SHIP Project Management Dashboard

Prepared for the Idaho Healthcare Coalition

Award Year 3 Quarter 2

May 1, 2017 – July 31, 2017

The SHIP Project Management Dashboard is an interim tool prepared for the Idaho Healthcare Coalition on a quarterly basis to monitor the SHIP success measures.

Project Implementation Updates

- Over 220,000 Idahoans have an EHR that is connected to HIE (Goal 2, Measure 2).
- Over 319,000 Idahoans are participating in SHIP and are having their needs coordinated by SHIP clinics.
- Thirty-two CHWs trained to date and Cohort 3 kicked off on August 22.
- Seven CHEMS programs have been established and Community Paramedics Cohort 2 is underway.

SHIP Success Measures

Goal 1	100%	100%	100%		100%		100%	76%	83%↓		58%↑
	QT = 200	QT = 110	QT = 110	CMMI	AT = 550	CMMI	AT = 55	AT = 55	QT = 60	CMMI	QT = 550k
Goal 2	100%			52%↑		25%			53%		
	QT = 85			QT = 425k		AT = 55			QT = 15		
Goal 3	100%			100%					100%↑		
	AT = 7			AT = 55		RETIRED			QT = 275k		
Goal 4	40%↑		100%↑		63%		64%↑			0%	
	QT = 15		SAT = 6		AT = 16		SAT = 50		AT = 0	AT = 36*	
Goal 5											
	AT = 0				AT = 0				QT = 0		
Goal 6	ND			ND			ND				
	AT = 4			AT = 275k			AT = 20%				
Goal 7		ND						ND			
		AT = TBD						AT = TBD			

- SHIP success measure is not reported
- SHIP success measure is on target (≥90% of target)
- SHIP success measure is slightly off target (between 75% and 89% of target)
- SHIP success measure is not on target (<75% of target)

QT = Quarterly Target (Q1=Apr 30, Q2=July 31, Q3=Oct 31, Q4=Jan 31)
AT = Annual Target (Jan 31)
CMMI = Federally defined and reported metric
SAT = Semiannual Target (Q2=July 31, Q4=Jan 31)

ND = No Data
↑= Increased since last reporting period
↓= Decreased since last reporting period

Please refer to the SHIP Operational Plan and goal charters for details regarding quarterly, semiannual, and annual targets.
*This model test target has been recommended for change and is pending CMMI approval

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SHIP Success Measures by Goal

Goal 1 Measurements: PCMH Transformation		
1	Q	Cumulative # (%) of primary care clinics that submit an interest survey to participate in a SHIP cohort. Model Test Target: 270.
2	Q	Cumulative # (%) of primary care clinics selected for a SHIP cohort that have completed a PCMH readiness assessment and a Transformation Plan. Model Test Target: 165.
3	Q	Cumulative # (%) of targeted primary care clinics selected for a SHIP cohort. Model Test Target: 165.
4	Q	CMMI Metric: Cumulative # (%) of primary care clinics selected for a SHIP cohort, of the total primary care clinics in Idaho.
5	A	Cumulative # (%) of targeted providers participating in primary care clinics selected for a SHIP cohort. Model Test Target: 1,650.
6	A	CMMI Metric: Cumulative # (%) of providers in primary care clinics selected for a SHIP cohort, of the total number of primary care providers in Idaho. Model Test Target: 1,650.
7	A	Cumulative # (%) of primary care clinics selected for a SHIP cohort receiving an initial transformation reimbursement payment and achieving technical support benchmarks for retaining the payment. Model Test Target: 165.
8	A	Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve their transformation goals as specified in their Transformation Plan. Model Test Target: 165.
9	Q	Cumulative # (%) of primary care clinics selected for a SHIP cohort that achieve national PCMH recognition/ accreditation. Model Test Target: 165.
10	Q	CMMI Metric: Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of total state population). Model Test Target: 825,000.
11	Q	Cumulative # (%) of Idahoans who enroll in a primary care clinic selected for a SHIP cohort (of target population). Model Test Target: 825,000.
Goal 2 Measurements: Electronic Health Records (EHRs)		
1	Q	Cumulative # (%) of primary care practices selected for a SHIP cohort with EHR systems that support HIE connectivity. Model Test Target: 165.
2	Q	Cumulative # (%) of Idahoans who enroll in a primary care practice selected for a SHIP cohort that have an EHR that is connected to HIE. Model Test Target: 825,000.
3	A	Cumulative # (%) of primary care practices selected for a SHIP cohort with an active connection to the HIE and sharing/receiving HIE transactions for care coordination. Model Test Target: 165.
4	Q	Cumulative # (%) of hospitals connected to the HIE and sharing data for care coordination. Model Test Target: 21.
Goal 3 Measurements: Regional Collaboratives (RCs)		
1	A	Cumulative # of RCs established and providing regional quality improvement guidance and working with PHDs to integrate the Medical-Health Neighborhood. Model Test Target: 7.
2	A	Cumulative # of primary care practices selected for a SHIP cohort that receive assistance through regional SHIP PHD team. Model Test Target: 165.
3	Q	Retired Metric: Cumulative # of primary care practices selected for a SHIP cohort who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. Model Test Target: 165.
4	Q	Cumulative # of patients enrolled in a primary care practice selected for a SHIP cohort whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. Model Test Target: 825,000.
Goal 4 Measurements: Virtual PCMHs		
1	Q	Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target: 50.
2	SA	Cumulative # (%) of regional CHEMS programs established. Model Test Target: 13.
3	A	Cumulative # (%) of CHEMS program personnel trained for Virtual PCMH coordination. Model Test Target: 35.
4	SA	Cumulative # (%) of new community health workers trained for Virtual PCMH coordination. Model Test Target: 125.
5	A	Cumulative # (%) of conferences held for CHW and CHEMS Virtual PCMH staff. Model Test Target: 2.
6	A	Cumulative # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. Model Test Target: 36*.
Goal 5 Measurements: Data Analytics		
1	A	Cumulative # (%) of primary care practices selected for a SHIP cohort with access to the analytics system and dashboard reporting. Model Test Target: 165 by 2020.
2	A	Cumulative # (%) of primary care practices selected for a SHIP cohort that are meeting the clinical quality reporting requirements for their cohort. Model Test Target: 165.
3	Q	Cumulative # (%) of RCs provided a report of PCMH clinic CQM performance data. Model Test Target: 7.
Goal 6 Measurements: Alternative Payment Reimbursement Models		
1	A	Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models. Model Test Target: 4.
2	A	Count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments from SHIP participating payers. Model Test Target: 825,000.
3	A	Percentage of payments made in non-fee-for-service arrangements compared to the total payments made by SHIP participating payers. Model Test Target: 80%.
Goal 7 Measurements: Lower Costs		
1	A	Total population-based PMPM index, defined as the total cost of care divided by the population risk score. Model Test Target: TBD.
2	A	Annual financial analysis indicates cost savings and positive ROI. Model Test Target: 197%.

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