

## GAP ANALYSIS MAIN CONCEPTS

Below is a synopsis of the main concepts identified by each of the four work group's gap analysis.

### Multi-Payer Workgroup

- Payers and consumers are risk adverse. They are reluctant to embrace new models due to fear of the unknown.
- Provider access is limited. Innovations that address access like tele-health are embraced.
- Product coverage is inconsistent throughout the state. Products need to be affordable and add value. (Cultural barrier — Is coverage something that is viewed as valuable?)
- Health Insurance Exchange does matter. There is no mention of the expected impact of the Health Exchange in Idaho.

### Network Workgroup

- System is lacking enrollee accountability. System needs solutions on how to incentivize/penalize/educate, or otherwise engage patients.
- System is lacking provider engagement. System needs solutions on how to incentivize/penalize/motivate providers to encourage patient engagement.
- Network inequality affects access and quality. Ability to hire provider staff and obtain reimbursement differs, preventing a level playing field. (The new model cannot be built on existing referral patterns.)
- Wellness and prevention are not reimbursed. Current reimbursement or care delivery models are episodic and volume based without emphasis on wellness and prevention.
- Network models are still relatively new. Shared savings, ACO, care coordination, and medical home (non-chronic care) are all relatively new, so it is difficult to identify bona-fide success stories.

### Clinical/Quality Workgroup

- Lack of consistent model or approach to define, collect, report, and utilize performance and measure data. Systems and providers don't always know which guidelines/performance measures to use and what quality improvement activities to implement and track.
- Cultural (provider and patient) barriers including socioeconomic, educational, and geographic. There is a general distrust for government and uniformity.
- Compensation is generally fee-for-service, which rewards volume and not quality performance. Smaller practices don't have resources for measuring and analyzing results.
- Difficulty sharing and analyzing data on statewide basis. Fear of transparency.

### HIT Workgroup

- The existing Statewide Information Health Data Exchange (IHDE):
  - Currently has low provider participation rate.
  - Provider participation requires significant cost and implementation effort.
  - Data repository contains limited data and functionality.
  - No clinical or financial data is currently being exchanged. There are no requirements or agreements related to data exchange desires in place.
  - There is insufficient staff and resources to perform statewide collection of data.

- The current infrastructure does not support inclusion of financial and clinical data from all potential Idaho participants.
- Providers have a variety of EHR solutions, software vendors and versions which address varying levels of meaningful use.
- The State has not implemented legal/regulatory/policy framework or mandates for sharing data.
- No statewide multi-payer information/data is being collected or stored.
- Currently no reporting or analytic capabilities for statewide analysis of information exist.
- There are no user agreements or 'buy-in' to share data or information. There are possible competitive and/or other impacts to sharing data/information.
- No organization exists to facilitate/manage sharing of clinical or financial information statewide today outside of IHDE.
- Regional and geographic issues exist today. For example, there are very low IHDE participation rates in North and East Idaho.