PROJECT CHARTER

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

Version 4.0 – FINAL

Summary

Mercer Lead	Jennifer Feliciano and Aliya Kazmi
SHIP Staff	Miro Barac
Key Participants	Idaho Department of Health and Welfare (IDHW), Idaho Health Collaborative (IHC), Regional Health Collaboratives (RCs), Public Health Districts (PHDs), Population Health Workgroup, Patient-Centered Medical Home (PCMH) Contractor, Idaho Medical Home Collaborative (IMHC), and Behavioral Health Integration Workgroup.
IHC Charge	Support the integration of each PCMH with the local Medical/Health Neighborhood by creating the Regional Health Collaborative infrastructure. RCs will support practices in PCMH transformation and will link the PCMHs to the Medical/Health Neighborhood to facilitate coordinated patient care through the entire provider community.

Success Measures

Success Measures	SHIP Desired Outcomes	Measurement
1.	• Support for PCMHs.	• Cumulative (CUM) # of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services. *Model Test Target: one RC in each of the seven health districts.* • Numerator: Count of PHDs that have established RCs. • Denominator: Count of PHDs

YR	Q1	Q2	Q3	Q4
Pre	-	-	-	-
1	7	7	7	7
2	7	7	7	7
3	7	7	7	7

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<table>
<tr><th>Success Measures</th><th>SHIP Desired Outcomes</th><th>Measurement</th></tr>
<tr><td></td><td></td><td>statewide.</td></tr>
<tr><td>2.</td><td>• Support for PCMHs.</td><td>• CUM # of designated PCMHs and primary care practices that can receive assistance through an RC. Model Test Target: 165.
• Numerator: Count of practices and PCMHs that received communication from RC about how to get assistance.
• Denominator: Count of practices that completed the application + Count of practices that achieved PCMH designation.

<table><tr><th>YR</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>Pre</td><td>-</td><td>-</td><td>-</td><td>-</td></tr><tr><td>1</td><td>55</td><td>55</td><td>55</td><td>55</td></tr><tr><td>2</td><td>110</td><td>110</td><td>110</td><td>110</td></tr><tr><td>3</td><td>165</td><td>165</td><td>165</td><td>165</td></tr></table></td></tr>
<tr><td>3.</td><td>• Increased coordination between PCMHs and the Medical/Health Neighborhood.</td><td>• CUM # of designated PCMHs who have established protocols for referrals and follow-up communications with service providers in their Medical/Health Neighborhood. Model Test Target: 165.
• Numerator: Count of designated PCMHs that have signed an attestation of having established protocols.
• Denominator: Count of designated PCMHs.

<table><tr><th>YR</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>Pre</td><td>-</td><td>-</td><td>-</td><td>-</td></tr><tr><td>1</td><td>-</td><td>-</td><td>25</td><td>55</td></tr><tr><td>2</td><td>110</td><td>110</td><td>110</td><td>110</td></tr><tr><td>3</td><td>110</td><td>110</td><td>135</td><td>165</td></tr></table></td></tr>
<tr><td>4.</td><td>• Coordinated patient care through the entire provider community.</td><td>• CUM # of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood,

<table><tr><th>YR</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr><tr><td>Pre</td><td>-</td><td>-</td><td></td><td></td></tr><tr><td>1</td><td></td><td></td><td></td><td>275,000</td></tr></table></td></tr>
</table>

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Success Measures	SHIP Desired Outcomes	Measurement					
		as needed. *Model Test Target: 825,000 (50.5% of Idahoans).*	**2**				550,000
			3	825,000	825,000	825,000	825,000

Planned Scope

Deliverable 1	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Establish RCs.	• Contract with PHDs and hire staff.	• IDHW • PHDs (led by SHIP Managers)	• Other RCs • IDHW • PHDs
Est. Timeframe	**Start**: 06/01/2015			**End**: 04/2016
Milestones	**Event**			**Target Date**
	• Negotiate sub-grant.			• 06/2015
	• Execute contract with PHDs.			• 07/2015
	• Hire SHIP staff (SHIP Manager, Quality Improvement/Quality Assurance (QI/QA) Specialist).			• 10/2015
	• Identify RC Advisory Group.			• 11/05/2015
	• Convene RC Advisory Group.			• 11/2015
	• Identify RC Representative to the IHC.			• 11/2015
	• Establish RC membership.			• 04/2016
Deliverable 2	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• RCs provide regional quality improvement and Medical/Health Neighborhood integration services.	• Implement plan that identifies how RCs will support PCMHs.	• RCs • PHDs • IDHW	• IHC • RCs • PCMH Contractor • PCMHs • PHDs
Est. Timeframe	**Start**: 07/2015			**End**: 04/2016
Milestones	**Event**			**Target Date**
	• Define services provided by RCs.			• 07/2015

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	• Develop plan (charter). • Implement plan. • Submit status report.			• 03/2016 • 03/2016 • 06/2016
Deliverable 3	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Evaluation plan to ensure RCs provide regional quality improvement and Medical/Health Neighborhood integration services within service level requirements.	• Plan for evaluating services from RCs to PCMHs.	• IDHW	• RCs • PCMHs • PHDs
Est. Timeframe	**Start**: 11/2015			**End**: 04/2016
Milestones	**Event**			**Target Date**
	• Develop plan. • Review/revise plan. • Finalize plan. • Implement plan.			• 01/2016 • 03/2016 • 04/2016 • 04/2016
Deliverable 4	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Communication from RCs to practices regarding availability of services.	• Communication to let practices know what RCs can do for them.	• RCs	• PCMH Contractor • IDHW Staff • IMHC • IHC
Est. Timeframe	**Start**: 11/2015			**End**: 01/31/2019
Milestones	**Event**			**Target Date**
	• Develop communication. • Review/revise communication. • Finalize communication. • Obtain list of designated PCMHs. • Initial communication with practices. • Ongoing communication with practices.			• 12/2015 • 02/2016 • 03/2016 • 03/2016 • 04/2016 • Ongoing

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Deliverable 5	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Established Medical/Health Neighborhoods.	• Information sharing across Medical/Health Neighborhoods for improved care coordination.	• RCs • PHDs • IDHW	• PCMHs • Providers
Est. Timeframe	**Start**: 7/2015			**End**: TBD
Milestones	**Event**			**Target Date**
	• Define Medical/Health Neighborhood.			• 11/2015
	• Identify participants in the Medical/Health Neighborhood.			• 05/2016
	• Submit list of participants to Department Project Manager.			• 06/2016
	• Report to the IHC the status of establishing Medical/Health Neighborhoods.			• Ongoing (at least annually)
Deliverable 6	**Result, Product, or Service**	**Description**	**Owner**	**Impacted Parties**
	• Sustainability Plan.	• [TBD]	• PHD • RCs	• Hospitals • PCMHs
Est. Timeframe	**Start**: MM/DD/YYYY			**End**: MM/DD/YYYY
Milestones	**Event**			**Target Date**
	• Begin the process of creating a Sustainability Plan.			• 06/2016
	• Submit Sustainability Plan.			• 12/2018

Project Risks, Assumptions, and Dependencies

Risk Identification	**Event**	**Likelihood**	**Seriousness**	**Potential Mitigation**
	1. RCs are not established in order to provide quality improvement and integration services to PCMHs in each region.	L	H	• Ongoing monitoring by IDHW SHIP Project Manager and PHD staff to determine each RC's capacity to support PCMHs. • Effective communication pathways between IHC and RCs. • Clear coordination with the PCMH Contractor. • Clear guidance on expectations of RCs.

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Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	2. Clinical and broader public/social health providers do not follow established protocols for referrals and follow-up communication.	M	M	• Participation of Medical/Health Neighborhood participants in development process of communication protocols. • Clear definition of Medical/Health Neighborhood and key participants. Consistent use of definition. • Effective communication process for Medical/Health Neighborhood participants to raise concerns.
	3. Misaligned timelines and duplicative efforts among Briljent, IHDE, and Data Analytics Contractor.	M	M	• Establish communication protocols for all contractors assisting with PCMH transformation, quality improvement, and data exchange efforts. • Contractor timing should be aligned.
Assumptions	• Implementation plan (charter) will be required for each RC. • Ongoing monitoring by Department Project Manager and PHD staff to determine RC capacity to support PCMHs. • RCs will set criteria for referrals and follow-up communication for Medical/Health Neighborhood participants.			
Dependencies and Constraints	• PHDs communicating effectively.			

Project Reporting and Scope Changes

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

Version Information

Authors	Jennifer Feliciano and Aliya Kazmi	**Date**	12/11/2015
Reviewers	Casey Moyer	**Date**	12/15/2015

Final Acceptance

Name/Signature	Title	Date	Approved via Email
Cynthia York	SHIP Administrator	12/18/2015	☒

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Name/Signature	Title	Date	Approved via Email
Katie Falls	Mercer Lead	12/18/2015	☒

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