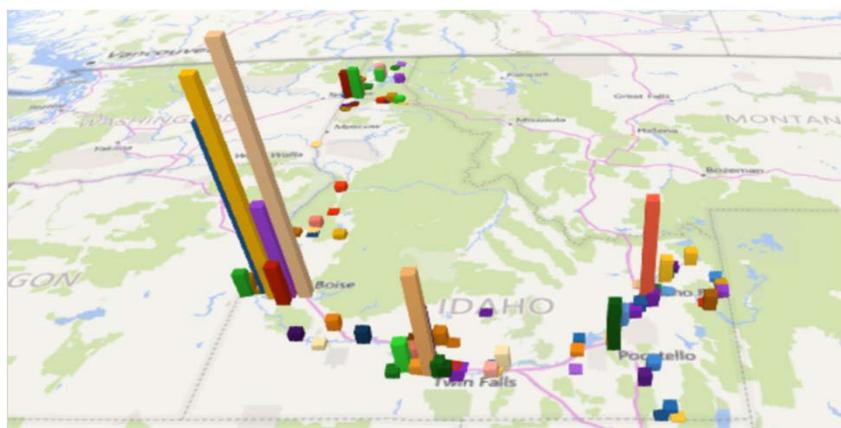
4

## SET Evaluation Details

- All participants giving feedback are VOLUNTEERS
- Coding and other methodological details covered in 100+ page appendix in final report (to be completed by the end of the grant period).
- Very few statistically significant relationships observed between type of county (urban, rural and frontier) or type of clinic (community health center, independently owned, hospital owned, or rural health center)

5

**1,143 Patients were  
interviewed from 92  
SHIP Cohort Clinics**



6

## Framework for Presentation of State-Level Evaluation Team (SET) Information

- 1/9/2019 Idaho Healthcare Coalition (IHC) Presentation will cover SET data collection from 9/16-9/18
- SHIP Goal 1: Patient and clinic staff interviews
- SHIP Goals 2 & 5: Overview of milestones in Health Information Technology accomplishments, issues and future directions
- SHIP Goal 3: Regional Collaborative Accomplishments
- SHIP Goal 4:
  - Project ECHO
  - CHWs and CHEMS addressed in 1/9/2019 IHC presentation and in the final SET report
- (Goals 6 & 7 were covered by Mercer)
- Information is summarized to help guide next steps for Idaho's ongoing healthcare transformation

7

## Patient- Centeredness

- Need to understand patient's own perspectives on what constitutes patient centered care as compared to fee for service episodic care. What are patients willing and able to do with their healthcare team in a patient centered medical home?
- Patient's definition of patient-centeredness is DIFFERENT from patient satisfaction with care as measured in CAHPS:  
Consumer Assessment of Healthcare – Providers and Systems

8

## Road map for value based change from In-person patient interviews



"Alone we can do so little, together we can do so much." --  
*Helen Keller*

9

### SHIP Goal 1

#### **Patient-Centeredness was measured with 7 open ended questions for 1143 patients**

- Patients' expectation of their own responsibilities for their personal health
- Care received from their healthcare team in the past year
- Patient's definition of primary care healthcare team's responsibilities for patient care
- Additional resources and/or help needed by patient to better take care of their health
- Patient's plans to change their health behavior in the next 6 months
- Role of their primary care healthcare team in helping with those changes
- Patient's own personal barriers to better self-care

10

## SHIP Goal 1

### 1. Patients' expectation of their own responsibilities for their personal health

- Overall, 68% of patients defined responsibility for their own health as a personal responsibility not involving their healthcare team
- Overall, 54% defined their responsibility as following MD and healthcare team's directions
- A combined subset, 36% of patients defined responsibility as encompassing both personal and following MD and healthcare team's directions

11

## SHIP Goal 1

### 2. Care received from healthcare team in past year

- Overall 70% of patients reported receiving at least one basic primary care medical service in the past year. Management of chronic conditions (46%) and regular checkups (43%) were the most frequently reported of these Services
- Overall 43% reported receiving at least one element of PCMH services (define PCMH services). Reciprocal listening (31%) and care coordination (31%) were the most frequently cited
- A combined subset of 22% of these patients reported receiving both PCMH and Basic primary care

12

## SHIP Goal 1

### 3. Patient's definition of primary care healthcare team's responsibilities for patient care

- Overall, 78% of all patients named at least one element of PCMH services verses basic care as something they felt their healthcare team was responsible for providing. ***Communication was by far the most frequent aspect of care sought (55% wished to have a healthcare team that listened to the patients' concerns and 35% wished the healthcare team would make sure the patient understood recommendations for care).***
- Overall, 43% of all patients listed at least one basic medical service as a healthcare team responsibility ***The most frequently occurring element patients expected was an informed and accurate differential diagnosis from their provider (60%) and prescribing of correct medications (27%).***
- A combined subset of 28% of these patients expected to receive both PCMH and Basic primary care

13

## SHIP Goal 1

### 4. Additional resources and/or help needed by patient to better take care of their health

- One hundred and forty-eight interviewees had specific additional services they would like to receive.

The top three new services were:

1. Increased explanation of care recommendations and more communication with their healthcare team (32%)
2. Counseling on nutrition (18%)
3. Care coordination (18%)

14



## SHIP Goal 1



### 5. Patient's plans to change their health behavior in the next 6 months

Most frequently cited changes planned for the next 6 months:

- Improvements in exercise (41%)
- Diet (31%)
- Within these two groups saying they were going to change diet or exercise, 21% also stated they had a responsibility to exercise and 20% stated they had a responsibility to eat properly

15



## SHIP Goal 1



### 6. Role of their primary care healthcare team in helping with those changes

- Overall, 38% of participants affirmed that their healthcare team was doing everything needed and doing a good job
- Overall, 32% could not state any additional role for their healthcare team

16

## SHIP Goal 1

### 7. Patient's own personal barriers to better self-care

- Of the 20 specific barriers to better self-care, the top three were:
  1. finances (15%)
  2. health issues (12%)
  3. personal motivational issues (12%)
- An additional 29% stated that nothing prevented them from taking better care of their health

17

## SHIP Goal 1

### Patient's Access to care: 1143 patients were asked about access to healthcare services

- Overall 61% of patients defined access as being able to see a physician and/or healthcare team when needed
- Overall 84% of patients reported being able to easily schedule an appointment with a doctor when they needed one
- Overall 89% had reliable transportation, 88% had ready access to primary care in the past 6 months, 60% had ready access to dental care, and 57% had insurance coverage
- In contrast, 44% of patients had specialty referrals available, and 33% reported access to behavioral health

18

## SHIP Goal 1

### Feedback to SHIP PCMH Clinics

- Each clinic received a summary report on the patient interviews highlighting areas where patients sought collaboration with their healthcare team
- Clinics were able to incorporate these summaries as an element of patient engagement into development of their NCQA PCMH applications

19

## SHIP Goal 1

### SHIP Clinics' Patient Centered Medical Home Journey

- In-person or phone interviews with PCMH clinic staff at 127 clinics were structured and coded to inquire as to the clinics' successes and priorities for the six NCQA (National Committee for Quality Assurance) PCMH Standards.
- The PCMH Portal Notes used over the course of the three cohorts of SHIP PCMH clinics to record and track transformation plans, progress and concerns/interest were also coded for content using these same six NCQA PCMH standards.

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## SHIP Goal 1

### SHIP Clinics' Patient Centered Medical Home Journey

Top two PCMH accomplishments and future priorities according to clinic staff interviews and PCMH portal notes:

- Access and continuity of care (50%)
- Care coordination (45%)
- Quality Improvement was a top priority for the coming year (average of 71%).

21

## SHIP Goal 2

### Health Information Technology

- Accomplishments :
  - Establishment of connectivity of 152 (92%) of SHIP clinics to the Idaho Health Data Exchange (IHDE) by 1/31/2019
- Hurdles to address in future HIT transformation efforts:
  - Maintenance fees
  - Electronic Health Record System's capacity for connection with IHDE
  - Details of Memos of understanding and Business agreements
  - Maintaining confidentiality of Protected Health Information

22

## SHIP Goal 5

*Success of Data Analytics System predicated on consistent quality data generated by clinical organizations*

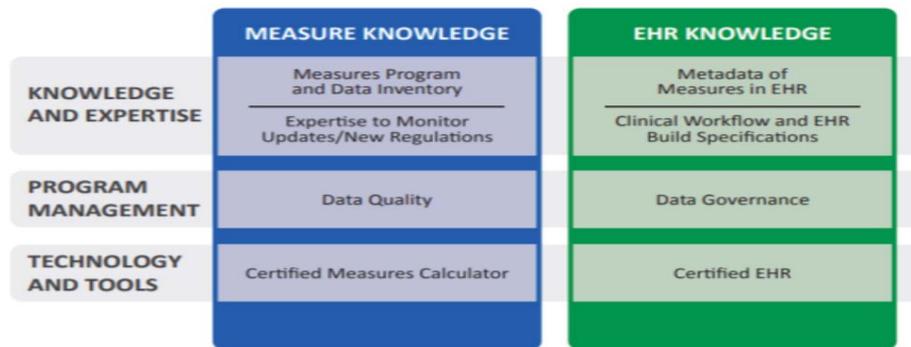
### Goal 5: Timeline and Evaluation Observations

- Challenges with analytics dashboard as well as results of data gap analyses reported regularly to the SHIP Data Governance Workgroup (DGW) beginning 8/2017 identify training opportunities for clinics.
  - Identified imperative for practices to understand data quality and data governance
- 11/2017 update to DGW on data quality issues
- IDHW, IHDE, HTS and other parties review data quality issues 9/2017-3/2018
- Technical Assistance approved with ONC consultant beginning 3/2018 with IDHW, IHDE and SET
- 7/30/2018 DGW announced data quality pivot
- 8/2018 SET Use Case in PHDs 6/7 underscored the importance of small, rural clinic staff being knowledgeable in Measure Knowledge and EHR Knowledge Domains
  - Majority of staff had beginner's understanding of Excel, data management, and clinical quality measures

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## SHIP Goal 5

### Health Information Technology – HIT Curriculum Development Measure Knowledge and EHR Knowledge Domains



24

## SHIP Goal 5

SHIP Goal 5: Health Information Technology Curriculum Development:  
**Measure Knowledge Issues** for Clinic staff addressed in Health Information Training Curriculum being developed by BSU Health informatics team and HMA consultant

- Data entry: understanding the necessity of correct placement of information in Electronic Health Record and using correct type of information
- Measure definition and specification: understanding the necessity of matching clinical definition of measure with measure specification, and, measure definition available in version of EHR

25

## SHIP Goal 5

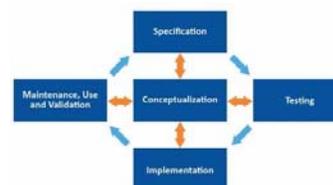
### EHR Knowledge Issues for Clinic staff

Data entry:

- Understanding the necessity of correct placement of information in Electronic Health Record (EHR)
  - Structured vs Unstructured
- Using appropriate data elements
  - Smoking Cessation Workflow example of a process measure requiring coordination of effort across a team for patient care
    1. clinic staff responsibilities in a clinic workflow for patient care
    2. the recording of those responsibilities in an EHR as appropriate
    3. the generation of a clinical quality measure from the accumulated, specified codes for that measure

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## Other HIT curriculum modules



- Design of clinical quality measures
- Definition/specification of clinical quality measures
- Testing clinical quality measures
- Maintenance, use and validation of clinical quality measures

- Curriculum Development Resources:

[https://cmit.cms.gov/CMIT\\_public/UserGuide](https://cmit.cms.gov/CMIT_public/UserGuide)

[https://cmit.cms.gov/CMIT\\_public/ListMeasures](https://cmit.cms.gov/CMIT_public/ListMeasures)

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/BlueprintVer14.pdf>

[https://www.ihe.net/uploadedFiles/Documents/QRPH/IHE\\_QRPH\\_WP\\_eCQM\\_Standards.pdf](https://www.ihe.net/uploadedFiles/Documents/QRPH/IHE_QRPH_WP_eCQM_Standards.pdf)

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## SHIP Goal 5

### Recommendations

- Future data workgroups are constituted with the groups below with each group having an equal voice in the governance process:
  - clinical content experts
  - technical HIT experts
  - policy experts
  - program administrators

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## Goal 3: Regional Collaboratives (RCs)

### RC accomplishments:

Monthly Public Health District SHIP Manager reports on RC activities coded using NCQA PCMH Standards

- Four of the five 2017 NCQA PCMH content areas appear in the top ten most frequently occurring RC activities. The PCMH content area of Access to Care was cited much less frequently.
- Five the seven SHIP Goals appear in the 10 most frequently occurring activities
- Goal 1 Coaching/PCMH Transformation technical assistance by far the most commonly reported across the 7 Regions (not differentiated by HMA or QI specialist)

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## Goal 4: Project Echo (Extension for Community Healthcare Outcomes)

- Project ECHO, a SHIP funded initiative is sponsored by the University of Idaho through the University of New Mexico's Project ECHO model
- Since March 2018, the U of Idaho's program has led biweekly sessions on opioid addiction and treatment. The evaluation reported here is based on patient case studies presented in the 2<sup>nd</sup> half of each session.
- Additional Information about the content of the ECHO program can be found @ <https://www.uidaho.edu/academics/wwami/echo>

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## Goal 4: Project Echo (Extension for Community Healthcare Outcomes)

### Project Echo evaluation

- 9 patient case studies were transcribed and coded by two Masters in Health Sciences graduate students for the following themes. Inter-rater reliability was 85%.
- Patient referred from another provider yes/no/ not cited
  1. Count of frequency of citation of medication reconciliation challenges
  2. Count of frequency of citation of medication/opioid overdose challenges
  3. Count of frequency of citation of patient mental health challenges
  4. Count of frequency of citation of medication reconciliation tapering/reduction challenges

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## Goal 4: Project Echo (Extension for Community Healthcare Outcomes)

### Project Echo: Frequency of Issues in Patient Case Studies

- Patient referred from another provider yes: 66%
  1. Medication reconciliation challenges in case study (32%) and in expert panel response (21%)
  2. Medication/opioid overdose challenges in case study (24%) and in expert panel response (20%)
  3. Patient mental health challenges in case study (23%) and in expert panel response (27%)
  4. Medication reconciliation tapering/reduction challenges in case study (27%) and in expert panel response (31%)

32

## Goal 4: Virtual PCMH

### Covered in the 1/9/19 Presentation to the IHC

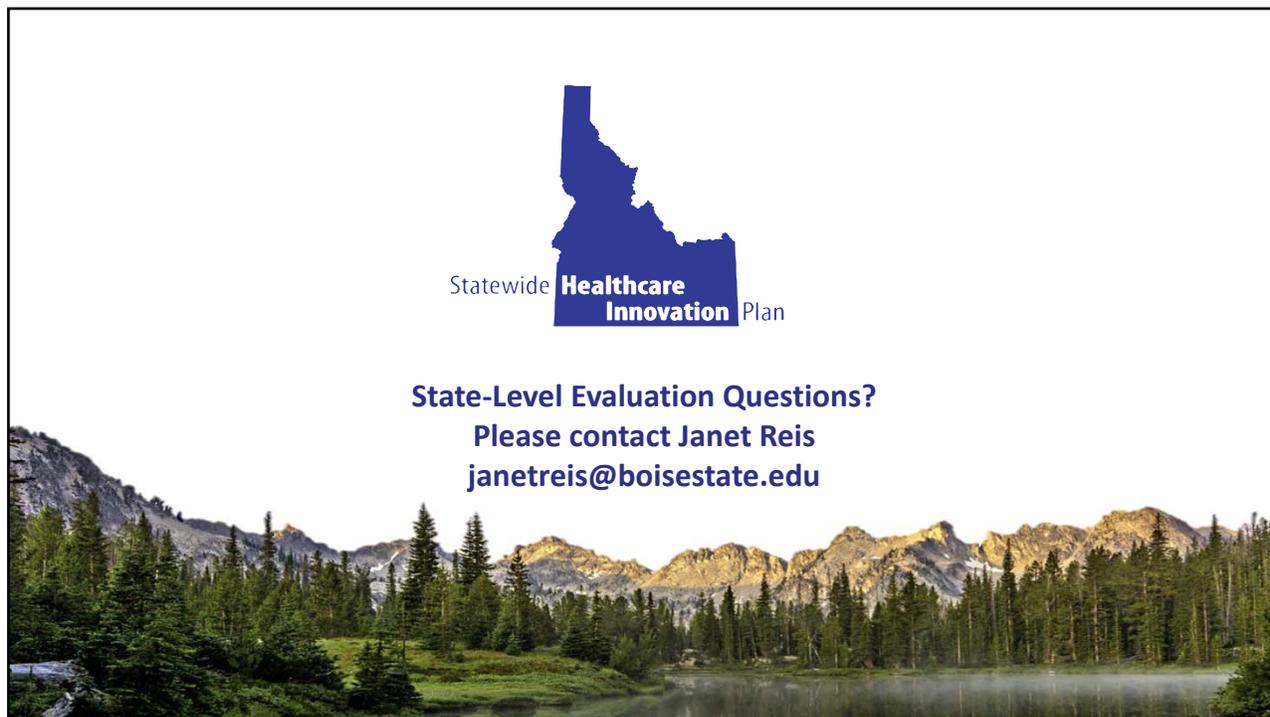
- **Community Health Workers**
- **Community Health Emergency Management Services (CHEMS)**

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## Recommendations

- Specific clinic staff training in basic HIT functions enabling clinics to participate in value based reporting as identified through SHIP Goals 2 & 5
- Prototypes for operationalizing referral partnerships in a primary care clinic's medical health neighborhood enabling clinics to address their patients' social determinants of health as identified through SHIP Goals 3 & 4
- Enhanced capacity for building patient-healthcare team partnerships and therefore maximizing care management and care coordination as identified through SHIP Goal 1

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Statewide **Healthcare  
Innovation** Plan

**State-Level Evaluation Questions?  
Please contact Janet Reis  
[janetreis@boisestate.edu](mailto:janetreis@boisestate.edu)**

# Idaho Health Data Exchange (IHDE) Update

January 9, 2019

Brad Erickson, Executive Director

Jim Borchers, Director – Business Development



## IHDE – SHIP, Customer Engagement Update

### SHIP Cohorts

154 of 166 clinics

connected or projected by Jan 31, 2019  
(includes ECW clinics that have one connection still pending)

111 Fully Bi-Directional Now

### Customer Visits

Contract Requirements Complete  
(90 Required by 1/31 per contract)

Actually Achieved >150 Clinic Visits  
>40 Hospital Visits

12 more hospital visits will occur in  
Spring 2019

### **Driving Connectivity**

### Training

Since last month: 166 new users

9 On-Site trainings

Including St. Luke's OB & Internal  
Medicine, Lighthouse Clinic and Blue  
Cross of Idaho

### Hospital Connections

9 Hospital Systems Connected  
(19 Individual Hospitals)

All Critical Access Hospital's (CAH's)  
contacted about connecting

- Strong interest; concerns over cost

# IHDE Maturity Assessment and Strategic Plan

- Brilljent (3<sup>rd</sup> Party Consultant) contracted in partnership w/DHW

## Maturity Assessment – 11 Key Dimensions

Technical Dimensions	Information Quality	Is the data being shared, timely, usable, high quality, complete and relevant?
	Transport	What is the maturity of the data transport mechanisms used? Push/Pull
	Security	What mechanisms are in place to ensure data is shared securely?
	Transaction/Query	What is the level of adoption of the Application Programming Interface (API) used?
People & Process Dimensions	Usability/Workflow	How easy is the information to consume? Is the information incorporated into the workflow?
	Alignment/Duplication	How many different mechanisms are available?
	Participation	Can all possible participant types (providers, patients, payers, ...) for the capability, participate, and how many are actually participating?
	Consent/Privacy	Can patients control (provide consent) who has access to data about them to a granularity appropriate to the capability?
Governance Dimensions	Data Governance	How mature are the processes to govern data involved in exchanges?
	Stakeholder Governance	How mature is the organizational structure and associated processes to govern exchanges for this capability?
	Sustainability	What are the resources available to sustain efforts for any capability; people, funds, skills, leadership?

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**MITRE**



3



# Strategic Plan

2019-2023

### FOUNDATION

**Our Vision**

Be the Trusted Partner for Health Information Exchange Across Our Region.

---

**Our Mission**

Lead Collaboration in the Healthcare Community to Improve Patient Care.

---

**Our Values & Principles**

- Collaborative
- Transparent
- Accurate
- Accountable
- Secure
- Innovative
- Agile

### STRATEGIC Goals

#### Best in Class Stakeholder Engagement & Services

- ❑ We will establish and maintain a shared vision for health information sharing across all leaders of healthcare in Idaho.
  - We will partner effectively with existing and emergent healthcare leadership groups and ensure alignment of priorities
  - We will facilitate semi-annual envisioning and strategy workshops for all leaders of healthcare in Idaho.
  - We will provide online access to promote and facilitate continuous improvement of the vision and strategy for health information sharing.
- ❑ The perceived value of each service we provide will be at least equal to the cost of each service
  - We will develop and share clear and transparent value models for all service offerings, current and planned.
- ❑ Our stakeholder satisfaction will exceed 90% each year.
  - We will conduct surveys and facilitate workshops to determine and improve stakeholder satisfaction.

#### Best in Class Infrastructure

- ❑ We will align and implement improvements to our capabilities and infrastructure based on industry and federal guidance for health information sharing
  - We will complete and maintain an assessment of our infrastructure based on federal guidance from CMS & ONC.
  - We will establish model-based blueprints and model-driven engineering to assist in planning, defining and implementing our improvement initiatives.
- ❑ We will establish a formal Quality Management Program
  - We will manage and monitor our performance as it pertains to key indicators and metrics managed through an enhanced collaborative governance process.

### MEASUREMENT

**Our Performance**



**Our Metrics**

- Governance
- Participation
- Use Case
- Information Completeness
- Security
- NQF Alignment
- Information Timeliness
- Usability & Usage
- Information Quality

---

**Our Sustainability**



 Strategic Plan 2019-2023

**Strategic Goals**

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 Strategic Plan 2019-2023

**Strategic Goals**

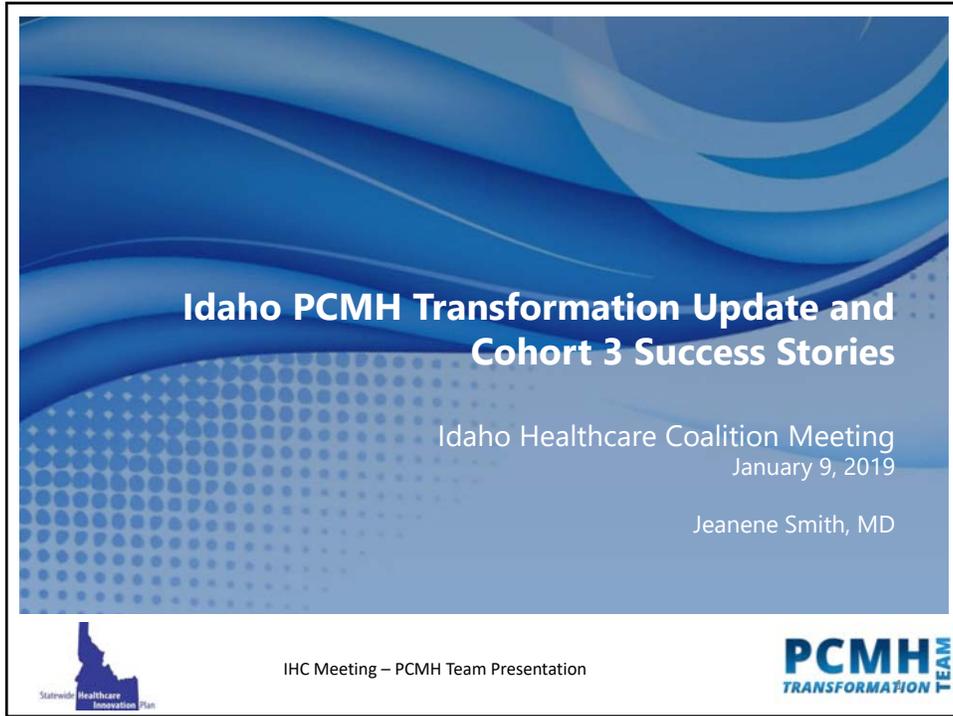
**Best in Class Infrastructure**

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- We will establish a formal Quality Management Program**
  - We will manage and monitor our performance as it pertains to key indicators and metrics defined through our collaborative governance process.

## Next Steps - Focus/Priorities in 2019

1. SHIP/Medicaid – continue to build connections
  - Focus on Hospital Connections – particularly Critical Access
2. Drive Long-term Sustainability
  - Increase customer value – particularly data sharing capabilities/analytics
  - Continue to partner with DHW on other funding opportunities
  - Assessment results – implement foundational processes and policies
3. IHDE 3.0 Technology Platform Upgrade
  - Portal platform/repository is a key component (target 2021 cut-over)
  - Move from single vendor architecture
    - Communication Services Layer
    - Data Services Layer



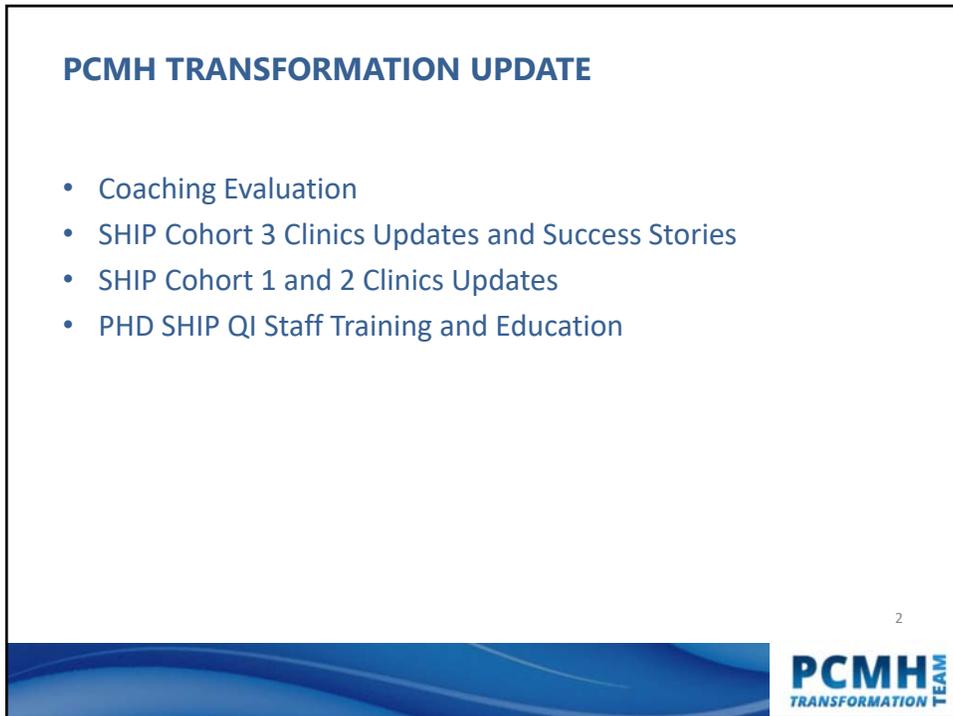


**Idaho PCMH Transformation Update and Cohort 3 Success Stories**

Idaho Healthcare Coalition Meeting  
January 9, 2019

Jeanene Smith, MD

 IHC Meeting – PCMH Team Presentation 



**PCMH TRANSFORMATION UPDATE**

- Coaching Evaluation
- SHIP Cohort 3 Clinics Updates and Success Stories
- SHIP Cohort 1 and 2 Clinics Updates
- PHD SHIP QI Staff Training and Education

2



### PCMH COACHES EVALUATION BY CLINICS



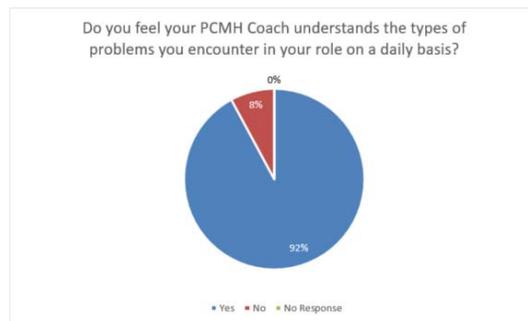
*"My Coach has gone out of her way to help us with team engagement, establishing a Change Management program, creating a plan for PCMH recognition, and brainstorming access barriers."*

*"Our Coach is a fantastic advocate of practices doing what they can, within their individual structure."*

3



### PCMH COACHES EVALUATION BY CLINICS



*"My Coach has made herself available to address specific transition barriers and help apply appropriate strategies to overcome those barriers."*

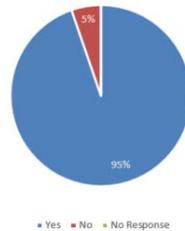
*"My Coach listens, takes questions that we have, and searches out ways that other local clinics have achieved a task/workflow."*

4



### PCMH COACHES EVALUATION BY CLINICS

Do you feel you know how to effectively utilize your PCMH Coach to get help with your PCMH transformation efforts?



*“Coaching calls and access to resources that are applicable to the situation help with criteria for submission and ideas on how to manage the processes.”*

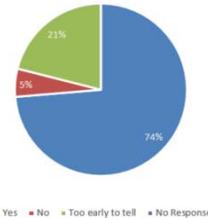
*“It was encouraging to see that there are areas that we have made progress on.”*

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### PCMH COACHES EVALUATION BY CLINICS

Do you feel you have accomplished more in your transformation efforts because of your PCMH Coach?



*“Coaching calls, webinars, learning collaboratives, etc. have all been very helpful.”*

*“We would not have known where to start without our Coach!”*

Next is an update on SHIP Cohort 3 Clinics

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## PCMH TRAINING AND TECHNICAL ASSISTANCE FOR COHORT 3 CLINICS

### Activities

- Webinars – 6 content-specific webinars every other month
- Clinic site visits / coaching calls with clinic staff, PHD SHIP QI staff, and PCMH Coach
- Learning Collaborative - Clinic teams and PHD SHIP QI staff

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**PCMH**  
TRANSFORMATION TEAM

## COHORT 3 CLINICS PCMH RECOGNITION

### Accomplishments

- 15 Cohort 3 clinics are nationally accredited, as of 1/7/19
  - 9 became accredited during this Cohort 3 year
  - 4 renewed accreditation this year
- 6 Cohort 3 practices are finalizing the process with NCQA\* and will likely be accredited by 1/31/19
- Clinics not yet recognized developed PCMH Transformation Roadmaps to continue transformation work

\* National Committee for Quality Assurance (NCQA)

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**PCMH**  
TRANSFORMATION TEAM

### COHORT 3 SUCCESS STORY: PCMH TRANSFORMATION

**Commitment to rural health care.** Challis Area Community Health Center is a small community health center in Challis, Idaho. Their providers serve the extremely rural area both through the clinic setting and through emergency medical outreach.

- When joining SHIP, they had just initiated expansion to include behavioral health services.
- Despite all of these potential barriers to PCMH implementation, they were committed to serving their rural community and devoted staff resources to successfully complete the PCMH transformation and application.
- Challis achieved NCQA 2017 PCMH accreditation on 11/30/18.
- Before the PCMH program concludes they have asked for additional help integrating telehealth services with their foundational PCMH program and plan to offer telepsychiatry visits within the next six months.

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### COHORT 3 SUCCESS STORY: PCMH TRANSFORMATION

**Slow and Steady.** Two Rivers Medical Clinic, Weiser, Idaho, attempted to participate in a PCMH pilot several years ago and discontinued because they didn't have an Electronic Medical Record (EMR); the manual work was just not feasible for them. They remained committed to transforming, migrated to an EMR and joined SHIP for Cohort 3.

- Two Rivers undertook a painstaking process of assigning every patient in their practice to a provider team and improving continuity of care with the assigned provider.
- A small team attended the SHIP's PCMH Learning Collaborative and indicated: "It's amazing what that little event has done." After the learning opportunity, the clinical champion began testing team huddles, the clinic upgraded their EMR to enable them to produce data reports for preventive and chronic condition management, and they initiated a connection to Idaho Health Data Exchange (IHDE) to facilitate care coordination.

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### COHORT 3 SUCCESS STORY: PCMH TRANSFORMATION

***Slow and Steady.*** *Family Medical Care* – Drs. Torquato and Roquiz

- Few resources but strong commitment as a small practice to transforming care
- Methodically reviewing the PCMH assessment and assigning out work areas/gaps step by step
- Dr. Roquiz leads the development of the processes, policies and procedures (P&Ps)
- Dr. Torquato leads the staff and culture change
- Family Medical Care has a good plan for achieving PCMH recognition

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**PCMH**  
TRANSFORMATION TEAM

### COHORT 3 SUCCESS STORY: PCMH TRANSFORMATION

***Holistic care in the medical home.*** *RHS Family Medical Clinic* is a “reverse” integration clinic that originally started as a behavioral health clinic and now has added primary care to enhance outcomes for their patients.

- They have begun the NCQA application process in QPASS.
- One of their key success in the transformation process was developing a new care management program for their high-risk patients that incorporates both behavioral health and physical health elements.

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**PCMH**  
TRANSFORMATION TEAM

### COHORT 3 SUCCESS STORY: PCMH TRANSFORMATION

- **Holistic care in the medical home.** Terry Reilly Health Services (TRHS) Melba started a diabetes care management program in a clinic with one provider that is only open three days a week, serving a small ranching and farming community. They have identified 80 patients with elevated hemoglobin A1Cs and started to do outreach in the spring.
- Despite staffing changes, including the departure of the clinic's nurse care manager, the office manager, and a behavioral health provider all in one month, they were able to rehire a nurse care manager. They now have over a dozen patients with several months of care management. They are also trying to hire a behavioral health counselor.
- TRHS demonstrated several success stories of reduced Hemoglobin A1C from double to single digits and even convinced some of their more reluctant patients with diabetes to participate in meeting with one of the pharmacists for medication reviews, when they were previously not willing to do so.
- The SHIP Quality Improvement (QI) Specialist has connected TRHS with public health district (PHD) experts on diabetes, and they have initiated the development of a diabetic nursing protocol.
- The clinic is also partnering with the QI Specialist on efforts to spread access to nutritional counseling to these patients.

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### COHORT 3 SUCCESS STORIES: PCMH RECOGNITION

**Teamwork can overcome lack of resources.** Total Family Medicine is a solo family practice led by Dr. Teresa Johnson.

- Successfully obtained NCQA PCMH recognition
- Accomplished a lot with very few resources through weekly team meetings that included support from their QI Specialist and through engaging all team members to take ownership of the process

**Resource Commitment and Teamwork.** Kootenai Health has achieved recognition for six sites in 9 months.

- Team of dedicated clinic leaders from all six sites meet weekly to lead the PCMH process
- Clinic leaders and staff met with PCMH Coaches monthly to build the transformational processes and culture change
- Working on a sustainability plan, and their team will continue to meet at least monthly

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## COHORT 1 AND 2 UPDATES

- Continued engagement and training for clinic staff through mentorship webinars. Topics included:
  - Behavioral Health Integration
  - Oral Health Integration
  - Care Management
  - Patient Engagement
  - Community Health Workers
- PCMH Transformation Roadmaps were updated in collaboration with clinic teams and PHD SHIP QI Staff (QI Staff)
  - Many Cohort 1 and 2 staff were excited to talk with us again and give us updates on their progress, and/or ask us questions on areas they are still working to build and improve

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**PCMH**  
TRANSFORMATION  
TEAM

## PHD SHIP QI STAFF TRAINING AND EDUCATION

- Learning Sessions for QI Staff in Model Test Years (Cohort) 1 and 2 (2016 and 2017)
- Regular touchpoints between PCMH Coaches and QI Staff to provide ongoing training and education
- Targeted educational webinars for QI Staff in Model Test Year 2 (2017)
- QI Staff annual Skills Assessment by PCMH Coach
- QI Staff Domains of Knowledge Self Assessment Survey each year
- Incredible growth in PCMH and QI knowledge, experience, and relationships throughout the three years!!

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**PCMH**  
TRANSFORMATION  
TEAM

Thank you!  
Questions/Comments?



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**PCMH**  
TRANSFORMATION  
TEAM



# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition January 9, 2019

## **SHIP OPERATIONS:**

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

- **Report Items:**
  - Requests for release of funds were approved by CMMI on December 13, 2018 for 1) the CEMT hybrid course, 2) a CEMS telehealth grant, 3) video/educational training services for SHIP Legacy Project and 4) the Langdon Group for the CEMS EMT meeting facilitation.
  - Contracts for the following activities were executed: 1) NCQA webinar series; 2) Fisher, Inc. video production services; and 3) Boise State University CEH portal subscriptions.
  - Amendments were processed for 1) the Idaho State University subgrant for the CEMT hybrid course and 2) the Boise State University CEH contract for the portal transition.
  - Thirty-day initial closeout letters were issued for all sub-grants and contracts for the Statewide Healthcare Innovation Plan (SHIP) grant.

### **SHIP Administrative Reporting:**

- **Report Items:**
  - The Goal 1 PCMH Mentorship webinar on patient engagement was held on December 19, 2018.
  - On December 13, 2018, the Office of Healthcare Policy Initiatives staff attended a session for OHPI visioning and public involvement facilitation training.

### **Regional Collaboratives (RCs):**

- **Report Items:**
  - **District 1:** No full RC meeting was held in November. A conference call was held on 11/30/18 by the SHIP manager and the RC chair regarding the transition plan, future PCMH efforts, successes, and continued opportunities.
  - **District 2:** No RC meeting was held in November. 11/7/18 SHIP manager and director participated in PHW. 11/14/18 SHIP manager and director participated in IHC meeting. 11/1/18 SHIP manager participated in PM meeting with OHPI.
  - **District 3:** There was no RC meeting in November. Rachel Blanton, Nikole Zogg and Andrew Baron participated in the November IHC meeting. The CHC and SWHC jointly submitted a proposal for enhanced funding focused on sustainability activities which was awarded.
  - **District 4:** Districts 3 & 4 have a joint RC meeting on December 4<sup>th</sup> to discuss next steps in working toward a combined structure post-SHIP.
  - **District 6:** The Southeastern Healthcare Collaborative Executive Committee met on November 28, 2018.
  - **District 7:** No RC meetings held in November.
  
- **Issues and topics discussed:**

- **District 1:** RC transition plan was discussed. Also discussed was the progress made with cohort clinics and CHEMS; CHW lack of progress; and future efforts to continue PCMH work. Also discussed PCPs from all three cohorts and their progress with PCMH transformation and recognition.
- **District 2:** None
- **District 3:** BHI Workgroup (11/26): Final BHI workgroup to transition workgroup activities to IIBHN and the BCI Foundation for Health; ED Utilization Summit (11/26): second meeting to focus on shared care coordination protocols and data sharing.
- **District 4:** District 3 & 4 have an upcoming joint RC meeting on December 4th and will be discussing next steps in working towards a combined structure post-SHIP.
- **District 6:** Executive committee meeting held on 11/28/18 to discuss the final clinic committee meeting for January 2019 and questions for December IHC meeting.
- **District 7:** Continued to solicit feedback on RC sustainability from clinics from meeting in September in preparation for final draft of RC transition plan. Continue to meet with executive team and PHD staff on SHIP transition plan as needed.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
  - Six of the telehealth subgrants ended December 31, 2018.
  - Idaho Department of Health and Welfare has been coordinating efforts with HMA to create lessons learned and “case studies” for telehealth grantee sites along with an executive summary. These will be completed by January 31, 2019.



### **Community Health Workers:**

- **Report Items:**
  - A Community Health Worker (CHW) sustainability transition meeting will be held on January 16, 2019. A draft of the purpose of the Idaho Alliance for CHWs, through the IDHW Diabetes, Heart Disease, and Stroke Prevention program, will support the mission of the Idaho CHW Association. It will work to promote and advance the CHW role with Idaho health partners and communities thereby improving the health and well-being of Idaho communities.

## **WORKGROUP REPORTS:**



### **Community Health EMS (CHEMS):**

- **Report Items:**
  - The workgroup did not meet in December 2018.



## **Idaho Medical Home Collaborative:**

- **Report Item:**
  - The Idaho Medical Home Collaborative did not meet in December 2018.



## **Data Governance:**

### **Report Item:**

The Data Governance Workgroup did not meet in December 2018.



## **Multi-Payer:**

- **Report Item:**

The MPW met December 11, 2018. The outcomes of the meeting include:

  - **SHIP Draft Financial Analysis Report for Award Year 4**

Scott Banken provided a high-level overview of the SHIP Financial Analysis Report for Award Year 4. Members of the workgroup provided input and were reminded by OHPI staff that this report is required by CMMI. Recommendations from workgroup members include the following:

    - Table 4 change Projected PMPMs to Actual and add Projected to the 2018 column.
    - Table 5 change “Family” to “Group” under Commercial.
    - It was suggested that in the conclusion, the percentage of reported annual expenditures be added.

Dr. Schott reminded members that it is important to note that while this is a good report for CMMI requirements, it is not a full representation of the amount of PCMH work that has been done in at least a third of the primary clinics across the state. To get information that actually reflects that work, data would have needed to be collected from SHIP participating clinics specifically.

- **Final review of Questions and Power Point for submission to IHC**

Mr. Varin explained to members that the Power Point and answers to the questions asked by the IHC transformation workgroup had been submitted to that group for review. Discussion was held about next steps for the Healthcare Transformation Council of Idaho (HTCI) that lead into the next agenda topic.
- **Healthcare Transformation Council of Idaho (HTCI) and future of OHPI update**

Ms. Falls explained that HTCI’s initial meeting is scheduled for February 21, 2019. Dr. Epperly and Dr. Pate met with Governor-elect Brad Little to provide a synopsis of the work the IHC has done and the importance of continuing healthcare transformation in Idaho through the HTCI. Governor-elect Little plans to attend the first HTCI meeting in February.

The council will not develop/assign specific workgroups yet, as they feel it is important to conduct an orientation at the first meeting where an emphasis will be educating the members about the HTCI functions that have been identified.

- While no specific workgroups have been identified, it is important to note that a primary function of the HTCI is to promote alignment of the delivery system and payment models to drive sustainable healthcare transformation. Continued payer and provider collaboration will be very important as the council identifies opportunities and barriers for change and develops strategies and activities to address obstacles and advance healthcare transformation.

## BHI

### **Behavioral Health:**

- **Report Item:**

- The BHI Sub-Committee met for the last time on Tuesday, December 18<sup>th</sup>, 2018.
- Gina provided an overview of the accomplishments of the BHI Sub-Committee over the last four years.
- Jennifer Yturriandobeitia provided an update on the activities, goals and objectives of the IIBHN for the next year.
- Casey Moyer discussed next steps for the Healthcare Transformation Council of Idaho (HTCI).
- Ross discussed his vision for the WICHE Steering Committee.

## PHW

### **Population Health:**

- **Report Item:**

- Discussions were held about the sustainability efforts for Project ECHO, CHW and CHEMS.
- Updates were provided on “Get Healthy Idaho” modifications and dashboard enhancements.
- Denise Jensen gave an overview of the new suicide prevention structure and integration with substance abuse.
- Highlights of the SHIP initiative were discussed by the group and included:
  - Development of CHWs
  - Development of “Get Healthy Idaho” website
  - Development of CHEMS program/infrastructure supports
  - Launch of Project ECHO
  - Integration of PHDs into the medical-health neighborhood
  - Development of the medical-health neighborhood and the RC structure
  - Support of clinics in allowing them to collaborate at the local level with other clinics.
  - Continuing programs at the PHD level:
    - IIBHN
    - Suicide prevention program in District 6
    - Behavioral Health support in schools in District 3
    - Continuance of care coordination initiative in District 3