



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, March 9, 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

Attendee URL: <https://access.dhw.idaho.gov/meeting/72207905/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone URL:

[junospulse://?method=meeting&action=join&host=access.dhw.idaho.gov&meetingid=72207905&signin=access.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b](https://access.dhw.idaho.gov/junospulse/?method=meeting&action=join&host=access.dhw.idaho.gov&meetingid=72207905&signin=access.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b)

Password: 12345

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, agenda review and approval of 2/10/16 meeting notes – <i>Dr. Ted Epperly, IHC Chair</i>
1:40 p.m.	Introduction to Data Analytics Contractor – <i>Sandeep Kapoor, CEO HealthTech Solutions</i>
1:55 p.m.	Project Management Update – <i>Katie Falls, Mercer ACTION ITEM</i>
2:10 p.m.	Briljent update on Learning Collaborative w/PCPs – <i>Grace Chandler, Briljent</i>
2:30 p.m.	Regional Collaborative Report – <i>Miro Barac, SHIP Operations &amp; RC representatives</i>
3:10 p.m.	Break
3:25 p.m.	Population Health Presentation – <i>Elke Shaw-Tulloch, Division of Public Health ACTION ITEM</i>
3:35 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – February 2016): <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>Burke Jensen, 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, Family Health Center, IMHC Workgroup Chair</i></li> </ul>
4:15 p.m.	Blue sky, 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:

---

**SUBJECT:** Idaho Healthcare Coalition      **DATE:** February 10, 2016

**ATTENDEES:** Dr. Ted Epperly, Denise Chuckovich, Cynthia York, Dr. Andrew Baron, Josh Bishop, Scott Carrell, Ross Edmunds, Lisa Hettinger, Yvonne Ketchum, Deena LaJoie, Dr. Robert Polk, Susie Pouliot, Dr. Kevin Rich, Neva Santos, Mary Sheridan, Larry Tisdale, Anne Wilde Nikole Zogg

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

**Teleconference:** Dr. Mike Dixon, Russell Duke, Rene LeBlanc, Maggie Mann, Dr. Casey Meza, Daniel Ordyna, Dr. David Peterman, Dr. Bill Woodhouse, Sarah Renner, Grace Chandler

**Members Absent:** Director Richard Armstrong, Jeff Crouch, Melissa Christian, Dr. Keith Davis, Dr. Scott Dunn, Senator Lee Heider, Dr. Glenn Jefferson, Dr. David Pate, Tammy Perkins, Elke Shaw-Tulloch, Dr. Boyd Southwick, Representative Fred Wood

**DHW Staff** Ann Watkins, Miro Barac, Casey Moyer, Kym Schreiber, Taylor Kaserman, Alexa Wilson, Burke Jensen

**Guests:** Rachel Harris, Kim Thurston, Scott Oien, Gina Pannell, Melissa Dilley, Norm Varin, Gina Westcott, Todd York

**Mercer:** Katie Falls, Jenny Feliciano

**STATUS:** Draft 02/10/16

## Summary of Motions/Decisions:

---

**Motion:** Lisa Hettinger moved to accept the minutes of the January 13, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

Mary Sheridan seconded the motion.

Motion carried.

**Motion:** Mary Sheridan moved that the Idaho Healthcare Coalition accept the SHIP telehealth expansion concept and next steps as presented.

Dr. Andrew Baron seconded the motion.

Motion carried.

**Motion:** Neva Santos moved that the Idaho Healthcare Coalition (IHC) accept the Behavioral Health Integration Workgroup's concept and next steps as presented.

Dr. Kevin Rich seconded the motion.

Motion carried.

**Motion:** Susie Pouliot moved that the Idaho Healthcare Coalition adopt the Statewide Healthcare Innovation Plan (SHIP) Communications Plan materials as presented by Mercer.

Deena LaJoie seconded the motion.

Motion carried.

## Agenda Topics:

---

**Opening remarks:** "Growth is never by mere chance. It is the result of forces working together." James Cash Penney

- ◆ Dr. Epperly called the roll, and welcomed everyone.
- ◆ Dr. Epperly introduced Alexa Wilson the new SHIP Administrative Assistant II.

### Agenda Topics

**SHIP Operations Update**— *Cynthia York, Administrator, OHPI:*

- ◆ Ms. York announced the SHIP pre-implementation year concluded on January 31, 2016 and recognized the SHIP team, IHC and Idaho stakeholders for their dedication and work that shows in the progress that has been made. As of February 1<sup>st</sup> 2016 all agreements from Brilljent have gone out to clinics as a legal agreement between the Cohort 1 PCMH clinics and Brilljent and their subcontractors. The agreements are due back to Brilljent by February 12<sup>th</sup>. After they are signed, the Idaho Health Data Exchange (IHDE) will begin contacting the clinics and will send out business agreements needed to begin establishing a shared connection between the IHDE and Cohort 1 PCMH clinics.

- ◆ On February 9<sup>th</sup> 2016 Kym Schreiber sent out a welcome letter to the Cohort 1 clinics from the SHIP team outlining next steps. There will also be a Memorandum of Understanding (MOU) going out shortly between the department and Cohort 1 clinics. This document helps ensure the clinics have a description of the department's roles and responsibilities. The MOU also outlines the responsibilities of the clinics to engage in PCMH transformation, data and information collection and IHDE connectivity for all three model test years.
- ◆ A PCMH learning webinar has been scheduled for February 16<sup>th</sup> and the in-person learning collaborative is scheduled for March 2<sup>nd</sup> -3<sup>rd</sup> for Cohort 1 clinics and PHD Ship staff.

**Update on Contracts w/ PCPs, learning session training schedule – Grace Chandler, Briljent:**

- ◆ Ms. Chandler gave an overview on the clinic agreements that have been sent out to all clinics on February 2<sup>nd</sup> and 3<sup>rd</sup>. Briljent is already receiving signed agreements. Twenty clinics have returned their signed agreements as of today. The final due date for return of all documents is Feb. 12<sup>th</sup>; these are needed back before training begins in March. Dr. Epperly asked what will happen with clinics who have not returned agreements by February 12<sup>th</sup>. Ms. Chandler said that clinics that have not turned in the agreements will be contacted on February 15<sup>th</sup> to ascertain where they are at in processing the documents.
- ◆ Ms. Renner went over the incentive payment and progress measure tracking system in I-PAS. These reports will be in the PCMH portal and on the dashboard that HMA is creating for the clinics.
- ◆ Dr. Epperly asked when Briljent will request data from the clinics. Ms. Renner said the collection of data will occur automatically as information is added into the portal.
- ◆ Ms. Chandler also discussed the transformation training and technical assistance that clinics will receive. They have a very aggressive timeline to help train everyone on PCMH transformation. Every clinic will receive individualized training and assistance to achieve PCMH recognition. The kick off session will be next Tuesday, February 16, 2016 via webinar with clinics and Public Health District staff. Briljent will also distribute a self-assessment tool to help clinics determine their current PCMH status. The learning collaboratives are going to take place the first week of March at which time Briljent will develop a transformation plan for all Cohort 1 clinics. This plan will be reviewed in the monthly coaching calls as a mechanism to help assist clinics in their transformation along with monthly webinars. Briljent is asking clinics to bring administration staff and clinic leaders to the March 2<sup>nd</sup>-3<sup>rd</sup> learning collaborative.
- ◆ Ms. Chandler reviewed the agendas, training topics and learning tracks for all four days of the learning collaboratives. She also responded to questions from IHC members.
- ◆ Mary Sheridan asked if there would be any opportunity to provide an overview to clinics on the SHIP Community Health Workers and medical-health neighborhood components. Ms. Chandler stated that on both days there will be panel discussions on these topics as well as other SHIP programs. Ms. York thanked Pacific Source for providing funds to purchase breakfast for the participants on day one of the clinics' learning collaborative.
- ◆ Yvonne Ketchum asked what evaluation surveys would be administered to measure the success of the learning collaboratives. Ms. Chandler said there will be surveys and a debriefing at the conclusion of the learning collaboratives. A one page summary recapping each learning session will be provided by Briljent at next month's IHC meeting.

**Regional Collaboratives Update – Miro Barac, SHIP RC Project Manager, DHW:**

- ◆ Mr. Barac presented an update on the Regional Collaboratives (RC's). He congratulated the Public Health Districts on hiring excellent SHIP managers. Mr. Barac covered the timeline for the sub grant with the Public Health Districts and their progression since July, 2015. On November 5<sup>th</sup> 2015 there was a regional collaborative kick off to begin developing roadmaps for each of the collaboratives.

- ◆ Regional Collaborative Champions and PHD SHIP staff have recruited ten to fifteen people to serve on the RCs and are working on filling all of the vacant positions. All of the RCs are engaging in projects; however, it is still too soon to gauge what their overall direction and focus will be in each of the seven areas. The PHD SHIP Managers have been instrumental in the formation of these groups and the identification of RC projects.
- ◆ It was pointed out that RCs are really focused on the PCMH transformation and a critical part of that transformation will be including consumer representation on the regional collaboratives.
- ◆ The frequency, method and mode of communication from the RC's to the IHC was raised by Mr. Barac.
- ◆ Dr. Epperly opened the floor for IHC members to respond to these questions. Dr. Baron informed the group that they have tried reaching out to potential consumers to be on their RC but have not been successful in having a consumer join their collaborative. Josh Bishop asked if there was a patient board in Idaho that potential consumers could be drawn from for the regional collaboratives. Dr. Rich asked that there be more communication on what each regional collaborative is doing and that the RC Champions meet to share what each area is doing as a part of SHIP. Dr. Epperly suggested monthly phone calls, and posting information on the regional collaborative page of the SHIP website. Ross Edmunds also suggested reaching out to the behavioral health boards as a way to engage consumers in SHIP.
- ◆ Dr. Epperly asked for suggestions on how to measure successes of the RCs and next steps moving forward. In the upcoming IHC meetings two regional collaborative chairs will present updates on their collaborative, so that the IHC may stay informed on their activities. It was suggested that the RCS in Regions 3 and 4 be asked to present at the next IHC meeting.

**SHIP Telehealth Expansion Plan Update – Mary Sheridan, Bureau Chief Rural Health, DHW:**

- ◆ Ms. Sheridan presented a summary on the Telehealth Council goal two subcommittee. The Telehealth goals within SHIP are to expand and test Telehealth services. She discussed the outcomes of the Telehealth subcommittee November meeting. Discussion points were: 1) the need for a Telehealth-readiness assessment, 2) should program development pieces be provided, and 3) PCMH support mechanisms for providing Telehealth. The committee also concluded there was a need to establish measures for monitoring success and best practices for the use of Telehealth in these clinics. The subcommittee is seeking the support of the IHC for this plan.
- ◆ Dr. Epperly opened the floor for questions or clarifications. Josh Bishop inquired if legislative action was a part of the plan. Mary Sheridan responded that legislative action was not part of their charge as a subcommittee. The IHC approved the summary plan as presented.

**Results of Behavioral Health Integration Survey – Gina Westcott, Hub Administrator Behavioral Health, DHW:**

- ◆ Ms. Westcott presented on the behavioral health survey, she talked about how Behavioral Health is related to diabetes, tobacco cessation and obesity, three of SHIP's clinical quality measures. She went on to thank the Regional Collaborative chairs for their help and comments on the Behavioral Health Integration survey.
- ◆ The Behavioral Health Integration survey was created as a mechanism to assess the current status of BHI. Ms. Westcott went on to talk about survey questions and methodologies and presented survey results from participating clinics.
- ◆ Moving forward to enhance Behavioral Health Integration in these clinics; the next steps for achieving these goals will be: 1) developing partnerships; 2) designing BHI learning sessions, curriculum and educational topics; 3) outlining specific goals for Behavioral Health integration; 4) looking at how the BHI workgroup can provide assistance and 5) future development of a peer to peer support model for clinics.
- ◆ Dr. Epperly asked for a motion of support for the proposed action plan. Dr. Woodhouse commented on that sustainability for BHI at the clinic level was an important consideration. Josh Bishop asked what are the

levels of training professionals have in the clinics. Ms. Westcott provided a recap of survey results as to the current levels of BH professional capacity. With there being no further questions the IHC moved to accept the workgroup's next steps as presented.

**Communications Update: Slide Decks – Katie Falls, Principal Mercer:**

- ◆ Ms. Falls presented the slide decks prepared by Mercer for use by IHC members on SHIP PCMH transformation. There are 4 slide decks targeted for specific audiences that will be posted on the SHIP website for IHC member access. Mr. Moyer demonstrated the SHIP website, the IHC membership page and membership login protocols. The login user name and password will be sent to IHC members in the very near future.
- ◆ Mr. Moyer also noted the communications feedback form that will be on the IHC member side of the SHIP website to track when these new communications tools are being utilized.
- ◆ Ms. Falls explained how these key messages were developed. The Mercer team wanted to make sure there was a consistent message among the various audiences. These slide decks are master decks each of which holds more slides than may be needed to make sure the presentation is well tailored to each target audience. Ms. Falls reviewed each section of the slide decks. She pointed out that these are version one and will change as they are utilized and the IHDW team receives feedback on the presentations.
- ◆ Dr. Epperly asked for a motion for approval and opened the floor to comments. There was a discussion on the process of adding new slides, the required approvals for new slides, and timeframes for approval of new slides by DHW. The IHC moved to adopt the updated communication materials as presented by Mercer.

**SHIP Operations and Advisory Group Reports/Updates – Cynthia York, Administrator, OHPI:**

- ◆ Mary Sheridan provided an update on the Community Health Emergency Medical Services (CHEMS) workgroup. CHEMS met once in January and will meet again in February and March. CHEMS will be preparing recommendations for next steps which will be presented at a future IHC meeting.
- ◆ Mr. Jensen provided the following updates from the HIT workgroup
  - Scott Carrell has stepped down as chair of this workgroup. The HIT workgroup is considering the selection of a chair and co-chair, similar to the structure of the Multi-payer Workgroup.
  - A data mapping subcommittee was formed and has met once in January. Their charge is to address mapping of the clinical quality measures to advance data collection and reporting pathways.

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

- ◆ Dr. Epperly asked members if there were any proposed agenda items for upcoming meetings.
- ◆ Dr. Epperly also suggested that IHC members email Ms. York with any agenda topics for upcoming meetings.

There being no further business Dr. Epperly adjourned the meeting at 4:23pm.



Idaho Healthcare Coalition (IHC)  
March 9, 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 February 10, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared.

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

Motion Carried.

---

■ 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.

---

■ Action Item 3 – Population Health Definition

IHC members will be asked to accept the Population Health Workgroup concept and definition of population health as presented by Elke Shaw-Tulloch.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition accept the Population Health Workgroup's concept and definition of population health as presented.

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

Motion Carried.



State of Idaho  
Department of Health and Welfare  
Statewide Healthcare Innovation Plan (SHIP)  
Data Analytics

Idaho Healthcare Coalition Meeting

March 9, 2016



## HealthTech Solutions, LLC - Introduction

- ❑ HTS was formed in 2011 with a vision of providing unprecedented experience in successfully implementing major, mission-critical Health and Human Services (HHS) systems
- ❑ HTS is an independent consulting firm based in Frankfort, Kentucky our team is made up of more than 70 consultants and information technology professionals
- ❑ The HTS team has extensive experience in HIT/HIE and Medicaid Enterprise Systems operations
- ❑ Over the past four years HealthTech Solutions has served clients in over 16 states including Fortune 500 companies, Top 25 Managed Care Organizations, and 3 out of 4 Medicaid Management Information Systems vendors

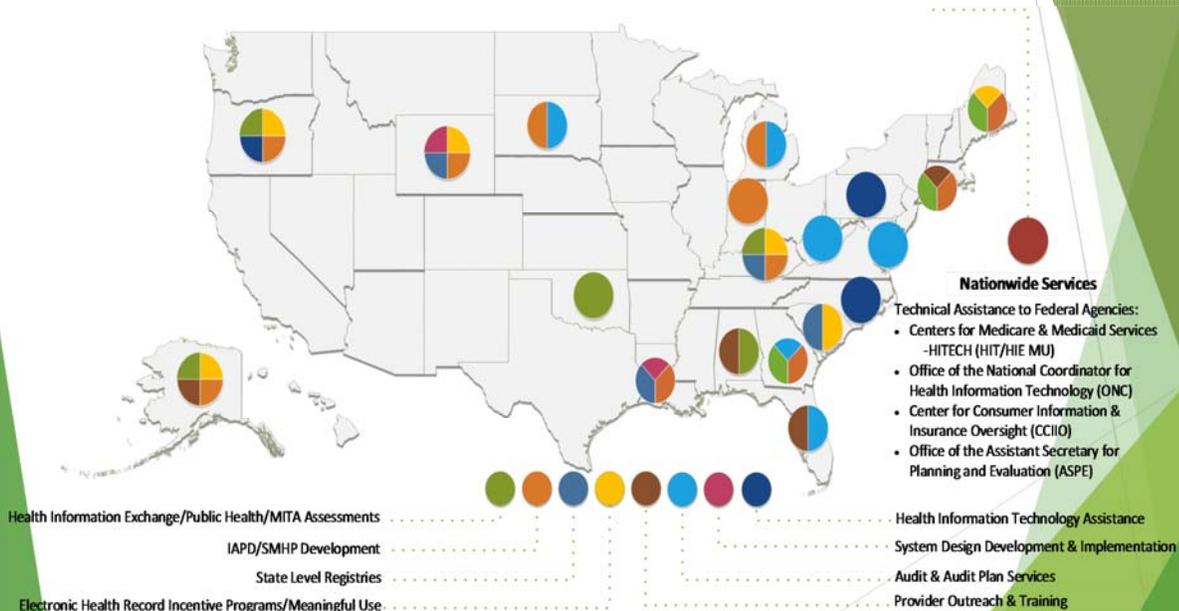


# Corporate Qualifications

- ❑ **IT Experience:** Our proposed team members have on average 20+ years of experience with health information technology systems design, development, implementation, and support
- ❑ **Mix of skillsets including:**
  - Project management
  - HIT/HIE policy knowledge
  - Business analysis
  - Programmers
  - Architects
  - System/network engineering
- ❑ **Healthcare Experience:** HTS has over 200+ years of subject matter expertise in HIT, HIE, EHR, and Meaningful Use implementations
- ❑ **Reputation for Delivery:** HTS has an outstanding reputation among our clients and we take pride in the following accomplishments:
  - *HTS has never been late on any of the deliverables on any of our contracts*
  - *HTS has always met its commitments and never been over-budget*
  - *Our unique thought-leadership approach and outlook ensures minimal risk*
  - *Clients value our contributions and have often rewarded us with repeat business*



# HTS Experience



# Case Example: Wyoming Analytics Project



## Wyoming Mission and Goals

“Our mission is to promote, protect, and enhance the health of all Wyoming citizens.”

### Historical state

#### Key characteristics

- Provider-centered
- Pay for volume
- Fragmented Care
- Focus on cost containment without focus on quality

#### Systems and Policies

- Fee-For-Service payment systems
- Fragmented information systems
- Lack of analytical capability to determine issues and outcomes

Public  
and  
private  
sectors

### Evolving future state

#### Key characteristics

- Patient-centered
- Pay for outcomes
- Coordinated care
- Quality health care focus as means to contain costs

#### Systems and Policies

- Value-based payment systems
- Patient Centered Medical Home Model
- Coordinated information systems
- Quality/cost transparency
- Population-based payments

## Building on What They Have

- ▶ CQMs measure quality very well
- ▶ Providers are required to submit CQMs to State Medicaid Agencies under Meaningful Use
- ▶ Incentive payment programs can be designed using CQMs as the standard measurement device
- ▶ Outcomes are dependent upon a starting point so that a patient's progress can be measured over time

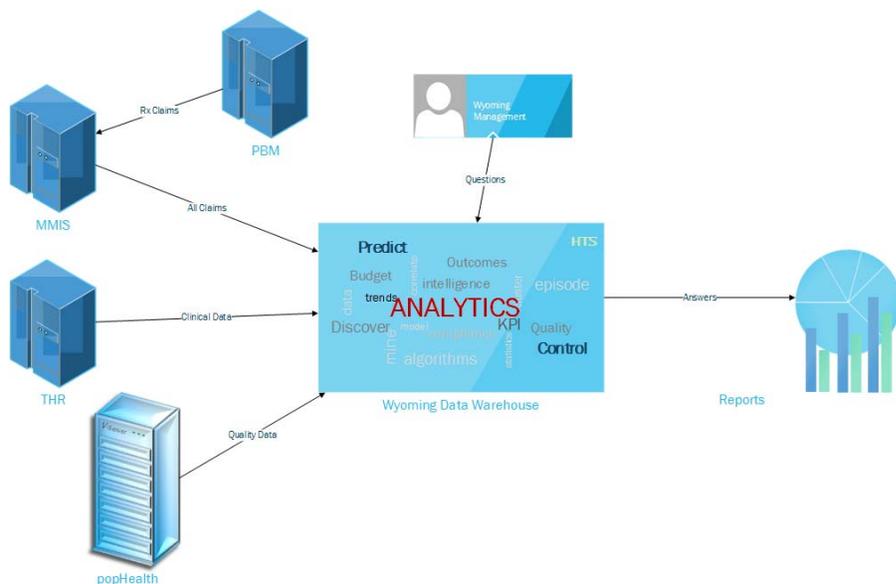
7

## HTS Solution for Wyoming

- ▶ HTS feeds parsed quality information into a data warehouse to be combined with existing claims and clinical sources from the Wyoming MMIS and Total Health Record systems.
- ▶ We created Provider, Claims, Member and Clinical universes
- ▶ From this integrated data set analysis can be performed to identify conditions, treatments, gaps in care and outcomes through the use of:
  - ▶ Heat Map Analysis
  - ▶ Data Exploration
  - ▶ Routine Reports
  - ▶ Web Intelligence® for convenient access

8

# Wyoming Overall Architecture



9

## HTS Data Analytics Solution Components

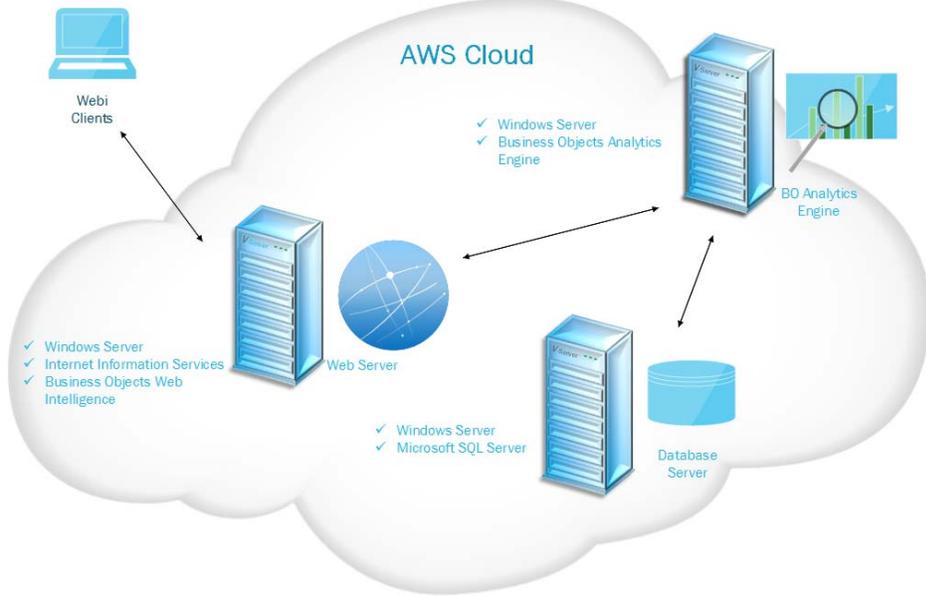
The HTS Data Analytics solution is developed using:

- ▶ SAP Business Objects Enterprise
- ▶ Microsoft SQL Server suite of products
- ▶ Hosted on a dedicated hardware on the Amazon Web Services (AWS) cloud.

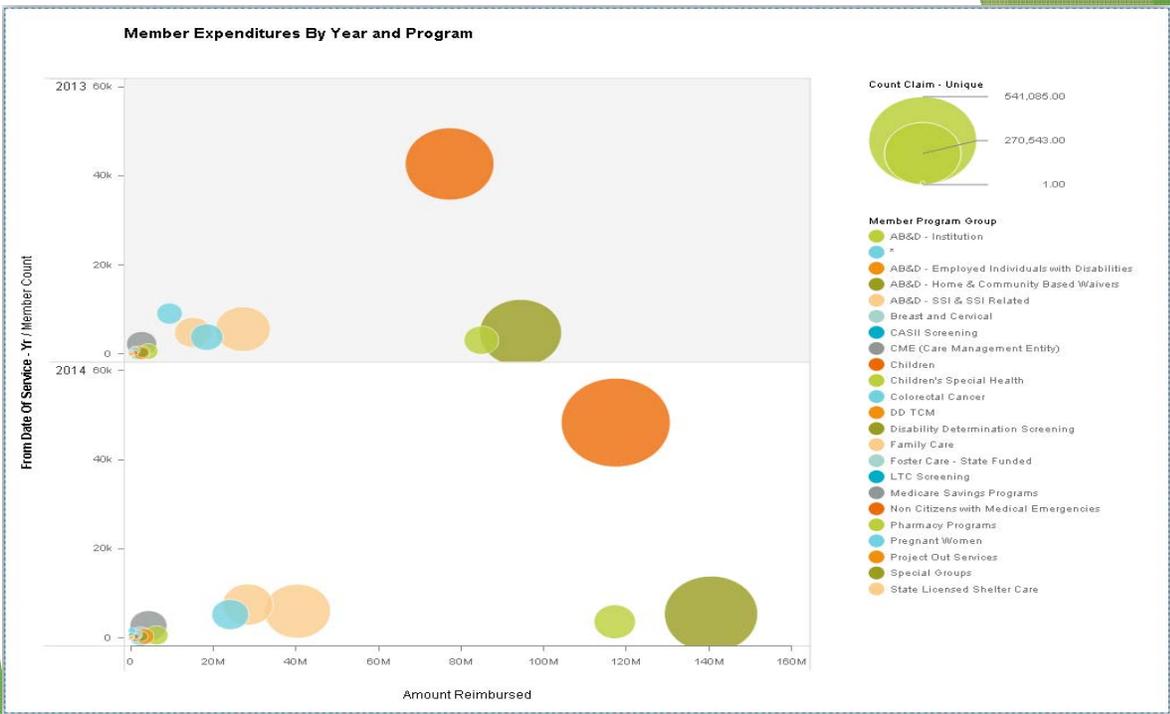
All 3 are leaders in the Gartner Magic Quadrants

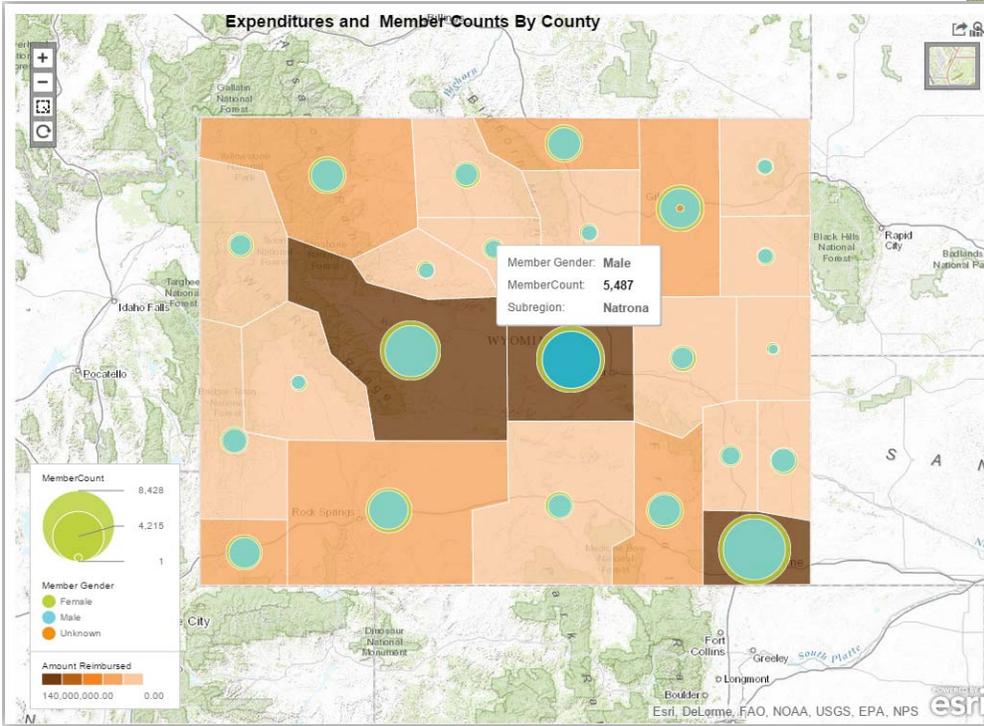
10

# Data Warehouse Architecture

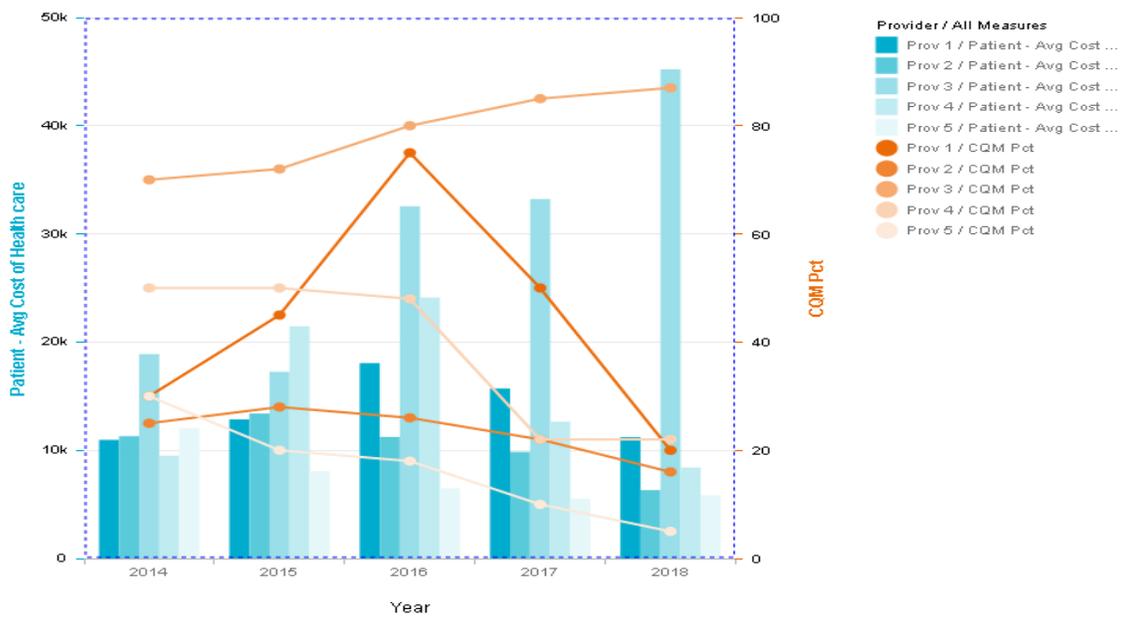


Sample Wyoming Reports :  
All data presented is fictitious





### CMS122v2-0059-Diabetes:Hemoglobin A1c Poor Control



## Wyoming Reports answer questions such as:

- ▶ What are the “actionable” interventions needed to improve outcomes that are specific to the Wyoming population
- ▶ How does the trend in Clinical Quality Measures for a provider relate to average healthcare spend for the patients included in that CQM reporting
- ▶ Medication reconciliation between claims and data in the total health record from the EHRs

17

# Questions?

**PCMH TRANSFORMATION TEAM**

**IHC PRESENTATION  
MARCH 9, 2016**



# 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 clinics that have:

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

### Results:

- 100% Success!
- 55 Clinics qualified for the \$10,000 incentive payment.



# PCMH Transformation Incentive Payment Measures

## Incentive Payment Measure 2:

### PCMH Recognition or Accreditation Program

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

- Oregon Patient-Centered Primary Care Home (PCPCH)
- National Committee for Quality Assurance (NCQA) PCMH Recognition
- 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 Progress Measures

## Progress Measures:

### Transformation Participation and Training

Monthly graphs will be provided on the Portal's Participation Dashboard 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%



**A Report on the PCMH Transformation Meetings in Boise, Idaho  
February 29 – March 3 2016**

# PHD SHIP STAFF LEARNING SESSION # 1

## FEBRUARY 29 & MARCH 1, 2016

- Held at the Pete T. Cenarussa Building, IDHW Central Office
- Met with the seven Public Health District (PHD) SHIP managers and QA\QI staff
- Content was “Practice Facilitation 101”
- HMA Team - Donna Strugar-Fritsch, Lori Weiselberg, Pat Dennehy and Nancy Jaeckels Kamp
- DHW SHIP Staff participating included Kym Schreiber, Miro Barac, and more

*What we learned: This enthusiastic group is ready to work but overall do not identify as experts, they will still benefit from continued training to become effective facilitators.*

*We have recommended additional training and coaching by HMA, and are in conversation with the state.*

# LEARNING COLLABORATIVE SESSION# 1

MARCH 2 & 3, 2016

- Held in Meridian, Idaho – at University of Phoenix
- A challenging but exciting start to our partnership
- A great meeting with engaged participants
- A surprising number of attendees arrived the day of the meeting and we are still reviewing the attendee list from both days. We counted 165 in the room on March 2.

*Despite a challenging space, HMA engaged with the teams and listened to their needs.*

*Thank you to our sponsor from PacificSource Health Plans for lunch.*

*We are planning the next webinar (#2) on April 19<sup>th</sup> –  
Electronic Health Records, Registries and Practical Applications  
to Population Health - Dr. Greg Vachon*

# LEARNING COLLABORATIVE SESSION# 1

MARCH 2 & 3 2016

- A very diverse cohort – about 50% have achieved PCMH III – Often with the 2011 NCQA program and they need to re-certify with 2014 standards, which was of interest to both advanced and early learners.

*We heard a request for support in mapping the differences and will plan a group coaching call on March 29, 2016 (11:30-12:30 PT / 12:30-1:30 MT). We will send more information later this week.*

# LEARNING COLLABORATIVE # 1

## EVALUATIONS

What the clinics told us in the evaluations was most helpful in the meeting:

- “Discussions with leaders from around Idaho”
- “Networking with other clinics”
- “Time with our coach and team mates away from work to plan”

Note: Evaluations to still be compiled





# SPECTRUM OF POPULATION HEALTH

## Population Health Workgroup

VERSION 5.0 – DRAFT – March 2, 2016

### Introduction

Due to the continued discussions about what is meant by the term population health, the Population Health Workgroup has developed a functional definition of population health for use by the Idaho Healthcare Coalition, Regional Health Collaboratives and SHIP partners to align conversations and provide for a more robust understanding of the spectrum of perspectives about population health.

### Background

Depending on your perspective, whether you are part of a healthcare organization or office or are a public health practitioner, you could potentially define population health differently. The healthcare sector leans toward measuring the health of specific subpopulations they serve and for which they are accountable and paid (population health management). Public health leans toward a more broad view of populations such as the population of people living within a geographic area with specific, similar health conditions, issues or demographics, regardless of how they are counted among a patient population (total population health); for example, public health may look at the number of low income people living in health district 2 with type 2 diabetes. We also know that your perspective and involvement in population health and population health management, impacts either very narrowly or broadly the health of the population, without necessarily considering the narrow or broad influence on the other.

Regardless of the vantage point for population health, the fundamental premise is changing behavior and moving toward better health outcomes for populations, narrowly or broadly defined. The relationship between the individual, clinical, provider-level responses to the broader, community-wide response is important and the bridge between the local, narrow impact and broad impact and finding common ground is important. The following language and schematic are designed to form the basis of a dialog between constituents that influence health at the local level through the constituents that influence health at the broad level and the spectrum of influence on population health.

To organize this conversation into areas of focus, the Centers for Disease Control and Prevention (CDC) has developed the following concept (modified) to help describe patient

health, population health and prevention. Bucket one describes what we commonly understand to occur in the clinician setting with a single patient as a one-on-one interaction. When we think about factors that affect health, clinical interventions have a narrower impact. Bucket two describes that intersection between the individual clinical patient care with an extension into the community for support to achieve a larger health impact. This is sometimes called clinical-community linkage. Bucket three describes a broader approach that has a larger impact on health because it helps change the environmental context to help make the individuals' choice to be healthy the easy choice. With a community wide focus and community construct it is more likely that socioeconomic factors and social determinants of health can be addressed. To further elaborate on the three buckets and their intersection and fluidity, a healthcare provider operating in a small rural clinic might not consider how their practice for managing their patient population who smokes might influence the smoking behaviors of the surrounding community. Conversely, the policies, practices and culture in their community related to smoking might influence the behavior of their patients who smoke. The provider might simply tell an individual patient to quit smoking without providing any resources. Or they might have a referral mechanism to cessation resources – either in person, online and/or telephonic – that are free. The cultural norm of the community might be very supportive of smokers through limited clean indoor air policies, easy access to tobacco products and an “everyone is doing it” mentality. The cultural norm of the community might be the opposite and support people in quitting, limit where smoking is allowed, having an active public health district and city council on which the physician can participate to influence the cultural norm through policy work so the healthy choice for their patient population of smokers is the easy choice.

<b>Bucket #1: Traditional Clinical Approaches</b>	<b>Bucket #2: Innovative Clinical Care Patient-Centered</b>	<b>Bucket #3: Community Wide Health</b>
Focused on an individual; patient construct		Focused on broad population; community construct
Typical clinical services done in a one on one patient interaction	Linkages that support patients in the community	Broader, mostly policy-focused
<b>DIABETES Example</b>		
Screening for pre-diabetes, diagnosis, treatment, medication, clinical guidance, A1C monitoring, eye exam, foot exam	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; policies to reduce tobacco usage and trans fats in foods
<b>OBESITY Example</b>		
Diagnosis, medication, weight and height to calculate body mass index and monitor, blood pressure, cholesterol screening, physician/patient counseling	Linkages and referrals to Diabetes Self-Management Education (DSME) classes, Registered Dietician-Nutritionist referral, dental referral and cavity risk assessment, CHW or CHEMS support for blood sugar monitoring and medication management	Community policy and practice to provide healthier communities; easier access to physical activity and proper nutrition; mandatory changes in school vending and physical education courses
<b>TOBACCO Example</b>		
Screening patients for smoking, ensuring smoking cessation referral, physician/patient counseling	Linkages that support patients in community or medical-health neighborhood, linking patient to cessation class or quitline	Practices and policies across to lower smoking rates statewide (clean indoor air policies, tobacco tax, etc)

### The Spectrum of Population Health

The graphic below depicts the spectrum of population health from the individual, provider and local impact to the broader impact of the community at large which includes policies, community supports, etc. All levels of the spectrum are influenced by the social determinants of health.

# Spectrum of Population Health



## Conclusion

The purpose of the Population Health Workgroup, as an arm of the Idaho Healthcare Coalition, is to support the Regional Health Collaboratives in the development of tools and messages that support their work to help transform primary care within their region and improve the health outcomes of the patients served in the clinics and the people living within their communities.

This is done through educating the medical-health neighborhood about what the spectrum of population health entails and how each level or point in the spectrum (bucket) is interrelated with the next. Collectively, population health is shared accountability for improving health outcomes for all Idahoans by bridging the gap of community determinants of health and the emphasis on healthier lifestyles through interventions, policies and data, to include preventative care, physical activity, nutrition and behavioral risk reduction as they relate to the Triple Aim.



# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition March 9, 2016

## **SHIP OPERATIONS:**

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

- **Report Items:**
  - The Data Analytics Contractor, Healthtech Solutions, LLC has executed their contract and has commenced work on the SHIP project.
  - The University of Idaho has been selected as the State Evaluator and we are awaiting release of funds from CMMI for commencement of the contract.
  - Brilljnt, LLC has executed a Year 2 contract for PCMH transformation.

### **SHIP Administrative Reporting:**

- **Report Items:**
  - Report submitted to the Governor for IHC Activities for SFY Quarter 2 (October 1, 2015-December 31, 2015)
  - Progress Report submitted to CMMI for Q4 2015 (November 1, 2015 – January 31, 2016)
  - FFATA Report for SHIP contractors and sub-grantees submitted February 17, 2016

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

- **Report Items:**
  - Public Health District staff is actively engaged in the PCMH transformation work with the first cohort of selected clinics. All staff attended a four day Learning Collaborative in Boise, February 29 – March 3.
  - The Regional Health Collaboratives have been meeting across the State. The Executive Leadership Members will be reporting on the progress of their RCs at the IHC March meeting.
  - PHD SHIP Programs are in the process of creating Operational Plans.
- **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:**
  - Telehealth SHIP Subcommittee met twice to further review and refine the Telehealth implementation plan. As part of the process, the Subcommittee engaged Oregon State

Office of Rural Health to survey processes and documentation related to Telehealth implementation as part of the Oregon's SIM grant.

- Working with Mercer, IDHW SHIP staff is preparing the Project Management Plan related to the virtual PCMH module of the SHIP grant.

- **Next Steps:**

- Engage the first cohort clinics in the process of determining Telehealth opportunities and challenges.
- Create a Telehealth assessment tool for CHEMS providers.

CHW

### Community Health Workers:

- **Report Items:**

- CHW Workgroup continues to pursue options with the Idaho State University representatives to finalize curriculum adoption and training delivery.
- CHW Workgroup met with the IDHW Diabetes, Heart Disease and Stroke Programs to coordinate outreach in identifying and recruiting potential CHW students for the first training cohort.

- **Next Steps:**

- The CHW Workgroup continues to engage stakeholders in soliciting best practices.
- The CHW workgroup is actively engaging stakeholders for a workshop on outcome measures, tentatively projected to take place in May.

CHEMS

### Community Health EMS:

- **Report Items:**

- The CHEMS Outcome Measures Design Workgroup met on February 25th at the Best Western Inn at the Airport for the second in the series of three meetings. The goal of this meeting was to:
  - Refine and work toward consensus on preliminary CHEMS measures
  - Examine and discuss data collection options
- Next meeting is scheduled for March 24, 2016

- **Next Steps:**

- 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:**

- No meetings have been scheduled. Nothing to report at this time.

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

## **HIT** Health Information Technology:

- **Report Item:**
  - Key Data Element Mapping Subcommittee members met to determine the best method of operationalizing the clinical quality measures.
  - The HIT Workgroup met on February 18, 2016.
    - HealthTech Solutions provided a demonstration of their solution.
    - The HIT Workgroup approved the motion to allow the Data Element Mapping Subcommittee to work directly with the Clinical Quality Measures Workgroup when making recommended changes to the clinical quality measures, while keeping the HIT Workgroup informed.
    - The Data Element Mapping Subcommittee will make recommendations to modify the clinical quality measures when HIT issues create barriers to operationalize reporting on the measures.
- **Next Steps:**
  - The IHC will appoint two new HIT Workgroup co-chairs in the coming weeks.
  - The next HIT Workgroup is scheduled to meet on March 17th.
  - IHDE will continue to complete the readiness assessments for establishing bi-directional connections with the clinics.
  - The next Data Element Mapping Subcommittee is scheduled to meet on March 10<sup>th</sup> and will continue the work of determining how to operationalize the clinical quality measures.

## **MPW** Multi-Payer:

- **Report Item:**
  - The workgroup is scheduled to meet on March 9. Topics for discussion include:
    - SHIP operations update and information about PCMH cohort 1.
    - Each Payer will present status on their organizations efforts to move to value based payment models
    - Self-funded update
    - Discussion on Population-based payment financial benchmarking
  - A verbal update of the outcome of the MPW March 9, 2016 meeting will be presented at the March 9, 2016 IHC meeting.

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

- **Report Item:**
  - No meetings have been scheduled. Nothing to report at this time.
- **Next Steps:**
  - Future meetings will occur ad hoc.

**BHI****Behavioral Health:**

- **Report Item:**
  - The BHI Sub-Committee met on Tuesday, February 2, 2016.
  - Reviewed and provided feedback for the final presentation to the IHC on February 10, 2016.
  - The BHI Sub-committee agreed to adjust the meeting schedule to every other month for the next 6 months.
  - The committee established a workgroup that will work towards supporting a Behaviorist Peer to Peer Consultation model.
  - The committee was introduced to the new HIT/Data Analytics Contract Monitor, Burke Jensen.
  
- **Next Steps:**
  - Gina presented the results and next steps to the IHC on the findings of the BH Integration survey at the February 10<sup>th</sup> IHC meeting. The IHC supported the next steps which include:
    - Working with the PCMH contractor to develop specific BH training topics.
    - Outlining areas of needed BH training for PHD staff.
    - Identifying clinics with BH expertise that are willing to provide assistance to PCMH clinics.
    - Pursuing a Behaviorist Peer to Peer Learning Model.
    - Looking for additional grant funding.
    - NASHP has offered to provide additional TA training targeted to PHD staff. Will work with the PHD contractor and SHIP staff to ensure there is not duplication of training efforts. Training is being planned for April/May.
    - A Peer to Peer Learning Model workgroup meeting has been set for Thursday, March 10<sup>th</sup>.
    - The next meeting will be April 5, 2016 at 1720 Westgate Drive.

**PHW****Population Health:**

- **Report Item:**
  - The workgroup did not meet for the month of March.
- **Next Steps:**
  - The workgroup's next meeting will be held on April 6<sup>th</sup>, 2016.