



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, January 13, 2016, 1:30PM – 4:30PM

JRW Building (Hall of Mirrors)

1<sup>st</sup> Floor East Conference Room

700 W State Street, Boise, Idaho

Call-In Number: 888-706-6468; Participation Code: 7989577

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, any new DHW staff, agenda review, and approval of 12/9/15 meeting notes – <i>Ted Epperly, Chair</i>
1:40 p.m.	Operational Plan Feedback – <i>Cynthia York, Administrator OHPI, Dr. Ted Epperly, Chair &amp; Denise Chuckovich, Co-Chair</i>
1:55 p.m.	Reimbursement Presentation – <i>Lisa Hettinger, IDHW Medicaid Administrator</i>
2:25 p.m.	Idaho Agency and Coalition Disclosure Laws & Practice – <i>Nicole McKay, Deputy Attorney General</i>
2:45 p.m.	Communications Plan Update – <i>Katie Falls, Mercer ACTION ITEM</i>
3:10 p.m.	Break
3:20 p.m.	Goal Charters Review – <i>Katie Falls, Mercer</i>
3:40 p.m.	PCMH Transition Update – <i>Grace Chandler, Briljent</i>
3:55 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – December 2015): <ul style="list-style-type: none"><li>• Presentations, Staffing, Contracts, and RFPs status – <i>Cynthia York, DHW</i></li><li>• Regional Collaboratives Update – <i>Miro Barac, DHW</i></li><li>• Telehealth, Community EMS, Community Health Workers – <i>Miro Barac, DHW</i></li><li>• HIT Workgroup – <i>Casey Moyer, DHW</i></li><li>• Multi-Payer Workgroup – <i>Dr. David Peterman, Primary Health and Jeff Crouch, Blue Cross of Idaho, Workgroup Chairs</i></li><li>• Quality Measures Workgroup – <i>Dr. Andrew Baron, Terry Reilly Clinics, Workgroup Chair</i></li><li>• Behavioral Health/Primary Care Integration Workgroup – <i>Ross Edmunds, Behavioral Health Division, Workgroup Co-Chair</i></li><li>• Population Health Workgroup – <i>Elke Shaw-Tulloch, Health Division, Workgroup Chair</i></li><li>• IMHC Workgroup – <i>Dr. Scott Dunn, IMHC Workgroup Chair</i></li></ul>
4:15 p.m.	Additional business & next steps – <i>Dr. Ted Epperly, Chair</i>
4:30 p.m.	<b>Adjourn</b>

## Mission and Vision

The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee-for-service, volume based system to a value based system of care that rewards improved health outcomes.

**Goal 1:** *Transform primary care practices across the state into patient-centered medical homes (PCMHs).*

**Goal 2:** *Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.*

**Goal 3:** *Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.*

**Goal 4:** *Improve rural patient access to PCMHs by developing virtual PCMHs.*

**Goal 5:** *Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.*

**Goal 6:** *Align payment mechanisms across payers to transform payment methodology from volume to value.*

**Goal 7:** *Reduce overall healthcare costs*



# Idaho Healthcare Coalition

## Meeting Minutes:

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**SUBJECT:** Idaho Healthcare Coalition      **DATE:** December 09, 2015

**ATTENDEES:** Dr. Ted Epperly, Denise Chuckovich, Cynthia York, Dr. Andrew Baron, Scott Carrell, Dr. Keith Davis, Russell Duke, Lisa Hettinger, Bruce Krosch, Deena LaJoie, Nicole McKay, Dr. David Peterman, Susie Pouliot, Dr. Robert Polk, Dr. Kevin Rich, Neva Santos, Mary Sheridan, Larry Tisdale, Elke Shaw-Tulloch, Jennifer Wheeler, Nikole Zogg

**LOCATION:** 700 W State Street, 1<sup>st</sup> Floor East Conference Room

**Teleconference:** Mike Dixon, Dr. Scott Dunn, Dr. Rene LeBlanc, Maggie Mann, Dr. Casey Meza, Carol Moehrle, Daniel Ordyna, Geri Rackow, Karen Vauk, Lora Whalen, Janet Willis, Dr. Bill Woodhouse, Mark Rouse, Pat Dennehy

**Members Absent:** Richard Armstrong, Josh Bishop, Melissa Christian, Jeff Crouch, Ross Edmunds, Senator Lee Heider, Yvonne Ketchum, Glenn Jefferson, Dr. David Pate, Tammy Perkins, Dr. Dave Schmitz, Dr. Boyd Southwick, Representative Fred Wood, Ann Wilde

**DHW Staff** Ann Watkins, Miro Barac, Casey Moyer, Kym Schreiber, Taylor Kaserman, Kim Thurston

**Guests:** Rachel Harris, Gina Pannell, Tim Heinze, Meg Hall, Hilary Klarc, Craig Nolte, Colby Cameron, Corey Surber

**Mercer:** Katie Falls

**Briljent:** Sarah Renner, Dr. Dan Roach

**STATUS:** Draft 12/14/15

## Summary of Motions/Decisions:

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**Motion:** Mary Sheridan moved to accept the minutes of the November 18, 2015, Idaho Healthcare Coalition (IHC) meeting as prepared.

Motion carried.

Lisa Hettinger seconded the motion.

**Motion:** Dr. Andrew Baron moved that the Idaho Healthcare Coalition support the next steps for Statewide Healthcare Innovation Plan (SHIP) Patient Centered Medical Home (PCMH) cohort 1 transformation engagement efforts as presented by the SHIP Team.

Motion carried.

Dr. Robert Polk seconded the motion.

**Motion:** Lisa Hettinger moved that the Idaho Healthcare Coalition adopt the SHIP Communications Plan materials with modifications as discussed.

Motion carried.

Susie Pouliot seconded the motion.

## Agenda Topics:

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**Opening remarks:** “I shall pass through this world but once. Any good therefore that I can do or any kindness that I can show to any human being, let me do it now. Let me not defer or neglect it, for I shall not pass this way again.” Stephen Grellet

- ◆ Dr. Epperly called the roll, welcomed everyone, and introduced our guest from the Federal Reserve Bank of San Francisco, Craig Nolte.
- ◆ Dr. Epperly thanked IHC members, Bruce Krosch and Tom Fronk for their active participation in the IHC and their dedication to improving healthcare in Idaho. The Coalition members all wished them well in their retirement.
- ◆ Mr. Krosch introduced his replacement, the new Director for Public Health District (PHD) 3 and a new candidate for IHC appointment consideration by the Governor, Nicole Zogg. Ms. Zogg has nearly 18 years of public health experience and comes to us from Advantage Dental in Central Oregon where she was a Regional Manager and Community Liaison.

### Agenda Topics

**Patient Centered Medical Home (PCMH) Selection Update** – *Kymerlee Schreiber, PCMH Project Manager, DHW, Casey Moyer, SHIP Operations Project Managers, DHW:*

- ◆ Mr. Moyer gave a brief overview of the PCMH selection process. The five (5) member evaluation team for the final application submissions for cohort 1 consisted of representatives from the Divisions of Public Health, Behavioral Health, Medicaid, SHIP Operations, and Health Management Associates (HMA/PCMH sub-contractor). The applications were stratified by public health district region; however, no points were assigned based on regional location. All identifying information was removed from the applications prior to scoring. Clinics were ranked in order of points acquired after scoring and weighting was applied. An organizational capitation was applied after lists were compiled and every region has a list of ranked back-up sites that will be offered a slot if another clinic chooses to withdraw.
- ◆ Ms. Schreiber presented a list of clinics that have been selected for the PCMH cohort 1. *A list of the selected clinics will be available on the SHIP website under meeting attachments.*
- ◆ Next steps for SHIP PCMH cohort 1 transformation engagement efforts are listed below:
  - Briljent will conduct a readiness assessment and GAP analysis for all cohort 1 clinics.
  - Briljent contract initiation with PCMH cohort 1 clinics.
  - Project MOU between PCMH cohort 1 clinics and DHW covering other clinic and SHIP relationships, e.g. Public Health Districts, IHDE, Data Analytics, Evaluations, etc .
  - PCMH portal launch by Briljent
  - First PCMH Learning Collaborative hosted by Briljent
  - Educational webinars provided by Briljent

**PCMH Contract Update** –*Pat Dennehy, Principal, Health Management Associates; Sarah Renner, Manager, Myers and Stauffer; Dan Roach, Director, Myers and Stauffer, Mark Rouse, Briljent:*

- ◆ Ms. Dennehy updated Coalition members on the PCMH Transformation Plan. In December the HMA will develop assessment tools for completion to assist in planning, training and coaching curriculum as well as learning collaborative activities. Also in December the Briljent PCMH Team will meet with the Public Health Districts (PHD) SHIP staff to assess the training needs of the staff for this project. In January, the Briljent PCMH Team will attend the IHC meeting to review and finalize plans for the first Learning Collaborative. Plans for February include holding the first Learning Collaborative and connecting users to the Briljent PCMH Team portal for educational session information and tracking system.
- ◆ Ms. Renner, described the Briljent PCMH Transformation web portal. Main components of the web portal are:
  - Collaboration
  - Learning
  - Scheduling
  - Evaluation
- ◆ Mr. Roach reported on the Incentive Payment Accounting System, I-PAS. I-PAS is a web-based module for incentive payment calculations and reporting that establishes and maintains a reliable financial accounting system. There are three (3) Incentive Payment Measures:
  1. Incentive Payment Measure 1: PCMH Practice Transformation Incentive
  2. Incentive Payment Measure 2: PCMH Recognition or Accreditation Program
  3. Incentive Payment Measure 3: Virtual PCMH
- ◆ Ms. Sheridan raised the question about virtual PCMH incentives being distributed exclusively to the clinics, suggesting that it might be counterintuitive in terms of EMS agencies being the ones establishing the community health EMS (CHEMS) programs.

**Communications Plan Materials** – *Katie Falls, Principal Mercer:*

- ◆ Ms. Falls presented two (2) documents for Communications Toolkit that contains talking points for the: 1) Regional Health Collaboratives and 2) Policy Makers. These talking points have been organized in a standardized template with three (3) sections:
  1. Section one contains the definition of the primary audience.
  2. Section two includes talking points and messaging that is to be communicated to the target audience.
  3. Section three describes the history and background.
- ◆ Coalition members recommended moving the reference of Medicaid Expansion to the end of the second section on Talking Points for Policy Makers. Coalition members also discussed differentiating between the RCs' role versus the role of the PHDs'. Concerns regarding how to title these documents were also raised by the Coalition members; it was recommended this be addressed.
- ◆ Ms. Falls highlighted the importance of version control. These will be living documents and listing the document's version is crucial. Each iteration of the document will not be required to have IHC group approval prior to use, rather the chair and co-chair will review iterative versions for alignment with the communications plan. In the event a discussion of the complete IHC is required, this will be scheduled on an as needed basis.

**Website Update** – *Casey Moyer, Operations Project Manager, DHW:*

- ◆ Mr. Moyer discussed developing a member's only section that is password protected on the SHIP Website. This would enable Coalition members to see materials not yet ready for public view. Coalition members discussed if there should be some kind of protocol in place to ensure materials are vetted appropriately; however, maintaining transparency was a concern. Additional clarification on the disclosure laws was also requested by the IHC membership. Coalition members agreed to revisit this topic as an agenda item for the January IHC meeting.

**SHIP Operations and Advisory Group Reports/Updates:**

- ◆ Due to time constraints the SHIP Operations and IHC Workgroup Report was not presented to the Coalition members. The written report was distributed to the Coalition members in their meeting packets. The Coalition members agreed to accept the report as prepared.

**Closing remarks and Next Steps** – *Dr. Ted Epperly:*

- ◆ The next IHC meeting is January 13, 2016, and will be located in the JRW Building East side conference room on the first floor.
- ◆ A reception honoring the work of the IHC members, Workgroup and Advisory groups, Stakeholders, SHIP staff, DHW staff, and DHW contractors was held at the conclusion of the meeting. All were thanked by Dr. Epperly for their time, contributions, and commitments to the SHIP and Idaho healthcare transformation efforts to date.

There being no further business Dr. Epperly adjourned the meeting at 4:00 p.m.



## Idaho Healthcare Coalition (IHC) January 13, 2016 Action Items

- Action Item 1 – Minutes

IHC members will be asked to adopt the minutes from the last IHC meeting:

Motion: I, \_\_\_\_\_ move to accept the minutes of the December 9, 2015, Idaho Healthcare Coalition (IHC) meeting as prepared.

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

Motion Carried.

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- Action Item 2 – Communication Plan Materials

IHC members will be asked to adopt the SHIP Communications Plan materials as presented by Mercer.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition adopt the SHIP Communications Plan materials as presented by Mercer.

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

Motion Carried.

**Idaho Medicaid Healthy Connections Payer Strategy Summary**  
**Updated January 2016**

Idaho Medicaid plans to implement changes to its payment structure for its Healthy Connections primary care program to incentivize patient centered medical home development in coordination with the State Healthcare Innovation Plan (SHIP). Patients are attributed to practices based on their provider selection, or if no provider is selected, based on their past claims and proximity to provider locations and provider availability.

- Providers will receive per member per month payments (PMPM) for attributed patients to support activities directed towards improved patient care and better coordinated services.
- PMPM Payment amounts will vary depending on member and provider characteristics, as outlined in the table below.
- New regulations are under development to support these changes. Providers had the opportunity to participate in drafting these rules and providing input on specific requirements through negotiated rulemaking sessions.
- Rates shown below were developed to support care management employees and physician involvement in practice transformation

<b>Healthy Connections Payments – Available to All Participating Healthy Connections Primary Care Providers</b>			
<b>Primary Care Program</b>	<b>PMPM amount</b>	<b>Qualification for Payment</b>	<b>Administrative Requirements</b>
<p><b>Healthy Connections</b>            Limited PMPM to reflect the minimal care coordination needs of patients</p>	<p><b>\$2.50</b> for <u>all</u> attributed Basic Plan Participants</p> <ul style="list-style-type: none"> <li>• <i>Well children</i></li> <li>• <i>Well adults</i></li> <li>• <i>Pregnant women</i></li> </ul> <p><b>\$3.00</b> for <u>all</u> attributed Enhanced Plan Participants</p> <ul style="list-style-type: none"> <li>• <i>Aged 65 and up</i></li> <li>• <i>Disabled and chronically ill adults</i></li> <li>• <i>Children with special health care needs</i></li> </ul> <p><i>Individuals with severe and persistent mental illness or serious emotional disturbance</i></p>	<p><b>Similar to existing Healthy Connections requirements:</b></p> <ul style="list-style-type: none"> <li>• Monitor and manage patient care</li> <li>• Provide preventive, routine and urgent care.</li> <li>• Coordinate care and provide referrals for designated services.</li> <li>• Management and documentation of patient’s medications.</li> <li>• 24/7 after-hours access to a medical professional for purposes of referral to services.</li> </ul>	<p><b>Reduced</b> - Referral no longer required for following services also requiring a physician’s order</p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Hospice</li> <li>• Children’s Developmental Disability Services</li> </ul>

**Idaho Medicaid Healthy Connections Payer Strategy Summary  
Updated January 2016**

<b>Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications</b>			
<b>Primary Care Program</b>	<b>PMPM amount</b>	<b>Qualification for Phase One Payments</b>	<b>Administrative Requirements</b>
<p><b>Healthy Connections Access Plus</b></p> <p>For providers with minimal care coordination and enhanced access to care</p>	<p><b>\$3.00</b> for <u>all</u> attributed Basic Plan Participants</p> <p><b>\$3.50</b> for <u>all</u> attributed Enhanced Plan Participants</p>	<p><b>Similar to existing Healthy Connections requirements with addition of enhanced access to care:</b></p> <ul style="list-style-type: none"> <li>• Complete a tier application.</li> <li>• Provide preventive, routine and urgent care</li> <li>• Coordinate care and provide referrals for designated services.</li> <li>• Management and documentation of patient’s medications.</li> <li>• 24/7 after-hours access to a medical professional for purposes of referral to services.</li> <li>• Enhanced patient access to care – must meet one of the following:               <ul style="list-style-type: none"> <li>○ 46 hours of access to care for patients</li> <li>○ Nearby Service Location with extended hours and shared EMR within same organization</li> <li>○ Patient portal to enhance access to care</li> <li>○ Telehealth - remote healthcare services</li> <li>○ Other – must be approved by the Dept.</li> </ul> </li> </ul>	<p><b>Reduced</b> - Referral no longer required for following services also requiring a physician’s order</p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Hospice</li> <li>• Children’s Developmental Disability Services</li> </ul>

**Idaho Medicaid Healthy Connections Payer Strategy Summary**  
**Updated January 2016**

<b>Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications</b>			
<b>Primary Care Program</b>	<b>PMPM amount</b>	<b>Qualification for Phase One Payments</b>	<b>Administrative Requirements</b>
<p><b>Healthy Connections Care Management</b></p> <p><i>For providers with some patient centered medical home capabilities</i></p>	<p><b>\$7.00</b> for <u>all</u> attributed Basic Plan Participants</p> <p><b>\$7.50</b> for <u>all</u> attributed Enhanced Plan Participants</p>	<p><b>Proposed criteria – similar to existing “Healthy Connections” program requirements with the addition of some PCMH capabilities</b></p> <p><b>Required:</b></p> <ul style="list-style-type: none"> <li>• Complete a readiness assessment and tier application.</li> <li>• Complete Patient Centered Medical Home Assessment (PCMH-A).</li> <li>• Create a well-defined 1 - 3 year plan to achieve national PCMH recognition. This plan must be submitted within six month and will be monitored by Medicaid primary care staff.</li> <li>• Enhanced patient access to care– must meet one of the following:               <ul style="list-style-type: none"> <li>○ 46 hours of access to care for patients</li> <li>○ Nearby Service Location with extended hours and shared EMR within same organization</li> <li>○ Patient portal to enhance access to care</li> <li>○ Telehealth - remote healthcare services</li> <li>○ Other – must be approved by the Dept.</li> </ul> </li> <li>• Provide physician leadership for PCMH efforts.</li> <li>• Dedicated care coordinator staff or equivalent support for care management of individuals with chronic illnesses.</li> <li>• Established connection to the Idaho Health Data Exchange (IHDE).</li> </ul> <p><b>And one of the following:</b></p> <ul style="list-style-type: none"> <li>• Enhanced care management activities – community health emergency medical services or community health workers, promotora model, home visiting model, or similar enhanced care coordination model with proven results.</li> <li>• Population health management capabilities - registry reminder system or other proactive patient management approach.</li> <li>• Behavioral health integration – co-located or highly integrated model of behavioral and physical health care delivery.</li> <li>• Referral tracking and follow-up system in place.</li> <li>• National Committee Quality Assurance (NCQA) level 1.2.pr 3 PCHM recognition or Utilization Review Accreditation Commission (URAC), Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or other PCMH national recognition.</li> </ul>	<p><b>Reduced</b> - Referral no longer required for following services also requiring a physician’s order</p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Hospice</li> <li>• Children’s Developmental Disability Services</li> </ul>

**Idaho Medicaid Healthy Connections Payer Strategy Summary**  
**Updated January 2016**

<b>Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications</b>			
<b>Primary Care Program</b>	<b>PMPM amount</b>	<b>Qualification for Phase One Payments</b>	<b>Administrative Requirements</b>
<p><b>Healthy Connections Medical Home</b></p> <p><i>Providers with advanced patient centered medical home capabilities</i></p>	<p><b>\$9.50</b> for <u>all</u> attributed Basic Plan Participants</p> <p><b>\$10.00</b> for <u>all</u> attributed Enhanced Plan Participants</p>	<p><b>Proposed criteria – similar to existing “Health Homes” program requirements:</b></p> <ul style="list-style-type: none"> <li>• Complete a readiness assessment and tier application.</li> <li>• Complete Patient Centered Medical Home Assessment (PCMH-A).</li> <li>• NCQA level 2 or 3 patient centered medical home recognition: URAC, Joint Commission, AAAHC or other patient centered medical home national accreditation.</li> <li>• Established bi-directional connection to the Idaho Health Data Exchange (IHDE) with demonstrated share relationship.</li> <li>• Provide physician leadership for PCMH efforts.</li> <li>• Dedicated care coordinator staff or equivalent support for care management of individuals with chronic illnesses.</li> <li>• Quality improvement activities directed at increased performance for quality measures.</li> <li>• Enhanced patient access to care – must meet one of the following:               <ul style="list-style-type: none"> <li>○ 46 hours of access to care for patients</li> <li>○ Nearby Service Location with extended hours and shared EMR within same organization</li> <li>○ Patient portal to enhance access to care</li> <li>○ Telehealth - remote healthcare services</li> <li>○ Other – must be approved by the Dept.</li> </ul> </li> </ul>	<p><b>Reduced</b> - Referral no longer required for following services also requiring a physician’s order</p> <ul style="list-style-type: none"> <li>• Durable Medical Equipment</li> <li>• Occupational Therapy</li> <li>• Physical Therapy</li> <li>• Speech Therapy</li> <li>• Hospice</li> <li>• Children’s Developmental Disability Services</li> </ul>

**Idaho Medicaid Healthy Connections Payer Strategy Summary**  
**Updated January 2016**

**Quality Measure Reporting**

Quality measurement tracking and reporting is a key component of Medicaid’s strategy to support patient centered medical homes. Data will be exchanged between Medicaid and the provider, and vice versa. This will be a key piece of future payment strategies.

During the first phase of implementation (as outlined in the tables above) a claims data dashboard will be reported back to provider locations by Healthy Connections representatives:

- *Diabetes* – A1C completion
- *Asthma* – Asthma Emergency Department visits
- *Low Birth Weight* – Low birth weight per 100 births
- *Medication Management* – Adherence to Anti-Psychotics for Individuals with Psychotic Diagnoses
- *Acute Care Hospitalization* – Percent of patients admitted

Quality measure reporting will expand to include clinical data collected through the Idaho Health Data Exchange for SHIP core measures when that functionality becomes available.

**Future Development Timeline**

2016	Implementation of first phase as described above
2016 – 2017	Development of capacity to collect clinical measures through IHDE <ul style="list-style-type: none"><li>• Work with IHDE and SHIP data analytics contractor to develop methods for clinical measure data collection and reporting</li><li>• Work with primary care providers to build EMR gateways to IHDE to facilitate data reporting</li></ul>
2017	Payment for performance based on quality measures begins for select providers on a voluntary basis <ul style="list-style-type: none"><li>• Quality measures will be collected via IHDE</li></ul>
2018	Expansion of payment for performance, to partially replace fee schedule reimbursement for providers electing to participate
2019 on	Development of shared savings approaches to reimbursement and fully capitated payments to primary care providers electing to participate



# IDAHO DEPARTMENT OF HEALTH & WELFARE

## Idaho Medicaid Patient-Centered Medical Home

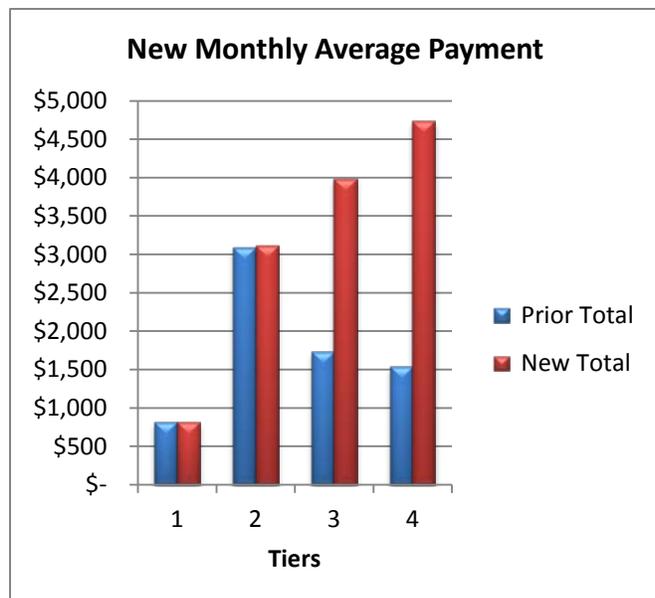
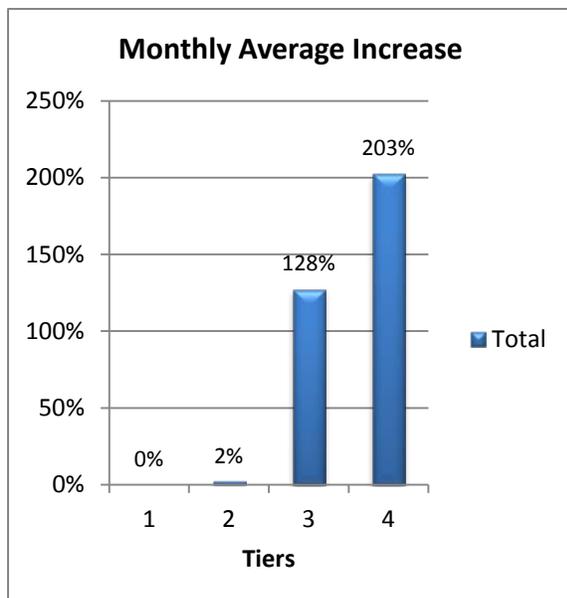
### Background

Medical homes are a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care. The patient-centered medical home (PCMH) is a model of care that aims to transform the delivery of comprehensive primary care to children, adolescents, and adults. The PCMH model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered. Building on the work of a large and growing community, a PCMH is not defined simply as a place; rather, a model of the organization of primary care that delivers the core functions of primary health care. As part of the State Health Innovation Plan (SHIP), the PCMH will soon be a reality.

### New Medical Home Tiers

The Healthy Connections and Health Home Programs will be combined into one program and the monthly case management payment will be based on both the complexity of the participant's health and the PCMH capabilities of the Healthy Connections (HC) clinic. HC clinics will qualify for one of the four tiers of reimbursement for all attributed participants. Tier placement and ongoing compliance with requirements will be closely monitored by the Healthy Connections staff.

Healthy Connection PMPM rates as of 2-1-2016		
Tier	Basic	Enhanced
1. Healthy Connections	\$ 2.50	\$ 3.00
2. Healthy Connections - Access Plus	\$ 3.00	\$ 3.50
3. Healthy Connections - Care Management	\$ 7.00	\$ 7.50
4. Healthy Connections - Medical Home	\$ 9.50	\$ 10.00





# Key SHIP Information for PCMH-Engaged Primary Care Providers

## SHIP Communications – V1.0

Partner Logo Space

Add your  
organizational logo or  
DELETE this element

**Primary Audience:** PCMH-Engaged Primary Care Providers

**Secondary Audience:** N/A

**For use by:** RC co-chairs, experienced PCMH practitioners, SHIP staff, healthcare provider members of the IHC, Brilljent, and healthcare association members of the IHC.

**Version:** 1.0 (01/2016) **DRAFT**

### SECTION 1: SOCO (Single Overriding Communications Objective)

**There are many supports available to primary care practices as they transform to the PCMH model.**

- Once practices are designated as Patient Centered Medical Homes (PCMH) as part of Idaho's Statewide Healthcare Innovation Plan (SHIP), they are expected to continue their transformation efforts to advance their PCMH capacity. Significant technical assistance and support resources are available to practices as they transform. Through a multi-pronged approach, IDHW SHIP staff, PHD SHIP staff, the PCMH transformation contractor and subcontractors all play a role in assisting clinics in the transformation process.
  - Technical assistance and transformation support will be available through Public Health Districts and Regional Health Collaboratives (RCs), which together are tasked with guiding practices through the PCMH transformation process by providing peer support and linkages to community resources through the medical/health neighborhood.
  - Transformation supports and resources will be available through the IDHW and its PCMH transformation contractor. Brilljent and its subcontractors, Health Management Associates (HMA) and Myers & Stauffer, have been secured by IDHW to provide training, learning collaboratives, on-site assistance, and additional support to practices. We encourage you to fully engage and take advantage of these resources.
- By transforming your practice to the PCMH model, you are making a major contribution to improving health care in Idaho. We appreciate your commitment to the work and overcoming the challenges involved in transforming your practice, and we will work with you to identify and provide the support you need to make this transformation.

### SECTION 2: Additional Messages

**Commitment to delivering coordinated care through a PCMH model is needed to be successful in the long term and reap all the benefits for practices and patients.**

- To some extent, the Model Test is a marathon not a sprint, and meaningful change will happen over time. Your long-term commitment is necessary for achieving better-coordinated care for your patients and benefits for your practice.



- Thirty-six (36) primary care providers went through the PCMH transformation experience during the Idaho Medical Home Collaborative (IMHC) pilot. Lessons learned from the pilot have been incorporated in the SHIP Model test to ease the obstacles of change on a statewide scale.
- Central to the PCMH model is a recognition that many factors impact an individual's total health: medical services, lifestyle, culture, nutrition, and socio-economic factors, to name a few—factors that primary care providers have been working to address for years, but are finally being recognized formally in this model. Collaborating on and improving these health factors will only happen with time, again, which requires a long-term commitment.
- While PCMH incentive payments will help mitigate the costs of change in the near term, the financial benefits of longer-term improvements will materialize in value-based reimbursements from commercial and public payers. Medicaid and Idaho's three largest private payers are working together to adopt strategies to transition from volume-based to value-based payments.

**Your feedback will help identify challenges and opportunities as we transform healthcare.**

- Feedback is critical to success of the PCMH model. The IMHC pilot test provided a solid blueprint for the model test, but meaningful change during implementation will require feedback on what is working and what is not at the clinic and community level.
- Sharing your experience as you transform your practice will help the IHC and RCs identify ways to improve the model and its implementation as well as provide peer support to other providers. We hope you will participate in collaborative forums with other providers to share your experience and exchange best practices.
- The SHIP Model includes an important focus on community and regional-specific unique healthcare system needs and the goal of improving the overall health of Idaho's population, which is why provider feedback is so critical.
- At the community, regional, and state level, information will be shared and analyzed to expand understanding of the health needs of Idaho's communities and residents.

### **SECTION 3: Background**

- The State Innovation Models (SIM) Initiative is a federal program operated by the Center for Medicare and Medicaid Innovation (CMMI), under the Centers for Medicare and Medicaid Services (CMS). The SIM Initiative provides grants to states to design, then test new payment and service delivery models to achieve broad, statewide health system transformation that improves healthcare outcomes and reduces costs.
- In April 2013, CMMI awarded the IDHW with a SIM "model design" grant to develop a SHIP, which is Idaho's blueprint for transforming the State's healthcare system. Idaho used the grant to design a SHIP Model that will transform the State's healthcare system from rewarding volume of services to a payment model that incentivizes improving health outcomes through the PCMH service delivery model. A PCMH model of care focuses on comprehensive care, patient-centeredness, coordinated care, accessible services, quality and safety.
- The IHC was formed in 2013 to oversee the development of the SHIP Model. The IHC is comprised of stakeholders from across the State, and includes primary care doctors,

specialty providers, Medicaid, Idaho's largest private payers, advocates, and PHD staff. The IHC established two overarching goals for the SHIP Model to achieve:

- 1) Improve Idahoan's health by strengthening primary and preventive care through the patient centered medical home, and
  - 2) Evolve from a fee-for-service, volume-based payment system of care to a value-based payment system of care that rewards improved health outcomes.
- In December 2014, Idaho was one of 11 states to receive a four-year "model test" grant to implement the model design. Idaho's grant totaled nearly \$40 million. In 2015, Idaho started preparing for the "model test" implementation, which will begin in February 2016. The SHIP grant is sponsored by Governor Otter, and managed by IDHW. The IHC continues to meet monthly to oversee the implementation of the model and transformation of Idaho's healthcare system.



# Key SHIP Information for Patients

## SHIP Communications – V1.0

Partner Logo Space

Add your  
organizational logo or  
DELETE this element

**Primary Audience:** Patients and Community Members

**Secondary Audience:** General Public

**For use by:** RC, RCE, PHD SHIP staff, Healthcare Provider Members of the IHC

**Version:** 1.0 (01/2016) **DRAFT**

### SECTION 1: SOCO (Single Overriding Communications Objective)

**If you receive your healthcare from a PCMH, you will continue to receive care with your same doctor, but receive additional benefits, such as having access to a team of healthcare professionals who will focus on and coordinate your entire health needs.**

- PCMH stands for Patient Centered Medical Home; a different model for receiving care from your primary care doctor.
- The patient is at the heart of the PCMH model as doctors and a team of healthcare professionals providing care through a PCMH focus on understanding and helping with all the patient's health needs, including helping the person get the services and supports needed to be healthy.
- When you receive your healthcare from a PCMH, your doctor's practice will coordinate your care with other health services you need, help you access the right services to maintain or improve your health, and communicate with you regularly about prevention and wellness activities to help you lead a healthy life.
- Many primary care doctors around the State are changing their practice from a traditional primary care model to a PCMH in order to improve care for their patients. While many doctors are interested in making this change for their practice, it can require time, staff, and other resources that may take some time to acquire. For example, some doctors may have to hire additional staff to increase care coordination for all their patients. If your doctor is not changing to a PCMH now, you may find that he or she plans to do so in the future.

### SECTION 2: Additional Messages

**Some patients can expect to see the benefits of PCMHs early in 2016.**

- As of January 2016, there are 55 primary care practices in Idaho that are PCMHs participating in the Statewide Healthcare Innovation Plan (SHIP). So, if your doctor's office is one of these 55 PCMHs, you may start to see these benefits soon.
- Many more primary care practices have expressed interest in becoming a PCMH. A group of doctors, nurses, other health professionals, health insurers, public health officials, and Idaho's Medicaid program are working together to reach a goal of 165 PCMHs across Idaho by February 2019.
- We believe these PCMHs will be able to serve roughly half of Idaho's population and, in doing so, improve the health of families, neighborhood, and communities around the State.



**PCMHs in rural areas will help patients get better care in areas where there is a shortage of doctors and services.**

- Special PCMHs, called “Virtual PCMHs”, are being created in rural areas. The virtual PCMHs will use other tools, like information technology, to make it easier for people to get the care they need. Virtual PCMHs may have additional people on their care team, like community health workers, who are members of the community (not doctors), that are specially trained to help patients understand and access services.
- The Virtual PCMH healthcare team will work with community members to identify other services needed in that community. For example, some communities may add Community Health Emergency Medical Services (CHEMS) workers to the Virtual PCMH. These are trained EMS people in the community who typically respond to emergencies only but, under the Virtual PCMH model, could be part of the team performing medical follow-up home visits with patients with chronic illness, such as diabetes, or helping administer flu shots to elderly persons who cannot get to the doctor’s office.

**Patients are an essential part of each healthcare team.**

- Your wellbeing is the heart of the PCMH model and your PCMH team will work to make sure your care needs are met. You can help by being an active participant in your care. PCMHs will support you at each step of the way.

### **SECTION 3: Background**

In December 2014, Idaho was one of 11 states to receive a four-year grant to help primary care doctors move to the PCMH model of care. Grant funds are being used to provide technical assistance and support to primary care practices as they switch from traditional care to a PCMH.



# Key SHIP Information for the Medical/Health Neighborhood SHIP Communications – V1.0

Partner Logo Space

Add your  
organizational logo or  
DELETE this element

**Primary Audience:** Medical/Health Neighborhood

**Secondary Audience:** PCMHs

**For use by:** PHD SHIP Team and PHD Division staff, RC members and co-chairs, medical and non-medical members of the IHC, primary care provider members of the IHC, and Healthcare Association members of the IHC.

**Version:** 1.0 (01/2016) **DRAFT**

## **SECTION 1: SOCO (Single Overriding Communications Objective)**

**Your patients and practice will improve through better coordination between primary care services, and the services they receive from the entire Medical/Health Neighborhood.**

- Through the Patient Centered Medical Home (PCMH) model, care for your patients will be carefully coordinated between your services, their primary care services in the PCMH and other specialty care and community services delivered by providers in the Medical/Health Neighborhood.
- Your patients will benefit from care delivered by a PCMH team of healthcare practitioners who address the patient's total health needs, coordinate their care, and engage the individual as an active participant in improving their own health.
- As part of the Medical/Health Neighborhood, you will benefit from this model by having the right patients come to you, for the right reason, at the right time.

**As a member of the Medical/Health Neighborhood, we need your help developing better mechanisms for referrals, processes to exchange information, and care coordination that will improve Idaho's healthcare system for your patients/clients and your practice/organization.**

- The Medical/Health Neighborhood is a clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease.
- The Medical/Health Neighborhood can include: medical specialists; community services such as food, housing and transportation providers; dietitians; behavioral health specialists; home health providers; dental professionals; and community health workers (CHW), community health emergency medical services (CHEMS), education providers, social service organizations, etc. that provide wrap-around, community level support for the PCMH and its patients to achieve better health outcomes and wellness.
- The PCMH consists of primary care practices and serves as the patient's primary "hub." PCMH teams help coordinate health care delivery with the Medical/Health Neighborhood.
- Input from the Medical/Health Neighborhood on referrals, exchange of information and coordination practices is critical to improve care. Members of the Medical/Health Neighborhood can best help collaborate on these items by working with Regional Health



Collaboratives (RCs). The Idaho Healthcare Coalition (IHC) is establishing seven RCs to provide local support for the health system transformation.

## SECTION 2: Additional Messages

**Idaho is implementing the PCMH model based on our positive experience with the PCMH pilot.**

- Idaho chose the PCMH model because the State has already piloted this model through the Idaho Medical Home Collaborative (IMHC) and found it provided better healthcare and reduced costs. The two-year PCMH pilot under the IMHC transformed 36 primary care practices into PCMHs that served 9,000 patients with chronic conditions.
- Idaho anticipates implementation of the SHIP Model will save overall Idaho's healthcare system, including both public and private payers, up to \$89 million over three years by reducing high-cost services, such as inappropriate emergency department use and avoidable hospital admissions, and providing better coordinated care to Idaho's population through PCMHs.

**Supporting Facts:** The PCMH pilot that began in January 2013 produced \$2.4 million in savings for Idaho's Medicaid program each year of the project.

## SECTION 3: Background

- The State Innovation Models (SIM) Initiative is a federal program operated by the Center for Medicare and Medicaid Innovation (CMMI), under the Centers for Medicare and Medicaid Services (CMS). The SIM Initiative provides grants to states to design, then test new payment and service delivery models to achieve broad, statewide health system transformation that improves healthcare outcomes and reduces costs.
- In April 2013, CMMI awarded the IDHW with a "model design" grant to develop a SHIP. Idaho used the grant to design a SHIP Model that will transform the State's healthcare system from volume to value, driven by improved health outcomes through PCMHs. A PCMH model of care focuses on comprehensive care, patient-centeredness, coordinated care, accessible services, quality and safety.
- The IHC was formed in 2013 to oversee the development of the SHIP Model. The IHC is comprised of stakeholders from across the State, and includes primary care doctors, specialty providers, Medicaid, Idaho's largest private payers, advocates, and PHD staff. The IHC established two overarching goals for the SHIP Model to achieve:
  - 1) Improve Idahoan's health by strengthening primary and preventive care through the patient centered medical home, and
  - 2) Evolve from a fee-for-service, volume-based payment system of care to a value-based payment system of care to a value-based payment system that rewards improved health outcomes.
- In December 2014, Idaho was one of 11 states to receive a four-year "model test" grant to implement the model design. Idaho's grant totaled nearly \$40 million. In 2015, Idaho started preparing for the "model test" implementation, which will begin in February 2016. The SHIP grant is sponsored by Governor Otter, and managed by IDHW. The IHC continues to meet monthly to oversee the implementation of the model and transformation of Idaho's healthcare system.



# Key SHIP Information for Potential Primary Care Provider PCMHs SHIP Communications – V1.0

Partner Logo Space

Add your  
organizational logo or  
DELETE this element

**Primary Audience:** Potential Primary Care Provider Participants in PCMH Model

**Secondary Audience:** N/A

**For use by:** RC co-chairs, experienced PCMH practitioners, SHIP staff, healthcare provider members of the IHC, Brilljent, and healthcare association members of the IHC.

**Version:** 1.0 (01/2016) **DRAFT**

## SECTION 1: SOCO (Single Overriding Communications Objective)

**Transforming to the PCMH model can be challenging, but resources are available to help practices transform.**

- The Idaho Healthcare Coalition (IHC) has established criteria to be designated as a Statewide Healthcare Innovation Plan (SHIP) PCMH. The criteria build off the successful IMHC Pilot. Once designated as a PCMH for the purposes of Idaho's SHIP project, practices will be expected to continue their transformation efforts.
- Resources exist in the form of technical assistance and transformation support, as well as financial incentives. Significant resources are available to help all practices in their transformation (e.g. technical assistance, affinity group facilitation, incentive payments and other contractor services).

**Public Health Districts (PHD) and Brilljent are tasked with guiding practices through the PCMH transformation process by, among other things; providing peer support and linkages to community resources. Additional resources will be available through Brilljent and its subcontractors, which have been hired by IDHW to provide training, learning collaboratives, on-site assistance, and additional support to practices.**

- There are also financial resources. PCMHs receive a one-time incentive payment of \$10,000 to help offset practice transformation costs. Technical assistance and support delivered by PHDs and Brilljent are free for practices.
- The PCMH model will also be supported by payer financial strategies that reward better clinical care and health outcomes (i.e. value). Idaho's Medicaid program and largest commercial market payers are participating in the project to incorporate value-based purchasing, which will reward the delivery of higher quality of care that demonstrates health outcomes.

## SECTION 2: Additional Messages

**A key benefit for your practice is the team-based approach that enables practitioners to focus time and attention where it is most needed.**

- Each PCMH team member is able to practice at the top of their license. Physicians are able to focus on clinical care requiring physician-level intervention while other staff, such as nurses and community health workers (CHWs), can provide care within the appropriate scope of their practice.



- The model will encourage patients to take a more participatory role in their care and general health.

**A key benefit of the model for your patients is the increased coordination of care that will occur with other services they need in the Medical/Health Neighborhood.**

- Patients will continue to receive all appropriate care through their primary care physician. The PCMH team will help coordinate specialty care and other services through the medical/health neighborhood.
- Many factors impact an individual's total health including medical services, lifestyle, culture, nutrition, and socio-economic factors. To address a person's total health needs, medical/health neighborhood services will be linked and coordinated with primary care through the PCMH to establish and maintain a "complete picture" of the individual's health status and care delivered across all service providers.

**Idaho is implementing the PCMH model based on our positive pilot experience.**

- The SHIP Model is built off of the experience Idaho gleaned from the two-year PCMH pilot under the Idaho's Medical Home Collaborative (IMHC) which transformed 36 primary care practices into PCMHs that served 9,000 patients with chronic conditions.
- Idaho anticipates that implementing the SHIP Model will save overall Idaho's healthcare system, including both public and private payers, up to \$89 million over three years by reducing high-cost services, such as inappropriate emergency department use and avoidable hospital admissions, and providing better coordinated care to Idaho's population through PCMHs.

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  - 1) Improve Idahoan's health by strengthening primary and preventive care through the patient centered medical home, and

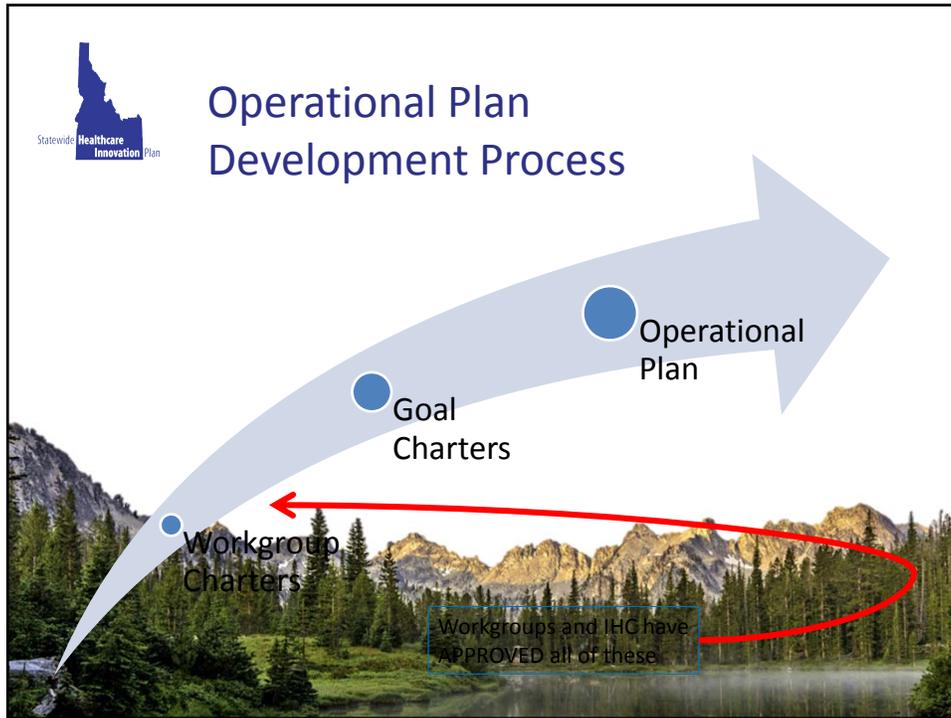
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- 2) Evolve from a fee-for-service, volume-based payment system of care to a value-based payment system of care that rewards improved health outcomes.
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## Implementing Idaho's SHIP Model

### Tools for Managing and Monitoring Implementation

1. Operational Plan
  - Drafted and approved by IHC.
  - Submitted to CMMI. Preliminary response is positive; received comments. Approval expected; will trigger Year 1 Model Test Year grant funding.
2. Master Project Management Plan
  - Details the project management approach, processes, and tools that will be used to manage and monitor the implementation of the SHIP model as outlined in the Operational Plan.
  - Tracks milestones and outcomes to support a cohesive, coordinated, and measurable implementation.



### Workgroup and Goal Charters

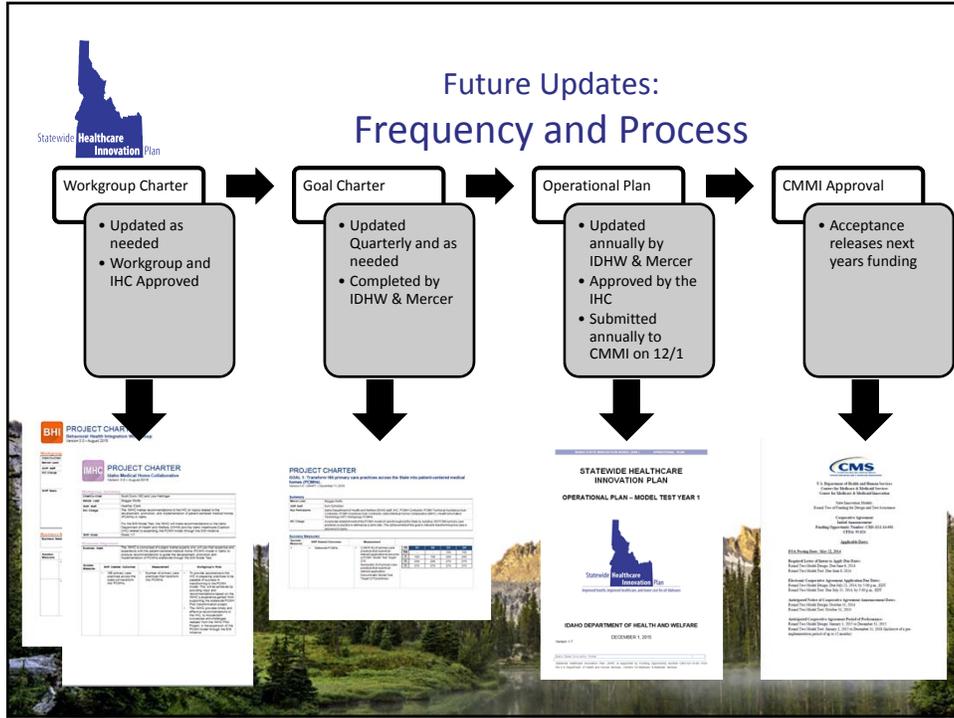
Workgroup Charters	Goal Charters
<ul style="list-style-type: none"> <li>➤ Identifies specific activities, milestones, deliverables, and timeframes that must occur <b>within each workgroup</b> to support the IHC in achieving the goals.</li> <li>➤ The IHC will assist workgroups with making adjustments to their charters as the model evolves during implementation.</li> </ul>	<ul style="list-style-type: none"> <li>➤ Identifies specific activities, milestones, deliverables, and timeframes that must occur <b>across the SHIP project</b> to support achieving the goals.                             <ul style="list-style-type: none"> <li>▪ Goal charters align all the activities (across the workgroups and all components of the SHIP Project) that must occur to achieve each goal.</li> <li>▪ Workgroup charters were used to develop the Goal charters.</li> </ul> </li> </ul>



## Operational Plan - Appendix B

Master Timeline						
ID	Outline Number	SM Component	Health IT Activity Supporting the SM Component	Start	Finish	Milestone(s)
1	1	<b>Patient Centered Medical Home (PCMH) Transformation</b>		Fri 5/1/15	Thu 1/24/19	
2	1.1	<b>Recruit Primary Care Practices</b>		Mon 6/1/15	Fri 1/5/18	
3	1.1.1	<b>Recruitment and Enrollment Plan</b>		Mon 6/1/15	Fri 1/5/18	
4	1.1.1.1	<b>Pre-Implementation Year</b>		Mon 6/1/15	Fri 1/8/16	
5	1.1.1.1.1	Draft PCMH recruitment and enrollment plan for Year 1.		Mon 6/1/15	Fri 6/12/15	
6	1.1.1.1.2	Feedback from stakeholders.		Mon 6/15/15	Thu 10/1/15	
7	1.1.1.1.3	Finalize PCMH recruitment and enrollment plan for Year 1.		Fri 10/2/15	Fri 10/16/15	
8	1.1.1.1.4	Implement PCMH recruitment and enrollment plan for Year 1.		Mon 10/19/15	Fri 1/8/16	
9	1.1.1.2	<b>Model Test Year 1</b>		Wed 6/1/16	Tue 1/3/17	
10	1.1.1.2.1	Evaluate recruitment and enrollment plan for Year 2 and make adjustments, as needed.		Wed 6/1/16	Thu 9/1/16	
11	1.1.1.2.2	Feedback from stakeholders.		Fri 9/2/16	Wed 10/12/16	
12	1.1.1.2.3	Implement PCMH recruitment and enrollment plan for Year 2.		Thu 10/13/16	Tue 1/3/17	
13	1.1.1.3	<b>Model Test Year 2</b>		Thu 6/1/17	Fri 1/5/18	
14	1.1.1.3.1	Evaluate recruitment and enrollment plan for Year 3 and make adjustments, as needed.		Thu 6/1/17	Fri 9/1/17	
15	1.1.1.3.2	Feedback from Stakeholders.		Mon 9/4/17	Fri 10/13/17	
16	1.1.1.3.3	Implement PCMH recruitment and enrollment plan for Year 3.		Mon 10/16/17	Fri 1/5/18	
17	1.1.2	<b>PCMH Interest Applications</b>	Incorporate HIT capabilities in application process.	Wed 7/1/15	Thu 12/14/17	10/9/15 - Determine which questions to ask about the practices current HIT capabilities.
18	1.1.2.1	<b>PCMH Interest Application</b>		Wed 7/1/15	Fri 11/2/17	
19	1.1.2.1.1	<b>Pre-Implementation Year</b>		Wed 7/1/15	Mon 9/14/15	
20	1.1.2.1.1.1	Create draft PCMH interest application.		Wed 7/1/15	Fri 7/31/15	

Page 1





# PROJECT CHARTER

## GOAL 1: Transform 165 primary care practices across the State into patient-centered medical homes (PCMHs).

Version 3.0 – FINAL

### Summary

<b>Mercer Lead</b>	Maggie Wolfe
<b>SHIP Staff</b>	Kym Schreiber
<b>Key Participants</b>	Idaho Department of Health and Welfare (IDHW) staff, IHC, PCMH Contractor, PCMH Technical Assistance Sub-Contractor, PCMH Incentives Sub-Contractor, Idaho Medical Home Collaborative (IMHC), Health Information Technology (HIT) Workgroup, PCMHs.
<b>IHC Charge</b>	Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices (a practice is defined as a clinic site). The achievement of this goal is critical to transforming how care is delivered in Idaho.

### Success Measures

Success Measures	SHIP Desired Outcomes	Measurement	YR	Q1	Q2	Q3	Q4
1.	<ul style="list-style-type: none"> <li>Statewide PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of primary care practices that submit an interest application to become a PCMH. <i>Model Test Target: 270.</i>            Numerator: # of primary care practices that submit an interest application.            Denominator: Model Test Target (270 practices)</li> </ul>	Pre	-	-	100	100
			1	100	100	200	200
			2	200	200	270	270
			3	270	270	270	270

1

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 1 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																														
2.	<ul style="list-style-type: none"> <li>Statewide PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. <i>Model Test Target: 165.</i> Numerator: # of designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. Denominator: Model Test Target (165 practices)</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	110	110	110	110	3	165	165	165	165				
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4.	<ul style="list-style-type: none"> <li>Statewide PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of practices designated PCMH of total primary care practices in Idaho that could become a PCMH. Numerator: # of practices designated PCMH Denominator: total primary care practices in Idaho (Estimated at 500. Data sources: Medicaid, Idaho Medical Association, and Idaho Academy of Family Physicians)</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	110	110	110	110	3	165	165	165	165				
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2 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 1 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																															
5.	<ul style="list-style-type: none"> <li>Statewide PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) number of providers participating in PCMHs, of total number of providers targeted for participation. Providers = staff employed at/represented by PCMHs, including licensed clinicians, other licensed professionals and allied health professionals. Average assumption = 10 providers per site.                      Numerator: number of providers participating in PCMHs                      Denominator: total number of providers in 165 PCMHs (estimated at 1,650).</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>550</td> <td>550</td> <td>550</td> <td>550</td> </tr> <tr> <td>2</td> <td>1110</td> <td>1110</td> <td>1110</td> <td>1110</td> </tr> <tr> <td>3</td> <td>1650</td> <td>1650</td> <td>1650</td> <td>1650</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	550	550	550	550	2	1110	1110	1110	1110	3	1650	1650	1650	1650					
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GOAL 1 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																														
6.	<ul style="list-style-type: none"> <li>Statewide PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) number of providers participating in PCMHs, of total providers in Idaho. Providers = staff employed at/represented by PCMHs, including licensed clinicians, other licensed professionals and allied health professionals. Average assumption = 10 providers per site.                      Numerator: number of providers participating in PCMHs                      Denominator: total number of providers in Idaho</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>550</td> <td>550</td> <td>550</td> <td>550</td> </tr> <tr> <td>2</td> <td>1110</td> <td>1110</td> <td>1110</td> <td>1110</td> </tr> <tr> <td>3</td> <td>1650</td> <td>1650</td> <td>1650</td> <td>1650</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	550	550	550	550	2	1110	1110	1110	1110	3	1650	1650	1650	1650				
YR	Q1	Q2	Q3	Q4																												
Pre	-	-	-	-																												
1	550	550	550	550																												
2	1110	1110	1110	1110																												
3	1650	1650	1650	1650																												
7.	<ul style="list-style-type: none"> <li>Support for PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of designated PCMHs receiving PCMH Technical Support and transformation incentives. <i>Model Test Target: 165.</i>                      Numerator: # of designated PCMHs receiving technical support and incentives                      Denominator: Model Test Target (165 practices)</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	110	110	110	110	3	165	165	165	165				
YR	Q1	Q2	Q3	Q4																												
Pre	-	-	-	-																												
1	55	55	55	55																												
2	110	110	110	110																												
3	165	165	165	165																												



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GOAL 1 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																														
8.	<ul style="list-style-type: none"> <li>PCMHs achieve increasing levels of national PCMH recognition.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of designated PCMHs that have achieved Idaho-specific or national PCMH recognition/accreditation. <i>Model Test Target: 165.</i> Numerator: number of PCMHs that achieve national PCMH recognition/accreditation Denominator: Model Test Target (165 practices)</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>18</td> </tr> <tr> <td>1</td> <td>18</td> <td>18</td> <td>18</td> <td>30</td> </tr> <tr> <td>2</td> <td>45</td> <td>60</td> <td>75</td> <td>100</td> </tr> <tr> <td>3</td> <td>100</td> <td>120</td> <td>150</td> <td>165</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	18	1	18	18	18	30	2	45	60	75	100	3	100	120	150	165				
YR	Q1	Q2	Q3	Q4																												
Pre	-	-	-	18																												
1	18	18	18	30																												
2	45	60	75	100																												
3	100	120	150	165																												
9.	<ul style="list-style-type: none"> <li>Idahoans will be enrolled in recognized PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of Idahoans who enroll in a designated PCMH (each practice estimated to have 5 providers, each with panel of 1,000). Numerator: number of Idahoans enrolled in a PCMH Denominator: total state population</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> </tr> <tr> <td>2</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> </tr> <tr> <td>3</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	275,000	275,000	275,000	275,000	2	550,000	550,000	550,000	550,000	3	825,000	825,000	825,000	825,000				
YR	Q1	Q2	Q3	Q4																												
Pre	-	-	-	-																												
1	275,000	275,000	275,000	275,000																												
2	550,000	550,000	550,000	550,000																												
3	825,000	825,000	825,000	825,000																												
10.	<ul style="list-style-type: none"> <li>Idahoans will be enrolled in recognized PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of targeted population who enroll in a designated PCMH (each practice estimated to have 5 providers, each with panel of 1,000). Numerator: number of Idahoans enrolled in a PCMH Denominator: Model Test Target (825,000 Idahoans (50.5%))</li> </ul>	<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> </tr> <tr> <td>2</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> </tr> <tr> <td>3</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	275,000	275,000	275,000	275,000	2	550,000	550,000	550,000	550,000	3	825,000	825,000	825,000	825,000				
YR	Q1	Q2	Q3	Q4																												
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1	275,000	275,000	275,000	275,000																												
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GOAL 1 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement					
11.	<ul style="list-style-type: none"> <li>PCMH patients will be active participants in their healthcare.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare. <i>Model Test Target: TBD</i></li> </ul> <p>Need to determine data collection methodology, numerator and denominator</p>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	-
			1	TBD	TBD	TBD	TBD
			2	TBD	TBD	TBD	TBD
			3	TBD	TBD	TBD	TBD

**Planned Scope**

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>PCMH recruitment project plan.</li> </ul>	<ul style="list-style-type: none"> <li>Detailed plan with activities, dates, and responsible parties.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor/PCMH Technical Assistance Sub-contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> <li>PCMH Contractor</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY		<b>End:</b> Ongoing	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Draft PCMH recruitment project plan for Year 1.</li> <li>Feedback from stakeholders.</li> <li>Finalize PCMH recruitment project plan for Year 1.</li> <li>Implement PCMH recruitment project plan for Year 1.</li> <li>Evaluate recruitment project plan and develop recruitment project plan for Years 2 and 3. Make adjustments as needed.</li> <li>Implement Year 2 and 3 recruitment plan.</li> </ul>		<ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>9/1/2016, 9/1/2017</li> <li>1/3/2017, 1/5/2018</li> </ul>	



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GOAL 1 PROJECT CHARTER

<b>Deliverable 2</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>PCMH designation criteria</li> </ul>	<ul style="list-style-type: none"> <li>The Idaho-specific criteria that will be used to designate PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> <li>PCMH Contractor</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY		<b>End:</b> By 2/1/2016	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>IMHC develops draft PCMH designation criteria.</li> <li>IHC approves designation criteria.</li> <li>Publish PCMH designation criteria and process on website.</li> </ul>		<ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>October 2016</li> </ul>	
<b>Deliverable 3</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Interest application in PCMH designation.</li> </ul>	<ul style="list-style-type: none"> <li>The document that practices will use to express interest in becoming a PCMH.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> <li>PCMH Contractor</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY		<b>End:</b> By 2/1/2016	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>IMHC created draft PCMH interest application for Year 1</li> <li>IHC approved PCMH interest application for Year 1.</li> <li>Send interest application to primary care practices.</li> <li>Practices submit interest application for Year 1.</li> <li>IDHW reviewed interest applications for Year 1.</li> <li>Determine whether/how the interest application will be used after Year 1 wave.</li> <li>Implement interest applications during Year 2 and Year 3</li> </ul>		<ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>9/1/2016, 9/1/2017</li> <li>11/2/2016, 11/3/2017</li> </ul>	



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GOAL 1 PROJECT CHARTER

Deliverable 4	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>PCMH application</li> </ul>	<ul style="list-style-type: none"> <li>The document that practices will use to attest that they meet the PCMH criteria</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> <li>PCMH Contractor</li> <li>PCMHs</li> </ul>
Est. Timeframe	Start: MM/DD/YYYY			End: By 2/1/2016
Milestones	<b>Event</b> <ul style="list-style-type: none"> <li>IMHC and IDHW create draft PCMH application, using information collected from the interest application.</li> <li>IMHC and IHC approve PCMH application.</li> <li>IDHW sends PCMH application and readiness assessment to practices (electronically).</li> <li>Practices begin to submit PCMH application (electronically).</li> <li>Determine process for receiving/processing applications for Year 1.</li> <li>Process Year 1 applications</li> <li>Determine application and application process for Year 2 and Year 3.</li> <li>Implement application process for Year 2 and Year 3</li> </ul>			<b>Target Date</b> <ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>[TBD]</li> <li>12/5/2016, 12/14/2017</li> </ul>



GOAL 1 PROJECT CHARTER

<b>Deliverable 5</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>PCMH readiness assessment</li> </ul>	<ul style="list-style-type: none"> <li>Process and materials to assess current practice capacity and identify gaps.</li> </ul>	<ul style="list-style-type: none"> <li>PCMH Contractor and PCMH Technical Assistance Sub-contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> By 2/1/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>PCMH Contractor develops PCMH readiness assessment.</li> <li>IDHW reviews the readiness assessment process and materials.</li> <li>IHC approves the readiness assessment process and materials.</li> <li>IDHW sends the readiness assessment to practices for Year 1 along with PCMH application.</li> <li>PCMH Contractor develops process to review and process readiness assessment results for Year 1.</li> <li>IDHW approves the process.</li> <li>PCMH Contractor and PCMH Technical Assistance Sub-contractor implement the readiness assessment process.</li> <li>PCMH Contractor develops process to distribute and collect readiness assessments for Years 2 and 3.</li> <li>IDHW approves the process.</li> <li>PCMH Contractor implements the readiness assessment process in Years 2 and 3.</li> </ul>			<ul style="list-style-type: none"> <li>Complete</li> <li>[TBD]</li> <li>[TBD]</li> <li>[TBD]</li> <li>12/2/2015</li> <li>By 12/17/2015</li> <li>1/28/2016</li> <li>12/7/2016, 11/30/2017</li> <li>[TBD]</li> <li>1/31/2016, 1/25/2018</li> </ul>



GOAL 1 PROJECT CHARTER

<b>Deliverable 6</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Hire a PCMH Contractor.</li> </ul>	<ul style="list-style-type: none"> <li>Responsibilities of PCMH contractor will include: recruit practices to become PCMHs, create and implement readiness assessment, enroll practices, distribute financial incentives, create and implement PCMH training and technical assistance plan, provide project management to support these tasks, provide data to IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>Regional Collaboratives</li> <li>IMHC</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start: MM/DD/YYYY</b>			<b>End: MM/DD/YYYY</b>
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Publish RFP.</li> <li>RFP responses due.</li> <li>Finalist selected.</li> <li>Send contract to CMMI.</li> <li>CMMI approval.</li> <li>Contract start date.</li> </ul>			<ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> <li>Complete</li> </ul>
<b>Deliverable 7</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Process for distributing financial incentives to qualifying PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Process to collect data from practices to support incentive distribution, process to implement controls to prevent fraud and abuse.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>PCMH Incentives Sub-Contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>IMHC</li> <li>PCMHs</li> </ul>

GOAL 1 PROJECT CHARTER

<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY		<b>End:</b> 2/1/2016	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Hire PCMH TA Contractor (Deliverable #5).</li> <li>Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.</li> <li>Obtain any necessary approvals of the financial distribution process.</li> <li>Complete any logistical steps needed to implement the process.</li> <li>PCMH contractor begins distribution of financial incentives and implementation of fraud/abuse protections.</li> </ul>		<ul style="list-style-type: none"> <li>Complete</li> <li>12/5/2015</li> <li>1/31/2016</li> <li>1/30/2016</li> <li>2/1/2016, 2/2/2017, 2/1/2018</li> </ul>	
<b>Deliverable 8</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Ongoing stakeholder communications regarding PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Communications plan and materials to communicate with a variety of stakeholders (primary care practices, specialists, hospitals, patients, RCs, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>PCMH Technical Assistance Subcontractor</li> <li>PCMH Incentives Sub-Contractor</li> <li>IHC</li> <li>PCMHs</li> <li>Patients and other stakeholders</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY		<b>End:</b> Ongoing	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Develop section of draft communications plan to include communications regarding PCMHs.</li> <li>IHC approves communication plan.</li> <li>Develop communications materials and implement the communications plan.</li> </ul>		<ul style="list-style-type: none"> <li>Complete</li> <li>Complete</li> <li>Ongoing</li> </ul>	



GOAL 1 PROJECT CHARTER

<b>Deliverable 9</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Technical support and mentoring to PCMH practices through a PCMH training program.</li> </ul>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>	<ul style="list-style-type: none"> <li>PCMH Contractor</li> <li>PCMH Technical Assistance Sub-Contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> Ongoing
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Develop PCMH training program.</li> <li>Implement PCMH training program.</li> <li>Evaluate PCMH training program and make adjustments as needed.</li> </ul>			<ul style="list-style-type: none"> <li>1/19/2016</li> <li>Ongoing</li> <li>Ongoing</li> </ul>
<b>Deliverable 10</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Hospital protocols for follow-up communications with designated PCMHs regarding hospitalizations.</li> </ul>	<ul style="list-style-type: none"> <li>Policy/procedure regarding what information to communicate to whom.</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals and PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>IMHC</li> <li>PCMHs</li> <li>IHDE</li> <li>RCs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> Ongoing
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Provide orientation to hospitals and PCMHs regarding communication protocols.</li> <li>Provide assistance to hospitals and PCMHs to develop communication protocols.</li> <li>Track and report to IDHW on the status of communication protocols.</li> <li>Assist hospitals and PCMHs in implementing communications protocols and making changes to the protocols as needed to support coordination and practice needs.</li> </ul>			<ul style="list-style-type: none"> <li>[TBD]</li> <li>[TBD]</li> <li>[TBD]</li> <li>[TBD]</li> </ul>

GOAL 1 PROJECT CHARTER

<b>Deliverable 11</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Increased use of EHRs among PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Develop PCMH capacity to use EHRs, connect to IHDE in order to collect and analyze data at the PCMH level and report data for regional and statewide analysis.</li> </ul>	<ul style="list-style-type: none"> <li>PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMHs</li> <li>PCMH Contractor</li> <li>PCMH Technical Assistance Sub-Contractor</li> <li>IHDE</li> <li>Data Analytics Contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> 07/01/16
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Provide support to PCMHs to increase use of EHRs and capacity for data collection and analysis.</li> <li>Support PCMHs in connecting to IHDE.</li> </ul>			<ul style="list-style-type: none"> <li>Ongoing</li> <li>Ongoing</li> </ul>
<b>Deliverable 12</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Patients enrolled in PCMHs are active participants in their healthcare.</li> </ul>	<ul style="list-style-type: none"> <li>Need to determine data collection methodology in order to create milestones.</li> </ul>	<ul style="list-style-type: none"> <li>Patients</li> <li>PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>IMHC</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> Ongoing
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>[TBD]</li> <li>[TBD]</li> <li>[TBD]</li> </ul>			<ul style="list-style-type: none"> <li>[TBD]</li> <li>[TBD]</li> <li>[TBD]</li> </ul>
<b>Deliverable 13</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Regular PCHM contractor project management reports</li> </ul>	<ul style="list-style-type: none"> <li>Detailed reports from PCMH contractor on status of PCMH activities and success measures</li> </ul>	<ul style="list-style-type: none"> <li>PCMH contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> </ul>



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Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 1 PROJECT CHARTER

<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> Ongoing
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Develop schedule, metrics and format of regular reports.</li> <li>IDHW approves schedule, metrics and format of regular reports.</li> <li>PCMH Contractor begins submitting regular reports to IDHW.</li> </ul>			<ul style="list-style-type: none"> <li>12/2/2015</li> <li>12/2/2015</li> <li>12/3/2015</li> </ul>
<b>Deliverable 14</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>List of designated PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>Regular list of designated PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>PCMH contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>IHC</li> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> Ongoing
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>PCMH Contractor enrolls designated PCMHs and develops list of designated PCMHs.</li> <li>PCMH Contractor updates list of designated PCMHs as additional practices enroll, or if a practice terminates participation in the Model Test.</li> <li>PCMH Contractor submits list of designated PCMHs to IDHW.</li> </ul>			<ul style="list-style-type: none"> <li>February, 2016</li> <li>Ongoing</li> <li>Ongoing</li> </ul>

**Project Risks, Assumptions, and Dependencies**

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	1. Rate of new PCMH recognition after Year 1 of the Model Test is lower than expected	M	M	Increase stakeholder education and recruitment activities to increase provider interest in becoming a PCMH. Evaluate ways to increase support for PCMHs, including leveraging the PCMH mentoring program.
	2. PCMH Contractor start date is later than expected	M	M	IDHW, IMHC and IHC begin to implement PCMH contractor responsibilities as appropriate until PCMH Contractor start date

GOAL 1 PROJECT CHARTER

<p>3. Challenges at the practice level in shifting to a coordinated patient-centered model.</p>	<p>M</p>	<p>M</p>	<p>Identify PCMHs that achieved quick successes and created collaborations among the teams in the regions to celebrate initial successes and share “best practices.” Share attempts which were not as successful, and study those efforts to understand how to achieve better results in the future.</p> <p>Provide incentives that support providers in making the transition in the short run.</p> <p>Eventually, new payment methodologies will help shift the culture of FFS to a model based on quality and outcomes on a broader scale.</p>
<p>4. The temptation to “check the box” on becoming a PCMH could pose a threat to true transformation at the practice level</p>	<p>L</p>	<p>H</p>	<p>Briljent will implement a robust training effort, paired with technical assistance to PCMHs. This includes interactive learning collaboratives, regional conferences, monthly coaching, and identification of champions.</p>
<p>5. Incorrect distribution of PCMH incentive payments: paying the wrong practice, incorrect reporting and accounting of federal funds, and delays in payments</p>	<p>L</p>	<p>H</p>	<p>Develop policies and procedures for collecting timely, accurate information from providers, including a policy for providers to notify the Briljent if their information changes.</p> <p>Develop minimum data elements needed to compute payments, and provide training to providers on reporting data needed for incentives.</p> <p>Establish policies and procedures for reporting incentive information.</p> <p>Require qualifying practices to sign an attestation as their agreement or acknowledgment that the practice is responsible for distributing funds among participating physicians.</p> <p>Define the process for adjudicating potential issues to avoid the appearance of, or the risk of, making arbitrary decisions</p>
<p>6. The low level of EHR use in the state presents a risk to achieving and measuring transformation success</p>	<p>M</p>	<p>M</p>	<p>Briljent and its Sub-Contractors will carefully assess the level of data availability at the initial phases of the project (September 1, 2015 - January 31, 2016) and find solutions to compensate for the practices selected for participation in the first cohort of the collaborative.</p>



GOAL 1 PROJECT CHARTER

	7. Multiple contractors requesting information could burden participating practices and threaten participation.	M	M	Before requesting information from the practices, Brilljent will share the request with other contractors to ensure that information is not already being collected or planned to be collected. Brilljent will also ensure that any data that is collected is reported back to the clinic so that they can use it for their improvement efforts.
<b>Assumptions</b>	• [TBD]			
<b>Dependencies and Constraints</b>	• [TBD]			

**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**

<b>Author</b>	Maggie Wolfe	<b>Date</b>	12/11/2015
<b>Reviewer</b>	Casey Moyer	<b>Date</b>	12/15/2015

**Final Acceptance**

<b>Name/Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator	12/18/2015	<input checked="" type="checkbox"/>
Katie Falls	Mercer Lead	12/18/2015	<input checked="" type="checkbox"/>



# PROJECT CHARTER

**GOAL 2: Improve care coordination by improving real-time communication between PCMHs, their patients, and other entities across the healthcare system (e.g., hospitals and specialty care) through adoption and use of EHRs and Health Information Exchange (HIE) connections among the 165 PCMHs, as well as building statewide capacity for data exchange across the system.**

Version 6.0 – FINAL

## Summary

<b>Mercer Lead</b>	David Shadick
<b>SHIP Staff</b>	Casey Moyer
<b>Key Participants</b>	Clinical Quality Measures Workgroup, Regional Health Collaboratives (RCs), Population Health Workgroup, Idaho Medical Home Collaborative (IMHC), Idaho Healthcare Coalition, Office of the Attorney General, Idaho Public Health Districts, Idaho Health Data Exchange (IHDE), Idaho Department of Health and Welfare (IDHW), Briljent (PCMH Contractor), IHDE Expansion and Connections Contractor, Data Analytics Contractor.
<b>IHC Charge</b>	Improve care coordination using electronic health records (EHRs) and health data connections to share clinical information among PCMHs and across the Medical/Health Neighborhood.

## Success Measures

Success Measures	SHIP Desired Outcomes	Measurement																									
1.	<ul style="list-style-type: none"> <li>Increased use of EHRs by PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative (CUM) # (%) of PCMH sites with EHR systems that support Health Information Exchange (HIE) connectivity capabilities. Model Test target: 165 PCMHs.</li> <li>Numerator: Number of PCMHs with EHR connectivity capabilities.</li> <li>Denominator: Model test target (165 PCMHs). Quarterly targets as shown in the table to the right.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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>75</td> <td>85</td> <td>95</td> <td>110</td> </tr> <tr> <td>3</td> <td>130</td> <td>140</td> <td>150</td> <td>165</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	75	85	95	110	3	130	140	150	165
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	55	55	55	55																							
2	75	85	95	110																							
3	130	140	150	165																							

1 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 2 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																									
		<ul style="list-style-type: none"> <li>Data Source: Quarterly survey of PCMH sites.</li> </ul>																									
2.	<ul style="list-style-type: none"> <li>Increased number of Idahoans who have a PCMH and an EHR.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative # (%) of patients in designated PCMHs (sites) that have an EHR (each practice estimated to have 5 providers, each with panel of 1,000). Model Test Target: 825,000 (50.4% of Idahoans).</li> <li>Numerator: PCMH members with electronic health records.</li> <li>Denominator: Model Test target (825,000 (50.4%) Idahoans). Quarterly targets as shown in the table to the right.</li> <li>Data Source: Quarterly survey of PCMHs.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> <td>275,000</td> </tr> <tr> <td>2</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> <td>550,000</td> </tr> <tr> <td>3</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> <td>825,000</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	275,000	275,000	275,000	275,000	2	550,000	550,000	550,000	550,000	3	825,000	825,000	825,000	825,000
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	275,000	275,000	275,000	275,000																							
2	550,000	550,000	550,000	550,000																							
3	825,000	825,000	825,000	825,000																							
3.	<ul style="list-style-type: none"> <li>Increased PCMH use of EHRs and health data connections to improve care coordination.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative # (%) of designated PCMHs with an active connection to the Idaho Health Data Exchange (IHDE) and utilizing the clinical portal to obtain patient summaries, etc. Model Test target: 165 PCMHs.</li> <li>Numerator: Number of PCMHs that sent/received IHDE transactions that were for the purpose of care coordination.</li> <li>Denominator: Model Test target (165 PCMHs). Quarterly targets as shown in the table to the right.</li> <li>Data Source: TBD</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	110	110	110	110	3	165	165	165	165
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	55	55	55	55																							
2	110	110	110	110																							
3	165	165	165	165																							



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GOAL 2 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement					
4.	<ul style="list-style-type: none"> <li>Increased HIT adoption and use by ID hospitals</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of hospitals connected to the IHDE. <i>Model Test target: 21</i></li> <li>Numerator: Number of hospitals that are connected to IHDE.</li> <li>Denominator: Model Test target (21 hospitals) Quarterly targets as shown in the table to the right.</li> <li>Data Source: IHDE data.</li> </ul>	<b>YR</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
			<b>Pre</b>	-	-	-	5
			<b>1</b>	-	-	-	15
			<b>2</b>	-	-	-	18
			<b>3</b>	-	-	-	21
5.	<ul style="list-style-type: none"> <li>Increased number of hospitals that are sharing data across the Medical/Health Neighborhood.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of hospitals connected to IHDE that provide information on PCMH enrolled patients. <i>Model Test target: 21.</i></li> <li>Numerator: Number of hospitals sending transactions via the IHDE</li> <li>Denominator: Model Test target of 21 hospitals.</li> <li>Data Source: IHDE data.</li> </ul>	<b>YR</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
			<b>Pre</b>	-	-	-	-
			<b>1</b>	-	-	-	15
			<b>2</b>	-	-	-	18
			<b>3</b>	-	-	-	21



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GOAL 2 PROJECT CHARTER

**Planned Scope**

<b>Deliverable 1</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Funding mechanisms are identified and secured to support statewide adoption and use of EHRs by PCMHs and hospitals.</li> </ul>	<ul style="list-style-type: none"> <li>Financial incentives to emphasize interoperable exchange of health information among provider networks at the national, state, and regional level.</li> </ul>	<ul style="list-style-type: none"> <li>HIT Workgroup</li> <li>PCMHs</li> <li>Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>CMMI</li> <li>IHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Identify the EHR status of designated PCMHs and hospitals.</li> <li>Identify available funding mechanisms to support development and implementation of EHRs.</li> <li>Determine/document the extent to which potential funding has been secured by designated PCMHs and hospitals.</li> <li>Conduct gap analysis to identify further opportunities for securing funding.</li> <li>Draft plan to close identified gaps.</li> <li>Feedback from stakeholders.</li> <li>Finalize Funding Plan.</li> <li>Execute Funding Plan.</li> <li>Conduct follow-up activities, as needed, to ensure maximum use of available funding mechanisms.</li> </ul>			<ul style="list-style-type: none"> <li>01/15/2016</li> <li>01/15/2016</li> <li>01/25/2016</li> <li>02/01/2016</li> <li>02/12/2016</li> <li>02/29/2016</li> <li>03/21/2016</li> <li>03/28/2016</li> <li>04/11/2016</li> </ul>
<b>Deliverable 2</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Supportive business, clinical, cultural and regulatory environments are addressed, defined and achieved.</li> </ul>	<ul style="list-style-type: none"> <li>Business and regulatory environments encourage interoperability.</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>HIT Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2019



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GOAL 2 PROJECT CHARTER

Milestones	Event	Target Date
	<ul style="list-style-type: none"> <li>Define information/ information sources needed to assess progress toward the desired results.</li> </ul>	<ul style="list-style-type: none"> <li>01/08/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Define and document Assessment Plan.</li> </ul>	<ul style="list-style-type: none"> <li>01/22/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Seek stakeholder feedback.</li> </ul>	<ul style="list-style-type: none"> <li>01/25/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Refine Assessment Plan based on stakeholder input.</li> </ul>	<ul style="list-style-type: none"> <li>02/01/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Collect information.</li> </ul>	<ul style="list-style-type: none"> <li>02/19/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Analyze information.</li> </ul>	<ul style="list-style-type: none"> <li>02/29/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Design results deliverable.</li> </ul>	<ul style="list-style-type: none"> <li>03/14/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Draft deliverable.</li> </ul>	<ul style="list-style-type: none"> <li>03/21/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Obtain peer review.</li> </ul>	<ul style="list-style-type: none"> <li>03/27/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Finalize deliverable.</li> </ul>	<ul style="list-style-type: none"> <li>04/15/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Identify follow-up activities to improve results, as needed.</li> </ul>	<ul style="list-style-type: none"> <li>04/22/2016</li> </ul>
	<ul style="list-style-type: none"> <li>Execute improvement activities.</li> </ul>	<ul style="list-style-type: none"> <li>04/29/2016</li> </ul>



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GOAL 2 PROJECT CHARTER

Deliverable 3	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>Core technical standards and functions are established for EHRs/IHDE data exchange.</li> </ul>	<ul style="list-style-type: none"> <li>Consistent data formats and semantics.</li> <li>Tightly defined common clinical data set.</li> <li>Data storage.</li> <li>Data extraction.</li> <li>Consistent, secure transport techniques.</li> <li>Data load capabilities.</li> <li>Standard, secure services.</li> <li>Accurate identity matching (patient/ provider attribution – standardize minimum individual attributes used for matching).</li> <li>Reliable resource location.</li> <li>Adherence to best available national technical standards for core interoperability functions as published by ONC.</li> </ul>	<ul style="list-style-type: none"> <li>RCs</li> <li>PCMHs</li> <li>IHDE</li> <li>Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>CMMI</li> <li>IHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016		<b>End:</b> 12/31/2019	
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define information and information sources needed to assess progress toward the desired results.</li> <li>Define and document Assessment Plan.</li> <li>Seek stakeholder feedback.</li> <li>Refine Assessment Plan based on stakeholder input.</li> <li>Collect information.</li> <li>Analyze information.</li> <li>Design results deliverable.</li> <li>Draft deliverable.</li> </ul>			<ul style="list-style-type: none"> <li>01/11/2016</li> <li>01/15/2016</li> <li>01/25/2016</li> <li>02/05/2016</li> <li>02/19/2016</li> <li>02/29/2016</li> <li>03/14/2016</li> <li>03/28/2016</li> </ul>



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GOAL 2 PROJECT CHARTER

- Obtain peer review.
  - Finalize deliverable.
  - Identify follow-up activities to improve results, as needed.
  - Execute improvement activities.
- 04/04/2016
  - 04/15/2016
  - 04/22/2016
  - 05/06/2016

Deliverable 4	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>• Privacy and security protections for health information are in place for the IHDE, PCMHs, and its consumer participants.</li> </ul>	<ul style="list-style-type: none"> <li>• Secure network service infrastructure.</li> <li>• Verifiable identity and authentication of all system users.</li> <li>• Consistent representation of permission to collect, share and use identifiable health information (consent management, including what may be obtained/ released for TPO without written permission (computable privacy)).</li> <li>• Consistent representation of authorization to access health information (consent management).</li> </ul>	<ul style="list-style-type: none"> <li>• IHC</li> <li>• IHDE</li> <li>• HIT Workgroup</li> <li>• SHIP team</li> </ul>	<ul style="list-style-type: none"> <li>• CMMI</li> <li>• IHC</li> <li>• Data Analytics Contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016		<b>End:</b> 12/31/2019	
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Define information and information sources needed to assess progress toward the desired results.</li> <li>• Define and document Assessment Plan.</li> </ul>			<ul style="list-style-type: none"> <li>• 01/08/2016</li> <li>• 01/22/2016</li> </ul>



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GOAL 2 PROJECT CHARTER

- Seek stakeholder feedback. • 01/25/2016
- Refine Assessment Plan based on stakeholder input. • 02/01/2016
- Collect information. • 02/19/2016
- Conduct gap analysis. • 03/04/2016
- Identify steps to remediate gaps. • 03/14/2016
- Design assessment results deliverable. • 03/14/2016
- Draft deliverable. • 03/27/2016
- Obtain peer review. • 04/15/2016
- Finalize deliverable. • 04/22/2016
- Identify remediation activities, as needed. • 04/22/2016
- Execute remediation activities to close gaps. • 04/29/2016

Deliverable 5	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>• PCMHs obtain technical assistance and training for implementation and ongoing support for EHRs.</li> </ul>	<ul style="list-style-type: none"> <li>• Technical assistance and training is made available to PMCHs to support adoption and use of EHRs.</li> </ul>	<ul style="list-style-type: none"> <li>• PCMHs</li> <li>• RCs</li> <li>• Brilljent (PCMH contractor)</li> </ul>	<ul style="list-style-type: none"> <li>• IHC</li> <li>• CMMI</li> </ul>
Est. Timeframe	Start: 01/01/2016			End: 12/31/2019
Milestones	Event			Target Date
	<ul style="list-style-type: none"> <li>• Define information and information sources needed to assess progress toward the desired results.</li> <li>• Define and document Assessment Plan.</li> <li>• Seek stakeholder feedback.</li> <li>• Refine Assessment Plan based on stakeholder input.</li> <li>• Collect information.</li> <li>• Conduct gap analysis.</li> <li>• Identify steps to remediate gaps.</li> <li>• Design assessment results deliverable.</li> <li>• Draft deliverable.</li> <li>• Obtain peer review.</li> </ul>			<ul style="list-style-type: none"> <li>• 01/08/2016</li> <li>• 01/22/2016</li> <li>• 01/25/2016</li> <li>• 02/01/2016</li> <li>• 02/19/2016</li> <li>• 03/04/2016</li> <li>• 03/14/2016</li> <li>• 03/14/2016</li> <li>• 03/27/2016</li> <li>• 04/15/2016</li> </ul>



8 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 2 PROJECT CHARTER

	<ul style="list-style-type: none"> <li>Finalize deliverable.</li> <li>Identify remediation activities, as needed.</li> <li>Execute remediation activities to close gaps.</li> </ul>		<ul style="list-style-type: none"> <li>04/22/2016</li> <li>04/22/2016</li> <li>04/29/2016</li> </ul>	
<b>Deliverable 6</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>IHDE participants obtain confirmation of EHRs to assure HIE connectivity and interoperability.</li> </ul>	<ul style="list-style-type: none"> <li>IHDE confirms connectivity interoperability (HIE enabled) with PCMH EHRs.</li> <li>IHDE initiates technical specifications and linkages.</li> </ul>	<ul style="list-style-type: none"> <li>PCMHs</li> <li>Hospitals</li> <li>IHDE</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define information and information sources needed to assess progress toward the desired results.</li> <li>Define and document Assessment Plan.</li> <li>Seek stakeholder feedback.</li> <li>Refine Assessment Plan based on stakeholder input.</li> <li>Collect information.</li> <li>Conduct analysis to identify interoperability gaps.</li> <li>Identify steps to remediate gaps.</li> <li>Design assessment results deliverable.</li> <li>Draft deliverable.</li> <li>Obtain peer review.</li> <li>Finalize deliverable.</li> <li>Identify remediation activities, as needed.</li> <li>Execute remediation activities to close gaps.</li> </ul>			<ul style="list-style-type: none"> <li>01/08/16</li> <li>01/22/2016</li> <li>01/25/2016</li> <li>02/01/2016</li> <li>02/19/2016</li> <li>03/04/2016</li> <li>03/14/2016</li> <li>03/14/2016</li> <li>03/27/2016</li> <li>04/15/2016</li> <li>04/18/2016</li> <li>04/29/2016</li> <li>05/16/2016</li> </ul>



GOAL 2 PROJECT CHARTER

Deliverable 7	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>PCMHs adopt and use EHRs for data exchange with IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 165 PCMHs obtain and deploy certified EHRs that enable them to send, receive, find, and use a common data set.</li> <li>Identify the universe of PCMHs and the quarterly status of ERH development, adoption, and certification.</li> <li>Capture the type of EHRs in use, as well as MU level and certification status.</li> <li>Capture the number of PCMH members and the number of members who have EHRs.</li> </ul>	<ul style="list-style-type: none"> <li>IHDE</li> <li>RCs</li> <li>PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>CMMI</li> <li>Brijlent (PCMH contractor)</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016		<b>End:</b> 12/31/2019	
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define information and information sources needed to assess progress toward the desired results (e.g., designated PCMHs with certified EHRs, EHRs in process, and without EHRs, and number of PCMH members who have an EHR).</li> <li>Define and document Assessment Plan for quarterly monitoring of progress.</li> <li>Seek stakeholder feedback.</li> <li>Refine Assessment Plan based on stakeholder input.</li> <li>Collect PCMH information each quarter.</li> <li>Conduct analysis to identify gaps.</li> <li>Identify steps to remediate gaps.</li> </ul>			<ul style="list-style-type: none"> <li>01/11/2016</li> <li>01/15/2016</li> <li>01/25/2016</li> <li>02/05/2016</li> <li>02/19/2016</li> <li>02/29/2016</li> <li>03/14/2016</li> </ul>



GOAL 2 PROJECT CHARTER

- Design assessment results deliverable. • 03/28/2016
- Draft deliverable. • 04/04/2016
- Obtain peer review. • 04/15/2016
- Finalize deliverable. • 04/22/2016
- Identify remediation activities, as needed. • 05/06/2016
- Execute remediation activities to close gaps. • 05/20/2016

Deliverable 8	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>• Hospitals adopt and use EHRs capable of exchanging data with IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>• By Model Test Year 3, Q4, 21 hospitals obtain and deploy EHRs that enable them to send, receive, find, and use a common data set.</li> <li>• Identify the universe of hospitals and the quarterly status of EHR development and adoption.</li> </ul>	<ul style="list-style-type: none"> <li>• Hospitals</li> </ul>	<ul style="list-style-type: none"> <li>• IHC</li> <li>• CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Define information and information sources needed to assess progress toward the desired results (e.g., quarterly list of hospitals with certified EHRs, EHRs in process, and without EHRs).</li> <li>• Define and document Assessment Plan for quarterly monitoring of progress.</li> <li>• Seek stakeholder feedback.</li> <li>• Refine Assessment Plan based on stakeholder input.</li> <li>• Collect hospital information each quarter.</li> <li>• Identify steps to remediate gaps.</li> <li>• Design assessment results deliverable.</li> <li>• Draft deliverable.</li> <li>• Obtain peer review.</li> </ul>			<ul style="list-style-type: none"> <li>• 01/08/2016</li> <li>• 01/22/2016</li> <li>• 01/25/2016</li> <li>• 02/01/2016</li> <li>• 02/19/2016</li> <li>• 03/04/2016</li> <li>• 03/14/2016</li> <li>• 03/21/2016</li> <li>• 03/27/2016</li> </ul>

GOAL 2 PROJECT CHARTER

	<ul style="list-style-type: none"> <li>Finalize deliverable.</li> <li>Identify remediation activities, as needed.</li> <li>Execute remediation activities to close gaps.</li> </ul>		<ul style="list-style-type: none"> <li>04/15/2016</li> <li>04/22/2016</li> <li>04/22/2016</li> </ul>	
<b>Deliverable 9</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>PCMHs contract with IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 165 PCMHs have contracts with IHDE to enable data exchange.</li> <li>Identify PCHMs contracting with the IHDE.</li> <li>Identify PCMHs by volume of executed transactions within the IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>IHDE</li> <li>PCMHs</li> </ul>	<ul style="list-style-type: none"> <li>HIT</li> <li>CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016		<b>End:</b> 12/31/2019	
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define information and information sources needed to assess progress toward the desired results.</li> <li>Define and document plan for quarterly monitoring.</li> <li>Seek stakeholder feedback.</li> <li>Refine monitoring plan based on stakeholder input.</li> <li>Collect IHDE PCMH contracting information each quarter.</li> <li>Design quarterly monitoring deliverable.</li> <li>Draft deliverable.</li> <li>Obtain peer review.</li> <li>Finalize deliverable design.</li> <li>Conduct quarterly monitoring.</li> <li>Issue quarterly deliverable comparing progress to quarterly goals.</li> <li>Identify remediation activities, as needed.</li> <li>Execute remediation activities to close gaps.</li> </ul>			<ul style="list-style-type: none"> <li>01/08/2016</li> <li>01/22/2016</li> <li>01/25/2016</li> <li>02/01/2016</li> <li>02/19/2016</li> <li>03/04/2016</li> <li>03/14/2016</li> <li>03/21/2016</li> <li>03/27/2016</li> <li>04/15/2016</li> <li>04/22/2016</li> <li>04/29/2016</li> <li>05/20/2016</li> </ul>

GOAL 2 PROJECT CHARTER

<b>Deliverable 10</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Hospitals contract with IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 21 hospitals have contracts with IHDE to enable data exchange with PCMHs.</li> <li>Identify hospitals contracting with the IHDE.</li> <li>Identify hospitals by volume of executed transactions with the IHDE.</li> </ul>	<ul style="list-style-type: none"> <li>IHDE</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define information and information sources needed to assess progress toward the desired results.</li> <li>Consult with IHDE and IDHW to determine funding.</li> <li>Assist IHDE in designing draft deliverables, providing support and consultation.</li> <li>Define and document plan for quarterly monitoring.</li> <li>Seek stakeholder feedback.</li> <li>Refine monitoring plan based on stakeholder input.</li> <li>Collect IHDE hospital contracting information each quarter.</li> <li>Design quarterly monitoring deliverable.</li> <li>Draft deliverable.</li> <li>Obtain peer review.</li> <li>Finalize deliverable design.</li> <li>Conduct quarterly monitoring.</li> <li>Issue quarterly deliverable comparing progress to quarterly goals.</li> <li>Identify remediation activities, as needed.</li> <li>Execute remediation activities to close gaps.</li> </ul>			<ul style="list-style-type: none"> <li>01/08/2016</li> <li>01/22/2016</li> <li>01/25/2016</li> <li>02/01/2016</li> <li>02/19/2016</li> <li>03/04/2016</li> <li>03/14/2016</li> <li>03/14/2016</li> <li>03/27/2016</li> <li>04/15/2016</li> <li>04/18/2016</li> <li>04/29/2016</li> <li>05/16/2016</li> <li>05/23/2016</li> <li>05/30/2016</li> </ul>

GOAL 2 PROJECT CHARTER

**Project Risks, Assumptions, and Dependencies**

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	1. State lacks resources to support data collection and reporting.	L	L	<ul style="list-style-type: none"> <li>Hire additional resources or outsource collection and reporting activities.</li> </ul>
	2. Statewide HIT contractors not in place by selected deadlines.	L	M	<ul style="list-style-type: none"> <li>HIT workgroup monitoring of selection process and vendor progress.</li> </ul>
	3. Statewide agreement on technology standards cannot be reached.	M	M	<ul style="list-style-type: none"> <li>IHC makes decisions on standards with assistance of the HIT workgroup.</li> </ul>
	4. Statewide HIT connections not in place by selected deadlines.	L	M	<ul style="list-style-type: none"> <li>HIT Workgroup will monitor of timeline for selection process.</li> </ul>
	5. Anticipated data sources unavailable/inadequate to meet reporting needs.	L	M	<ul style="list-style-type: none"> <li>Seek alternative data sources.</li> </ul>
	6. PCMHs/IHDE lack resources to support data collection and reporting.	L	M	<ul style="list-style-type: none"> <li>Hire additional resources or outsource collection and reporting activities.</li> </ul>
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>Adequate funding is available to support this project.</li> <li>Supportive business, clinical, cultural, and regulatory environments are achieved.</li> <li>ONC will deliver national standards for consideration.</li> <li>Project governance will be in place to guide adoption of technical standards and/or resolve roadblocks.</li> <li>Core technical standards to support interoperability will be adopted statewide.</li> <li>PCMHs and hospitals will attain adequate technical advice and training to support implementation of EHRs.</li> <li>EHRs will be certified to assure connectivity and interoperability.</li> </ul>			

## GOAL 2 PROJECT CHARTER

<b>Dependencies and Constraints</b>	<p>Dependencies:</p> <ul style="list-style-type: none"> <li>• Goal 1: Transform primary care practices across the state into PCMHs. This must precede Goal 2.</li> <li>• Goal 3: Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood – this must occur, either prior to, or at the start of Goal 2 activities.</li> <li>• Goal 5: Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels.</li> </ul> <p>Constraints:</p> <ul style="list-style-type: none"> <li>• Funding.</li> <li>• Availability of TA Contractor time.</li> <li>• Willingness and speed at which PCMHs and hospitals adopt and use certified EHRs.</li> <li>• Ability to resolve significant technology standardization to support interoperability.</li> </ul>
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### 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

<b>Authors</b>	David Shadick	<b>Date</b>	10/21/2015
<b>Reviewers</b>	Casey Moyer	<b>Date</b>	10/22/2015

### Final Acceptance

<b>Name/Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator	11/23/2015	<input checked="" type="checkbox"/>
Katie Falls	Mercer Lead	11/23/2015	<input checked="" type="checkbox"/>



# 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

<b>Mercer Lead</b>	Jennifer Feliciano and Aliya Kazmi
<b>SHIP Staff</b>	Miro Barac
<b>Key Participants</b>	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.
<b>IHC Charge</b>	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					
			YR	Q1	Q2	Q3	Q4
1.	<ul style="list-style-type: none"> <li>Support for PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative (CUM) # of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services. <i>Model Test Target: one RC in each of the seven health districts.</i></li> <li>Numerator: Count of PHDs that have established RCs.</li> <li>Denominator: Count of PHDs</li> </ul>	<b>Pre</b>	-	-	-	-
			<b>1</b>	7	7	7	7
			<b>2</b>	7	7	7	7
			<b>3</b>	7	7	7	7

1

Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 3 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement																									
		statewide.																									
2.	<ul style="list-style-type: none"> <li>Support for PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # of designated PCMHs and primary care practices that can receive assistance through an RC. <i>Model Test Target: 165.</i></li> <li>Numerator: Count of practices and PCMHs that received communication from RC about how to get assistance.</li> <li>Denominator: Count of practices that completed the application + Count of practices that achieved PCMH designation.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	55	55	55	55	2	110	110	110	110	3	165	165	165	165
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	55	55	55	55																							
2	110	110	110	110																							
3	165	165	165	165																							
3.	<ul style="list-style-type: none"> <li>Increased coordination between PCMHs and the Medical/Health Neighborhood.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # of designated PCMHs who have established protocols for referrals and follow-up communications with service providers in their Medical/Health Neighborhood. <i>Model Test Target: 165.</i></li> <li>Numerator: Count of designated PCMHs that have signed an attestation of having established protocols.</li> <li>Denominator: Count of designated PCMHs.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	-	-	25	55	2	110	110	110	110	3	110	110	135	165
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	-	-	25	55																							
2	110	110	110	110																							
3	110	110	135	165																							
4.	<ul style="list-style-type: none"> <li>Coordinated patient care through the entire provider community.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood,</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <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> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-			1				275,000										
YR	Q1	Q2	Q3	Q4																							
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GOAL 3 PROJECT CHARTER

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

**Planned Scope**

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>Establish RCs.</li> </ul>	<ul style="list-style-type: none"> <li>Contract with PHDs and hire staff.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PHDs (led by SHIP Managers)</li> </ul>	<ul style="list-style-type: none"> <li>Other RCs</li> <li>IDHW</li> <li>PHDs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 06/01/2015			<b>End:</b> 04/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Negotiate sub-grant.</li> <li>Execute contract with PHDs.</li> <li>Hire SHIP staff (SHIP Manager, Quality Improvement/Quality Assurance (QI/QA) Specialist).</li> <li>Identify RC Advisory Group.</li> <li>Convene RC Advisory Group.</li> <li>Identify RC Representative to the IHC.</li> <li>Establish RC membership.</li> </ul>			<ul style="list-style-type: none"> <li>06/2015</li> <li>07/2015</li> <li>10/2015</li> <li>11/05/2015</li> <li>11/2015</li> <li>11/2015</li> <li>04/2016</li> </ul>
Deliverable 2	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>RCs provide regional quality improvement and Medical/Health Neighborhood integration services.</li> </ul>	<ul style="list-style-type: none"> <li>Implement plan that identifies how RCs will support PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>RCs</li> <li>PHDs</li> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>RCs</li> <li>PCMH Contractor</li> <li>PCMHs</li> <li>PHDs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 07/2015			<b>End:</b> 04/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define services provided by RCs.</li> </ul>			<ul style="list-style-type: none"> <li>07/2015</li> </ul>



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GOAL 3 PROJECT CHARTER

	<ul style="list-style-type: none"> <li>• Develop plan (charter).</li> <li>• Implement plan.</li> <li>• Submit status report.</li> </ul>			<ul style="list-style-type: none"> <li>• 03/2016</li> <li>• 03/2016</li> <li>• 06/2016</li> </ul>
<b>Deliverable 3</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>• Evaluation plan to ensure RCs provide regional quality improvement and Medical/Health Neighborhood integration services within service level requirements.</li> </ul>	<ul style="list-style-type: none"> <li>• Plan for evaluating services from RCs to PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>• IDHW</li> </ul>	<ul style="list-style-type: none"> <li>• RCs</li> <li>• PCMHs</li> <li>• PHDs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 11/2015			<b>End:</b> 04/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Develop plan.</li> <li>• Review/revise plan.</li> <li>• Finalize plan.</li> <li>• Implement plan.</li> </ul>			<ul style="list-style-type: none"> <li>• 01/2016</li> <li>• 03/2016</li> <li>• 04/2016</li> <li>• 04/2016</li> </ul>
<b>Deliverable 4</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>• Communication from RCs to practices regarding availability of services.</li> </ul>	<ul style="list-style-type: none"> <li>• Communication to let practices know what RCs can do for them.</li> </ul>	<ul style="list-style-type: none"> <li>• RCs</li> </ul>	<ul style="list-style-type: none"> <li>• PCMH Contractor</li> <li>• IDHW Staff</li> <li>• IMHC</li> <li>• IHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 11/2015			<b>End:</b> 01/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Develop communication.</li> <li>• Review/revise communication.</li> <li>• Finalize communication.</li> <li>• Obtain list of designated PCMHs.</li> <li>• Initial communication with practices.</li> <li>• Ongoing communication with practices.</li> </ul>			<ul style="list-style-type: none"> <li>• 12/2015</li> <li>• 02/2016</li> <li>• 03/2016</li> <li>• 03/2016</li> <li>• 04/2016</li> <li>• Ongoing</li> </ul>



4

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GOAL 3 PROJECT CHARTER

<b>Deliverable 5</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Established Medical/Health Neighborhoods.</li> </ul>	<ul style="list-style-type: none"> <li>Information sharing across Medical/Health Neighborhoods for improved care coordination.</li> </ul>	<ul style="list-style-type: none"> <li>RCs</li> <li>PHDs</li> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>PCMHs</li> <li>Providers</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 7/2015			<b>End:</b> TBD
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Define Medical/Health Neighborhood.</li> <li>Identify participants in the Medical/Health Neighborhood.</li> <li>Submit list of participants to Department Project Manager.</li> <li>Report to the IHC the status of establishing Medical/Health Neighborhoods.</li> </ul>			<ul style="list-style-type: none"> <li>11/2015</li> <li>05/2016</li> <li>06/2016</li> <li>Ongoing (at least annually)</li> </ul>
<b>Deliverable 6</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Sustainability Plan.</li> </ul>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>	<ul style="list-style-type: none"> <li>PHD</li> <li>RCs</li> </ul>	<ul style="list-style-type: none"> <li>Hospitals</li> <li>PCMHs</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> MM/DD/YYYY			<b>End:</b> MM/DD/YYYY
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Begin the process of creating a Sustainability Plan.</li> <li>Submit Sustainability Plan.</li> </ul>			<ul style="list-style-type: none"> <li>06/2016</li> <li>12/2018</li> </ul>

**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	<ul style="list-style-type: none"> <li>Ongoing monitoring by IDHW SHIP Project Manager and PHD staff to determine each RC's capacity to support PCMHs.</li> <li>Effective communication pathways between IHC and RCs.</li> <li>Clear coordination with the PCMH Contractor.</li> <li>Clear guidance on expectations of RCs.</li> </ul>



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## GOAL 3 PROJECT CHARTER

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	<ul style="list-style-type: none"> <li>Participation of Medical/Health Neighborhood participants in development process of communication protocols.</li> <li>Clear definition of Medical/Health Neighborhood and key participants. Consistent use of definition.</li> <li>Effective communication process for Medical/Health Neighborhood participants to raise concerns.</li> </ul>
	3. Misaligned timelines and duplicative efforts among Brilljent, IHDE, and Data Analytics Contractor.	M	M	<ul style="list-style-type: none"> <li>Establish communication protocols for all contractors assisting with PCMH transformation, quality improvement, and data exchange efforts.</li> <li>Contractor timing should be aligned.</li> </ul>
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>Implementation plan (charter) will be required for each RC.</li> <li>Ongoing monitoring by Department Project Manager and PHD staff to determine RC capacity to support PCMHs.</li> <li>RCs will set criteria for referrals and follow-up communication for Medical/Health Neighborhood participants.</li> </ul>			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>PHDs communicating effectively.</li> </ul>			

### 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

<b>Authors</b>	Jennifer Feliciano and Aliya Kazmi	<b>Date</b>	12/11/2015
<b>Reviewers</b>	Casey Moyer	<b>Date</b>	12/15/2015

### Final Acceptance

Name/Signature	Title	Date	Approved via Email
Cynthia York	SHIP Administrator	12/18/2015	<input checked="" type="checkbox"/>

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GOAL 3 PROJECT CHARTER

Name/Signature	Title	Date	Approved via Email
Katie Falls	Mercer Lead	12/18/2015	<input checked="" type="checkbox"/>

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# PROJECT CHARTER

## GOAL 4: Improve rural patient access to patient-centered medical homes (PCMHs) by developing virtual PCMHs.

Version 3.0 – FINAL

### Summary

<b>Mercer Lead</b>	Jenny Feliciano
<b>SHIP Staff</b>	Miro Barac
<b>Key Participants</b>	Community Health EMS (CHEMS), Community Health Worker (CHW) Workgroups, State EMS Agencies, Virtual Patient Centered Medical Homes (PCMHs), Idaho Department of Health and Welfare (IDHW), Regional Health Collaboratives (RCs), Telehealth Goal 2 Subcommittee, Telehealth Council, PCMHs volunteering for PCMH mentoring program, PCMH Contractor (includes incentive distribution and technical assistance), and educational institutions to be contracted for providing CHW and CHEMS training.
<b>IHC Charge</b>	Support the development of the Virtual PCMH model in Idaho by utilizing CHWs, CHEMS, and integration of telehealth into rural and underserved areas to improve access to physical, behavioral, and specialty healthcare services.

### Success Measures

Success Measures	SHIP Desired Outcomes	Measurement					
			YR	Q1	Q2	Q3	Q4
1.	<ul style="list-style-type: none"> <li>Recruit and establish Virtual PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative (CUM) # (%) of Virtual PCMHs established in rural communities following assessment of need. <i>Model Test Target: 50.</i></li> </ul>	Pre	-	-	-	-
			1	0	0	0	15
			2	15	15	15	30
			3	30	30	30	50

1 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 4 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement					
			YR	Q1	Q2	Q3	Q4
2.	<ul style="list-style-type: none"> <li>Establish CHEMS programs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of regional CHEMS programs established. <i>Model Test Target: 16.</i></li> </ul>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	1
			1	6	6	6	6
			2	11	11	11	11
			3	16	16	16	16
3.	<ul style="list-style-type: none"> <li>Integration of CHEMS in Virtual PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination. <i>Model Test Target: 52.</i></li> </ul>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	2
			1	16	16	16	16
			2	38	38	38	38
			3	52	52	52	52
4.	<ul style="list-style-type: none"> <li>Train CHWs on Virtual PCMH integration.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of new community health workers trained for Virtual PCMH coordination. <i>Model Test Target: 200 (25 per training).</i></li> </ul>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	
			1	0	0	0	50
			2	50	50	50	125
			3	125	125	125	200
5.	<ul style="list-style-type: none"> <li>Continuing education for CHEMs and CHWs.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff. <i>Model Test Target: 2 for Target 252 CHWS and CHEMS community health workers.</i></li> </ul>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	-
			1	-	-	-	-
			2	-	-	-	1
			3	-	-	-	2
6.	<ul style="list-style-type: none"> <li>Enhanced use of telehealth tools by Virtual PCMHs for behavioral health and other specialty services.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. <i>Model Test Target: 36.</i></li> </ul>	YR	Q1	Q2	Q3	Q4
			Pre	-	-	-	-
			1	-			12
			2	12	12	12	24
			3	24	24	24	36

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GOAL 4 PROJECT CHARTER

**Planned Scope**

<b>Deliverable 1</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Virtual PCMH requirements, standards, designation criteria, and recruitment plan.</li> </ul>	<ul style="list-style-type: none"> <li>Requirements and recruitment plan for developing Virtual PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>PCMH Contractor</li> <li>IMHC</li> <li>RCs</li> <li>EMS Agencies</li> <li>PCMH Contractor</li> <li>Primary Care Providers/Potential Virtual PCMH partner sites</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 05/01/2015			<b>End:</b> 02/01/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Collect information to build the Virtual PCMH recruitment plan.</li> <li>Develop requirements, standards, and designation criteria.</li> <li>Draft Virtual PCMH recruitment plan.</li> <li>Feedback from Stakeholders.</li> <li>Present on requirements and standards to IHC in January meeting.</li> <li>IHC approval.</li> <li>Final Virtual PCMH recruitment plan.</li> <li>Implement Virtual PCMH recruitment plan.</li> <li>Evaluate recruitment plan periodically and make adjustments, as needed.</li> </ul>			<ul style="list-style-type: none"> <li>11/13/2015</li> <li>11/30/ 2015</li> <li>12/01/2015</li> <li>01/01/2016</li> <li>01/13/2016</li> <li>01/13/2016</li> <li>01/29/2016</li> <li>02/01/2016</li> <li>Ongoing</li> </ul>
<b>Deliverable 2</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Financial incentives for qualifying PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Incentive structure for Virtual PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>PCMH Contractor</li> <li>IMHC</li> <li>PCMHs</li> <li>RCs</li> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 12/01/2015			<b>End:</b> 12/01/2019
<b>Milestones</b>	<b>Event</b>			<b>Target date</b>
	<ul style="list-style-type: none"> <li>Hire PCMH Contractor (and Incentive Distribution Contractor).</li> </ul>			<ul style="list-style-type: none"> <li>12/01/2016</li> </ul>



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GOAL 4 PROJECT CHARTER

	<ul style="list-style-type: none"> <li>Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.</li> <li>Obtain any necessary approvals of the financial distribution process.</li> <li>Complete any logistical steps needed to implement the process.</li> <li>PCMH Contractor begins distribution of financial incentives.</li> </ul>	<ul style="list-style-type: none"> <li>01/31/2016</li> <li>01/31/2016</li> <li>01/31/2016</li> <li>02/02/2016</li> </ul>												
<b>Deliverable 3</b>	<table border="1"> <thead> <tr> <th>Result, Product, or Service</th> <th>Description</th> <th>Owner</th> <th>Impacted Parties</th> </tr> </thead> <tbody> <tr> <td>Virtual PCMH mentoring program.</td> <td> <ul style="list-style-type: none"> <li>Peer mentoring program.</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>PCMH Contractor</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>Local EMS agencies</li> <li>Local CHW</li> <li>Selected virtual PCMH</li> <li>Telehealth Goal 2 Subcommittee CHEMS Workgroup</li> <li>CHW Workgroup</li> </ul> </td> </tr> </tbody> </table>	Result, Product, or Service	Description	Owner	Impacted Parties	Virtual PCMH mentoring program.	<ul style="list-style-type: none"> <li>Peer mentoring program.</li> </ul>	<ul style="list-style-type: none"> <li>PCMH Contractor</li> </ul>	<ul style="list-style-type: none"> <li>Local EMS agencies</li> <li>Local CHW</li> <li>Selected virtual PCMH</li> <li>Telehealth Goal 2 Subcommittee CHEMS Workgroup</li> <li>CHW Workgroup</li> </ul>					
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GOAL 4 PROJECT CHARTER

	<ul style="list-style-type: none"> <li>Build initial infrastructure.</li> </ul>			<ul style="list-style-type: none"> <li>01/01/2017</li> </ul>
<b>Deliverable 5</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Training program for CHEMS agencies participating in Virtual PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Training program for CHEMS.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>Selected EMS agencies</li> <li>Virtual PCMH staff</li> <li>PCMH Contractor</li> <li>Data Collection and Analysis Contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 04/30/15			<b>End:</b> 01/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Establish CHEMS workgroup and identify CHEMS sub-committee leads.</li> <li>Identify CHEMS standards and certification requirements.</li> <li>Execute contract with training vendor to provide CHEMS trainings.</li> <li>Collect best practice resources and policies for program implementation.</li> <li>Identify CHEMS program for basic life support (BLS) and intermediate life support (ILS) agencies.</li> <li>Identify required metrics and reporting process.</li> </ul>			<ul style="list-style-type: none"> <li>08/30/2015</li> <li>01/31/2016</li> <li>01/31/2016</li> <li>01/31/2016</li> <li>01/01/2017</li> <li>02/29/2016</li> </ul>
<b>Deliverable 6</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Virtual PCMH staff training program for CHW.</li> </ul>	<ul style="list-style-type: none"> <li>Training program for CHW.</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> <li>CHW</li> <li>Virtual PCMH staff</li> <li>PCMH Contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 03/1/2015			<b>End:</b> 01/31/2019
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Establish CHW workgroup and identify CHW sub-committee leads.</li> <li>Collect best practice resources and policies for program implementation.</li> <li>Identify CHW standards and certification requirements.</li> <li>Contract with training vendor to provide CHW trainings.</li> <li>Identify required metrics and reporting process.</li> </ul>			<ul style="list-style-type: none"> <li>08/31/2015</li> <li>01/31/2016</li> <li>01/31/2016</li> <li>02/29/2016</li> <li>03/10/2016</li> </ul>

GOAL 4 PROJECT CHARTER

<b>Deliverable 7</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Technical assistance program.</li> </ul>	<ul style="list-style-type: none"> <li>TA for CHEMS, CHWs, selected virtual PCMHs, and RCs in identified areas.</li> </ul>	<ul style="list-style-type: none"> <li>PCMH Contractor</li> </ul>	<ul style="list-style-type: none"> <li>All CHEMS and CHWs, Training Contractor, selected Virtual PCMHs, and RCs in identified areas</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/14/2016			<b>End:</b> 01/31/2017
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Begin developing transformation support program.</li> <li>Develop “how-to” guide or coaching manual to address educational needs (BLS, ILS, and ALS).</li> </ul>			<ul style="list-style-type: none"> <li>01/04/2016</li> <li>02/02/2016 (ILS);</li> <li>01/31/2017 (BLS/ALS)</li> </ul>
<b>Deliverable 8</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Implement new CHEMS telehealth programs.</li> </ul>	<ul style="list-style-type: none"> <li>Select CHEMS agencies to receive telehealth equipment.</li> </ul>	<ul style="list-style-type: none"> <li>CHEMS Workgroup</li> <li>Telehealth Council</li> </ul>	<ul style="list-style-type: none"> <li>CHEMS and CHW supporting agencies</li> <li>Hospitals in selected areas</li> <li>PCMHs</li> <li>IDHW</li> <li>IDHE</li> <li>Analytics contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 02/1/2016			<b>End:</b> 02/30/2017
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Establish criteria for participation.</li> <li>Conduct readiness assessment and selection.</li> <li>Write and release RFP.</li> <li>Procure telehealth equipment.</li> <li>Telehealth go-live.</li> </ul>			<ul style="list-style-type: none"> <li>03/02/2016</li> <li>06/01/2016</li> <li>09/01/2016</li> <li>01/31/2017</li> <li>02/01/2017</li> </ul>
<b>Deliverable 9</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Sustainability plan for CHEMS and CHW.</li> </ul>	<ul style="list-style-type: none"> <li>Sustainability of program resources.</li> </ul>	<ul style="list-style-type: none"> <li>CHEMS Workgroup</li> <li>CHW Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IDHW</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 02/01/2017			<b>End:</b> 01/01/2019

GOAL 4 PROJECT CHARTER

<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Collect information/feedback from CHEMS agencies.</li> <li>Solicit stakeholder input.</li> <li>Develop proposed plan.</li> <li>Implement plan.</li> </ul>		<ul style="list-style-type: none"> <li>01/30/2018</li> <li>[TBD]</li> <li>[TBD]</li> </ul>	
<b>Deliverable 10</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Telehealth implementation plan.</li> </ul>	<ul style="list-style-type: none"> <li>Plan to implement telehealth in Virtual PCMH model.</li> </ul>	<ul style="list-style-type: none"> <li>Telehealth Council</li> </ul>	<ul style="list-style-type: none"> <li>Selected PCMHs</li> <li>Telehealth contractor</li> <li>IHC</li> <li>IHDE</li> <li>Data Collection and Analysis Contractor</li> </ul>
<b>Est. Timeframe</b>	<b>Start: 09/01/2015</b>		<b>End: 12/02/2015</b>	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Research other state telehealth standards.</li> <li>Collect input from key stakeholders on draft telehealth standards.</li> <li>Develop draft telehealth standards.</li> <li>Obtain feedback, as needed.</li> <li>Finalize telehealth standards.</li> </ul>		<ul style="list-style-type: none"> <li>10/01/2015</li> <li>11/02/2015</li> <li>11/02/2015</li> <li>12/02/2015</li> <li>12/02/2015</li> </ul>	



7 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

GOAL 4 PROJECT CHARTER

**Project Risks, Assumptions, and Dependencies**

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	1. Inability to integrate CHEMS data reporting with IHDE requirements.	M	M	Assure communication between CHEMS and HIT workgroup.
	2. Newly trained CHEMS professionals do not remain engaged with EMS agencies.	L	M	Address in the contract/MOUs with EMS agencies.
	3. CMMI funding restriction for training.	M	M	None.
	4. Lack of sustainability plan for CHW training.	M	M	Integrate CHW program with regional health collaborative sustainability planning.
	5. Limited CHW model adoption by PCMHs.	M	M	Increase outreach coordination with medical home collaborative and Regional Health Collaboratives.
	6. Lack of student participation in training.	M	M	Alignment with CHW outreach committee to assure appropriate information distribution to stakeholders and potential CHWs.
<b>Assumptions</b>	TBD			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>• Establishment and finalizing of the Virtual PCMH model.</li> <li>• Ability to recruit and train a sufficient number of practices, CHWs, and CHEMS.</li> <li>• Selection of the CHEMS agencies dependent on the selection of the PCMH cohorts.</li> <li>• Timeline for EMTs training dependent on training availability.</li> <li>• CHEMS metrics dependent on SHIP metrics catalog.</li> <li>• Identifying training program curriculum and delivery strategy is dependent on the CHW training committee recommendation, IHC approval, CMMI release of funding, and establishment of appropriate agreement (contract or sub-grant).</li> <li>• Testing the CHW program requires the development of metrics, data collection, and reporting strategies.</li> <li>• Implementing a peer-mentoring program is dependent on the identification of CHWs and primary care clinicians with successful programs and a willingness to travel to PCMHs with new programs.</li> </ul>			

GOAL 4 PROJECT CHARTER

**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**

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<b>Author</b>	Jenny Feliciano and Ralph Magrish	<b>Date</b>	12/22/2015
<b>Reviewer</b>	Casey Moyer	<b>Date</b>	12/23/2015

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**Final Acceptance**

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<b>Name/Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator	12/24/2015	<input checked="" type="checkbox"/>
Katie Falls	Mercer Lead	12/24/2015	<input checked="" type="checkbox"/>

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# PROJECT CHARTER

**GOAL 5: Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels.**

Version 6.0 – FINAL

## Summary

<b>Mercer Lead</b>	David Shadick
<b>SHIP Staff</b>	Casey Moyer
<b>Key Participants</b>	Clinical Quality Measures Workgroup, Population Health Workgroup, Regional Health Collaboratives (RCs), Population Health Workgroup, Idaho Medical Home Collaborative (IMHC), Behavioral Health/Primary Health Integration Workgroup, Idaho Healthcare Coalition (IHC), Office of the Attorney General, Idaho Public Health Districts, Idaho Health Data Exchange (IHDE), Idaho Department of Health and Welfare (IDHW), Patient Centered Medical Home (PCMH) Performance Reporting Training and Technical Assistance Contractor, IHDE Expansion and Connections Contractor, Data Collection and Analytics Contractor.
<b>IHC Charge</b>	Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.

## Success Measures

Success Measures	SHIP Desired Outcomes	Measurement
1.	<ul style="list-style-type: none"> <li>Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.</li> </ul>	<ul style="list-style-type: none"> <li>Cumulative (CUM) # (%) of designated PCMH (sites) with access from the Data Analytics Vendor to the analytics system that provides dashboards and reporting. Model Test Target: 165 PCMHs by 2020 (60 prepared to report on identified measures in Model Test Year 2; 120 in Model Test Year 3; and 165 in 2019).</li> <li>Numerator: Number and % of</li> </ul>

YR	Q1	Q2	Q3	Q4
Pre	-	-	-	-
1	-	-	-	-
2	15	30	45	60
3	65	85	95	110
4*	135	150	165	165

\*Reporting run out required through 1 year post Model Test Year 3

1 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

Success Measures	SHIP Desired Outcomes	Measurement																									
		<p>PCMHs that have access to data analytics system.</p> <ul style="list-style-type: none"> <li>Denominator: Quarterly targets as shown in the table on the right.</li> <li>Data Source: PCMH reporting (or Data Analytics Vendor reporting).</li> </ul>																									
2.	<ul style="list-style-type: none"> <li>Identification of statewide measures for targeted performance reporting at PCMH level.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of quality measures that are reported by all PCMH practices. Model Test Target: 16 by model test year 3.</li> <li>Numerator: Number of identified measures reported by PCMHs.</li> <li>Denominator: Quarterly targets as shown in the table on the right.</li> <li>Data Source Data Analytics Vendor reporting.</li> </ul>																									
		<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>-</td> <td>-</td> <td>-</td> <td>4</td> </tr> <tr> <td>2</td> <td>-</td> <td>-</td> <td>-</td> <td>10</td> </tr> <tr> <td>3</td> <td>16</td> <td>16</td> <td>16</td> <td>16</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	-	-	-	4	2	-	-	-	10	3	16	16	16	16
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	-	-	-	4																							
2	-	-	-	10																							
3	16	16	16	16																							
3.	<ul style="list-style-type: none"> <li>Data collection and analytics for targeted performance reporting to support quality improvement efforts.</li> </ul>	<ul style="list-style-type: none"> <li>CUM # (%) of designated PCMH practices that receive community health needs assessment results from an RC. (Results may guide PCMH quality improvement initiatives.) <i>Model Test Target: 165.</i></li> <li>Numerator: Number of PCMHs that receive community health needs assessment results from an RC.</li> <li>Denominator: Quarterly targets as shown in the table on the right.</li> <li>Data Source: PCMH and PHD reporting.</li> </ul>																									
		<table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>-</td> <td>-</td> <td>-</td> <td>-</td> </tr> <tr> <td>1</td> <td>-</td> <td>-</td> <td>-</td> <td>55</td> </tr> <tr> <td>2</td> <td>-</td> <td>-</td> <td>-</td> <td>110</td> </tr> <tr> <td>3</td> <td>-</td> <td>-</td> <td>-</td> <td>165</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	-	-	-	-	1	-	-	-	55	2	-	-	-	110	3	-	-	-	165
YR	Q1	Q2	Q3	Q4																							
Pre	-	-	-	-																							
1	-	-	-	55																							
2	-	-	-	110																							
3	-	-	-	165																							



2 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

### Planned Scope

Deliverable 1	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>• Reports to analyze identified clinical quality measures.</li> <li>• Periodic reporting that compares quality and cost data against a baseline and for each subsequent year throughout the Model Test.</li> </ul>	<ul style="list-style-type: none"> <li>• Create and track regular reports that assess quality and cost improvements across all levels (patient, clinic, county, region, and statewide).</li> </ul>	<ul style="list-style-type: none"> <li>• CQM Workgroup</li> <li>• PHW</li> <li>• HIT Workgroup</li> <li>• IHDE</li> <li>• SHIP staff.</li> <li>• SHIP Statewide Evaluator.</li> </ul>	<ul style="list-style-type: none"> <li>• IHC</li> <li>• CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Identify cost and quality performance measures at the patient, regional and statewide levels.</li> <li>• Determine method and process for data collection and collection roles and responsibilities.</li> <li>• Test data collection process.</li> <li>• Refine process as necessary.</li> <li>• Determine point in time for capturing data.</li> <li>• Design reports and reporting schedule.</li> <li>• Define plan of action for hospitals/PCMHs that refuse/fail to report data or that report unacceptable levels.</li> <li>• Collect data.</li> <li>• Execute reports.</li> <li>• Analyze results.</li> <li>• Implement plans of action for failure to report data or reporting data that does not meet quality standards, as needed.</li> </ul>			<ul style="list-style-type: none"> <li>• 01/06/2016</li> <li>• 01/15/2016</li> <li>• 02/15/2016</li> <li>• 02/19/2016</li> <li>• 02/29/2016</li> <li>• 03/15/2016</li> <li>• 03/01/2016</li> <li>• 03/15/2016</li> <li>• 03/11/2016</li> <li>• 03/25/2016</li> <li>• 04/01/2016</li> </ul>

3

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	<ul style="list-style-type: none"> <li>Execute follow up activities, as needed.</li> </ul>			<ul style="list-style-type: none"> <li>04/15/2016</li> </ul>
<b>Deliverable 2</b>	<b>Result, Product, or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Identify ongoing evaluation and tracking of performance metrics for community health needs assessment results to monitor improvement of:                             <ul style="list-style-type: none"> <li>Care of the patient population at the practice level.</li> <li>Population health at the regional level.</li> <li>Overall statewide performance.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Create and track agreed upon performance metrics for community health needs assessment results among all SHIP workgroups.</li> </ul>	<ul style="list-style-type: none"> <li>CQM Workgroup</li> <li>PHW</li> <li>HIT Workgroup</li> <li>IHDE</li> <li>SHIP staff</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> <li>CMMI</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>Identify performance metrics for tracking and ongoing evaluation of improvements in patient care, regional population health, and overall statewide performance based on the PCMHs response to community health needs assessment results provided by the RCs.</li> <li>Obtain consensus on performance metrics among all SHIP workgroups.</li> <li>Document performance metrics.</li> <li>Document milestones for Model Test Years 1–3.</li> <li>Establish method for monitoring performance against milestones.</li> <li>Define data collection method and collection roles and responsibilities.</li> <li>Test data collection process.</li> <li>Refine process as necessary.</li> <li>Determine point in time for capturing data.</li> </ul>			<ul style="list-style-type: none"> <li>01/8/16</li> <li>01/22/2016</li> <li>01/25/2016</li> <li>02/01/2016</li> <li>02/19/2016</li> <li>03/04/2016</li> <li>03/14/2016</li> <li>03/14/2016</li> <li>03/27/2016</li> </ul>



4 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

- Design report and reporting schedule. • 04/15/2016
- Collect data. • 04/22/2016
- Execute reports. • 04/22/2016
- Analyze results. • 04/29/2016
- Define plan of corrective action for failure to meet established milestone(s). • 05/06/2016
- Implement plans of corrective action, as needed. • 05/27/2016
- Execute follow up activities, as needed. • 06/10/2016

Deliverable 3	Result, Product, or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>• Ensure Data Analytics vendor is reaching their contractual and educational access requirements for PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing monitoring of Data Analytics vendor contract milestones.</li> </ul>	<ul style="list-style-type: none"> <li>• Data Analytics Vendor</li> <li>• SHIP staff</li> </ul>	<ul style="list-style-type: none"> <li>• IHC</li> <li>• HIT Workgroup</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/01/2016			<b>End:</b> 12/31/2016
<b>Milestones</b>	<b>Event</b>			<b>Target Date</b>
	<ul style="list-style-type: none"> <li>• Identify contractual milestones. • 01/22/2016</li> <li>• Establish method for monitoring the Data Analytics vendor performance against milestones. • 01/25/2016</li> <li>• Define data collection method and collection roles and responsibilities. • 02/01/2016</li> <li>• Test data collection process. • 02/19/2016</li> <li>• Refine process as necessary. • 02/29/2016</li> <li>• Determine point in time for capturing data. • 03/14/2016</li> <li>• Design report and reporting schedule. • 03/21/2016</li> <li>• Define plan of action for vendor failure to meet contractual milestone(s). • 03/27/2016</li> <li>• Collect data. • 04/15/2016</li> <li>• Execute reports. • 04/22/2016</li> <li>• Analyze results. • 04/29/2016</li> <li>• Implement plans of action for vendor failure. • 05/13/2016</li> </ul>			

- Execute follow up activities, as needed.

• 05/20/2016

### Project Risks, Assumptions, and Dependencies

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	1. Statewide HIT contractors not in place by selected deadlines.	L	M	<ul style="list-style-type: none"> <li>• Hire additional resources or outsource monitoring activities.</li> </ul>
	2. Workgroup approval of metrics that track performance at all levels is not timely.	M	M	<ul style="list-style-type: none"> <li>• Clinical Quality and Population Health Workgroups make final decisions on performance measures.</li> </ul>
	3. Data Analytics vendor not in place by selected deadline.	M	M	<ul style="list-style-type: none"> <li>• HIT workgroup monitoring of vendor selection process.</li> </ul>
	4. IDHW lacks resources to conduct monitoring of Data Analysis vendor.	M	M	<ul style="list-style-type: none"> <li>• Restructure responsibilities of IDHW SHIP Team to allow for monitoring of activities.</li> </ul>
	5. State lacks resources to collect and report data.	L	M	<ul style="list-style-type: none"> <li>• HIT workgroup monitoring of vendor selection process.</li> </ul>
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>• Success Measures established for Goal 2 will also support Goal 5, and measurement activities do not need to be replicated for Goal 5.</li> </ul>			

6 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

<b>Dependencies and Constraints</b>	<p>Dependencies:</p> <ul style="list-style-type: none"> <li>• Identification and definition of Data Analysis vendor contractual performance goals.</li> <li>• IMHC’s ability to monitor the vendor’s performance.</li> <li>• Adequacy of technical assistance to support PCMH reporting.</li> <li>• Quality of the community health needs assessments from the RCs and capability of the PCMHs to use results to guide QI initiatives.</li> <li>• Timeliness of Goal 2 activities (to improve care coordination through use of electronic health records) that also support Goal 5 (build a statewide data analytics system).</li> </ul> <p>Constraints:</p> <ul style="list-style-type: none"> <li>• Time</li> <li>• Resources</li> <li>• Cost</li> </ul>
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### 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

<b>Authors</b>	David Shadick	<b>Date</b>	10/21/2015
<b>Reviewers</b>	Casey Moyer	<b>Date</b>	10/22/2015

### Final Acceptance

<b>Name/Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator	11/23/2015	☒
Katie Falls	Mercer Lead	11/23/2015	☒



7 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.



# PROJECT CHARTER

## GOAL 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

Version 3.0 – FINAL

### Summary

<b>Mercer Lead</b>	Scott Banken
<b>SHIP Staff</b>	Cynthia York
<b>Key Participants</b>	PCMHs, Commercial payers, Medicare, and the Idaho Department of Health and Welfare
<b>IHC Charge</b>	<ul style="list-style-type: none"> <li>Through collaboration across payers and providers, transform payment methodology from volume to performance-based value.</li> <li>Develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a patient-centered medical home (PCMH) through transition to a payment system based on outcomes.</li> </ul>

### Success Measures

Success Measures	SHIP Desired Outcomes	Measurement																									
1.	<ul style="list-style-type: none"> <li>Payers contract with PCMH practices to receive alternative (non-volume based) reimbursements.</li> </ul>	<ul style="list-style-type: none"> <li>Count of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>TBD</td> </tr> <tr> <td>1</td> <td>TBD</td> </tr> <tr> <td>2</td> <td>TBD</td> </tr> <tr> <td>3</td> <td>TBD</td> </tr> </tbody> </table>	YR	Q4	Pre	TBD	1	TBD	2	TBD	3	TBD															
YR	Q4																										
Pre	TBD																										
1	TBD																										
2	TBD																										
3	TBD																										
2.	<ul style="list-style-type: none"> <li>Payers representing at least 80% of the Idaho population adopt new reimbursement models.</li> </ul>	<ul style="list-style-type: none"> <li>Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.</li> </ul> <table border="1"> <thead> <tr> <th>YR</th> <th>Q1</th> <th>Q2</th> <th>Q3</th> <th>Q4</th> </tr> </thead> <tbody> <tr> <td>Pre</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>1</td> <td>0</td> <td>0</td> <td>0</td> <td>4</td> </tr> <tr> <td>2</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> </tr> <tr> <td>3</td> <td>4</td> <td>4</td> <td>4</td> <td>4</td> </tr> </tbody> </table>	YR	Q1	Q2	Q3	Q4	Pre	0	0	0	0	1	0	0	0	4	2	4	4	4	4	3	4	4	4	4
YR	Q1	Q2	Q3	Q4																							
Pre	0	0	0	0																							
1	0	0	0	4																							
2	4	4	4	4																							
3	4	4	4	4																							

GOAL 6 PROJECT CHARTER

Success Measures	SHIP Desired Outcomes	Measurement		
3.	<ul style="list-style-type: none"> <li>Beneficiaries are attributed to PCMHs for purposes of alternative reimbursement payments.</li> </ul>	<ul style="list-style-type: none"> <li>The count of beneficiaries attributed for purposes of alternative reimbursement payments.</li> </ul>		<b>Q4</b>
			<b>Pre</b>	0
			<b>1</b>	275,000
			<b>2</b>	550,000
			<b>3</b>	825,000
4.	<ul style="list-style-type: none"> <li>80% of all payments are under alternative reimbursement models</li> </ul>	<ul style="list-style-type: none"> <li>Percentage of payments made in non-FFS arrangements compared to total payments made.</li> </ul>	<b>YR</b>	<b>Q4</b>
			<b>Pre</b>	10%
			<b>1</b>	20%
			<b>2</b>	50%
			<b>3</b>	80%

**Planned Scope**

Deliverable 1	Result, Product or Service	Description	Owner	Impacted Parties
	<ul style="list-style-type: none"> <li>Payer matrix summary.</li> </ul>	<ul style="list-style-type: none"> <li>Matrix of payers and payment methods included in contracts with PCMHs.</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 06/01/2015		<b>End:</b> 08/12/2015	
<b>Milestones</b>	<b>Event</b>		<b>Target Date</b>	
	<ul style="list-style-type: none"> <li>Payer submissions of draft matrix with updates of parameters for the payers' patient attribution, population risk/stratification methodology upon which the payers will build their payment amounts.</li> </ul>		<ul style="list-style-type: none"> <li>07/31/2015</li> </ul>	
	<ul style="list-style-type: none"> <li>Approval of final matrix.</li> </ul>		<ul style="list-style-type: none"> <li>08/12/2015</li> </ul>	



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GOAL 6 PROJECT CHARTER

<b>Deliverable 2</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Attribution Report</li> </ul>	<ul style="list-style-type: none"> <li>Number of beneficiaries attributed to providers under alternative (non-fee-for-service) payment models</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015		<b>End:</b> 01/31/2019	
<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<ul style="list-style-type: none"> <li>01/31/2016</li> <li>01/31/2017</li> <li>01/31/2018</li> <li>01/31/2019</li> </ul>		
<b>Deliverable 3</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Alternative Payments Report</li> </ul>	<ul style="list-style-type: none"> <li>Total payments made to providers under alternative reimbursement models (Note: total payments made to all providers are gathered in goal 7)</li> </ul>	<ul style="list-style-type: none"> <li>Multi Payer Workgroup</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015		<b>End:</b> 01/31/2019	
<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<ul style="list-style-type: none"> <li>01/31/2016</li> <li>01/31/2017</li> <li>01/31/2018</li> <li>01/31/2019</li> </ul>		
<b>Deliverable 4</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Providers with alternative reimbursement contracts</li> </ul>	<ul style="list-style-type: none"> <li>Count of providers under contract with at least one payer to receive alternative (non-volume based) reimbursements.</li> </ul>	<ul style="list-style-type: none"> <li>Mercer, IMHC</li> </ul>	<ul style="list-style-type: none"> <li>IMHC</li> </ul>



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GOAL 6 PROJECT CHARTER

<b>Est. Timeframe</b>	<b>Start:</b> 01/31/2015	<b>End:</b> 01/31/2019
<b>Milestones</b>	<b>Event</b> <ul style="list-style-type: none"> <li>Year 1</li> <li>Year 2</li> <li>Year 3</li> <li>Year 4</li> </ul>	<b>Target Date</b> <ul style="list-style-type: none"> <li>01/31/2016</li> <li>01/31/2017</li> <li>01/31/2018</li> <li>01/31/2019</li> </ul>

**Project Risks, Assumptions, and Dependencies**

<b>Risk Identification</b>	<b>Event</b>	<b>Likelihood</b>	<b>Seriousness</b>	<b>Potential Mitigation</b>
	<ul style="list-style-type: none"> <li>Enough beneficiaries fail to attribute to each provider for each payer, making risk arrangements unfeasible.</li> </ul>	L	M	Lower minimum threshold for beneficiary attribution and institute risk corridors to minimize risk for both payer and providers.
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>[TBD]</li> </ul>			

**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**

<b>Author</b>	Scott Banken	<b>Date</b>	12/22/2015
<b>Reviewer</b>	Casey Moyer	<b>Date</b>	12/23/2015

**Final Acceptance**

<b>Name / Signature</b>	<b>Title</b>	<b>Date</b>	<b>Approved via Email</b>
Cynthia York	SHIP Administrator	12/24/2015	<input checked="" type="checkbox"/>
Katie Falls	Mercer Lead	12/24/2015	<input checked="" type="checkbox"/>





# PROJECT CHARTER

## GOAL 7: Reduce overall healthcare costs

Version 1.0 – FINAL

### Summary

<b>Mercer Leads</b>	Scott Banken and Katie Falls
<b>SHIP Staff</b>	Cynthia York
<b>Key Participants</b>	Idaho Health Coalition (IHC), Multi-payer Workgroup, Regional Collaboratives
<b>IHC Charge</b>	Determine the cost savings and return on investment of the model, and progress toward meeting implementation goals throughout the Model Test period, as well as health outcomes predicted by the Model.

### Success Measures

Success Measures	SHIP Desired Outcomes	Measurement		
1.	<ul style="list-style-type: none"> <li>Progression towards cost savings of \$89 Million and ROI of 225%.</li> </ul>	<ul style="list-style-type: none"> <li>Total population-based PMPM index.</li> </ul>	<b>YR</b>	<b>Q4</b>
			<b>Pre</b>	TBD
			<b>1</b>	TBD
			<b>2</b>	TBD
			<b>3</b>	TBD
2.	<ul style="list-style-type: none"> <li>Progression towards cost savings of \$89 Million and ROI of 225%.</li> </ul>	<ul style="list-style-type: none"> <li>SIM Model Test return on investment (ROI).</li> </ul>	<b>YR</b>	<b>Q4</b>
			<b>Pre</b>	-
			<b>1</b>	TBD
			<b>2</b>	TBD
			<b>3</b>	TBD
		<b>4</b>	225%	

1

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GOAL 7 PROJECT CHARTER

**Planned Scope**

<b>Deliverable 1</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Implementation of PCMH.</li> </ul>	<ul style="list-style-type: none"> <li>Establish PCMH and/or primary care practice sites.</li> <li>Payers contract with practices using alternative payment arrangements.</li> <li>Beneficiaries attribute to PCMHs or primary care.</li> </ul>	IHC	<ul style="list-style-type: none"> <li>Payers</li> <li>Providers</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 02/01/16	<b>End:</b> 01/31/2019		
<b>Deliverable 2</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Implementation of alternative payment arrangements.</li> </ul>	<ul style="list-style-type: none"> <li>Payers contract with practices using alternative payment arrangements.</li> </ul>	IHC	<ul style="list-style-type: none"> <li>Payers</li> <li>Providers</li> </ul>
<b>Deliverable 3</b>	<b>Result, Product or Service</b>	<b>Description</b>	<b>Owner</b>	<b>Impacted Parties</b>
	<ul style="list-style-type: none"> <li>Cost savings projection</li> </ul>	<ul style="list-style-type: none"> <li>Data is received to conduct cost savings analysis by October 5, 2015.</li> </ul>	<ul style="list-style-type: none"> <li>IHC</li> </ul>	<ul style="list-style-type: none"> <li>Payers</li> <li>Providers</li> </ul>
<b>Est. Timeframe</b>	<b>Start:</b> 12/15/2015	<b>End:</b> 01/31/2019 (or 3 months later)		
<b>Milestones</b>	<b>Event</b>	<b>Target Date</b>		
	<ul style="list-style-type: none"> <li>Data is received to conduct cost savings analysis.</li> <li>Data set for analysis is complete.</li> <li>Annual report on actual savings versus financial analysis.</li> </ul>	<ul style="list-style-type: none"> <li>10/05/2015</li> <li>12/31/2015</li> <li>04/30/2017 and annually thereafter.</li> </ul>		



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GOAL 7 PROJECT CHARTER

**Project Risks, Assumptions, and Dependencies**

Risk Identification	Event	Likelihood	Seriousness	Potential Mitigation
	1. Failure to implement the SIM model.	M	M	Allowing additional primary care based models in lieu of PCMH practices where payments still incent outcome over volume. Engage IHC in discussion and planning of alternatives that can be operationalized.
	2. Failure to implement alternative payment arrangements.	M	M	Identify PCMH's and primary care provider's levels of attribution by payers to determine if thresholds should be adjusted.
	3. Failure to report financial results timely or accurately.	L	M	Determine if NAIC filings for commercial data and the CMS website for Medicare FFS data have adequate detail to proceed with the financial analysis.
<b>Assumptions</b>	<ul style="list-style-type: none"> <li>• Cost savings analysis requires all participating payers to submit the data.</li> <li>• All payers participating in the model are willing to provide necessary data.</li> </ul>			
<b>Dependencies and Constraints</b>	<ul style="list-style-type: none"> <li>• Confidentiality requirements and data-sharing agreements are established between payers and Mercer.</li> <li>• Complying with data request does not present a significant burden on payers' resources.</li> </ul>			

**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**

<b>Author</b>	Scott Banken	<b>Date</b>	12/22/2015
<b>Reviewer</b>	Cynthia York	<b>Date</b>	12/23/2015

**Final Acceptance**

Name / Signature	Title	Date	Approved via Email
Cynthia York	SHIP Administrator	12/24/2015	<input checked="" type="checkbox"/>
Katie Falls	Mercer Lead	12/24/2015	<input checked="" type="checkbox"/>

3 Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Center for Medicare & Medicaid Services.

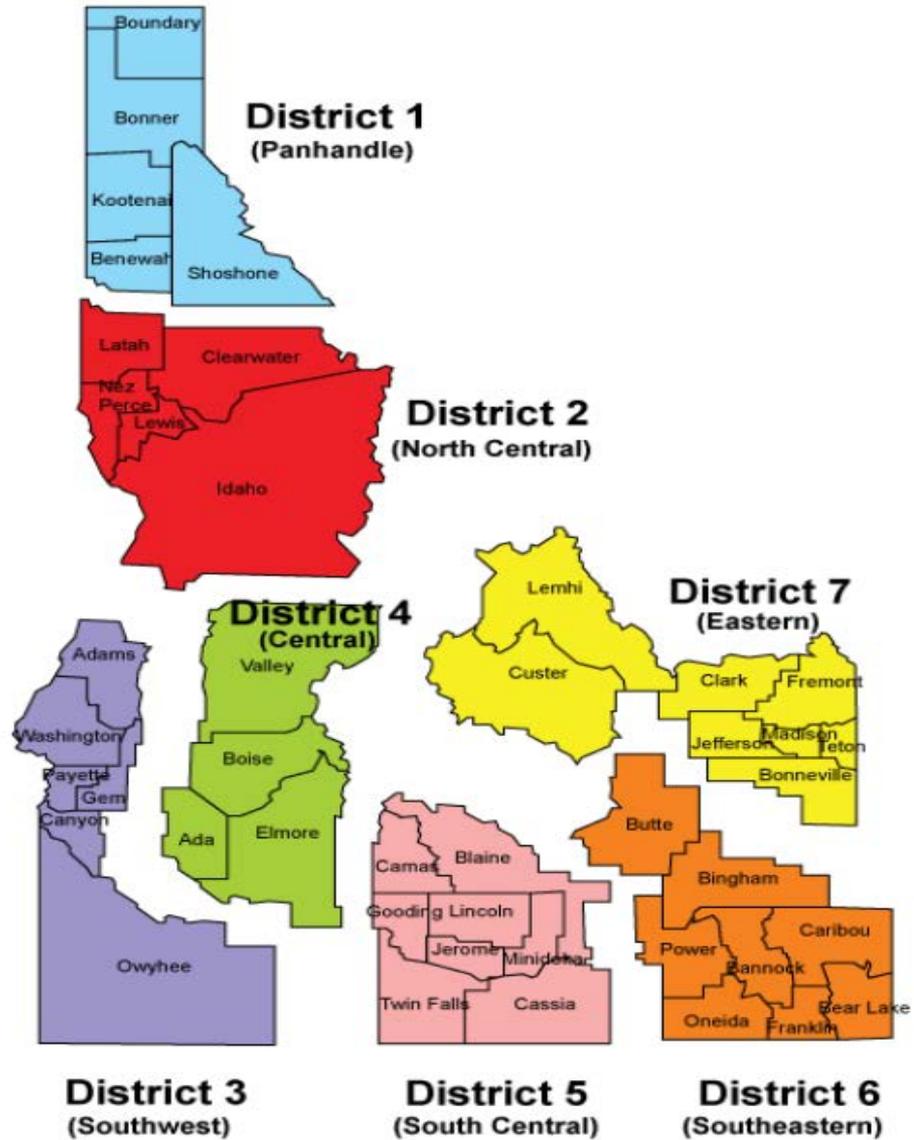
# PCMH Transformation

## PCMH SELECTED PRACTICES - 2016

PORTAL  
INCENTIVE PAYMENTS  
TRAINING AND TECHNICAL ASSISTANCE

January 13, 2016

# IDAHO PUBLIC HEALTH DISTRICTS



## DISTRICT1 - PANHANDLE

	Selected Clinics	County	City
1	Benewah Medical & Wellness Center	Benewah	Plummer
2	Heritage Health Post Falls	Kootenai	Post Falls
3	Heritage Health Rathdrum Clinic	Kootenai	Rathdrum
4	Family Health Center	Bonner	Sandpoint
5	Kaniksu – Ponderay	Bonner	Ponderay
6	Kaniksu – Sandpoint Peds	Bonner	Sandpoint
7	Mountain Health Care	Shoshone	Kellogg

## DISTRICT1 - PANHANDLE

Selected Clinics	Patient Panel Size per PCP	# patient visits year for all providers	# patients who made at least one visit to the clinic in 2014	EHR Brand /Connectivity Potential to IHDE	PCMH Accreditation Date
<b>Benewah Medical &amp; Wellness Center</b>	925	38,639	6,160	NextGen/Yes	AAAHC Jun 2013
<b>Heritage Health Post Falls</b>	3,188	5,840	2,123	NextGen/Yes	None
<b>Heritage Health Rathdrum Clinic</b>	3,656	4,061	1,476	NextGen/Yes	None
<b>Family Health Center</b>	2,442	17,288	6,049	NextGen/Yes	NCQA Level III/ Mar 2014
<b>Kaniksu – Ponderay</b>	665	20,921	6,193	NextGen/Yes	NCQA Level III/ Dec 2014
<b>Kaniksu – Sandpoint Peds</b>	789	6,804	3,021	NextGen/Yes	NCQA Level III/ Dec 2014
<b>Mountain Health Care</b>	2,706	15,858	5,766	Intergy by Greenway Health/Yes	None

## DISTRICT 2 – NORTH CENTRAL

	Selected Clinics	County	City
1	CHAS Latah Community Health	Latah	Moscow
2	St. Mary's Clinic – Cottonwood	Idaho	Cottonwood
3	Orofino Health Center	Clearwater	Orofino
4	St. Mary's Clinic - Kamiah	Lewis	Kamiah
5	Valley Medical Center, PLLC	Nez Perce	Lewiston

## DISTRICT 2 – NORTH CENTRAL

Selected Clinics	Patient Panel Size per PCP	# patient visits/year for all providers	# patients who made at least one visit to the clinic in 2014	EHR Brand Connectivity Potential to IHDE	PCMH Accreditation
<b>CHAS Latah Community Health</b>	1,309	6,614	1,347	athenaClinicals - Yes	NCQA Level II/ Aug 2015
<b>St. Mary's Clinic – Cottonwood</b>	900	10,569	3,810	Centricity EMR by GE - Yes	NCQA Level III/ Mar 2015
<b>Orofino Health Center</b>	700	15,124	5,028	Centricity EMR by GE - Yes	NCQA Level III/ Oct 2014
<b>St. Mary's Clinic - Kamiah</b>	900	8,660	2,889	Centricity EMR by GE - Yes	NCQA Level III/ Mar 2015
<b>Valley Medical Center, PLLC</b>	2,071	106,000	33,000	Centricity EMR by GE - Yes	NCQA Level III/ Nov 2014

## DISTRICT 3 - SOUTHWEST

	Selected Clinics	County	City
1	Valley Family Health Care, Inc - New Plymouth	Payette	New Plymouth
2	Terry Reilly Health Services Homedale Clinic	Owyhee	Homedale
3	Terry Reilly Health Services Marsing Clinic	Owyhee	Marsing
4	Terry Reilly Health Services Nampa 1st Street Clinic	Canyon	Nampa
5	Adams County Health Center Inc	Adams	Council
6	Primary Health Medical Group - South Nampa	Canyon	Nampa
7	Primary Health Medical Group – Caldwell	Canyon	Caldwell
8	SAMG Elm	Canyon	Caldwell
9	St. Luke's Clinic Nampa Family Medicine Nampa Greenhurst	Canyon	Nampa
10	Valley Health Center	Owyhee	Grand View

## DISTRICT 3 - SOUTHWEST

Selected Clinics	Patient Panel Size per PCP	# patient visits/year for all providers	# patients with at least one visit to the clinic in 2014	EHR Brand/Connectivity Potential to IHDE	PCMH Accreditation
<b>Valley Family Health Care, Inc - New Plymouth</b>	1,275	3,868	1,263	Intergy by Greenway Health/Yes	NCQA Level II/ Dec 2013
<b>Terry Reilly Health Services Homedale Clinic</b>	1,000	4,515	1,654	Centricity EMR by GE/Yes	NCQA Level III/ Mar 2015
<b>Terry Reilly Health Services Marsing Clinic</b>	1,200	4,814	1,689	Centricity EMR by GE/Yes	NCQA Level III/ Mar 2015
<b>Terry Reilly Health Services Nampa 1st Street Clinic</b>	1,000	20,548	8,370	Centricity EMR by GE/Yes	NCQA Level III/ Mar 2015
<b>Adams County Health Center Inc</b>	n/a	9,932	3,381	NextGen/Yes	NCQA Level II/ Sept 2014

## DISTRICT 3 - SOUTHWEST

Selected Clinics	Patient Panel Size per PCP	# patient visits/year for all providers	# patients with at least one visit to the clinic in 2014	EHR Brand Connectivity Potential to IHDE	PCMH Accreditation
<b>Primary Health Medical Group - South Nampa</b>	1,664	17,603	8,036	eClinicalWorks/Yes	None
<b>Primary Health Medical Group – Caldwell</b>	2,206	28,027	11,785	eClinicalWorks/Yes	None
<b>SAMG Elm</b>	1,164	69,528	36,403	NextGen/Yes	None
<b>St. Luke's Clinic Nampa Family Medicine Nampa Greenhurst</b>	1,573	14,326	13,873	Epic/Yes	None
<b>Valley Health Center</b>	600	3,979	996	Greenway PrimeSuite/Yes	NCQA Level II/ Sept 2014

## DISTRICT 4 - CENTRAL

	Selected Clinics	County	City
1	Sonshine Family Health Clinic, LLC	Ada	Boise
2	Payette Lakes Medical Clinic/McCall Medical Clinic	Valley	McCall
3	Terry Reilly Health Services Boise 23rd Street Clinic	Ada	Boise
4	Primary Health Medical Group - West Boise	Ada	Boise
5	Primary Health Medical Group - Overland	Ada	Boise
6	Primary Health Medical Group - Pediatrics	Ada	Boise
7	SAMG Eagle Health Plaza	Ada	Boise
8	SAMG McMillan	Ada	Boise
9	St. Luke's Internal Medicine-Cloverdale	Ada	Boise
10	SAMG Overland	Ada	Boise
11	Family Medicine Health Center- Raymond	Ada	Boise
12	Family Medicine Health Center- Meridian	Ada	Meridian
13	Family Medicine Health Center- Emerald	Ada	Boise
14	Glenns Ferry Health Center	Elmore	Glenns Ferry
15	Desert Sage Health Center	Elmore	Mountain Home

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## DISTRICT 4 - CENTRAL

<b>Selected Clinics</b>	<b>Patient Panel Size per PCP</b>	<b># patient visits/ year for all providers</b>	<b># patients with at least one visit to the clinic in 2014</b>	<b>EHR Brand Connectivity Potential to IHDE</b>	<b>PCMH Accreditation</b>
<b>Sonshine Family Health Clinic, LLC</b>	n/a	n/a	n/a	SOAPware/Yes	None
<b>Payette Lakes Medical Clinic/McCall Medical Clinic</b>	982	22,739	8,170	Epic/Yes	None
<b>Terry Reilly Health Services Boise 23rd Street Clinic</b>	1,000	15,986	4,586	Centricity EMR by GE/Yes	NCQA Level III/ Mar 2015
<b>Primary Health Medical Group - West Boise</b>	2,088	21,816	10,177	eClinicalWorks - Yes	None
<b>Primary Health Medical Group - Overland</b>	1,672	35,122	17,566	eClinicalWorks - Yes	None
<b>Primary Health Medical Group - Pediatrics</b>	1,440	16,663	3,838	eClinicalWorks - Yes	NCQA Level III
<b>SAMG Eagle Health Plaza</b>	1,193	13,936	6,095	NextGen/Yes	NCQA Level II / Jun 2014

## DISTRICT 4 - CENTRAL

Selected Clinics	Patient Panel Size per PCP	# patient visits/year for all providers	# patients with at least one visit to the clinic in 2014	EHR Brand Connectivity Potential to IHDE	PCMH Accreditation
<b>SAMG Eagle Health Plaza</b>	1,193	13,936	6,095	NextGen/Yes	NCQA Level II/ Jun 2014
<b>SAMG McMillan</b>	1,301	17,542	6,132	NextGen/Yes	NCQA Level II/ Jun 2014
<b>St. Luke's Internal Medicine-Cloverdale</b>	929	9,205	5,574	Epic/Yes	None
<b>SAMG Overland</b>	1,265	14,341	6,510	Cerner/Yes	None
<b>Family Medicine Health Center- Raymond</b>	500	18,775	5,638	Centricity EMR by GE/Yes	NCQA Level III/ Dec 2010
<b>Family Medicine Health Center- Meridian</b>	500	9,308	2,819	Centricity EMR by GE/Yes	NCQA Level III/ Dec 2015
<b>Family Medicine Health Center- Emerald</b>	500	11,437	4,354	Centricity EMR by GE/Yes	NCQA Level III/ Dec 2010
<b>Glenns Ferry Health Center</b>	856	6920	1631	Greenway PrimeSuite/Yes	NCQA Level II/ Sept 2013
<b>Desert Sage Health Center</b>	1,167	21,731	5,021	Greenway PrimeSuite/Yes	NCQA Level II/ Sept 2014

# DISTRICT 5 – SOUTH CENTRAL

*\*\* Two slots from district 5 were reallocated to districts 1 & 7*

	<b>Selected Clinics</b>	<b>County</b>	<b>City</b>
<b>1</b>	Crosspointe Family Services	Twin Falls	Twin Falls
<b>2</b>	Shoshone Family Medical Center	Lincoln	Shoshone
<b>3</b>	Family Health Services - Twin Falls	Twin Falls	Twin Falls
<b>4</b>	Family Health Services - Kimberly Medical	Twin Falls	Kimberly

<b>Selected Clinics</b>	<b>Patient Panel Size per PCP</b>	<b># patient visits/year for all providers</b>	<b># patients with at least one visit to the clinic in 2014</b>	<b>EHR Brand Connectivity Potential to IHDE</b>	<b>PCMH Accreditation</b>
<b>Crosspointe Family Services</b>	603	2,300	220	eClinicalWorks/ Yes	NCQA Level III/ Mar 2015
<b>Shoshone Family Medical Center</b>	1,500	5,457	2,639	eClinicalWorks/ Yes	NCQA Level III
<b>Family Health Services - Twin Falls</b>	1,025	14,769	6,150	NextGen/Yes	None
<b>Family Health Services - Kimberly Medical</b>	749	3,714	1,498	NextGen/Yes	None

## DISTRICT 6 - SOUTHEASTERN

	<b>Selected Clinics</b>	<b>County</b>	<b>City</b>
<b>1</b>	Health West Aberdeen Clinic	Bingham	Aberdeen
<b>2</b>	Health West American Falls Clinic	Power	Idaho
<b>3</b>	Health West Pocatello Clinic	Bannock	Pocatello
<b>4</b>	Pocatello Children's Clinic	Bannock	Pocatello
<b>5</b>	Portneuf Primary Care Clinic	Bannock	Pocatello
<b>6</b>	Not-tsoo Gah-nee Indian Health Center	Bingham	Fort Hall

## DISTRICT 6 - SOUTHEASTERN

Selected Clinics	Patient Panel Size per PCP	# patient visits/year for all providers	# patients with at least one visit to the clinic in 2014	EHR Brand Connectivity Potential to IHDE	PCMH Accreditation
<b>Health West Aberdeen Clinic</b>	750	3,227	1,666	<i>Unspecified/Yes</i>	NCQA Level III/ Apr 2015
<b>Health West American Falls Clinic</b>	750	2,896	1,553	SuccessEHS by Greenway Health/Yes	NCQA Level III/ Apr 2015
<b>Health West Pocatello Clinic</b>	1,000	6,966	2,951	SuccessEHS by Greenway Health/Yes	NCQA Level III/ Nov 2014
<b>Pocatello Children's Clinic</b>	2,400	29,830	13,027	Office Practicum/Yes	NCQA Level II/ Jul 2015
<b>Portneuf Primary Care Clinic</b>	500	4,000	1,529	Practice Partner by McKesson/Yes	None
<b>Not-tsoo Gah-nee Indian Health Center</b>	750	14,489	4,400	IHS Resource and Patient Mgmt. System (RPMS)	None

## DISTRICT 7 - EASTERN

	Selected Clinics	County	City
1	Driggs Health Clinic	Teton	Driggs
2	Victor Health Clinic	Teton	Driggs
3	Madison Memorial Rexburg Medical Clinic	Madison	Rexburg
4	Complete Family Care	Madison	Rexburg
5	Tueller Counseling Services	Bonneville	Idaho Falls
6	Rocky Mountain Diabetes and Osteoporosis Center PA	Bonneville	Idaho Falls
7	Family First Medical Center	Bonneville	Idaho Falls
8	Upper Valley Community Health Services	Idaho	St. Anthony

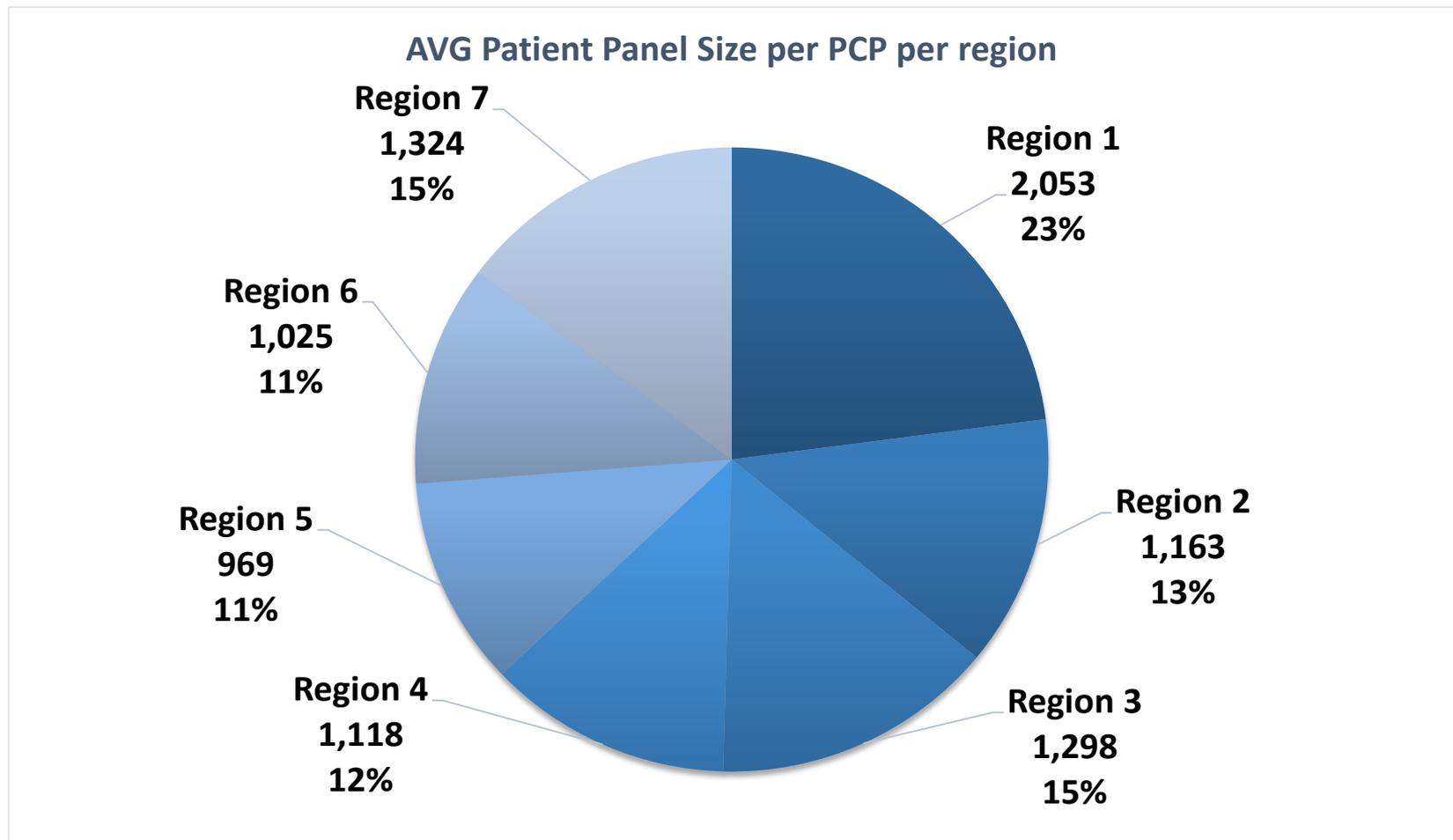
## DISTRICT 7 - EASTERN

<b>Selected Clinics</b>	<b>Patient Panel Size per PCP</b>	<b># patient visits/ year - all providers</b>	<b># patients with at least 1 visit to the clinic in 2014</b>	<b>EHR Brand Connectivity Potential to IHDE</b>	<b>PCMH Accreditation</b>
<b>Driggs Health Clinic</b>	967	9,963	5,801	Centricity EMR by GE/Yes	None
<b>Victor Health Clinic</b>	818	2,549	1,637	Centricity EMR by GE/Yes	None
<b>Madison Memorial Rexburg Medical Clinic</b>	20	28,800	n/a	eClinicalWorks/Yes	NCQA Level II/ Jun 2015
<b>Complete Family Care</b>	1,500	6,597	2,100	eClinicalWorks/Yes	None
<b>Tueller Counseling Services</b>	75	52,650	1,350	AdvancedMD/ Yes	None
<b>Rocky Mountain Diabetes and Osteoporosis Center PA</b>	2,500	26,00	8,686	eClinicalWorks/Yes	None
<b>Family First Medical Center</b>	3,387	19,091	6,238	eClinicalWorks/Yes	None
<b>Upper Valley Community Health Services</b>	1,100	5,400	1,100	eClinicalWorks - Yes	NCQA Level III/ Sep 2014

## PATIENT PANEL SIZE - *SUMMARY*

District	AVG Patient Panel Size per PCP per district	AVG # patient visits/year for all providers per district	AVG # patients who made at least one visit to the clinic in 2014 per district
District 1	2,053	15,630	4,398
District 2	1,163	25,395	7,862
District 3	1,298	17,714	8,745
District 4	1,118	17,585	6,652
District 5	969	6,560	2,627
District 6	1,025	10,235	4,188
District 7	1,324	19,942	4,302
<b>AVERAGE</b>	<b>1,109</b>	<b>13,580</b>	<b>4,442</b>

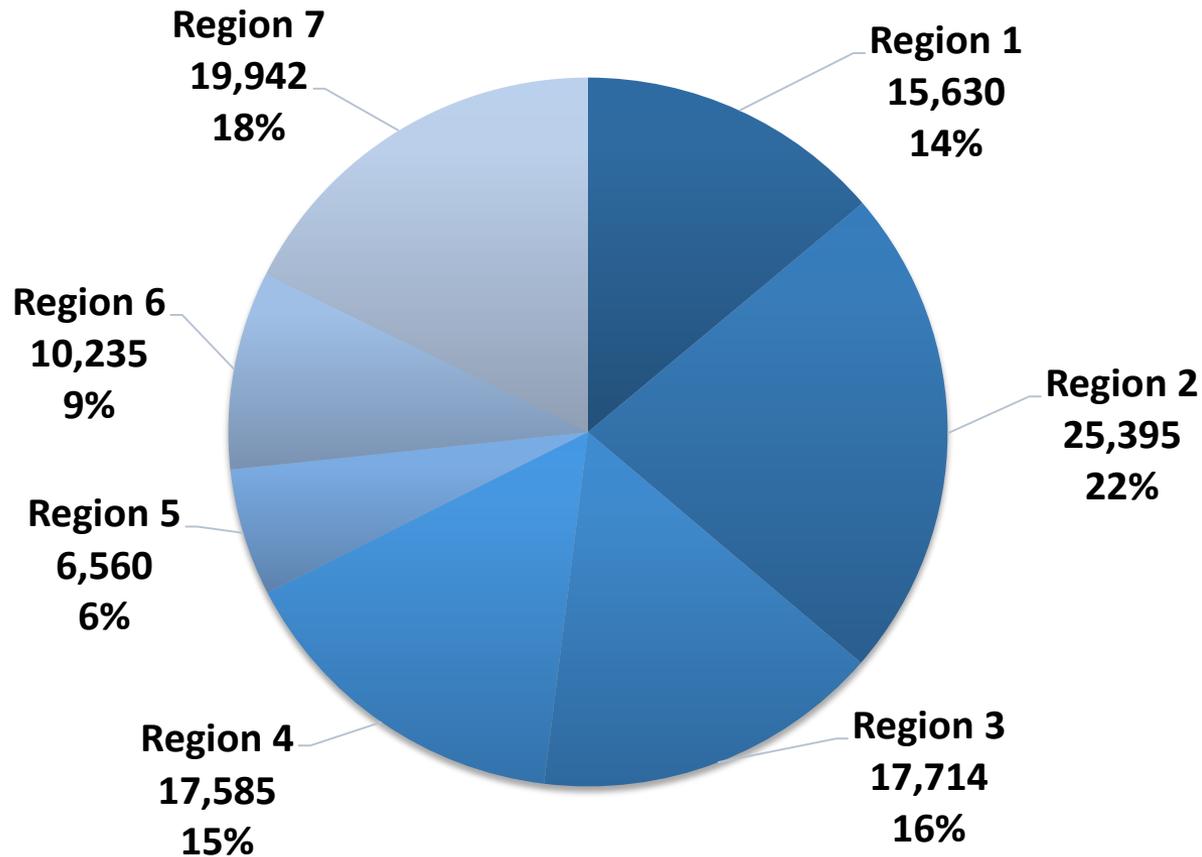
# PATIENT PANEL SIZE – SUMMARY



Region = District

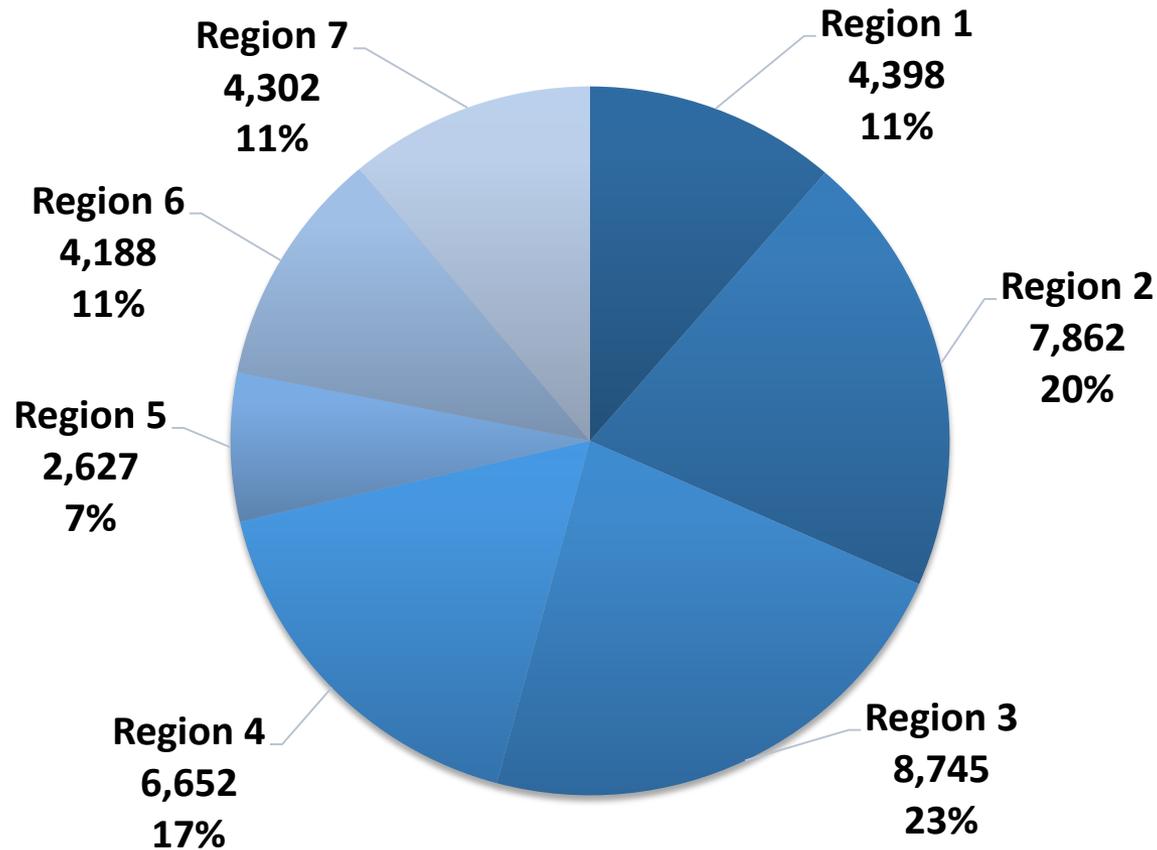
# PATIENT VISITS- *SUMMARY*

AVG # patient visits/year for all providers per region



# PATIENTS CLINIC VISIT: *SUMMARY*

AVG # patients who made at least one visit to the clinic in 2014 per region



# PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>Terry Reilly Health Services</b>	4	--	--
• Boise 23rd Street Clinic	--	4	III
• Homedale Clinic	--	3	III
• Marsing Clinic	--	3	III
• Nampa 1st Street Clinic	--	3	III
<b>SAMG</b>	4	--	--
• Eagle Health Plaza	--	3	II
• Elm	--	4	None
• McMillan	--	4	II
• Overland	--	4	None

## PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>Primary Health Medical Group</b>	5	--	--
• Caldwell	--	3	None
• Overland	--	4	None
• Pediatrics	--	4	III
• West Boise	--	4	None
• South Nampa	--	3	None
<b>Family Medicine Health Center</b>	3	--	--
• Emerald	--	3	III
• Meridian	--	4	III
• Raymond	--	4	III

# PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>Health West</b>	3	--	--
• Aberdeen Clinic	--	6	III
• American Falls Clinic	--	6	III
• Pocatello Clinic	--	6	III
<b>Heritage Health</b>	3	--	--
• Post Falls	--	1	None
• Rathdrum Clinic	--	1	None
• Mountain Health Care Clinic	--	--	n/a

## PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>Essentia</b>	3	--	--
• St. Mary's Clinic	--	2	III
• St. Mary's Kamiah Clinic	--	2	III
• Orofino Health Center	--	2	III
<b>Glenns Ferry Health Center, Inc</b>	3	--	--
• Valley Health Center	--	3	II
• Desert Sage Health Center	--	4	II
• Glenns Ferry Health Center	--	4	II

## PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>St. Luke's</b>	3	--	--
<ul style="list-style-type: none"> <li>St. Luke's Family Medicine – Nampa Greenhurst</li> </ul>	--	3	n/a
<ul style="list-style-type: none"> <li>St. Luke's Internal Medicine -- Cloverdale</li> </ul>	--	4	n/a
<ul style="list-style-type: none"> <li>Payette Lakes Medical Clinic</li> </ul>	--	4	n/a
<b>Kaniksu Health Services</b>	4	--	--
<ul style="list-style-type: none"> <li>Ponderay</li> </ul>	--	4	III
<ul style="list-style-type: none"> <li>Sandpoint Pediatrics</li> </ul>	--	3	III

# PRACTICE GROUPS

Name	No. of Awarded Clinics from each corporation	Which Regions	PCMH Accreditations
<b>Family Health Services</b>	4	--	--
• Kimberly Medical	--	3	II
• Twin Falls	--	4	None
<b>Teton Valley Health Care, Inc.</b>	2	--	--
• Victor Health Clinic	--	7	n/a
• Driggs Health Clinic	--	7	n/a

# IDAHO PCMH – TECHNICAL ASSISTANCE & TRAINING

- Practice assessment and transformation plan
  - Individual Practice Application assessment
  - Deeper PCMH assessment with some practices, as needed
  - Face-to-face discussions with practice teams and co-creating transformation plan
- Learning Collaborative sessions
  - 2-day sessions focused on the 6 PCMH areas; access, team-based care, population health, care management and support, care coordination and transitions, performance measurement and Quality Improvement (QI)
  - Affinity tracks based on level of structure and sophistication already in place at practices – Level 2 and 3 groups may participate in more advanced learning topics such:
    - Behavioral health integration models
    - Population Health Registry use
    - Telehealth
- Monthly coaching sessions and Content webinars
- Progress towards PCMH transformation

# PCMH Transformation Web Portal

**PCMH**  
TRANSFORMATION TEAM

Transforming Idaho's Healthcare System

**Login**



Username

Password

remember me | [forgot password?](#)

Login

# PCMH Transformation Portal Access

Access to the PCMH Transformation Portal will::

- **Be Secure**
  - Encrypted Connection (Secure Socket Layer)
  - Login Form is the only public facing page
  - Registration through administrator only
- **Hierarchal**

Access is controlled by a “Top Down” hierarchy which segregates information based on the users access level.

  - A practice level user will never have access to information for a different practice.
  - Public Health District (PHD) users will have access to all practice level information for practices within their district, but will not have access to practice level information for practices outside their district.
- **Discrete**

There will be no financial, banking or personal information presented on the portal. Most information will be “Read-Only” for most users. All materials will be reviewed before made visible to users.

## PORTAL ACCESS LEVELS

Users can be assigned to one or more access categories. Again, users can only access content where their assigned access category matches the access category assigned to the content item.

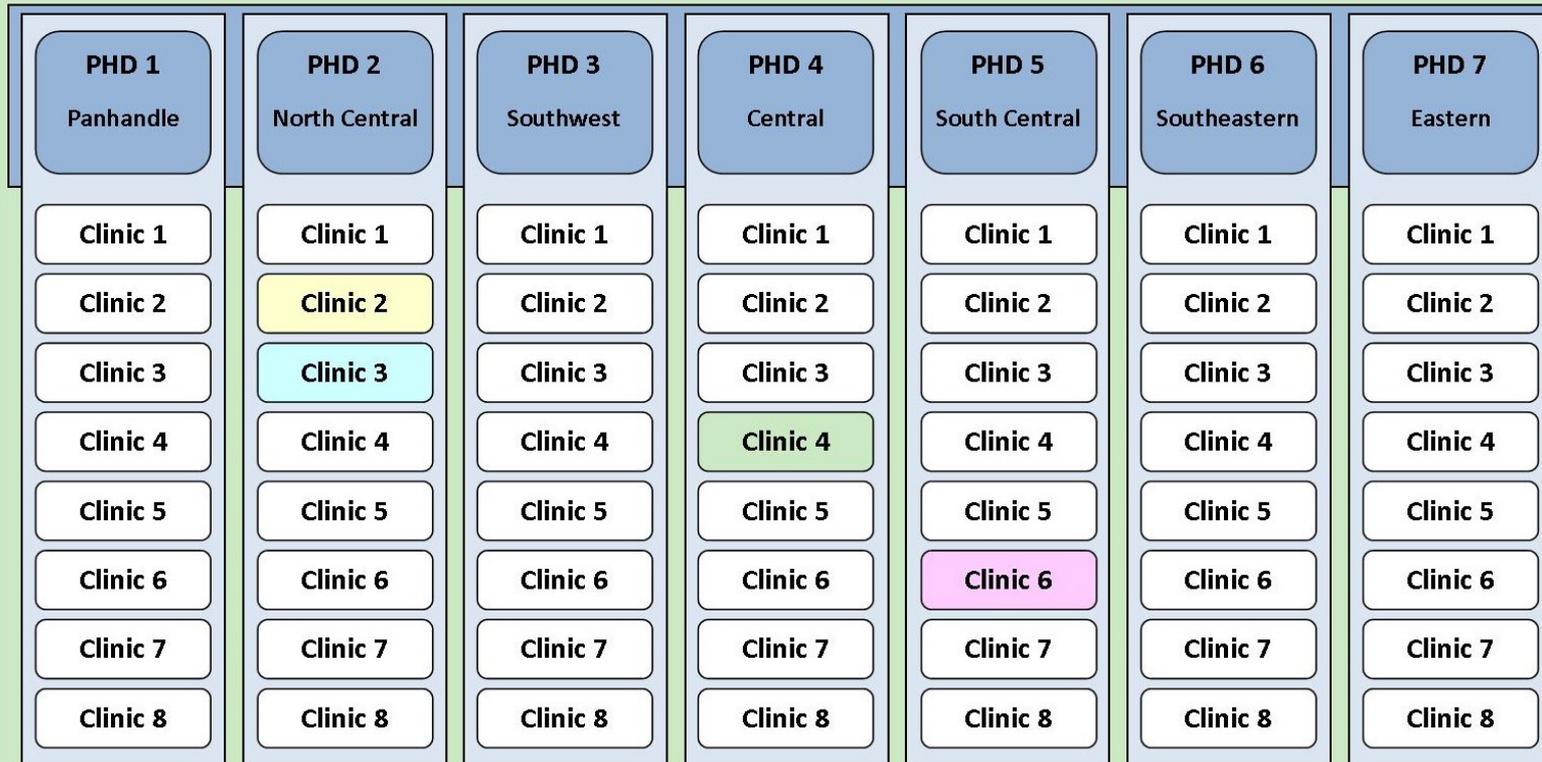
The most restricted access levels are the individual provider practices. Each clinic is assigned its own access category. This allows each clinic to be able to view information specific to the clinic plus any content that is available to all logged-in users.

Special access can be created on request, to provide organization-level access in the event that an organization has multiple participating practices.

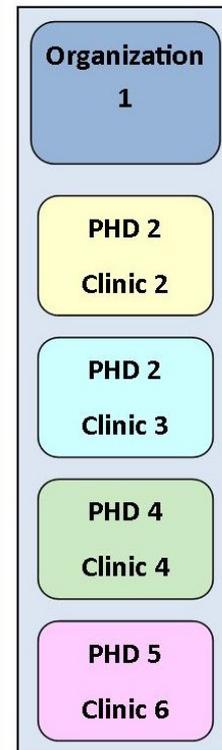
# Portal Access Hierarchy

PCMH Transformation Team

SHIP/State Leadership



Organizations have custom access privileges by request.



# PCMH Transformation Progress and Collaboration

The PCMH Transformation Portal will share information with the I-PAS system to allow clinics and PHD Staff to collaborate and track progress within the context of the entire cohort. Key features include:

1. **Dashboard** – Will include a de-identified way for clinics to view how they stand in relation to other clinics
2. **Help desk** – A clinic that wants to reach out to a clinic that is doing well, would reach out to the help desk to connect them
3. **Forum** – Affinity groups forum discussions are possible by topic or issue – users will be able to set alerts and receive updates from the forums.
4. **Document Sharing** – Documents will be shared at state and district levels.
5. **Usage** – Methods for tracking and promoting usage of the portal will be developed and implemented.
6. **PHD Staff Collaboration** – The Portal and weekly meetings will encourage PHD staff to collaborate and share information to promote the success of every clinic.

# PCMH Transformation Incentive Payment Measures

## Incentive Payment Measure 1:

### PCMH Practice Transformation Incentive

\$10,000 incentive payment will be paid in one installment to SHIP approved practice locations that have:

- A completed application and
- A fully executed contract with Brilljent.

# PCMH Transformation Incentive Payment Measures

## Incentive Payment Measure 2:

### PCMH Recognition or Accreditation Program

\$5,000 will be paid based on evidence of PCMH accreditation or recognition from one of the following:

- Oregon Patient-Centered Primary Care Home (PCPCH)
- National Committee for Quality Assurance (NCQA) PCMH Recognition 2014
- Accreditation Association for Ambulatory Health Care, Inc. (AAHC) Medical Home Accreditation
- The Joint Commission (JC) Primary Care Medical Home (PCMH)
- Other SHIP approved programs

# PCMH Transformation Incentive Payment Measures

## Incentive Payment Measure 3: Virtual PCMH

\$2,500 will be paid to individual practice locations with a SHIP approved virtual PCMH component of one or a combination of the following:

- Telehealth
- Community Health Worker (CHW)
- Community Health Emergency Medical Services (CHEMS)

# PCMH Transformation Incentive Progress Measures

## Progress Measures:

### Transformation Participation and Training

Monthly and quarterly reports will be provided so that practices are aware of their success attainment.

- Count of learning collaborative participation (2);  
Benchmark is 100%
- Count of webinar participation (6);  
Benchmark is 70%
- Count of coaching session participation (12);  
Benchmark is 75%

## PCMH TRANSFORMATION RECOUPMENT

If the clinic fails to meet the progress measure benchmarks, recoupment will occur in the following amounts:

- \$5,000 for failure to participate in at least a minimum of 75% of the coaching sessions (9 of 12).
- \$2,500 for failure to participate in at least a minimum of 70% of the webinars (4 of 6).
- \$2,500 for failure to participate in 100% of the learning collaborative sessions (2 of 2).

The SHIP Team and PCMH Team expect clinics and practices will want to participate and that therefore this recoupment will not be necessary.

## INCENTIVE PAYMENT ACCOUNTING SYSTEM (I-PAS) Data Flow

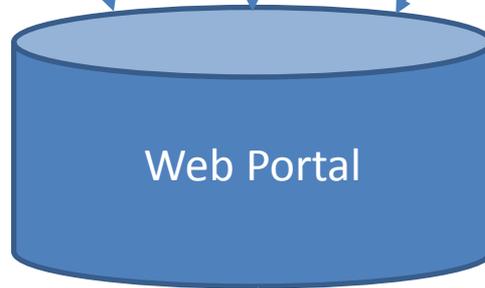
- Briljent collects data through portal or other mechanisms.
- Web services interface between Briljent portal and I-PAS.
- Analytics and reporting done within I-PAS.
- Results passed back to portal through web services interface.

# I-PAS Data Flow

55 PCMH Clinics



Briljent



- ✓ Upload documentation 
- ✓ Access Incentive Payment Participation Reports 

Myers and Stauffer



## I-PAS REPORTING

- Incentive Payment and Progress Measure reports will be generated by I-PAS and displayed on the Brilljent portal.
- Reports may be displayed monthly, quarterly, and annually.
- Reports are generated and viewable by intended users:
  - SHIP Team
  - PHD SHIP Team
  - Individual practice locations/clinics
  - Organization or Practice (upon request)

*Thank you*  
Questions/Comments?



# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition November 18, 2015

## **SHIP OPERATIONS:**

- **SHIP Staffing: Report Items:**

- Burke Jensen started in the HIT/Payer Project Manager position on January 11, 2016. Burke is a certified project manager and has 11 years' experience as a project manager. Kim Thurston has accepted a position with Public Health District 4 as a Health Educator for the 1305 grant program. Interviews for Administrative Assistant II are being conducted this month.

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

- **Report Items:**

- The Data Analytics Contractor has been identified. The appeal process ends January 12, 2016.
- The State Evaluator Application packets have been sent to the three major Idaho universities with a revised return date of January 25, 2016.
- Year 2 Contracts for our technical assistance contractors are being developed in accordance with Model Test Year 1 activities.

## **Regional Collaboratives (RC):**

- **Report Items:**

- All PHDs have full staff rosters as of January 2016.
- The Regional Health Collaboratives have been formed.
- Several Districts have already facilitated inaugural meetings with the full RC membership. Other Districts are scheduling initial meetings.

- **Next Steps:**

- Continue supporting establishment of functioning Regional Collaboratives.
- Continue coordinating PHDs effort with other programs and entities.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**

- Met several times to review and discuss the Telehealth expansion plan.
- Created a draft one-page Telehealth expansion plan overview.
- Conducted research of Telehealth assessment tools and created a draft assessment tool for Telehealth provider sites.
- Began creating a Telehealth Council Goal 2 Subcommittee web page on the SHIP website.

- **Next Steps:**

- Finalize the one-page Telehealth expansion plan overview.
- Finalize the Telehealth Council Goal 2 Subcommittee web page.

- Create assessment tool for CHEMS providers.

CHW

### **Community Health Workers:**

- **Report Items:**
  - The Community Health Worker (CHW) Advisory Group is in the process of operationalizing the training delivery for the first cohort of CHWs by adopting the Massachusetts curriculum (available in Spring 2016) that will be customized for Idaho. The Idaho State University is exploring the option of providing initial ‘train the trainer’ in person education. Advisory Group is also engaging with practices and systems that are already utilizing CHWs to better understand the practices workflow and referral mechanisms in regard to CHWs.

CHEMS

### **Community Health EMS:**

- **Report Items:**
  - The CHEMS Outcome Measures Design Workshop is scheduled for January 22<sup>nd</sup>, at the Best Western Inn at the Airport. Keynote speaker is Matt Zavadsky, Public Affairs Director at MedStar Mobile Healthcare in Fort Worth, Texas. More than 30 confirmed attendees represent EMS Agencies, Healthcare and Educational Institutions and various Government entities.
  - At least 8 paramedics from 3 EMS agencies will start a yearlong community paramedicine education at the Idaho State University. The training includes community needs assessments and clinical education.
  - The contract with Idaho State University is in its final phase.
- **Next Steps:**
  - Following the workshop, SHIP will establish a common foundation for Idaho CHEMS across the State.
  - Following the workshop, SHIP will have identified preliminary CHEMS measures including corresponding collection and reporting mechanisms with an ultimate goal of demonstrating the value and impact of CHEMS programs.

## **WORKGROUP REPORTS:**

IMHC

### **IMHC:**

- **Report Item:**
  - Briljent reviewed PCMH portal that will be utilized by Briljent/HMA/Myers & Stauffer, SHIP staff, PHD staff, and Cohort 1 PCMH clinics
  - IMHC recommended some additions to the portal regarding dashboards, help desk, a forum, document sharing, and viewing options.
  - Kym Schreiber reviewed the “Patient Centered Medical Home; what is it and why should I participate?” single-page document that was emailed to members and asked for

feedback on the content. Dr. Dunn offered some changes and other members will email her with any thoughts or changes.

- **Next Steps:**
  - Future meetings will occur ad hoc.

## **HIT** Health Information Technology:

- **Report Item:**
  - The HIT Workgroup did not meet during the month of December
  - HIT continues to monitor the progress on the Data Analytics RFP process.
  - The HIT webpage has been updated with meeting documents, a brief history, summary and a section dedicated to RFP process updates for the public.
- **Next Steps:**
  - The HIT Workgroup will be meeting next week with a full agenda
  - The Workgroup continues to monitor the progress on the Data Analytics RFP process.

## **MPW** Multi-Payer:

- **Report Item:**
  - The workgroup has not met since last report. SHIP staff is working with the MP workgroup chairs concerning the need to meet in February.

## **CQM** Clinical/Quality Measures Quality Measures Workgroup:

- **Report Item:**
  - No meetings have been scheduled. Nothing to report at this time.

## **BHI** Behavioral Health:

- **Report Item:**
  - The BH Integration survey site visits were concluded in December.
  - Gina Wescott presented the Behavioral Health Integration draft survey results to the BHI Subcommittee for feedback and recommendations.
  - SHIP updates were shared via report.
- **Next Steps:**
  - Next BHI Subcommittee meeting is February 2nd, 2016.
  - BHI sub-committee will formally request to present the findings of the BHI Integration survey at the February 10<sup>th</sup> IHC meeting.



## **Population Health:**

- **Report Item:**

- PHW met on January 6<sup>th</sup>, 2016. Meeting highlights are listed below:
  - Nicole Runner presented the Idaho Wellness Guide ([wellness.idaho.gov](http://wellness.idaho.gov))  
*Summary:* The Idaho Wellness Guide is a website created to help the public to find local resources to stay healthy or manage a chronic condition like diabetes, heart disease, cancer, and others. Also resources about quitting tobacco lose weight; take care of oral health and many more. Healthy behaviors—such as eating a nutritious diet, being physically active and not smoking— can prevent, lessen and even eliminate some chronic health problems.
  - Qualis Health gave a presentation on the work they were doing that aligns with population health.
  - The Time Sensitive Emergency System of Care was presented, [tse.idaho.gov](http://tse.idaho.gov) site. *Summary:* The TSE program creates a seamless transition between each level of care and integrates existing community resources to improve patient outcomes and reduce costs. It will get the patient to the right place in the right time with the right care
  - Discussion on working definition of Population Health continued.

- **Next Steps:**

- Next meeting is scheduled for February 3, 2016.