



# Idaho Healthcare Coalition

## Meeting Agenda

Wednesday, May 18, 2016, 1:30PM – 3:30PM

JRW Building (Hall of Mirrors)  
1<sup>st</sup> Floor East Conference Room  
700 W State Street, Boise, Idaho

Call-In Number: 877-820-7831; Participation Code: 302163

Attendee URL: <https://rap.dhw.idaho.gov/meeting/39226944/827ccb0eea8a706c4c34a16891f84e7b>

Attendee Smartphone URL:

<pulsesecure:///method=meeting&action=join&host=rap.dhw.idaho.gov&meetingid=39226944&signin=rap.dhw.idaho.gov%2Fmeeting%2F&stoken=827ccb0eea8a706c4c34a16891f84e7b>

Password: 12345

1:30 p.m.	Opening remarks, roll call, introduce any new members, guests, any new DHW staff, agenda review, and approval of 04/13/2016 meeting notes – <i>Dr. Ted Epperly, Chair</i> <b>ACTION ITEM</b>
1:40 p.m.	Idaho Caregivers Alliance - Update on the work of the Caregiver Task Force – <i>Sarah Toevs PhD, Boise State University</i>
2:00 p.m.	CHEMS Measures Update - <i>Mary Sheridan, Public Health, Mark Babson Ada County Paramedics</i> <b>ACTION ITEM</b>
2:20 p.m.	Update on HIPAA and Behavioral health records (EMR records) BHI – <i>Ross Edmunds, Behavioral Health</i>
2:30 p.m.	Communication Materials Update – <i>Katie Falls, Mercer</i> <b>ACTION ITEM</b>
2:45 p.m.	Briljent Portal Demonstration – <i>Sarah Renner, Myers and Stauffer</i>
3:00 p.m.	Regional Collaboratives Update – <i>Dr. Keith Davis, South Central Public Health District and Dr. Bill Woodhouse, Southeastern Idaho Public Health District</i>
3:10 p.m.	SHIP Operations and Advisory Group Reports/ Updates – Please see written report (SHIP Operations and IHC Workgroup Reports – April 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 Josh Bishop, PacificSource, Workgroup Chairs</i></li> <li>• Clinical Quality Measures Workgroup – <i>Dr. Andrew Baron, Terry Reilly Clinics, Workgroup Chair</i></li> <li>• Behavioral Health 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>
3:20 p.m.	Additional business & next steps – <i>Dr. Ted Epperly, Chair</i> Tribute to Denise – work she has done to help in Idaho’s Healthcare transformation
3:30-4:30 p.m.	<b>Adjourn – Denise’s Retirement Celebration</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:** IHC April Minutes

**DATE:** April 13, 2016

**ATTENDEES:** Dr. Andrew Baron, Josh Bishop,  
Denise Chuckovich, Russell  
Duke, Lisa Hettinger, Yvonne  
Ketchum, Deena LaJoie, Carol  
Moehrle, Dr. Robert Polk, Geri  
Rackow, Dr. Kevin Rich, Neva  
Santos, Dr. Dave Schmitz, Elke  
Shaw-Tulloch, Mary Sheridan,  
Larry Tisdale, Lora Whalen,  
Jennifer Wheeler, Cynthia York,  
Nikole Zogg, Katherine Hansen

**Teleconference:** Scott Carrell, Dr. Mike Dixon, Dr.  
Scott Dunn, Susie Pouliot, Karen  
Vauk, Anne Wilde, Janet Willis,  
Pat Dennehy

**Members Absent:** Director Richard Armstrong,  
Melissa Christian, Jeff Crouch,  
Dr. Keith Davis, Ross Edmunds,  
Dr. Ted Epperly, Lee Heider, Dr.  
Glenn Jefferson, Rene LeBlanc,  
Maggie Mann, Nicole McKay,  
Casey Meza, Daniel Ordyna, Dr.  
David Pate, Tammy Perkins, Dr.  
David Peterman, Dr. Boyd  
Southwick, Dr. Fred Wood, Dr.  
Bill Woodhouse

**Guests:** Janica Hardin, Ethan Mansfield,  
Linda Rowe, Norm Varin, Matt  
Wimmer, Rachel Harris and Gina  
Pannell

**IDHW Staff:** Miro Barac, Wayne Denny, Burke  
Jensen, Taylor Kaserman, Casey  
Moyer, Kym Schreiber, Ann  
Watkins, Alexa Wilson

**Mercer:** Katie Falls, Jennifer Feliciano

**STATUS:** Draft (04/19/2016)

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

## Summary of Motions/Decisions:

---

**Motion:**

Jennifer Wheeler moved to accept the minutes of the March 9, 2016, Idaho Healthcare Coalition (IHC) meeting as prepared with edits to the attendance list.

**Outcome:**

Lisa Hettinger seconded the motion.

Motion carried

Dr. Baron moved that the Idaho Healthcare Coalition recommend the governor appoint Katherine Hansen to the IHC.

Russell Duke seconded the motion.

Motion carried

Neva Santos moved that the Idaho Healthcare Coalition adopt the SHIP Communications Plan dashboard as presented by Mercer with minor edits.

Katherine Hansen seconded the motion.

Motion carried.

Lora Whalen moved that the Idaho Healthcare Coalition accept the CHEMS advisory group's transition to a workgroup as presented by Mary Sheridan.

Elke Shaw-Tulloch seconded the motion.

Motion carried.

Neva Santos moved that the Idaho Healthcare Coalition adopt the updated Clinical Quality Measures for the SHIP as presented.

Mary Sheridan seconded the motion.

Motion carried.

Neva Santos moved that the Idaho Healthcare Coalition accept Josh Bishop as co-chair of the Multi-Payer Workgroup.

Lisa Hettinger seconded the motion.

Motion carried.

Dr. Baron moved that the Idaho Healthcare Coalition accept Janica Hardin as co-chair of the Health Information Technology Workgroup and recommend the governor appoint her to the IHC.

Lisa Hettinger seconded the motion.

Motion carried.

## Agenda Topics:

---

**Opening remarks, Introductions, Agenda review, Approve minutes –**

- ◆ Denise Chuckovich called the roll, and welcomed everyone to the meeting.
- ◆ Katherine Hansen was introduced to the IHC and gave a brief bio as well as her role as executive director of the Community Partnerships of Idaho, Inc. She also provided an overview of the services provided by Community Partnerships of Idaho, Inc.
- ◆ Denise Chuckovich requested a motion to approve the minutes from March 2016, and to approve the recommendation that the governor appoint Katherine Hansen to the Idaho Healthcare Coalition.
- ◆ The IHC members were informed of a date change for the May meeting from May 11<sup>th</sup> to May 18<sup>th</sup> due to a conflict in dates with the Idaho Healthcare Summit.

**Agenda Topics**

**Workforce Development Presentation – *Dr. David Schmitz, Chairman, Idaho Health Professions Education Council and Ethan Mansfield, Economist, Idaho Department of Labor***

- ◆ Dr. David Schmitz presented on behalf of the Idaho Health Professions Education Council. Dr. Schmitz gave a background on what the council does and their reporting to the governor on recommendations for what health educational activities benefit Idahoans.
- ◆ Ethan Mansfield who works at the Idaho Department of Labor as a regional economist presented on the new approach they used to analyze Idaho physician workforce data. This research was done to identify where physicians are located in the state as well as age and specialty demographic data. The data available from the Idaho State Board of Medicine also gives them additional information which they will further analyze. Their work links the Idaho Department of Labor with the Idaho State Board of Medicine.
- ◆ Research methodology looked at the number of physicians in covered employment in Idaho – e.g. are they covered by unemployment insurance (UI). In comparing the raw numbers they found a gap of 400 jobs held by physicians who are not covered by UI. Additionally they also found that 227 jobs may be attributable to physicians working with multiple employers.
- ◆ They cross matched addresses by county, rural and urban designations. For this study urban is defined as a hub county with one county in each region labeled as urban that has the largest population. This research allowed them to identify gaps in physician workforce by area. Their report showed the distribution of doctors in both urban and rural areas.
- ◆ For example, Ada County employs almost half of the physician workforce within the state. There are seven urban counties within the state. They also looked at specialties by district, compared and contrasted urban and rural specialties by district. The larger the urban hub the more specialties of medicine. There are only six specialties in rural areas of district four.
- ◆ Looking at the age of physicians in both rural and urban Idaho they found that 37% of doctors are over 55 in rural areas of Idaho; 58% of the workforce in district one's rural area is over the age of 55. They also looked at the number of physicians within family practice.
- ◆ Dr. Schmitz followed the presentation with examples of why this information is important.
- ◆ The IHC members asked questions regarding their research and the study. Yvonne Ketchum asked about the timeframe of the study. The data was pulled in October 2015. Ms. Ketchum also asked if they can benchmark this data on a per capita base, Ethan Mansfield answered that yes they could do this.
- ◆ Janica Hardin asked if the specialty took into consideration credential or operational specialty. They looked at the Idaho State Board of Medicine's information that showed the specifics of specialties, but to do further analysis of the data requires more funding.
- ◆ Dr. Scott Dunn asked if they did an analysis with an overlay of general population e.g. if half the population is in Ada County; it would make sense that half the states physicians are located there as well. It would be interesting to look at equity issues using economic data and a similar research model.

**Communications Materials and Dashboard – Katie Falls, Mercer & Jenny Feliciano, Mercer:**

- ◆ Jennifer Feliciano presented an example of the Dashboard draft that Dr. Epperly had requested at the January IHC meeting. This dashboard would be updated on a quarterly basis. Ms. Feliciano went through the layout of the dashboard, segmented by goal and the related measures/metrics. She also reviewed the colors codes, their definitions and how the data is collected.
- ◆ Ms. Feliciano asked the IHC members if they had any questions. Members asked if any data on the measures has been collected yet. Data has not yet been collected but Mercer and the IDHW SHIP teams are working on it and will have the first dashboard populated with data at the June IHC meeting. Casey Moyer gave an explanation of the data to be collected, reporting frequency and why?
- ◆ Denise suggested that headings be inserted in the boxes on page two of the dashboard key (to aid in goal identification). On page 1, Janica Hardin also suggested inserting the number or value associated with each measure in the corresponding bubble to add additional clarity. Ms. Feliciano will look into putting the percentage in and will work on that further.
- ◆ Katie Falls gave an update on the communication tools that Mercer has been producing; the latest is a poster for clinics to post in their lobbies talking about what a medical-health neighborhood. This tool will be available following suggested edits and approval from the IHC.
- ◆ IHC members had several questions regarding the poster and its graphic design. Members wanted to know where the patient centered medical home was on the graphic; currently there is not one however this will be added. They also wanted to know if there would be an online version and if there would be website links listed for the medical-health neighborhood locations depicted on the graphic. This is a possibility but will require a lot more work and collaboration with the Regional Collaboratives. Primarily this is for patients to help them determine what resources are available to them in their medical-health neighborhood.
- ◆ IHC members also wanted to know if the poster had been reviewed by patients and if they had gotten feedback from that target audience. It has not been vetted by patients, it is at a slightly higher reading level than the general population, but the SHIP and Mercer teams will talk internally to see if it is possible to get patient feedback. Members would also like these changes to the graphic: 1) designated spot for a medical home, 2) a behavioral health clinic, and 3) Josh Bishop mentioned that amongst providers Health Plan is a more preferable phrase over Insurance Provider which is also missing from the graphic and 4) less text on the poster is recommended. Members also asked that “Nutrition Specialists” be changed to “Nutrition”.
- ◆ Mary Sheridan wanted to know if this poster would be used for both the patients and providers and does it align with the definition of the medical-health neighborhood. Casey Moyer responded that it does align with the definition of the medical-health neighborhood. Casey also asked if the SHIP Cohort clinics and medical-health neighborhood participants would like to have a hand out with similar information in addition to the poster. The IHC members liked this idea and a medical health neighborhood fact sheet will be produced to align with the poster. Katie and the Mercer team will work with the SHIP team to address these edits, present the updated product at the May meeting
- ◆ The Mercer team has also developed a multipage hand out on the Virtual PCMH that will be presented at the May meeting. They are also developing a brief survey on use of communication tools that will be available in May. They would like suggestions for the next piece for development to augment the toolkit. The English and Spanish version of the patient brochure will be available by this Friday.

**Results of Learning Collaborative Evaluations and Coaching Call Updates – Pat Dennehy, HMA:**

- ◆ Pat Dennehy went over the survey results from the learning collaborative that occurred on March 2-3, 2016 with cohort one clinics. Overall the feedback for both days was very positive; however day one showed a lower satisfaction rate but on day two the satisfaction rate went up.

- ◆ Ms. Dennehy went over what material from the learning collaborative was most helpful to attendees according to the returned surveys. The coaches were able to learn a lot about what people/clinics wanted to work on as part of their transformation plan. There are some topics that are more interesting to clinics than others. There are also areas of interest specifically focused on how to help clinics achieve PCMH recognition.
- ◆ Ms. Dennehy went over what the positive comments were from the first day and what attendees found most helpful; mostly they wanted more detailed information.
- ◆ On the second day they kept the clinics together which worked well and everyone seemed to really enjoy the team time and networking time spent on day two.
- ◆ A lot of positive comments on leadership and change on day two- the examples and scenarios given were helpful. They only received six negative comments on day two.
- ◆ The HMA team has met since the learning collaborative and is working to incorporate this feedback and come up with ways to make the next learning collaborative even better and more effective. The coaches have engaged with their clinics in coaching calls since the learning collaborative and these are helping as well.
- ◆ The next webinar is scheduled for April 19<sup>th</sup> on population health. There is also a group coaching call that is being scheduled in May. Ms. Dennehy answered additional questions from IHC members on the results of the surveys.
- ◆ Denise Chuckovich asked if there was a way to get feedback from the group coaching calls, and yes they will be getting feedback on these soon. Once they have this information they will provide an update to IHC.

**CHEMS Update and Transition to Workgroup** – *Mary Sheridan, Bureau Chief, Bureau of Rural Health and Primary Care:*

- ◆ Casey Moyer went over the differences between an advisory group and a SHIP workgroup. Advisory groups exist outside of the IHC and SHIP. An example of this is the Telehealth subcommittee which is linked to the Idaho Telehealth Council e.g. outside of SHIP and the IHC. Often these are time limited groups that oversee the advisory groups.
- ◆ Workgroups are housed under the IHC because they are a sole source entity related to the IHC and are not attached to another group or department. The CHEMS group is now asking to become a workgroup because the CHEMS taskforce that initially provided oversight of the advisory group is now gone. A considerable amount of work has been accomplished by the CHEMS measures workgroup. The culmination of their work will be presented at the May meeting. Therefore it is proposed that CHEMS move to IHC workgroup status and continue to meet regularly to achieve the SHIP CHEMS initiative.
- ◆ Mary Sheridan presented on the CHEMS initiative that is within SHIP and what is being established statewide as a part of SHIP. Mary Sheridan and Wayne Denny will chair and co-chair this workgroup.
- ◆ IHC members asked questions about advisory group members transitioning with the workgroup; nearly all of them will continue with CHEMS as it transitions.

**Regional Collaboratives Update** – *Lora Whalen, Panhandle District RC (Region 1) & Dr. Andrew Baron, Southwest District RC (Region 3):*

- ◆ Lora Whalen presented on what Region 1 is currently working on as a regional collaborative. They have diverse representation of medical professionals on the collaborative. Early successes included a meeting with Cohort One Clinics on March 30<sup>th</sup> to discuss quality improvement and indicators chosen by SHIP. The collaborative also identified QI measures within their region. Some initial regional measures they are considering are: 1) dental-fluoride varnish use and 2) over prescribing of opiates. The group then split up by specialty to have focused discussions. Participants were excited following the meeting. The regional

collaborative is now working to get feedback on the meeting. The regional collaborative would like help in getting baseline data for at least the first three measures. Everyone except one clinic in their region is using the same EHR-Nextgen.

- ◆ Dr. Dunn added that there was some enthusiasm around incorporating Telehealth but there are problems with Telehealth reimbursement that the payment reform group should be aware of as a future consideration.
- ◆ Dr. Baron presented on Region 3 collaborative. They have had four monthly meetings with about twenty people on the collaborative. They have a wide range of representation within the medical community. They have formed workgroups focusing on: 1) senior health - to work with the senior population on fall risk assessment and how to better reach this community; 2) Hispanic/Latino health issues and 3) a Behavioral Health Integration workgroup who are working with Gina Westcott, DHW Behavioral Health to improve mental health services within in their regional collaborative, and within their PCMHs. The PCMH support groups are also trying to get clinics to look at their goals and related timelines and how will they be able to achieve these goals. A challenge that they face is surrounding access to data as well. They want to zero in and focus on projects where there is room for improvement. The PCMH workgroup meets tomorrow.
- ◆ Casey Moyer gave an update on the availability of data which is a challenge that is being worked on by the HIT data element mapping subcommittee and HealthTech Solutions. There will be limited data for year one on the first four clinical quality measures. There are changes to the way data is being collected and these data collection protocols will be developed and refined over the next three years. IHDE does not necessarily have the exact details that are needed for the data collection on the current quality metrics. IHDE is currently building out connections which will help HealthTech Solutions to normalize the data when they get it. SHIP is looking at the end of this year before data is available on the first four clinical quality measures. They might be able to create baselines from previous data from the EHRs. At the RC level there are several data sources to use to obtain this data.
- ◆ Elke Shaw-Tulloch commented that the division of population health has some of this data but they need to know what data would be useful to the clinics. Scott Carrell commented that they have conducted readiness calls with the majority of clinics and there will need to be course adjustments. They won't be able to have one standard approach to connection and data collection. Mr. Carrell also spoke about consulting with Oklahoma and what they have done to set up connections and collect the data they need.
- ◆ Denise Chuckovich clarified that we have the statewide clinical quality measures that we are committed to but the regional collaboratives might be interested in regional data specific to their location.
- ◆ Casey Moyer also commented that this is not just about data flows but also about improvement of communications.

**Clinical Quality Measures Update – Dr. Andrew Baron, CQM Chair:**

- ◆ Dr. Baron presented on the year one clinical quality measures. Originally these measures were developed over three years ago. Last Thursday the clinical quality measures workgroup reviewed the first four measures. They reached consensus on the first four measures and modified them to align with SHIP and national criteria.
- ◆ Dr. Baron went over what these four measures were and the changes that were made since they were first proposed. Dr. Baron took questions regarding selection criteria for these measures. Mary Sheridan asked a question on measure three and why they choose to look at the data of patients with A1C higher than nine, Dr. Baron answered that is was because studies have shown it is a better way to collect data on diabetes.
- ◆ Discussion continued around what these measures meant and how they would be recorded and by whom.

**Co-Chair for Multi-Payer and HIT Workgroups – Casey Moyer, DHW:**

- ◆ Casey Moyer presented the new proposed co-chairs for both the HIT and MPW workgroups.

- ◆ The recommended co-chair for the HIT workgroup is Janica Hardin. She has been with Saint Alphonsus for eight years and is now the director of informatics and analytics, charged with data extraction.
- ◆ There is a proposal for Jeff Crouch's position as co-chair of the MPW group to rotate to Josh Bishop. Josh is the vice president and Idaho regional director of Pacific Source and has sat on the IHC since July 2015.

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

- ◆ Denise Chuckovich asked members if they had any comments or questions regarding the workgroup reports from the past month. There were no questions or comments.

**Closing remarks and Next Steps** – *Denise Chuckovich, Deputy Director:*

- ◆ Denise Chuckovich asked if members had anything further to discuss before closing the meeting.
- ◆ Lisa Hettinger announced the Comprehensive Primary Care Plus (CPC+) program. From April 15-June 1, 2016, CMS will solicit payer proposals to partner in CPC+. Based on payer interest and coverage, CMS will announce the CPC+ regions in July 2016, and request applications from eligible practices within these geographic locales. More information will be posted on the SHIP website.

There being no further business Denise Chuckovich adjourned the meeting at **4:20pm**.



# Idaho Healthcare Coalition

## Action Items

May 18, 2016

- 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 April 13, 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 – Community Health Emergency Medical Services

IHC members will be asked to approve the set of measures created by the CHEMS measures design workgroup as presented by Mary Sheridan.

Motion: I, \_\_\_\_\_ move that the Idaho Healthcare Coalition approve the set of measures created by the CHEMS measures design workgroup as presented by Mary Sheridan.

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

Motion Carried.

---



# CAREGIVERS IN IDAHO

---

Idaho Caregiver Alliance

**Sponsoring Agencies:**

Idaho Commission on Aging

Center for the Study of Aging, Boise State University

*Administration for Community Living (ACL)*

*US Department of Health and Human Services*



# Idaho Caregiver Alliance

**Advancing the well-being  
of caregivers by improving  
access to quality support  
and resources across the  
lifespan.**



**1 in 4** of us are unpaid caregivers of  
of family members with chronic  
conditions or disabilities.

# Idaho Caregiver Alliance

- statewide voice, convener, and catalyst for supporting these essential providers of care
- more than 50 public and private organizations and 250 individual members

# 1 in 4 Idahoans are family caregivers

- make it possible for children and adults living with disabilities, long term illnesses and frailty to live in their home and community
- provide estimated \$2 billion/year in unpaid care
- most juggle paid work and caregiving responsibilities

# Family caregivers provide complex care

- 6 of 10 caregivers (57%):
  - Provide injections, tube feedings, catheter and colostomy care
  - Monitor blood pressure or blood sugar
  - Operate specialized equipment

Source: *Caregiving in the US*. NAC and AARP, 2015  
(<http://www.caregiving.org/caregiving2015>)

# Idaho Family Caregivers

- Save resources by delaying need for institutional care
  - Medicaid is the primary payer for institutional care in Idaho
    - \$2.4 billion expenditure in 2012

Medicaid Expenditures for Long-Term Services and Supports in FFY 2012, CMS, April 28, 2014. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf>

# Alliance Action

Statewide Caregiver Summits

House Concurrent Resolution 24 (2015)

- Caregiver Taskforce
  - examine policies, resources and programs
  - identify innovative ways to support unpaid family caregivers

# Caregiver Taskforce

- **AARP Idaho**
- **Ada County Community Paramedics**
- **Advocates for Families/Caregivers**
- **Area Agency on Aging - CSI**
- **Blue Cross of Idaho**
- **Caregivers**
- **Caregiver Support Agencies**
- **Center for the Study of Aging - BSU**
- **Community Partnerships of Idaho**
- **Disability Rights Idaho**
- **Friends in Action**
- **Home Care and Hospice Agencies**
- **Idaho Alzheimer's Planning Group**
- **Idaho Area Health Education Center**
- **Idaho Association of Counties**
- **Idaho Commission on Aging**
- **IDHW - Behavioral Health, Public Health, Medicaid**
- **Idaho Health Care Association**
- **Idaho Hospital Association**
- **Idaho Parents Unlimited**
- **Jannus**
- **Living Independence Network**
- **MS Society**
- **Northwest A.D.A. Center of Idaho**
- **Qualis Health**
- **Regence Blue Shield**
- **Senior Health Insurance Benefits Advisors (SHIBA)**
- **St. Luke's, Mountain States Tumor Institute**
- **Treasure Valley YMCA**
- **Veteran's Administration**

# Taskforce Findings: gaps in resources

- Assistance is limited, fragmented and based mostly on the care recipient.
- Inadequate training and information for caregivers.
- Caregiver support is lacking.
- Caregiver stress has costs.
- Non-profits have not been a sustainable resource.
- Respite resources are inadequate and underfunded.
- Few options for pediatric respite care in Idaho.

# Taskforce Recommendations

## Support for Caregivers

- Expand network of individuals who assist family caregivers to understand, access, and arrange complex services.
- Provide access to training for caregivers on fundamental care responsibilities and self-care strategies.

## Awareness and Engagement

- Increase public awareness about caregiving.
- Assist family caregivers identify as caregivers.



# Taskforce Recommendations

## **Integrate Family Caregivers into Transformation Efforts**

- CHEMS
- Community Health Workers
- Regional Collaboratives
- Regional Behavioral Health Boards

# Going Forward

- ✓ Engage public and policy makers
  - ✓ Caregiver Platform Project
- ✓ Develop State Plan for Family Caregivers
- ✓ Collaborate with Idaho SHIP
- ✓ Engage health delivery systems and payers
- ✓ Expand caregiver networks
  - ✓ Powerful Tools for Caregivers
  - ✓ Respite Care Provider Training

# Idaho Caregiver Alliance

## Leadership Team:

Pam Oliason, [Pam.Catt-Oliason@aging.idaho.gov](mailto:Pam.Catt-Oliason@aging.idaho.gov)

Kelle Sweeney, [kelle@fiaboise.org](mailto:kelle@fiaboise.org)

Marilyn Sword, [frontiergroupidaho@gmail.com](mailto:frontiergroupidaho@gmail.com)

Sarah Toevs, [stoevs@boisestate.edu](mailto:stoevs@boisestate.edu)

Tiffeny Kiiha (MSW intern)  
[tiffenykiiha@u.boisestate.edu](mailto:tiffenykiiha@u.boisestate.edu)

# Caregivers in Idaho

A Report from the Idaho Family Caregiver Task Force  
and the Idaho Caregiver Alliance

December, 2015

Supported with funds from AARP – Idaho and the  
Idaho Caregiver Alliance (sponsored by the Idaho Commission  
on Aging Lifespan Respite Grant)

## Caregivers in Idaho

### A report from the Idaho Family Caregiver Task Force and the Idaho Caregiver Alliance

With the passage of House Concurrent Resolution 24, the 2015 Idaho legislature formally recognized family caregivers as an essential part of Idaho's health care system, providing uncompensated support and care to a family member or loved one who is elderly or has a physical or intellectual disability or mental illness. It also endorsed the efforts of the Idaho Caregiver Alliance and supported the creation of a Family Caregiver Task Force to:

- Explore innovative means to support uncompensated family caregivers across the lifespan in Idaho;
- Examine policies, resources and programs and share findings with leadership of the State Healthcare Innovation Plan (SHIP); and
- Report findings to members of the 2016 Idaho Legislature.

The Idaho Caregiver Alliance is pleased to release the *Caregivers in Idaho* report. Designed as a foundational document, the results are intended to guide the development and implementation of an Idaho State Family Caregiver Plan. A guiding principle in the development of the report was to identify existing opportunities within public and private initiatives such as, the SHIP, the Idaho Healthcare Coalition, No Wrong Door, and Idaho 2-1-1 Careline.

This report, and the work of the Idaho Caregiver Alliance, represents a successful public-private partnership with leadership provided by the Idaho Commission on Aging, the Center for the Study of Aging at Boise State University and Jannus with funding from a three-year grant from the Administration for Community Living. The Alliance also recognizes AARP of Idaho for the leadership and financial support provided for the development of the report.

Please share this report with members of your community who support strong families and communities. Investing in family caregivers will save the state of Idaho money, jobs, and lives.

### Task Force Membership by Agency/Sector

AARP Idaho  
Ada County Community Paramedics  
Advocates for Families/Caregivers  
Area Agency on Aging -  
    College of Southern Idaho  
Blue Cross of Idaho  
Caregivers  
Caregiver Support Service Agencies  
Boise State University -  
    Center for the Study of  
Aging  
Community Partnerships of Idaho  
Disability Rights Idaho  
Friends in Action  
Home Care and Hospice Agencies  
Idaho Alzheimer's Planning Group  
Idaho Area Health Education Center  
Idaho Association of Counties  
Idaho Commission on Aging  
Idaho Department of Health and  
Welfare Divisions -  
    Behavioral Health  
    Public Health  
    Medicaid  
Idaho Health Care Association  
Idaho Hospital Association  
Idaho Parents Unlimited  
Jannus  
Living Independence Network  
MS Society  
Northwest A.D.A. Center of Idaho  
Qualis Health  
Regence Blue Shield  
Senior Health Insurance Benefits  
Advisors (SHIBA)  
St. Luke's, Mountain States Tumor  
    Institute  
Treasure Valley YMCA

Access the document electronically at: <http://hs.boisestate.edu/csa/idaho-caregiver-alliance/>

## EXECUTIVE SUMMARY

Every day, thousands of Idahoans work 24/7, with love and dedication taking care of a family member who is elderly or has a physical or intellectual disability or mental illness. For some, caregiving lasts a few years. For others, particularly parents of children with physical or emotional disabilities, it lasts a lifetime. These caregivers are the largest workforce in Idaho and, while they find joy in their role as a caregiver, they are exhausted and burning out.

In response to this need and HCR 24, passed in 2015, the Idaho Caregiver Alliance formed a Task Force comprised of a wide array of individuals, many of whom had not worked together before, to examine policies, resources and programs available for caregivers in Idaho and other states. The Task Force also studied innovative ways to support unpaid family caregivers.

What the Task Force discovered was that although there are well-intentioned efforts across the state, they are fragmented, siloed, and often limited to specific conditions or geographic areas. In short, **the supports for unpaid family caregivers are inadequate to meet the present and forecasted needs**. Caregivers in Idaho must manage multi-faceted and complex care on behalf of their loved one, and they must do this without the information, training, and support they need. The result of this is caregiver burnout, costly hospitalization, or institutional care for the care recipient.

### Task Force Findings:

- ✓ Family caregiving impacts all aspects of a family's economic, physical, cultural, and social wellbeing.
  - Most caregivers are juggling paid work and caregiving.
  - Caregiver stress has costs.
- ✓ Assistance is fragmented and mostly focused on the care recipient.
- ✓ Demographics are changing; 23 % of Idaho's population will be over age 60 by the year 2030, an increase of 33 % from 2012 (US Census Bureau, 2009 Projections).
- ✓ Non-profit organizations have not been a sustainable source of support for caregivers.
- ✓ Respite care is inadequate.

**We can and must do better.** The Task Force offers the following recommendations to begin the process of supporting these caregivers. Recommendations have been organized by support category and color.

## FAMILY CAREGIVERS SUPPORTS

- ***Priority #1*** – Equip and expand a network of individuals who assist family caregivers to understand, access, and arrange complex services.
- ***Priority #2*** – Provide access to training for caregivers on fundamental care responsibilities and self-care strategies.

## COMMUNITY AWARENESS AND ENGAGEMENT

- ***Priority #1*** – Increase public awareness about caregiving including helping people identify as caregivers.

## SYSTEMS CHANGE

- ***Priority #1*** - Influence health care providers to recognize family caregivers as integral members of the health care team.
- ***Priority #2*** - Build community resources within the medical-health neighborhood to support those in a family caregiver role, through the seven State Health Innovation Plan (SHIP) Regional Health Collaboratives.
- ***Priority #3*** - Integrate the needs and contributions of unpaid family caregivers in other system transformation efforts.

**But this is just the beginning.** Addressing the priorities identified by the Task Force will not happen without a coordinated and sustained effort. The Idaho Caregiver Alliance has made progress (**see Attachment A**), but developing the supports caregivers need and deserve will require the involvement of policy makers and private and public funding. We know an investment in family caregivers will save the state of Idaho money, jobs, and lives.

### We ask that you:

- ✓ Learn more about the issues facing unpaid family caregivers in Idaho
- ✓ Identify the caregivers in your life
- ✓ Partner with the Idaho Caregiver Alliance to identify resources for family caregivers
- ✓ Endorse the collaboration between the Idaho SHIP and the Caregiver Alliance
- ✓ Support the development of a plan to implement the recommendations identified in this report
- ✓ **Become a caregiver champion!**

## INTRODUCTION

There is a huge, invisible workforce in Idaho. Each year, more than 300,000 Idaho family members (more than 1 in 4), assume critical, ongoing care responsibilities for aging parents, siblings, spouses, children or grandchildren with physical or emotional disabilities, or chronic illnesses.<sup>1,2</sup> These family members provide 201 million hours of uncompensated care annually at an estimated value of \$2 billion to Idaho's economy.<sup>3</sup> This is equivalent to Idaho's budget for all publicly-funded long-term care services.<sup>4</sup>

This report tells you their story. It highlights the current state of caregiver services in Idaho. It offers recommendations to support this workforce, ensuring they have the information and resources needed to prevent caregiver burn out and the inability to continue providing care. The recommendations were developed during an intensive 6-month period of shared learning, deliberation, and consensus building among a diverse group of professionals from private and public sectors, caregivers, and care recipients striving to remain in their home and community. The energy and commitment to this process embodies the urgency and gravity of the state of affairs for family caregivers in Idaho

## WHO ARE FAMILY CAREGIVERS?

- An attorney in solo practice in Boise whose otherwise healthy wife had a stroke and was being discharged from a rehabilitation facility.
- A young couple in Bonners Ferry with two small children, the father works in the North Dakota oilfields, and they have a new baby with significant disabilities.
- A 42-year-old mother of four in Eagle who works full time and whose 10-year-old adopted daughter struggles with critical behaviors due to schizoaffective disorder and reactive attachment disorder.

### What do Family Caregivers Provide?

- ✓ Complex medication management
- ✓ Care coordination
- ✓ Wound care
- ✓ Mental health planning & supervision
- ✓ Personal care
- ✓ Financial management
- ✓ Health insurance advocacy
- ✓ Transportation
- ✓ Emotional and spiritual support
- ✓ Medical equipment operation
- ✓ Interpreting medical directions

<sup>1</sup> Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work (AARP Public Policy Institute)

<sup>2</sup> Idaho 2014 Needs Assessment, Boise State University, Center for the Study of Aging

<sup>3</sup> Across the States: Profiles of Long-Term Care and Independent Living Idaho 2012: Valuing the Invaluable Update: Understanding the Impact of Family Caregiving on Work (AARP Public Policy Institute)

<sup>4</sup> FY 2016 Legislative Budget Book, Department of Health and Welfare FY 2015 appropriation, p. 2-8

- A 45-year-old long-haul trucker who lives in Payette who learns that his 73-year-old mother in Salmon was found wandering in the street unaware of where she was.
- A 69-year-old-widow in Filer who just learned that her daughter had been seriously injured in an accident; the widow is the only family member who can care for her three grandchildren, ages 2, 5, and 7.
- A school teacher in Caldwell, trying to help her teenage son with disabilities find a job after high school, while also supporting her 85-year-old grandmother who has Parkinson's, diabetes, and a heart condition.

**What do these Idahoans have in common? They are all family caregivers.** They are your brothers and sisters, parents and grandparents, children, cousins, friends. They are you. There are thousands of family caregivers across Idaho who work every day, 24/7, with love and dedication to take care of their family member. For some, it lasts a few years. For others it lasts a lifetime. Caregivers recognize and accept their responsibilities but they are isolated, frustrated, and exhausted. They are burning out.

**Most caregivers are juggling work and caregiving.** While each situation is unique, nearly 70% of Idaho caregivers are employed full or part-time and caring for their own children and an aging parent.<sup>5</sup> For parents of children or adults with disabilities, it is a full-time job. If the caregiver is employed outside the home and has no flexibility such as personal leave, caregiver demands may require reducing paid employment or leaving employment altogether. Employment changes cause a ripple effect: loss of health care benefits, diminished financial independence, and physical and emotional stress.

**Family caregiving impacts all aspects of a family's economic, physical, cultural, and social wellbeing.** The demands create stress not only on the caregiver, but other family members as well. The demands can jeopardize the health of the caregiver. Caregiving can jeopardize a family's ability to maintain their housing or provide community-based care for a loved one, or cause a family member (including the caregiver) to postpone educational opportunities that could improve their future. For families with children with disabilities,

siblings also feel the impact as the family focuses their energies and attention on the demands of the child with special needs.

*"I was surprised that my doctor's office had no information. Putting brochures and giving them information seems like a good place. Everything I learned I had to research and ask lots of questions because none of the agencies had information about options but their own."*

*Respondent to NWD Survey, p. 60*

**Informational resources are fragmented and difficult to access.** As family caregivers seek information about services, they are confronted with a confusing array of information filled with acronyms and complex eligibility requirements.

<sup>5</sup> Idaho Caregiver Needs and Respite Capacity Report, 2014., Tami Cirerol and Sarah E. Toevs, p. 8

Information and programs are often poorly coordinated, siloed, inconsistent, or the family just does not know what they need or where to find it. Families without easy access to the internet are particularly challenged to know where to seek help. And as the baby boomers age and the care becomes more complex, the pressure on caregivers is increasing.

**Changing demographics.** From 2015 through 2020, the number of Idahoans age 65 and older will increase by more than 20%, while those 25 to 64 (those providing care for the older population) will grow by 5% or less.<sup>6</sup>

## CAREGIVER RESOURCE GAPS IN IDAHO

**Assistance is limited, fragmented and based mostly on the care recipient.** Across Idaho, there are pockets of assistance for family caregivers. These supports are often specific to a defined health condition, such as autism or Alzheimer’s disease or only available in a limited number of communities. Services and resources are not connected across disciplines, communities or agencies, and **in almost every situation, available support is based on the needs of the care recipient, not the caregiver.** Privacy regulations specific to health information also make it difficult for caregivers to get the information and support they need to be effective in their caregiving responsibilities.

**Inadequate training and information for caregivers.** Caregivers are increasingly expected to manage complex medical and/or psychological conditions with little to no information, instruction, or support. They may need technical medical information to manage changes in behavioral health, provide wound care, operate medical equipment in the home, or administer medications correctly. Caregivers must anticipate needs and changes in health status, but they are often not included in the conversation or they are overwhelmed by the information. The results of this can be costly – crises, medical complications, hospitalization, even death.

**Caregiver support is lacking.** In addition to technical information, caregivers benefit from time off from caregiving (respite), transportation assistance, spiritual and emotional support (such as provided through a church or support group), sharing of caregiving responsibilities so a job is not in jeopardy, flexible work hours, and other tangible supports are needed. These forms of assistance can mean the difference between the care recipient remaining at home, or being placed in a nursing home or other facility.

*“Caregiving isn’t a disease. Although many similar issues are involved, caregiver stress inexorably arises from caregiving duties.”*

*Pamela T.*

*Caregiver of adult son with disabilities*

---

<sup>6</sup> 2015 Fiscal Facts. Idaho Legislative Services Office, p. 7

**Caregiver stress has costs.** When a family caregiver is not empowered with knowledge and resources, they feel overwhelmed with the endless tasks in caregiving which can lead them to taking their loved one to the emergency room. When the community does not

*“Caregiving has all the features of a chronic stress experience: It creates physical and psychological strain over extended periods of time, is accompanied by high levels of unpredictability and uncontrollability, has the capacity to create secondary stress in multiple life domains such as work and family relationships, and frequently requires high levels of vigilance.”*

*Schulz and Sherwood  
In Physical and Mental Health Effects  
of Family Caregiving, 2009*

prioritize the health of the caregiver, the amount of people needing medical care is exponentially increased. Not only will the patient need services, so will the caregiver. “These caregivers fill an important role for their families and provide an estimated \$375 billion in cost savings nationwide”<sup>7</sup>, costs that the health care system will incur if caregivers are not supported.

**Non-profits have not been a sustainable resource.** Utilizing a private non-profit model to meet the needs of caregivers in Idaho has proven to be unsustainable. An example is the Boise-based Friends in Action (FIA), founded in Boise in 2004 with seed money from the Robert Wood Johnson Foundation. FIA trained volunteers to deliver a wide array of services to caregivers across the Treasure Valley, including respite, caregiver coaching, and education. In 2015, after many years of seeking grant support, private donations, and collaboration with other organizations, FIA was forced to drastically reduce services due to lack of funding. The two remaining staff are struggling to provide services to the more than 100 families currently on a waiting list.<sup>8</sup>

*“I wait on my (blind) husband 24/7. Sometimes I need to get away. Sometimes I need to shop for necessities. Family members are not reliable. They have families of their own to care for. When I want to scream, I am not so nice to my husband and he is a wonderful person.”*

*Respondent to NWD Survey, p. 62*

Legacy Corps, an AmeriCorps program focused on providing support to caregivers of veterans and military family members, will allow respite services to continue through 2017, although all other education and support services offered through FIA will cease in March of 2016. This will leave a large gap in services among some of Idaho’s most vulnerable caregiving populations.

Legacy Corps is funded partially by federal tax dollars through the Corporation for National and Community Service, with match funding provided primarily by the Idaho Division of

<sup>7</sup> Institute of Medicine. Retooling for an Aging American: Building the Health Care Workforce. Washington, DC: The National Academies Press; 2008; [http://books.nap.edu/openbook.php?record\\_id=12-89](http://books.nap.edu/openbook.php?record_id=12-89). Accessed March 24, 2011

<sup>8</sup> Email communication from Kelle Sweeney, Friends in Action, 12/18/2015

Veteran Services. Without funding from this federal and state partnership, these services too would cease.

### **Respite care resource information is inadequate and respite resources underfunded.**

An analysis of respite care, the ability to have some “time away” from the responsibility of providing care, in Idaho, conducted by Boise State University, demonstrates the inadequacy and fragmentation of respite assistance. This research reveals that there is:

- no common definition of “respite care”
- no standards for respite care providers (except for basic standards in Children’s Mental Health)
- no statewide registry of providers
- widely varying costs and reimbursement rates for a range of services that might fit under the definition of respite.

These gaps and inconsistencies create challenges for the consumer/caregiver including:

- lack of understanding about what respite is
- difficulty finding respite care, and
- difficulty having the resources to pay for it.

These challenges lead to underutilization of available services and caregiver burnout.

**Currently there are no options for pediatric respite care in Idaho.** According to case manager Freda Reed, RN at St. Luke’s Children’s Hospital in Boise, respite admissions at St. Luke’s Children’s Hospital account for up to 3% of annual admissions. Parents of children with life-limiting, multi-faceted and complex diagnoses have nowhere to turn but to inpatient hospitalization when they have reached the point of caregiver burnout. When possible, case management and social workers at St. Luke’s try to secure nursing hours for patients through private home health agencies, but this is not always possible depending upon the caregiver’s income, geography and insurance. There is currently an effort by a private individual to open a small respite facility in Eagle for children with such conditions. Lucas House, named after a son born with significant disabilities, is in fundraising mode and completion of the facility is still uncertain.

### **TASK FORCE PROCESS:**

The Task Force (See **Attachment B** for members) began its work in July, 2015, and over the course of 6 months invested significant time and energy in learning from each other, discussing challenges and ideas, reviewing data (see **Attachment D**) and brainstorming innovative concepts that can improve the status quo. Task Force members were informed about:

- respite needs and use statewide

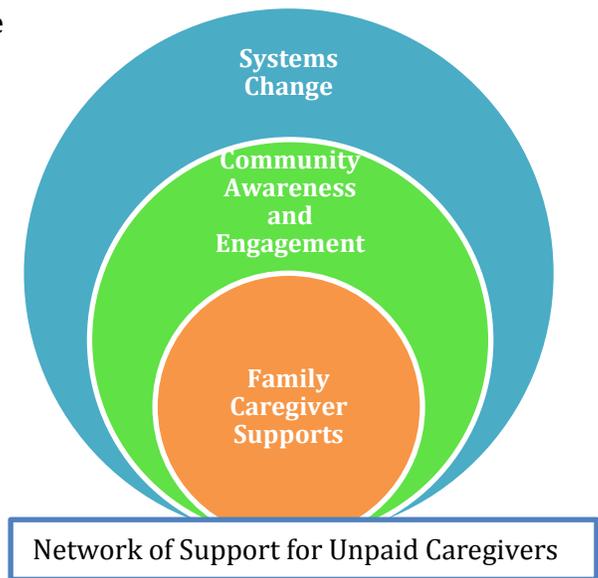
- the State Healthcare Innovation Plan (SHIP) and how caregivers can be integrated in the development of medical/health neighborhoods
- the Idaho Commission on Aging’s No Wrong Door (NWD) Initiative’s intent to streamline access to long-term care and the important role caregivers assume in accessibility to long term care
- caregiver challenges expressed at two regional summits attended by more than 200 caregivers
- care coordination within insurance plans
- policy issues impacting caregiving at the national level as well as in other states.

By examining current policy initiatives and available information and research, members grouped their concerns into categories for more in-depth work, listed in **Attachment C**. That work resulted in the following recommendations. These recommendations reflect initial steps in the development of a network of support and assistance for caregivers in Idaho.

**RECOMMENDATIONS:**

**A. FAMILY CAREGIVERS SUPPORTS:**

**Supports for Family Caregivers** – Family caregivers require assistance to navigate the complex systems and information essential to providing quality care. They also need training on fundamental caregiving responsibilities, such as dispensing medications and managing complex medical and psychological conditions, providing personal care, financial management, and coordinating transportation. Receiving this support and training translates into better caregiving and cost savings to our health and social service systems.



**● Priority #1 – Equip and expand a network of individuals who assist family caregivers to understand, access, and arrange complex services.**

*Action Steps:*

- Create a system of individuals with expertise in caregiver needs and assistance to serve caregivers across the lifespan. This should be linked to the new initiatives of the SHIP and NWD.*
- Identify an assessment tool and process that can be used to determine caregiver needs and competencies to assume and maintain caregiving responsibilities.*

- c. *Develop the scope for a collaboratively funded, standards-based statewide Respite Registry, providing caregivers with information to make decisions about care providers.*
- d. *Equip the Idaho 2-1-1 Careline and the No Wrong Door systems with a caregiver portal designed to provide access to person-centered information and resources.*
- e. *Develop an individualized package of information, local caregiving resources, and strategies that can be provided to caregivers and others at critical points.*

 **Priority #2 – Provide access to training for caregivers on fundamental care responsibilities and self-care strategies.**

*Action Steps:*

- a. *Expand the Powerful Tools for Caregivers training program throughout the state.*
- b. *Identify other best-practice training, such as REST (Respite Education and Support Tools training) that could be accessed or made available to Idaho family caregivers.*
- c. *Include a track for training caregivers at the annual Human Partnerships conference and other events/venues as appropriate.*

**B. COMMUNITY AWARENESS AND ENGAGEMENT:**

**Information, Education and Public Awareness** – Family caregivers are more likely to seek help such as respite, information, and training when they recognize they are in a caregiving role. This self “identification” removes a major hurdle to seeking assistance with stress, isolation, and other caregiving challenges. A public campaign is needed to increase the number of individuals who recognize they are caregivers, to increase awareness about the value of caregivers, and to connect family caregivers with support, information and training so they can continue providing care.

 **Priority #1 – Increase public awareness about caregiving including helping people identify as caregivers.**

*Action Steps:*

- a. *Utilize social media and other strategies to build awareness of caregiving and help caregivers self-identify.*
- b. *Inform and build support for family caregivers using a variety of venues (workshops, presentations, conferences, networking, the written word, public service announcements, etc.).*
- c. *Continue to expand community engagement through the coordination of regional and statewide alliance meetings.*

- d. *Promote November as National Family Caregiver Month with a Governor’s Proclamation and other means.*
- e. *Develop liaison with other like-minded organizations and coalitions to advance similar agendas (e.g. Justice Alliance for Vulnerable Adults, JAVA).*

**C. SYSTEMS CHANGE:**

**Integration of Family Caregivers into Health Systems Transformations –**

Caregivers are a critical but often unrecognized member of the health care team. Integrating family caregivers into a team-based approach helps caregivers be effective in providing the specialized care their family member needs, and is critical to reducing unnecessary medical care use (e.g. emergency room visits or hospitalizations). Integration means family caregivers are included appropriately in decisions about their family member’s health and medical care, including access to the person’s medical records, training regarding specialized procedures or medication administration, or being provided information about caregiving resources and support. The current transformation and streamlining of the primary care and long-term service systems to becoming more patient- and family-focused provide opportunities for caregivers to be integrated as a team member.

*“How much easier our caregiving journey would have been if more of the medical providers around us had understood what we needed to win our battle. Often we have felt like victims of a paternalistic system dispensed by people who either didn’t realize what we were going through, or who didn’t care.”*

*Pamela T.  
Caregiver of adult son with disabilities*

**● Priority #1 - Influence health care providers to recognize family caregivers as integral members of the health care team.**

*Action Steps:*

- a. *Work with partners and the SHIP initiative to include a caregiver module in training programs for community health emergency medical services (CHEMS) and community health workers (CHWs).*
- b. *Through the seven SHIP Regional Health Collaboratives, work to bring an understanding of caregiver roles and needs to medical practices transforming to patient-centered medical homes.*

**● Priority #2 – Build community resources with the medical-health neighborhood to support those in a family caregiver role through the seven State Health Innovation Plan (SHIP) Regional Health Collaboratives.**

*Action Steps:*

- a. *Identify local family caregivers to serve as liaisons to the each of the seven Regional Health Collaboratives.*
- b. *Ensure that family caregiver needs and roles are included in health system transformation through the Idaho Caregiver Alliance serving as a foundational advisory group to the SHIP, the Idaho Healthcare Coalition, and the seven Regional Health Collaboratives.*

 ***Priority #3 – Integrate the needs and contributions of unpaid family caregivers in other system transformation efforts.***

*Action Steps:*

- a. *Collaborate with the No Wrong Door (NWD) Initiative to include and strengthen the role of and information for caregivers in the development of Person-Centered Planning training.*
- b. *Connect family caregivers serving at the state and regional level in the Behavioral Health Care system to the Idaho Caregiver Alliance.*

## **GOING FORWARD**

**Unfinished business.** Members of the Idaho Caregiver Alliance and the Task Force wish to underscore the urgency to enact these recommendations. Not only are there significant and growing unmet needs within Idaho’s caregiver population, but as we look to the future, the importance of the caregiver in delaying or reducing the need for institutional care will grow exponentially. In Idaho, Medicaid, the primary public payer for these services, spent approximately \$2.4 billion in 2012 on costs for institutional care.<sup>9</sup> Imagine if families did not provide home-based care. The costs would be unsustainable. Investing in supports for family caregivers makes sense in both a fiscal and human terms.

### **We ask that you:**

- ✓ Learn more about the issues facing unpaid family caregivers in Idaho
- ✓ Identify the caregivers in your life
- ✓ Partner with the Idaho Caregiver Alliance to identify resources for family caregivers
- ✓ Endorse the collaboration between the Idaho SHIP and the Caregiver Alliance
- ✓ Support the development of a plan to implement the recommendations identified in this report
- ✓ **Become a caregiver champion!**

---

<sup>9</sup> Medicaid Expenditures for Long-Term Services and Supports in FFY 2012, CMS, April 28, 2014. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-servoces-and-supports/downloads/ltss-expenditures-2012.pdf>

## ATTACHMENT A

### IDAHO CAREGIVER ALLIANCE AND FAMILY CAREGIVER TASK FORCE

The Idaho Caregiver Alliance began as the Idaho Lifespan Respite Coalition, a consortium of organizations and agencies that advise and support the Lifespan Respite grant received by the Idaho Commission on Aging and funded by the Administration on Community Living. The mission of this three-year grant, funded in 2013, is to “advance the well-being of caregivers by promoting collaboration that improves access to quality, responsive lifespan respite care across the state.” The Alliance has helped raise awareness of family caregiving, its benefits and costs, and the importance of supporting family caregivers to maximize at-home care.

With the grant funds, the partners within the Idaho Caregiver Alliance have achieved the following:

- ✓ Completion of a statewide respite capacity and needs assessment
- ✓ Implementation of Caregiver Summits in northern and eastern Idaho to engage local communities and caregivers
- ✓ Implementation of a study to examine impact of behavioral health crises on family caregivers, first responders, and health care systems
- ✓ Development of partnerships with 2-1-1 Careline, Idaho’s No Wrong Door Initiative, and the Statewide Healthcare Innovation Plan (SHIP) to assure that the voice of family caregivers is included in statewide transformation activities
- ✓ Implementation of a pilot program of Emergency Respite in collaboration with the Idaho Federation of Families for Children’s Mental Health
- ✓ Passage of HCR 24 during the 2015 Legislative Session which endorsed the Idaho Caregiver Alliance and called for the creation of a Caregiver Task Force to “explore innovative means to support uncompensated family caregivers in Idaho.”

The Idaho Family Caregiver Task Force formed in June, 2015 under the leadership and funding of AARP, the Center for the Study of Aging at Boise State University, the Idaho Commission on Aging and Jannus (formerly Mountain States Group). The Task Force was open to any family caregiver or agency or organizational representative with expertise and an interest in family caregiving. More than 40 caregivers, community leaders, organizational representatives, and others have participated in this effort since June of this year. Members come from across the state and represent diverse perspectives, backgrounds, and expertise, from hospitals to emergency medical personnel to parents of children with disabilities or emotional disturbance. The focus was statewide and across the lifespan.

## ATTACHMENT B

### Idaho Family Caregiver Task Force

#### Participants

<b>Tammy Avella</b> The Care Managers	<b>Monique Johns</b> Blue Cross of Idaho MMCP
<b>Cindy Bahora</b> Veterans Administration	<b>Zoe Johnson</b> Living Independence Network (LINC)
<b>Jim Baugh</b> Disability Rights Idaho	<b>Courtney Keith</b> 2-1-1 Careline
<b>Stephanie Bender-Kitz</b> Jannus	<b>Karen Kouba</b> Home Watch Caregivers
<b>Mike Berlin</b> Idaho Alzheimer's Planning Group	<b>Toni Lawson</b> Idaho Hospital Association
<b>Mary Biddle-Newberry</b> Treasure Valley YMCA	<b>Angela Lindig</b> Idaho Parents Unlimited
<b>Dan Blocksom</b> Idaho Association of Counties	<b>Amy Mart</b> Community Partnerships of Idaho Care Plus
<b>Pam Catt-Oliason</b> Idaho Commission on Aging	<b>Amber Mausling</b> Formerly with LINC
<b>Karen Clark</b> SHIBA	<b>Cathy McDougall</b> AARP of Idaho
<b>Brenda Collins</b> Living Independence Network	<b>Jenny Moorman</b> Caregiver/Technology Consultant
<b>Dieuwke Dizney-Spencer</b> Division of Public Health, Health & Welfare	<b>Peggy Munson</b> AARP Volunteer Leader
<b>Martha Doyle</b> Regence Blue Shield	<b>Kimberly Ouwehand</b> Treasure Valley Hospice
<b>Kris Ellis</b> Idaho Health Care Association	<b>Pam Page</b> MS Society
<b>Raul Enriquez</b> Idaho Commission on Aging/NWD	<b>Melissa Radloff</b> Friends in Action
<b>Lee Flinn</b> Formerly with AARP of Idaho	<b>Dawn Rae</b> Ada County Community Paramedics
<b>Dana Gover</b> Northwest ADA Center of Idaho	<b>Tammy Ray</b> Idaho Home Choice Program Medicaid/DHW
<b>Honey Goodman</b> Treasure Valley Hospice	<b>Donna Rogers</b> Bright Star Home Care and Medical Staffing
<b>Jennifer Griffis</b> Caregiver/Children's Mental Health Advocate	<b>Jackie Smith</b> Trinity Home Care and Resource
<b>Katherine Hansen</b> Community Partnerships of Idaho	<b>Sarah Swanson</b> St. Luke's, Mountain States Tumor Institute
<b>Jackie Hansen</b> Community Partnerships of Idaho	<b>Kelle Sweeney</b> Friends in Action
<b>Anthony Hickman</b> ElderCare of Idaho	<b>Marilyn Sword</b> The Frontier Group (Task Force facilitator)

<b>Katrina Hoff</b> Idaho Area Health Education Center	<b>Victoria Thompson</b> St. Luke's, Mountain States Tumor Institute
<b>Stephanie Hoffman</b> Behavioral Health, DHW	<b>Pamela Thorson</b> Caregiver/LPN
<b>Roger Howard</b> Living Independence Network	<b>Sarah Toevs</b> Center for the Study of Aging at BSU
<b>Martha Jaworski</b> Qualis	<b>Katie Vant</b> Living Independence Network
<b>Shawna Wasko</b> CSI Area Agency on Aging	

## ATTACHMENT C

### Caregiver Concerns

#### Caregiver Supports

- Respite providers are not adequately trained
- Too much responsibility for caregivers; they won't ask for help, especially in rural areas
- Education for caregivers; normalizing and validating their feelings
- Aging caregivers who may need care/help themselves; they may be caring for an adult child
- Need for "mobile" support group; goes to caregiver's home
- Education, insurance plans that are affordable and accessible
- Social isolation can lead to depression
- Develop mentoring relationships between caregivers
- No centralized help/no advocate role
- Timely, easy, effective caregiver assessments
- People go to a facility for respite and never leave
- Emergency respite – who? where?
- Concerns for others in the family; supports for them
- Support groups operating as co-ops
- Crisis situations – inadequate support/resources
- Caregiver advocate role
- Put boundaries on caregiving at the beginning
- Impact on caregiver of physical demands (falls, etc.)/elders taking care of elders
- People do not want others outside the family to help
- Early identification for caregivers; connect them
- Resources for non-indigent; someone to check on family member
- Exhaustion, guilt (parent caring for child)
- Lifespan focus – all ages
- Caregivers should get resources as soon as the person they are caring for leaves a facility (hospital, nursing home, rehab facility)
- Access to self-care (massages, etc.) for caregivers; way to bring in the business community
- Need a crisis (this is different from emergency) respite program for children and families that provides another option than hospitalization. Managing a severe mental health crisis within a family takes specialized resources.
- Funding for respite for children on Medicaid
- Mental exhaustion

#### Information

- People (all ages) don't know where to go for information or what questions to ask
- Who is prepared to help?
- Need free resource guide with information by region of the state (younger people need this too)
- Accurate, timely information
- Local issue – who is coming into my home?
- Education for caregivers; normalizing and validating their feelings
- Training (in-home, short modules that fit caregiver schedules, accessible)
- Information lacking; would like to see public service announcements (PSAs), etc.

- Timely, easy, effective caregiver assessments
- Information on stress management
- Caregiver Tool Box – What do I need to plan for? Where do I look? What do I ask? (have this through the Employee Assistance Program as well)
- Feel like victims of system, terminology confusing; need a road map and a helper to decode
- EMS services called in (because people wait too long or don't know who else to call)
- Lifespan focus – all ages

### **Work/Employer Interface**

- Lack of employer benefits (folks have to use vacation, sick leave to take leave without pay)
- Education, insurance plans that are affordable and accessible
- Education for employers re: promoting employee assistance programs and encouraging their use (coaching)
- Caregiver Tool Box – What do I need to plan for? Where do I look? What do I ask? (have this through the Employee Assistance Program as well)
- Working full time and trying to meet the needs of my mother
- Exhaustion of sick leave hours at work due to multiple medical events for mother.

### **Legal/Financial Issues**

- Legislature doesn't know what the caregiver gaps are
- Financial assistance
- Power of Attorney problems; hospitals may not recognize; need standardized form
- Information about guardianship
- Advance care planning
- Family member abuse (financial, physical, emotional) of caregiver person

### **Public Awareness**

- Too much responsibility for caregivers; they won't ask for help, especially in rural areas
- Overcoming stigma of being a caregiver
- Legislature doesn't know what the caregiver gaps are
- Promote culture of "it's OK to ask for help"
- Advance care planning
- Information lacking; would like to see public service announcements (PSAs), etc.

### **Lack of Services**

- Lack of services in rural areas
- Financial assistance
- Impact of lack of transportation on isolation
- Increased access to home and community based services (HCBS) and long term care (LTC)
- Insufficient monitoring of chronic conditions and lack of access to primary care that results in overuse of emergency room
- Crisis situations – inadequate support/resources
- EMS services called in (because people wait too long or don't know who else to call)
- Lack of care coordination
- Transportation
- Resources for non-indigent; someone to check on family member

- Caregivers should get resources as soon as the person they are caring for leaves a facility (hospital, nursing home, rehab facility)
- Access in community for people with disabilities
- Need a crisis respite (this is different from emergency) program for children and families that provides another option than hospitalization. Managing a severe mental health crisis within a family takes specialized resources.
- Funding for respite for children on Medicaid

**Other**

- Non-native English speakers
- Include faith-based community
- System is not very helpful
- Embed ways of measuring impact; how will we know if we are making a difference; need this to effectively tell our story

## ATTACHMENT D

### DATA SOURCES

2016 Legislative Budget Book, Idaho Legislative Services Office, 2015

Appendix 1: Federal Programs that may be Potentially Accessed by States, Local Agencies, or Individuals for Respite Services, Support, or Funding. ARCH National Respite Network and Resource Center

*Caregiver Support Blueprint for Delaware: A Report to the Delaware General Assembly*, Family Caregiving Task Force, May 31, 2015.

*Caregiver Support Blueprint for Mississippi*, prepared by the Mississippi Caregivers Task Force, 2014.

*Caregiving in the U.S. Executive Summary*, AARP Public Policy Institute and National Alliance for Caregiving, June, 2015

*A descriptive analysis of respite in Idaho*. Power Point presentation by Tami Cirerol, BSU Health Science and Stephanie Leonard, BSU Community and Regional Planning, Presented to Idaho Caregiver Task Force, October 16, 2015.

*The Facts About Idaho Medicaid*, Power Point presentation by Lisa Hettinger, Medicaid Administrator, August 14, 2014

*Family Caregiving: 20 Years of Federal Policy*. Debra Lipson, InFOCUS, Mathematica Policy research, October, 2015.

House Concurrent Resolution 24, 63<sup>rd</sup> Idaho Legislature, First Regular Session

*Idaho Caregiver Alliance/Idaho Lifespan Respite Coalition*. Power Point presentation by Pam Catt-Oliason to the Caregiving in Idaho Lifespan Respite Summit, Lewiston, ID, July, 2015

*Idaho Caregiver Needs and Respite Capacity Report*, prepared by Tami Cirerol and Sarah E. Toevs, Boise State University Center for the Study of Aging, for the Idaho Lifespan Respite Coalition, October, 2014

Idaho Community Health Worker (CHW) Project, CHW Training Committee Recommendations, Idaho Statewide Healthcare Innovation Plan (SHIP)

*Idaho Fiscal Facts: A Legislator's Handbook of Facts, Figures, and Trends*, Idaho Legislative Services Office, 2015

Idaho Home and Community-Based Waiver Services that include Respite. Prepared by Catherine Perrin, ARCH National Respite Network, November, 2011

Idaho Respite Funding and Eligibility Opportunities. Prepared by the ARCH National Respite Network for the Idaho Lifespan Respite Coalition, May, 2013

Independent Living Resource Center Caregiver Needs and Provider Capacity Assessment, 2014.

Institute of Medicine. Retooling for an Aging American: Building the Health Care Workforce. Washington, DC: The National Academies Press; 2008;  
[http://books.nap.edu/openbook.php?record\\_id=12-89](http://books.nap.edu/openbook.php?record_id=12-89). Accessed March 24, 2011

*Lifespan Respite: Engaging Collaborative Partners*. Power Point presentation by Jill Kagan, ARCH National Respite Network and Resource Center for the Caregiving in Idaho Lifespan Respite Summit, Lewiston, Idaho, July 16, 2015

Medicaid Expenditures for Long-Term Services and Supports in FFY 2012, CMS, April 28, 2014. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-2012.pdf>

Medical-Health Neighborhood, SHIP Population Health Workgroup, October, 2015

*More people age at home, raising demand for support services*, Jennifer Levitz, Wall Street Journal

Notes from the Caregiving in Idaho Lifespan Respite Summit, Lewiston, ID, July 16, 2015

No Wrong Door Caregiver Materials, presentation to the Idaho Family Caregiver Task Force by Raul Enriquez, NWD Coordinator for the Idaho Commission on Aging, September 18, 2015

*No Wrong Door System: An Assessment of Long-Term Supports and Services in Idaho, Executive Summary*, Idaho Commission on Aging, April 21, 2015

*Physical and Mental Health Effects of Family Caregiving*. Richard Schultz, PhD and Paula R. Sherwood, PhD, RN, CNRN. Published in final edited form as: Am J Nurs. 2008 September; 108(9 Suppl): 23–27. doi:10.1097/01.NAJ.0000336406.45248.4c

*Policies to Support Family Caregivers*. Power Point presentation by Enzo Pastore, Government Affairs, AARP, to the Idaho Family Caregiver Task Force, August, 2015

*Report of the Care Coordination Work Group*, HJM4 Family Caregiver Task Force, New Mexico Aging and Long-Term Services Department, March 27, 2015.

REST – Respite Education and Support Tools – Information Sheet

SHIP Model Test Proposal Mission Structure, handout for Idaho Family Caregiver Task Force

*Statewide Healthcare Innovation Plan.* Power Point presentation by Dieuwke Disney-Spencer, Deputy Administrator, Idaho Division of Public Health, Department of Health and Welfare. Presented to the Idaho Caregiver Task Force, September 18, 2015.

*Summary of Care Coordination Findings,* a report by the Care Coordination subcommittee of the Idaho Family Caregiver Task Force.

Summary of Next Step in Care, a program of the [United Hospital Fund](http://www.nextstepincare.org), [www.nextstepincare.org](http://www.nextstepincare.org)

Training for Caregivers in Idaho. Table of information gathered by members of the Idaho Caregiver Task Force, 2015.

*Training Resources Compendium for Dementia Care Providers and Volunteers.* Elizabeth Gould, Patty Yuen, Sari Shuman, Kate Gordon, Madga Ignaczak, for Erin Long, Administration on Aging, Administration for Community Living; RTI Project Number 0212050.035.001.001.001, September, 2015.

*U.S. CENSUS BUREAU* (<http://www.census.gov/people/>). *Population projections and estimates were created using 2010 Census.*

*Valuing the Invaluable: 2015 Update,* Sarah C. Reinhard, Lynn Friss Feinberg, Rita Choula, and Ari Houser, AARP Public Policy Institute, July, 2015.

Where are Navigators in Idaho? Table of information gathered by members of the Idaho Caregiver Task Force, 2015.



# COMMUNITY HEALTH EMS (CHEMS) MEASURES DESIGN WORKGROUP



**Mark Babson**, Community Paramedic  
Ada County Paramedics

**Mary Sheridan**, Bureau Chief  
Rural Health & Primary Care, Division of Public Health,  
Idaho Department of Health and Welfare

May 18, 2016



IDAHO DEPARTMENT OF HEALTH & WELFARE  
**DIVISION OF PUBLIC HEALTH**



Statewide **Healthcare**  
**Innovation Plan**

Improved health, improved healthcare, and lower cost for all Idahoans



# WHAT IS COMMUNITY HEALTH EMS (CHEMS)?

An evolving, innovative healthcare delivery model where emergency medical services (EMS) personnel extend the reach of primary care and preventative services outside of the traditional clinical settings and often into the patient's home environment.

An expanded role and work within their current scope of practice.

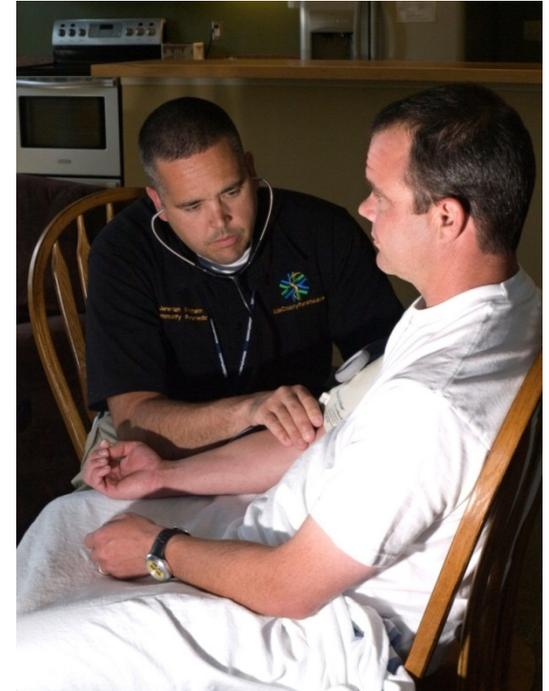
Examples:

- Healthcare navigators for patients
- Transitional care for patients following hospital discharge
- Vaccinations
- Resource coordination
- Basic medical therapeutics



# CHEMS Concept

- Meeting healthcare needs with untapped EMS providers and infrastructure
- Closing healthcare gaps/expanding access by expanding the role of EMS professionals
- National concept – locally tailored
- Leveraging resources/partnerships
- Additional education and medical oversight





# EMS Professionals and Medical-Health Neighborhood



- EMS Professionals - communicate with every other individual involved in health care.
- EMS Professionals - perform many aspects of healthcare and care coordination which require multiple healthcare providers.
- EMS Professionals - work independently in nonclinical settings.



# EMS Agencies & Professionals

- Extend provider reach
- Designed to deliver care at the point of need – patient environment
- Integrated with system resources
- Interdisciplinary team approach
- Clinical plan – address barriers to care plan implementation
- Link into the healthcare system
- Perception vs. Reality





# SHIP CHEMS Initiatives



Ada County Paramedics - Blackfoot Fire Department  
Initial Community Paramedic Training  
Monday, March 7<sup>th</sup>, 2016 – 370 N. Benjamin Lane, Boise ID 83704

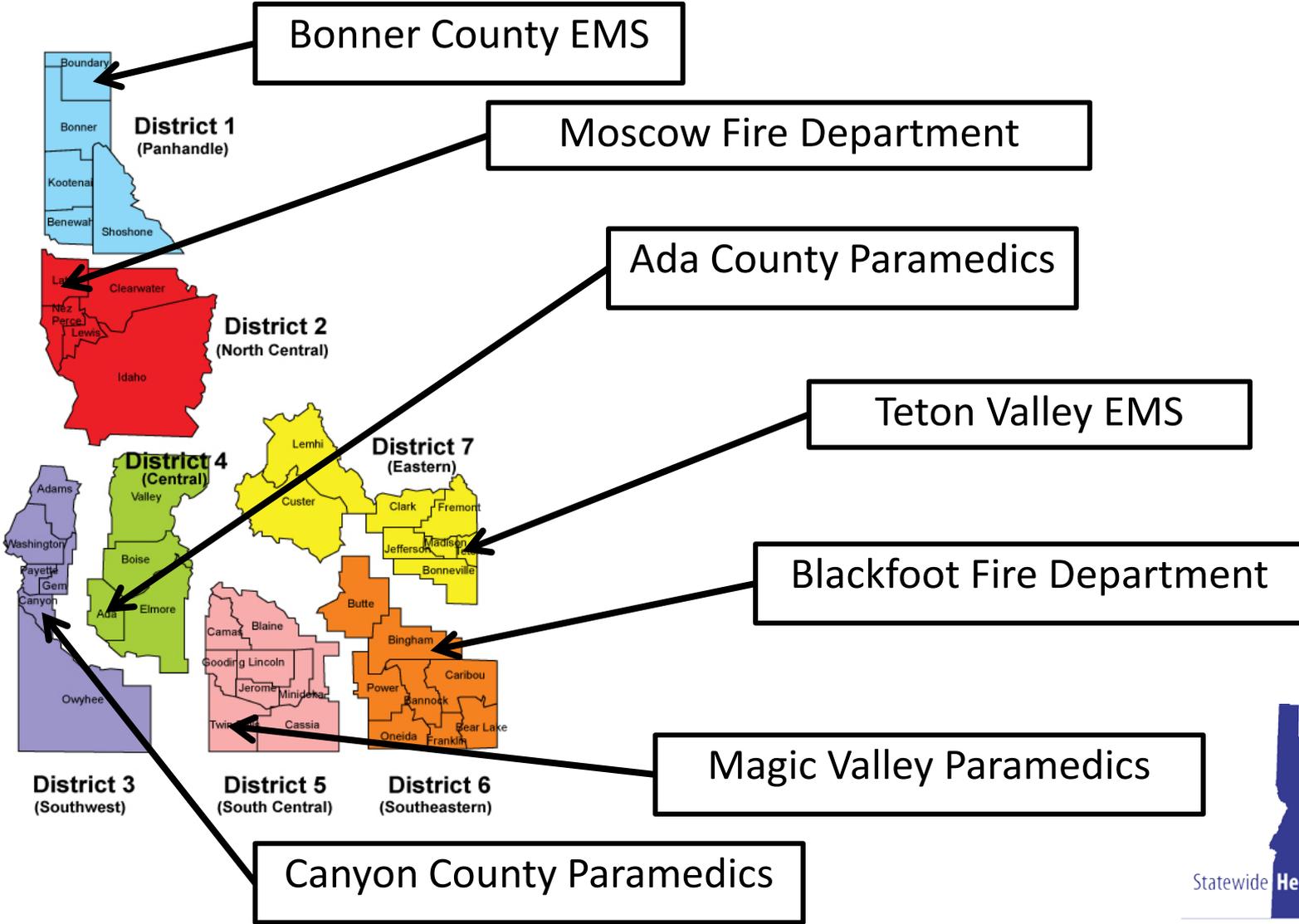
### Training Day Agenda

- 9:00-9:30**  
- Introductions and General Program Overview
- 9:30-10:15**  
- Review Mental Hold Diversion Program
- 10:30-12:30**  
- Review the CARE Program - Saint Alphonse Health Systems Partnership  
- Possible Site Visit – Saint Alphonse Hospital Emergency Department
- 12:30-1:15**  
- Lunch
- 1:15-2:00**  
- Review Ada County Community Paramedics' Field Referral Program
- 2:00-3:00**  
- Review CHEMS Talking Outreach/Talking Points  
- Open Roundtable Discussion – Personnel Questions  
- Next Steps

(All times and agenda items subject to change)

Contact Information:  
Mark Babson – [mbabson@adaweb.net](mailto:mbabson@adaweb.net) - 208-287-2993  
Emily Shaw – [eshaw@adaweb.net](mailto:eshaw@adaweb.net) - 208-287-2991

- External and Internal Engagement Strategies and Resources
- Outcome Measures Design to Test CHEMS Concept
- Education
  - Community Paramedic & Community EMT
- Mentoring Programs
- Telehealth





# MEASURES DESIGN WORKGROUP

**Goal:** Identify metrics, data collection mechanisms, and data reporting strategies to test CHEMS.

**Points of Alignment:** Triple Aim, SHIP Priorities, PCMH/medical-health neighborhood concept

## **Strategy:**

- Planning, facilitation, member recruitment, great participation
- 32 members, diverse expertise and statewide representation
- Subject matter expert: Matt Zavadsky, MedStar Mobile Healthcare, National Measures Design Team
- 3 full-day facilitated meetings between January-March 2016



# NATIONAL MEASURES DESIGN TEAM

## Mobile Integrated Healthcare Program

### Measurement Strategy Overview

#### Aim

*A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish?*

Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of-hospital environment and achieves the Triple Aim<sup>®</sup> — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

#### Measures Definition:

1. **Core Measures (BOLD)**
  - a. Measures that are considered essential for program integrity, patient safety and outcome demonstration.
2. **CMMI Big Four Measures (RED)**
  - a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.
3. **MIH Big Four Measures (PURPLE)**
  - a. Measures that are considered mandatory to be reported in order to classify the program as a bona-fide MIH or Community Paramedic program.
4. **Top 17 Measures (Isolated)**
  - a. The 17 measures identified by operating MIH/CP programs as essential, collectable and highest priority to healthcare partners.
  - b. These measures are isolated in this document for ease of reference.

#### Notes:

1. All financial calculations are based on the *national average Medicare payment* for the intervention described. Providers are encouraged to also determine the *regional average Medicare payment* for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.





# MEASURES DESIGN WORKGROUP





# CHEMS MEASURE RECOMMENDATIONS

(REFER TO SUMMARY REPORT APPENDIX)

Quality and Experience Measure: Patient health-related quality of life

Utilization Measure: Reduction in emergency department use

Cost Measure: Expenditure savings related to a reduction in emergency department use

Quality Measure: Patient connection to primary care provider

Quality and Safety Measure: Medication inventory to identify and reduce medication discrepancies



## NEXT STEPS...



- CHEMS Workgroup member recruitment and kick-off in late June
- Blackfoot stakeholder meeting with Critical Access Hospital June 6
- Outreach talking points and PPT for agencies now available
- Recruiting next cohort
- CHEMS EMT education strategy
- Developing mentoring resources



## Statewide Healthcare Innovation Plan (SHIP)

### Community Health EMS (CHEMS) Measures Design Workgroup Recommendations

#### Background and Introduction:

Community Health Emergency Medical Services (CHEMS) is an evolving, innovative healthcare delivery model wherein emergency medical services (EMS) personnel serve to extend the reach of primary care and preventative services outside of the traditional clinical settings. CHEMS providers in Idaho have an expanded provider role and work within their current scope of practice. Examples of these expanded roles may include:

- Acting as healthcare navigators for patients
- Transitional care for patients following discharge from a hospital stay
- Vaccinations
- Medication inventories
- Resource coordination
- Basic medical therapeutics

The Statewide Healthcare Innovation Plan (SHIP) includes the development and implementation of CHEMS programs in rural and underserved communities as part of the “virtual” Patient-Centered Medical Home. These programs will help expand primary care reach and capacity, become assets in the medical-health neighborhood, and improve access to healthcare services.

#### SHIP CHEMS Measures Design Workgroup

A SHIP CHEMS Measures Design Workgroup was convened to identify metrics, data collection mechanisms, and data reporting strategies to test CHEMS against the Triple Aim. The workgroup included 32 stakeholders from a wide range of expertise; including health systems, primary care, higher education, payers, EMS agencies, Division of Public Health staff, critical access hospitals, Public Health Districts, and Qualis Health. This workgroup convened for three full-day facilitated meetings between January-March 2016 and additional work was accomplished electronically between meetings.

#### CHEMS Measures Design Workgroup Highlights:

- **Subject Matter Expert:** Matt Zavadsky, MS-HSA, EMT, a nationally-recognized subject matter expert, presented information and best practices regarding the development of a standard set of outcome measures EMS agencies can use to test program effectiveness. This work has been vetted on the national level by organizations such as the Agency for Healthcare Research and Quality, National Committee for Quality Assurance, and Institute for Healthcare Improvement. Mr. Zavadsky referenced an outcome measures strategy tool agencies can refer to when developing

their measures. Please refer to these links to view his presentation and measures tool:

- <http://www.ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Outcome%20Metrics%20Presentation%201-22-2016.pdf>
- [http://www.ship.idaho.gov/Portals/93/Documents/CHEMS/MIH%20Metrics%20for%20Community%20Health%20Interventions%20Top%2017%20Isolated%204-7-15%20\(J%20%20%20.pdf](http://www.ship.idaho.gov/Portals/93/Documents/CHEMS/MIH%20Metrics%20for%20Community%20Health%20Interventions%20Top%2017%20Isolated%204-7-15%20(J%20%20%20.pdf)

- ***Measure Design and Recommendations:*** The measure tool and information presented by Mr. Zavadsky generated important discussions and stakeholder suggestions about measures SHIP CHEMS agencies can implement. Through facilitated decision-making, the workgroup identified a set of outcome measures CHEMS agencies should collect and report to test the CHEMS concept. The measures for recommendation to the Idaho Healthcare Coalition include the following:

- ***Quality and Experience Measure:*** Patient health-related quality of life
- ***Utilization Measure:*** Reduction in emergency department use
- ***Cost Measure:*** Expenditure savings related to a reduction in emergency department use
- ***Quality Measure:*** Patient connection to primary care provider
- ***Quality and Safety Measure:*** Medication inventory to identify and reduce medication discrepancies

***\*\*Please see Appendix A, page 3, for details about each measure.***

- ***Data Collection and Reporting Methods:*** EMS Agency workgroup members were surveyed to provide feedback and perspective about data collection and reporting capacity. The workgroup discussed the survey results, general data collection questions, potential audience (i.e., who needs the information to guide decision-making about the value/impact of CHEMS), data format, and other considerations. Key results include:

- ***EMS Agency Survey Information:*** EMS Agencies indicated that collecting 4-6 measures is feasible and they can collect the recommended measures in applications such as Excel and Access.
- ***Data Collection and Analysis:*** SHIP personnel received feedback from the SHIP data analytics contractor with regard to aggregating and analyzing CHEMS measures. The contractor can be a resource to support analysis of the recommended measures. If other more automated strategies are not available, the workgroup determined agency data could be collected and reported to SHIP or IDHW staff. This data could subsequently be sent to the data analytics team for analysis. The data analytics contractor suggested an on-line survey instrument, such as Survey Monkey professional version, could also be considered.

***\*\*Further discussions and decisions regarding data collection and reporting strategies will occur in future CHEMS Workgroup meetings.***

Please see the SHIP CHEMS webpage to view workgroup materials and information: <http://www.ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx>

**Appendix A**

**IDAHO COMMUNITY HEALTH EMS (CHEMS)  
MEASURES DESIGN WORKGROUP  
Measures and Data Elements**

**MEASURE 1: Health Related Quality of Life**

Data Elements/Questions

Patients will answer the following questions at or around their last anticipated community paramedic (CP) visit:

- 1) Thinking back to *before* the start of your Community Paramedic visits, please rate your level of confidence in managing your own health.

Very low	Low	Moderate	High	Very high
1	2	3	4	5

- 2) Thinking about how you feel *today*, please rate your level of confidence in managing your own health.

Very low	Low	Moderate	High	Very high
1	2	3	4	5

- 3) How would you describe your overall health *before* the start of your Community Paramedic visits?

Very poor	Poor	Moderate	Good	Excellent
1	2	3	4	5

- 4) How would you describe your overall health *today*?

Very poor	Poor	Moderate	Good	Excellent
1	2	3	4	5

- 5) Thinking back to *before* the start of your Community Paramedic visits, how much did your health negatively impact your daily activities?

Not at all	A little bit	Somewhat	Quite a bit	Very much
1	2	3	4	5

- 6) How much does your health negatively impact your daily activities *today*?

Not at all	A little bit	Somewhat	Quite a bit	Very much
1	2	3	4	5

### Notes/Considerations

- Given workgroup discussions about balancing simplicity and valid measurement methods, the retrospective self-report approach is recommended.
- This measure can be administered by the Community Paramedic (CP) at the last anticipated visit, or via a follow up confidential phone survey conducted by someone perceived as neutral to the patient. If the former, the CP can provide the survey (electronically or hard copy), and give the patient privacy to complete it confidentially. Completion during a visit would likely maximize the response rate.
- The measure calculation would involve comparing before and after program average scores.

## **MEASURE 2: Reduction in Emergency Department (ED) Visits**

### Data Elements/Questions

Community paramedics will ask patients to report the *number of ED visits*:

- 1) Twelve months prior to starting community paramedic visits, and
- 2) During their participation in the community paramedic program.

### Notes/Considerations

- ED visits is defined as any visit to an ED, regardless of the mode of transport to the ED and whether or not the patient was admitted to the hospital.
- The number of ED visits prior to CP involvement can be *proportionally compared* to the number during CP involvement. While longer-term follow up may be ideal, this is a simple way to begin quantifying differences in ED visits before and during CP program involvement.
- For long-term CHEMS patients, consider capturing ED visit frequency on various schedules (e.g., 30 days, 60 days, 6 months, etc.). In doing this, keep in mind convenience for the practitioner (to facilitate good data collection practices) and meaningful time periods that also support good comparison with short-term patients.
- In the future, it may be advisable to link this measure to hospital or payer records.
- In the future, perhaps track other types of unplanned, “emergency-type” visits (e.g., urgent care or immediate visits to the primary care clinic).

## **MEASURE 3: Expenditure Savings**

### Data Elements/Questions

The calculations used in Measure 2 can be linked to an accepted national average ED visit expenditure to demonstrate an initial estimate of financial savings.

### Notes/Considerations

- 1) It is recommended the Medicaid national average expenditure figure be used.
- 2) It is acknowledged that these calculations will significantly underestimate actual costs, but will provide a starting place for capturing this aspect of CHEMS impact.
- 3) Programming this function into the data reporting tool will automate the calculation based on Measure 2.

## **MEASURE 4: Patient Connection with Primary Care Provider (PCP)**

### Data Elements/Questions

Community paramedics will ask patients at the beginning of their work together whether or not they have an established relationship with a PCP. If not, the CP will ask why (e.g., due to not knowing who is available, insurance issues, none available in the community, etc.). For those not connected, the CP will follow up with the patient throughout the CP program to facilitate a PCP connection, and track the outcome at the end of the CP program. For “no” PCP, the CP will capture cases where no PCP is available in the area or if the patient connected with another type of provider or clinic.

### Notes/Considerations

- This measure is based on the assumptions that:
  - a. Many patients may not be connected to PCPs prior to their participation in the CP program, and
  - b. PCP connection is a best practice in improving patient health outcomes (i.e., a foundation of the SHIP).
- “Established relationship” may mean having a currently practicing PCP identified and having visited the PCP in the last year.
- A new PCP “connection” may be defined as the CP facilitating selection of an available PCP (e.g., one who accepts the patient’s insurance, if any), making a first appointment, and the patient attending that first appointment.

## **MEASURE 5: Reduction in Medication Discrepancies**

### Data Elements/Questions

CPs will conduct a medication inventory at each visit with the patient, noting the number of “issues” or discrepancies at each visit. Issues and discrepancies will also be communicated back to PCPs.

### Notes/Considerations

- 1) Medication discrepancies or “issues” will need to be very carefully defined to ensure alignment across all CPs.
- 2) This measure is based on the assumptions that medication discrepancies are common and have a significant impact on patient health.



# SHIP Project Management Dashboard

## Prepared for the Idaho Healthcare Coalition

### Quarter 1 Grant Year 2

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

### Project Implementation Updates

- IHDE’s readiness review of PCMHs is behind schedule for several reasons, including practices requesting postponement of the review due to undergoing transition to new EMR vendor, practices not being ready to participate in the readiness review due to not fully understanding the commitment/engagement level required, etc.
- All 55 PCMHs have signed agreements with Brilljent. 80% of practices have completed MOUs with IDHW.

### SHIP Success Measures

Goal 1	100%↑	92%↑	92%↑	92%↑	75%↑	80%↑	92%↑	90%↑	92%↑	92%↑	ND
	QT = 100	QT = 55	QT = 55	QT = 55	QT = 550	QT = 550	QT = 55	QT = 18	QT = 275k	QT = 275k	QT = TBD
Goal 2	92%↑		92%↑		50%↑		ND		ND		ND
	QT = 55		QT = 275k		QT = 55		QT = 0		QT = 0		QT = 0
Goal 3	100%↑		0%		ND		ND		ND		ND
	QT = 7		QT = 55		QT = 0		QT = 0		QT = 0		QT = 0
Goal 4	ND	50%↑	50%↑		ND		ND		ND		ND
	QT = 0	QT = 6	QT = 16		QT = 0		QT = 0		QT = 0		QT = 0
Goal 5	ND		ND		ND		ND		ND		ND
	QT = 0		QT = 0		QT = 0		QT = 0		QT = 0		QT = 0
Goal 6	ND	100%↑			ND		ND		ND		ND
	AT = TBD	AT = 4			AT = 275k		AT = 20%				
Goal 7	ND		ND		ND		ND		ND		ND
	AT = TBD		AT = TBD		AT = TBD		AT = TBD		AT = TBD		AT = TBD

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

QT = Quarterly Target (Jan 31, Apr 30, July 31, Oct 31)

AT = Annual Target (Jan 31)

ND = No Data

Please refer to the SHIP Operational Plan and project charters for details regarding all quarterly and annual accountability targets.

## SHIP Success Measures by Goal

### Goal 1 Measurements

1	Q	Cumulative # (%) of primary care practices that submit an interest application to become a PCMH. Model Test Target: 270.
2	Q	Cumulative # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation. Model Test Target: 165.
3	Q	Cumulative # (%) of practices designated PCMH. Model Test Target: 165.
4	Q	Cumulative # (%) of practices designated PCMH of total primary care practices in Idaho that could become a PCMH. Model Test Target: 165.
5	Q	Cumulative # (%) of providers participating in PCMHs, of total number of providers targeted for participation. Model Test Target: 1,650.
6	Q	Cumulative # (%) of providers participating in PCMHs, of total providers in Idaho. Model Test Target: 1,650.
7	Q	Cumulative # (%) of designated PCMHs receiving PCMH Technical Support and transformation incentives. Model Test Target: 165.
8	Q	Cumulative # (%) of designated PCMHs that have achieved Idaho-specific or national PCMH recognition/accreditation. Model Test Target: 165.
9	Q	Cumulative # (%) of Idahoans who enroll in a designated PCMH. Model Test Target: 825,000.
10	Q	Cumulative # (%) of targeted population who enroll in a designated PCMH. Model Test Target: 825,000.
11	Q	Cumulative # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare. Model Test Target: TBD.

### Goal 2 Measurements

1	Q	Cumulative # (%) of PCMH sites with EHR systems that support Health Information Exchange (HIE) connectivity capabilities. Model Test Target: 165 PCMHs.
2	Q	Cumulative # (%) of patients in designated PCMHs (sites) that have an EHR. Model Test Target: 825,000 (50.4% of Idahoans).
3	Q	Cumulative # (%) of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc. Model Test Target: 165 PCMHs.
4	Q	Cumulative # (%) of hospitals connected to the IHDE. Model Test Target: 21.
5	Q	Cumulative # (%) of hospitals connected to IHDE that provide information on PCMH enrolled patients. Model Test Target: 21.

### Goal 3 Measurements

1	Q	Cumulative # of RCs established and providing regional quality improvement and Medical-Health Neighborhood integration services. Model Test Target: 7.
2	Q	Cumulative # of designated PCMHs and primary care practices that can receive assistance through an RC. Model Test Target: 165.
3	Q	Cumulative # of designated PCMHs who have established protocols for referrals and follow-up communications with service providers in their Medical-Health Neighborhood. Model Test Target: 165.
4	Q	Cumulative # of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical-Health Neighborhood, as needed. Model Test Target: 825,000 (50.5% of Idahoans).

### Goal 4 Measurements

1	Q	Cumulative # (%) of Virtual PCMHs established in rural communities following assessment of need. Model Test Target: 50.
2	Q	Cumulative # (%) of regional CHEMS programs established. Model Test Target: 16.
3	Q	Cumulative # (%) of CHEMS program personnel trained for Virtual PCMH coordination. Model Test Target: 52.
4	Q	Cumulative # (%) of new community health workers trained for Virtual PCMH coordination. Model Test Target: 200.
5	Q	Cumulative # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff. Model Test Target: 2.
6	Q	Cumulative # of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients. Model Test Target: 36.

### Goal 5 Measurements

1	Q	Cumulative # (%) 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.
2	Q	Cumulative # (%) of quality measures that are reported by all PCMH practices. Model Test Target: 16.
3	Q	Cumulative # (%) of designated PCMH practices that receive community health needs assessment results from an RC. Model Test Target: 165.

### Goal 6 Measurements

1	A	Count of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements. Model Test Target: TBD.
2	A	Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models. Model Test Target: 4.    <b>This success measure has been reached.</b>
3	A	Count of beneficiaries attributed for purposes of alternative reimbursement payments. Model Test Target: 1.3M.
4	A	Percentage of payments made in non-FFS arrangements compared to total payments made. Model Test Target 80%.

### Goal 7 Measurements

1	A	Total population-based PMPM index, defined as the total cost of care divided by the population risk score. Model Test Target: TBD.
2	A	Annual financial analysis indicates cost savings and positive ROI. Model Test Target: 225%.    <b>Data is not currently available.</b>



# COMMUNITY HEALTH WORKERS

## A COMMUNITY HEALTH WORKER (CHW)

A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.<sup>3</sup>

CHWs are an effective way to become a Virtual PCMH and extend healthcare services to medically-underserved areas. As a member of the PCMH team, CHWs will serve as the bridge between individuals in the community and the health and social services in the community.

The Idaho Healthcare Coalition (IHC) is overseeing the expansion of Idaho CHWs who can serve rural communities as part of the Virtual PCMH.

Idaho will adopt and adapt the Massachusetts CHW training curriculum.

Training will be delivered through both live-online training and online course electives.

The Institute of Medicine's 2003 and 2010 Reports noted the positive impact of CHWs and recommended that CHWs can be used as essential members of a healthcare team.

CHWs have been found to:

- Improve access to primary care services
- Improve utilization of services
- Improve quality of care
- Reduce cost of care
- Improve the rate of health insurance coverage
- Significantly contribute to an increase in health promotion and disease prevention
- Help reduce health disparities by providing and arranging for cultural competent services<sup>4</sup>

<sup>3</sup> American Public Health Association definition of CHWs.

<sup>4</sup> "The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2013 - 2014." Patient-centered Primary Care Collaborative, Milbank Memorial Fund. January 2015

## Background and Support for the Virtual PCMH Model

Idaho received federal State Innovation Model (SIM) grant funding to support and test the impact of transforming primary care services to a PCMH model.

The Idaho Healthcare Coalition, comprised of healthcare providers, payers, IDHW, Public Health Districts and other stakeholders, is overseeing the implementation of Idaho's healthcare transformation that is largely funded by the State's SIM grant.

The IHC has designated a significant portion of grant funds to establish Virtual PCMHs in rural communities.

Clinics participating in the Idaho's State Health Improvement Plan (SHIP) Model Test and working toward the PCMH model of care delivery are eligible to receive a \$2,500 Virtual PCMH incentive payment upon incorporating any of the three options identified as virtual modules: CHWs, CHEMS, and/or telehealth.

Support will also be provided to clinics interested in establishing a Virtual PCMH through trainings, peer mentoring programs, learning collaboratives, and other resources identified by the IHC.

# THE VIRTUAL PATIENT-CENTERED MEDICAL HOME (PCMH)

## A Model for Idaho's Rural and Underserved Communities

A Patient-Centered Medical Home (PCMH) is a partnership between the patient, primary care provider, and a team of healthcare professionals to provide coordinated services that focus on the patient's total health needs.

Virtual PCMHs are an important part of the Idaho's goal to expand access to the PCMH team-based model through an innovative approach that maximizes and creates new community resources.

### What is a Virtual Patient-Centered Medical Home?

The Virtual PCMH model is Idaho's unique approach to establishing PCMHs in rural, medically under-served areas. Through the Virtual PCMH, the traditional PCMH healthcare team is expanded to include previously untapped existing local resources and remote resources technology.



Based on community needs and resources, any or all of the three options may be used to establish a Virtual PCMH.

- 1 Expand the PCMH team to include local Community Health Workers (CHWs).
- 2 Engage local Community Health Emergency Medical Services (CHEMS) personnel to participate in the PCMH team.
- 3 Utilize telehealth technology to access and coordinate with healthcare specialists not available in the community.

## Benefits of a Virtual PCMH

A Virtual PCMH will realize the same benefits as a traditional PCMH by extending the PCMH team-based care model that improves quality and coordination of services.

A recent report<sup>1</sup> looked at 28 studies on the impact of the PCMH model and found:

- 17 demonstrated improvements in the cost of care
- 24 found utilization of services improved
- 11 showed improvements in quality
- 10 demonstrated improvements in access
- 8 found improvements in patient satisfaction

The Virtual PCMH model will introduce new resources into rural, medically under-served communities that will help fill the gaps in Idaho's healthcare professional workforce shortage areas.

<sup>1</sup> The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2013 - 2014." Patient-centered Primary Care Collaborative, Milbank Memorial Fund. January 2015





# TELEHEALTH

**TELEHEALTH** is a mode of delivering healthcare services that uses information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health providers.<sup>2</sup>

Many Idahoans have limited access to behavioral health and specialty services, particularly those living in one of the state's 35 rural or frontier counties.

Telehealth is an important tool for providing access to essential services that may not otherwise be available in medically-underserved communities.

The IHC is working with an Idaho Telehealth Council subcommittee and stakeholders from around the state to expand telehealth services. A SHIP telehealth plan is being developed to operationalize telehealth in rural PCMH clinics.

The SHIP Telehealth plan will include:

- Onsite and virtual training resources for PCMHs, CHEMS, and Public Health District SHIP staff
- Best practice resources for the delivery of telehealth services.
- A peer mentoring program for new users of telehealth technology.

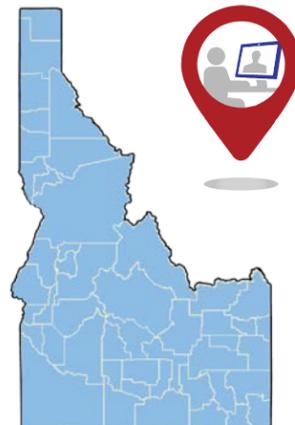
Clinics employing telehealth can be designated as a Virtual PCMH while offering their patients the benefits of telehealth technology, which may include:

- Earlier diagnosis and treatment
- Access to specialists for those with chronic or complex medical conditions
- Reductions in ER visits and hospital admissions
- Timely evaluation of behavioral health needs
- Transportation savings and missed work savings for patients
- Reducing or containing healthcare costs through better disease management, reduced patient complications, and fewer or shorter hospital

<sup>2</sup> Legislative Citation: <https://goo.gl/dZeVPB>

## Behavioral Health and Physical Health Integration

There is a severe shortage of behavioral health (BH) professionals across all of Idaho. Telehealth can help provide access to mental health and substance abuse services and help integrate BH services in the primary care setting.



The IHC is working with the Telehealth Council, providers, and other stakeholders to:

- Identify training, equipment, and other resources needed to increase access to BH services through telehealth.
- Establish telehealth capacity in at least 18 Virtual PCMHs in order to expand access to timely behavioral health services in rural underserved communities.

# COMMUNITY HEALTH EMS



**COMMUNITY HEALTH EMERGENCY MEDICAL SERVICES (CHEMS)** is an innovative model where emergency medical services (EMS) personnel are incorporated into the general healthcare delivery system to increase access to healthcare and extend the reach of primary care into a patient's environment.

The CHEMS model draws upon the extensive medical expertise of Idaho's emergency medical services (EMS) to expand access to primary care services for Idaho's rural and underserved residents.

Traditionally, EMS personnel deliver care in a non-clinical setting, function within interdisciplinary teams, and provide medical services during transport to emergency departments and hospitals. The CHEMS model expands the role of EMS personnel beyond emergency and crisis services to extending primary care services as part of the Virtual PCMH team-based care.

As part of the PCMH team, EMS personnel communicate with the primary care provider to ensure care coordination, appropriate care oversight, and implementation of a care plan. This occurs by leveraging and partnering with current resources and other healthcare providers.

Data will be collected on the CHEMS model to evaluate the impact on patient care and costs.

A Virtual PCMH using the CHEMS model can use EMS personnel in a number of different ways as a member of the PCMH team.

Potential role for CHEMS:

- In-home follow up after a hospital stay or discharge from an emergency department
- Administering vaccinations
- Hospice support
- Follow up and support for individuals with chronic conditions
- Health checks for frequent 911 callers
- Health care navigators
- Basic medical therapeutics
- Medication inventories
- Resource and care coordination

## LEARN MORE ABOUT IDAHO'S VIRTUAL PCMH

Contact your Public Health District SHIP Project Manager for more information about how to establish a Virtual PCMH.

Panhandle Health Collaborative (PHD District 1)  
SHIP Manager @

North Central Health Collaborative (PHD District 2)

Southwest Health Collaborative (PHD District 3)  
XXXX @

Central Health Collaborative (PHD District 4)  
XXXX @

South Central Health Collaborative (PHD District 5)  
XXXX @

Southeastern Health Collaborative (PHD District 6)  
XXXX @

Eastern Health Collaborative (PHD District 7)  
XXXX @

More information can also be found at: <http://ship.idaho.gov/>



# SHIP Operations and IHC Workgroup Report to the Idaho Healthcare Coalition May 18, 2016

## **SHIP OPERATIONS:**

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

- **Report Items:**

- A Kickoff meeting was held on May 9, 2016 with the State Evaluator team to discuss matters relevant to the state evaluator contract and scope of work.
- An RFP for a data analytics vendor for population health is currently being advertised
- An RFQ has been developed to begin the process of selecting a Telehealth vendor to provide technical assistance and training related to the design of the SHIP Telehealth program.
- Contract development is underway for the Community Health Worker Curriculum design and delivery as well as a Request for Release of Funding to CMMI.

### **SHIP Administrative Reporting:**

- **Report Items:**

- A CMMI SHIP Annual Report was submitted to CMMI this month highlighting SHIP Pre-Implementation Year Activities from 2/1/2015-1/31/2016.
- Mercer and SHIP project management staff continue to work on refinements to the Master Project Management Plan (MPMP).
- Mercer and SHIP staff are finalizing data collection protocols related to Goals 1 – 6 metric measurements to comply with CMMI reporting requirements.
- Cynthia York, Casey Moyer, Miro Barac, Kym Schreiber, Burke Jensen and Ann Watkins attended the Idaho Healthcare Summit in Coeur d'Alene on May 10, 2016 and also met with stakeholders in Regions 1 and 2 to discuss SHIP related activities, questions and operational matters.
- Research Triangle Institute (RTI), CMMI federal evaluator will conduct their initial site visit to evaluate Idaho's SHIP model test during the week of May 23, 2016.

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

- **Report Items:**

- Public Health District Directors and SHIP Program Managers are actively participating in finalizing requirements for the new subgrant to take effect on July 1st, 2016.
- All Regional Health Collaboratives met since the last IHC meeting in April. The Executive Leadership Teams from Regions 5 and 6 will be reporting their progress.
- Idaho Department of Health and Welfare Division of Public Health is working on alternative approaches to provide actionable information to the Regional Health Collaboratives until clinical quality measures reports become available later this year.

- **Next Steps:**

- Continue supporting establishment of functioning Regional Collaboratives.
- Continue coordinating PHDs effort with other programs and entities.
- PHD Subgrants are due to be renewed by July 1st 2016 and will include Regional Health Collaboratives Strategic Plans as part of the subgrant deliverables.

## **ADVISORY GROUP REPORTS:**



### **Telehealth SHIP Subcommittee:**

- **Report Items:**
  - The Telehealth Council Goal Two Subcommittee responsible for Telehealth expansion is convening on June 17<sup>th</sup>, 2016. Presenters from Telehealth Alliance of Oregon and Oregon Office of Rural Health will share information and best practices. Oregon has successfully implemented Telehealth as part of the SIM grant.
- **Next Steps:**
  - Idaho SHIP is developing a request for quotation (RFQ) seeking Telehealth consultation services and expertise to support PCMH Telehealth expansion under SHIP. This RFQ will also include Telehealth training webinar series for PCMHs.



### **Community Health Workers:**

- **Report Items:**
  - The CHW Workgroup scheduled meetings with St Luke's Health System, Terry Reilly Health Service, and Family Medicine Residency of Idaho to learn about models of CHW utilization in their respective organizations, with an emphasis on measures and evaluation processes.
  - Idaho SHIP is finalizing a contract with Idaho State University to train the first cohort of CHW students. The training is scheduled to begin on August 22<sup>nd</sup>. Recruitment of instructors will start in early June.
  - Idaho SHIP is submitting the proposed Idaho State University contract to the Center for Medicare and Medicaid Innovation for approval.
  - The Bureau of Community and Environmental Health, Division of Public Health, is recruiting primary care clinics with CHWs to participate in the development of short, informative videos about CHW work. While not a SHIP activity, when the project is complete, these materials can be used to inform stakeholders about CHWs and leverage this work to support SHIP CHW program development.
- **Next Steps:**
  - The CHW Advisory Group continues to engage stakeholders in soliciting best practices.

## **WORKGROUP REPORTS:**



### **Community Health EMS:**

- **Report Items:**
  - Mary Sheridan, Bureau Chief of the Office of Rural Health and Primary Care together with Mark Babson of Ada County Paramedics will be reporting on CHEMS efforts undertaken under SHIP. In their report, they will elaborate on the concept of community paramedicine, overview of the national and state efforts and history of CP. Main focus will be CHEMS outcome measures collection and reporting mechanisms.

- **Next Steps:**
  - Engage SHIP Data Analytics vendor to operationalize collection and reporting mechanisms for the identified measures with an ultimate goal of demonstrating the value and impact of CHEMS programs.



### **Idaho Medical Home Collaborative:**

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



### **Health Information Technology:**

- **Report Item:**
  - The HIT Workgroup met on April 21, 2016.
  - IHDE has continued conducting readiness assessments in preparation for establishing connections with the SHIP Cohort 1 clinics.
  - Creation of a Use Cases Subcommittee to define supporting documentation and specifications HealthTech will leverage to create dashboard reports and system functionality.
  - Discussed the importance of ensuring the IHDE patient privacy notice and associated policies were reviewed and updated, if necessary, to accommodate for the data being shared with HealthTech Solutions for clinical quality reporting.
  - The Data Element Mapping Subcommittee met on April 14, 2016.
  - Discussed the clinical quality measures for Years 2 and 3 and recommended aligning the Depression Screening, Childhood Immunization and the Non-malignant Opioid Use Measures with CMS/PQRS measures.
- **Next Steps:**
  - The next HIT Workgroup meeting is scheduled for May 19.
  - The HIT Workgroup leadership will schedule the Use Cases Subcommittee meetings for June and begin planning for it.
  - IHDE will work with its legal counsel and its Privacy and Security Council to ensure its policies reflect the data sharing with IHDE.
  - The Data Element Mapping Subcommittee leadership will work with the Clinical Quality Measures (CQM) Workgroup to consider the recommendations for the next set of measures as well as to obtain clarification on the CQM Workgroup's vision for the remaining measures that require claims data.
  - The Data Element Mapping Subcommittee leadership will work with the Behavioral Health Integration (BHI) Workgroup to clarify and refine the Adherence to Anti-Psychotic Medications measure.

- The SHIP Operations team will select a few clinics to send a manual batch of CCDA patient files to IHDE and ultimately to HealthTech Solutions to begin the process of mapping the data.

## **MPW** Multi-Payer:

- **Report Item:**
  - The MPW determined at the 3/9/16 meeting they would meet quarterly. The quarterly meeting has not been scheduled; however the SHIP Administrator met with the MPW workgroup chairs to establish next steps.
- **Next Steps:**
  - Develop a value based payment framework for Idaho to gain clarity into the different payment methodologies that exist in the Idaho marketplace for primary care and create a common language for primary care providers and payers to communicate about contracting methodologies. This will help in categorizing methodologies to aid in reporting aggregate lives within each category to meet CMMI deliverables.

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

- **Report Item:**
  - The workgroup has not met since the last IHC meeting.
- **Next Steps:**
  - The CQM Workgroup will convene before the next IHC meeting to consider the next round of recommendations from the HIT Workgroup.

## **BHI** Behavioral Health:

- **Report Item:**
  - No meeting was held in May, nothing to report at this time.
- **Next steps:**
  - No meeting was held in May, nothing to report at this time.

## **PHW** Population Health:

- **Report Item:**
  - The PHWG convened their ninth meeting on May 4, 2016.
    - The group reviewed the Idaho Live Better website, received an update on the CHEMS, CHW and Telehealth workgroups, learned about the Centers for Disease Control and Prevention (CDC) 6|18 Initiative, discussed a document being created by the DHW, Division of Public Health that is being created to create an inventory of work being done in clinics across the state, discussed the status of the population health data display, and held time of workgroup member sharing.

- The CDC 6|18 Initiative is centered on six high-burden preventable conditions (tobacco use, high blood pressure, health care-associated infections, asthma, unintended pregnancies and diabetes) and eighteen evidence-based interventions. The interventions were named based on input from experts in insurance, health care and health administration about interventions that improve health and control costs based on the type of evidence payers consider when selecting new services. The interventions are focused on the clinical setting and the community-clinical linkages and not necessarily the community at large.
  - The Division's clinical work inventory project is to demonstrate the initiatives being done in health care clinics across the state in an effort to, when feasible, prevent district staff and partners from bumping into one another in clinics, reduce redundancy for clinics, ensure coordinated approaches, etc. The inventory shows clinics that have multiple initiatives in which they are involved.
  - Examples of work include the SHIP PCMH transformation, public health around colorectal cancer screening, diabetes and heart disease and academic detailing, and Qualis activities.
- **Next Steps:**
    - The next meeting of the PHWG is June 7. The group determined that the July meeting will be canceled and reconvene in August depending on activities and need.