

# STATEWIDE HEALTHCARE INNOVATION PLAN

## OPERATIONAL PLAN – MODEL TEST YEAR 1



## IDAHO DEPARTMENT OF HEALTH AND WELFARE

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Version 1.7



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## Glossary of Terms

**Community Health Emergency Medical Services (CHEMS)** – An innovative model for using emergency medical services (EMS) personnel to provide primary care and preventative services, such as hospital discharge follow-ups, medication reconciliation, and wound care.

**Community Health Worker (CHW)** – A trained community member that assists others in understanding and accessing available services to improve health outcomes.

**Driver Diagram** – A conceptual model of Idaho’s SIM Model that identifies components of the healthcare system that Idaho is targeting in the SIM Model Test, and how the proposed initiatives will lead to healthcare system transformation.

**Electronic Health Record (EHR)** – A digital record of patient-level health information, which may include: demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

**Fee-for-service (FFS)** – A reimbursement model in which medical services are billed and paid individually as they are administered.

**Frontier area** – A remote and sparsely populated geographic area. Much of Idaho’s geography is classified as a frontier area.

**Get Healthy Idaho** – Idaho’s population health plan that reflects a statewide health assessment and a plan to address priority health issues.

**Health professional shortage area (HPSA)** – A geographical area, specific population, or medical facility identified by the U.S. Department of Health and Human Services as having a shortage of healthcare professionals in the categories of primary care, dental care, or mental healthcare.

**Idaho Department of Health and Welfare (IDHW)** – The Idaho State agency responsible for administering various social service programs, including Medicaid and CHIP, as well as the SIM Model Test.

**IDHW SHIP Team** – IDHW staff, mostly housed in the Office of Healthcare Policy Initiatives, responsible for implementing and monitoring SIM Model Test activities.

**Idaho Healthcare Coalition (IHC)** – A group of stakeholders officially organized through a 2014 Executive Order that are responsible for providing strategic oversight and guidance on the SIM Model Test.

**Idaho Health Data Exchange (IHDE)** – Nonprofit corporation established to develop and oversee the implementation of a health information exchange (HIE) in Idaho.

**Idaho Health Professions Education Council (IHPEC)** – Council established by Governor Otter in 2009 to review, analyze, and publish Idaho-specific data on the status of the healthcare workforce and make recommendations to address workforce capacity gaps. The IHPEC is composed of healthcare organizations, Idaho colleges and universities, and the public.

**Idaho Medical Home Collaborative (IMHC)** – A collaboration of primary care physicians, private health insurers, healthcare organizations, and Idaho Medicaid established by Governor Otter in 2010 in order to promote the statewide development and implementation of a patient-centered medical home (PCMH) model of care.

**IMHC Pilot** – A pilot program created by the IMHC and implemented January 1, 2013 to test the PCMH model of care in Idaho. The two-year IMHC Pilot ended in 2015.

**Incentive Distribution Contractor** – A contractor selected by IDHW responsible for issuing and tracking incentive payments to PCMHs.

**Initial Core Performance Measurement Catalog (“Catalog”)** – Set of health indicators identified as areas in need of health improvement for Idahoans. The Catalog reflects stakeholder input, serves as the starting point for Idaho’s coordinated quality reporting system, and is a key milestone in the State’s efforts to align measures across payers in support of population health management.

**Leadership champion** – A designated physician or individual within each PCMH site charged with implementing the long-term vision of the Model, including encouraging participation of physicians and providers.

**Medical/Health Neighborhood** – The Medical/Health Neighborhood is the clinical-community partnership that includes the medical, social, and public health supports necessary to enhance health and the prevention of disease, with the PCMH serving as the patient’s primary “hub” and coordinator of healthcare delivery, with a focus on prevention and wellness within the context of services available outside the clinic setting. The Medical/Health Neighborhood can include: medical specialists; community services such as food, housing and transportation; dietitians; behavioral health specialists; home health; dental professionals; community health workers, community health emergency medical services, education, social services, etc. — that help provide wrap-around, community-level support for the PCMH, and patient to achieve better health outcomes and wellness.

**Model Test Year** – One of the three years of Idaho’s SIM Model Test during which model participants will be working to implement the model.

**Patient-centered medical home (PCMH)** – A model of care that emphasizes care coordination and communication to transform primary care. The PCMH model focuses on core attributes and functions of comprehensive care, patient-centeredness, coordinated care, accessible services, quality, and safety.

**PCMH Contractor** – A contractor selected by IDHW to assist primary care practices with PCMH transformation.

**PCMH accreditation or PCMH recognition** – The milestone of meeting national or Idaho-specific criteria for recognition as a PCMH.

**PCMH designation** – The milestone of a primary care practice meeting Idaho-specific criteria for participation as a PCMH in the SIM Model Test.

**PCMH enrollment** – The process of enrolling primary care providers in the PCMH model, which includes an application, readiness assessment, and signing a memorandum of understanding (MOU) with the PCMH Contractor.

**PCMH incentive payments** – SIM Model Test grant-funded payments made to providers participating in the PCMH model to support practice transformation.

**PCMH primary care practice** – A primary care clinic site that operates as a PCMH.

**PCMH readiness assessment** – The process of evaluating a primary care provider’s competencies, commitment, and ability to modify their practice to meet the goals of the PCMH model as well as their qualifications for participating in the SIM Model Test. The PCMH readiness assessment will be conducted by the PCMH Contractor.

**PCMH Technical Assistance, Training, and Coaching Contractor** – The contractor selected by IDHW responsible for conducting PCMH readiness assessments, creating training and technical assistance resources based on readiness assessments, and guiding primary care providers through successful adoption of the PCMH model.

**PCMH Transformation Team** – PCMH site-specific team generally consisting of a physician, a practice office manager, and a PCMH change agent or project lead identified by clinic leadership.

**Population health** – The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

**Pre-Implementation Year** – The period starting January 1, 2015 and ending January 30, 2016 dedicated to building the infrastructure and groundwork for successful implementation of the Model Test.

**Project Management and Financial Analysis Contractor** – A contractor selected by IDHW responsible for overall project management support to the SIM Model Test and for performing financial analysis related to the model cost metrics.

**Public Health District (PHD)** – A quasi-governmental agency that works closely with IDHW and other state and local agencies to respond to local health needs of community members. The seven PHDs in Idaho have been designated as the convener of the Regional Health Collaboratives (RCs) and will serve as the main facilitators of the regional effort to achieve Idaho’s seven healthcare system transformation goals.

**Regional Collaborative Executive Leadership Committees (RCEs)** – The decision-making body of each Regional Health Collaborative (RC), comprised of two co-chairs, the PHD Director and the SHIP Manager. The RCEs are responsible for leading the RC’s efforts and communicating with the IHC on Model implementation progress.

**Regional Health Collaborative (RC)** – A regional body comprised of local representatives from PCMHs and the Medical/Health Neighborhood and PHDs who will advance and support the SHIP goals through facilitating development of the Medical/Health Neighborhood and contributing local area expertise to strengthen care coordination opportunities between the PCMH and the Medical/Health Neighborhood. The PHDs will convene and support the RCs.

**State Evaluator** – A contractor selected by IDHW to monitor and evaluate SIM activities to support continuous quality improvements efforts using core metrics and accountability targets.

**State Innovation Model Design (SIM Model Design)** – The stakeholder-driven design process that led to the development of Idaho’s State Healthcare Innovation Plan (SHIP), which serves as a blueprint for the Model Test.

**State Innovation Model Test (SIM Model Test)** – The implementation of the SIM Model Design in Idaho, also referred to as Idaho’s Model Test.

**Statewide Data Analytics Contractor** – A contractor selected by IDHW to develop and implement the infrastructure to collect, analyze and report performance measure data for the SIM Model Test.

**Telehealth** – As defined by Idaho House Concurrent Resolution No. 46, 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. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's health status.

**Telehealth Contractor** – A contractor selected by IDHW responsible for helping expand telehealth technology in Virtual PCMHs, including training and technical assistance.

**Triple Aim** – A framework developed by the Institute for Healthcare Improvement to optimize health system performance through improved health outcomes, improved quality and patient experience of care, and lower care costs. Idaho has adopted the Triple Aim as the pillar of its SIM Model Test.

**Virtual PCMH** – An Idaho PCMH that incorporates CHWs, CHEMS, or telehealth into its care delivery system to provide access to the PCMH model for residents of rural, underserved areas, including increased access to behavioral and specialty healthcare.

## Acronyms

ALS	Advanced life support
BLS	Basic life support
BMI	Body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CHEMS	Community Health Emergency Medical Services
CHW	Community Health Worker
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CQI	Clinical Quality Improvement
DO	Doctor of Osteopathic Medicine
ED	Emergency Department
EHR	Electronic Health Record
EMS	Emergency Medical Services
FFS	Fee-for-service
FTE	Full-time employee
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange

HIT	Health Information Technology
HMA	Health Management Associates
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IDHW	Idaho Department of Health and Welfare
IHC	Idaho Healthcare Coalition
IHDE	Idaho Health Data Exchange
IHPEC	Idaho Health Professions Education Council
IHS	Indian Health Services
ILS	Intermediate Life Support
IMHC	Idaho Medical Home Collaborative
LPN	Licensed Practical Nurse
MD	Doctor of Medicine
MDE	Major Depressive Episode
MHPSA	Mental Health Professional Shortage Area
MOU	Memorandum of Understanding
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NICU	Neonatal Intensive Care Unit
NIS	National Immunization Survey
NP	Nurse Practitioner
ONC	Office of the National Coordinator
PA	Physician Assistant
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PHAB	Public Health Accreditation Board
PHD	Public Health District
PMPM	Per-Member Per-Month
QA	Quality Assurance
QI	Quality Improvement
RC	Regional Health Collaborative
RCE	Regional Collaborative Executive Leadership Committee
RFP	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
ROI	Return on Investment
RTT	Rural Training Track
SHIP	State Health Innovation Plan
SIM	State Innovation Model
SME	Subject Matter Expert
SMI	Serious Mental Illness
SPA	State Plan Amendment

# 1. Project Summary

## 1.1. Project Summary

Idaho envisions a statewide healthcare system transformation that changes the standard of practice for healthcare for the State, delivering integrated, efficient, and effective primary care services through the patient-centered medical home (PCMH), which is integrated within the local Medical/Health Neighborhood, and supported and incentivized by value-based multi-payer payment methods.

Through this transformation, Idaho will improve the quality and experience of care for all Idahoans, improve health outcomes, and control costs. Idaho envisions a State healthcare system in which:

- PCMH teams provide high-quality, integrated, and coordinated care for all Idahoans in a cost-effective way.
- The broader healthcare system is organized at the regional level as robust Medical/Health Neighborhoods, integrating a spectrum of ancillary healthcare providers and non-medical community-based organizations with primary care.
- All providers are linked electronically so clear and timely communication occurs.
- Public and private payers are aligned to support these practices through a value-based payment model that rewards quality over quantity.
- The system is patient-centered and partners with engaged patients in shared decision making. Health promotion and wellness are central tenets of Idaho's healthcare redesign.

All of these principles, activated at the community level, will create the sustainable healthcare system Idaho needs. Idaho has translated these principles into seven goals, which, if achieved, will advance the mission of Idaho's statewide healthcare transformation.

**MISSION**

**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 outcome**

**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/Health Neighborhood.

**Goal 3:** Establish seven Regional Health Collaboratives to support the integration of each PCMH with the broader Medical/Health 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 embarks on this ambitious transformation in response to stakeholders' demands for improved access to care, lower costs, and better health. Currently almost 18% of Idaho's 1.6 million residents are uninsured. Those who do have healthcare coverage may have difficulty accessing services, as 96.7% of Idaho is a federally-designated shortage area for primary care, and the entire State is a federally-designated shortage area for behavioral health. This Model Test will convert Idaho's deficits to assets by implementing changes like:

- Addressing the State's workforce shortage through the PCMH model.
- Creating a Virtual PCMH to bring high-quality healthcare to extremely rural communities.
- Recruiting local community leaders and stakeholders to serve as Regional Health Collaboratives (RCs), integrating public health and physical health at the local level.

Idaho has made several modifications to the State's Health Innovation Plan (SHIP) Model Test since submission of the last Operational Plan in September 2014 as a result of the reduced Model Test proposal budget. Even with the reductions, Idaho has committed to maintaining the integrity of all aspects of the proposed model and goals. Key budget reduction strategies included reducing:

1. The number of primary care practices to be transformed from 60 per year to 55 per year for a three-year total of 165 practices transformed.
2. The amount of financial incentives awarded to participating practices.
3. Technical assistance contracts to assist practices in transformation.
4. The project management/financial analysis contract.
5. Proposed equipment to be purchased to support telehealth in rural and frontier communities.
6. Proposed Idaho Department of Health and Welfare (IDHW) staff from 8.5 full time employees to 8 full time employees.
7. The overhead allocated to the Public Health Districts (PHDs) to support the RCs.

8. The proposed State evaluation to reflect the reduced total budget request.

Several other changes have been identified as a result of Idaho's planning efforts in the pre-implementation period. All changes have been carefully considered and documented by the Idaho Healthcare Coalition (IHC) and IDHW, and occurred as a result of stakeholder input, lessons learned from the Idaho Medical Home Collaborative (IMHC) piloting of the PMCH model, and/or additional information received from the Center for Medicare and Medicaid Innovation (CMMI). Key revisions to Idaho's goals and objectives and the Model include:

- Aligning Model Test activities to focus on shifting 80% of all payers' payments to alternatives to fee-for-service (FFS) arrangements instead of targeting moving 80% of the State's population enrolled into PCMH model clinics.
- Not requiring PCMHs participating in Idaho's Model Test to obtain recognition/accreditation by a national body such as NCQA. Instead, practices will be encouraged to complete activities necessary to obtain recognition/accreditation, either by a national entity or by meeting Idaho-specific recognition criteria. Idaho changed this requirement as a result of "lessons learned" from the Idaho Medical Home Collaborative PCMH pilot initiative.
- Refining several of the State's Model metrics. Idaho modified a metric in the Initial Core Performance Measurement Catalog to broaden the measure beyond the original diagnostic group identified.
- Additional stakeholders have been named to the IHC to ensure broader representation.

Additional description of how Idaho has begun to operationalize these changes can be found in the component area narratives in Section 2.

## 1.2. Driver Diagram

Idaho submits the following driver diagram, which serves as a conceptual model of Idaho's State Innovation Model (SIM) initiative. The driver diagram identifies the aspects of the healthcare system that Idaho is targeting in the SIM Model Test, how the proposed initiatives will lead to healthcare system transformation, and the populations that will be impacted by the Model Test.

Figure 1 shows the master driver diagram. Idaho's aim is to achieve the Triple Aim of (1) improving health outcomes, (2) improving quality, and patient experience of care, and (3) reducing the cost of healthcare in the State. The primary drivers of system transformation are the seven goals of Idaho's SIM Model Test, discussed in greater detail in Section 2 of this Operational Plan. The secondary drivers of system transformation are the outcomes associated with each goal, which will be the areas of focused activity on the part of payers, providers, patients, and others during Idaho's Model Test.

Figures 2–5 show the breakdown of each of the four primary drivers, with the associated metrics for each driver that will be monitored and reported to track the model's progress. Accountability targets for each metric are also shown, which will serve as guideposts for evaluating the Model's performance during implementation. Further description of the metrics and accountability targets can be found in Section 1.3 of this Operational Plan.

Figure 1 — Driver Diagram

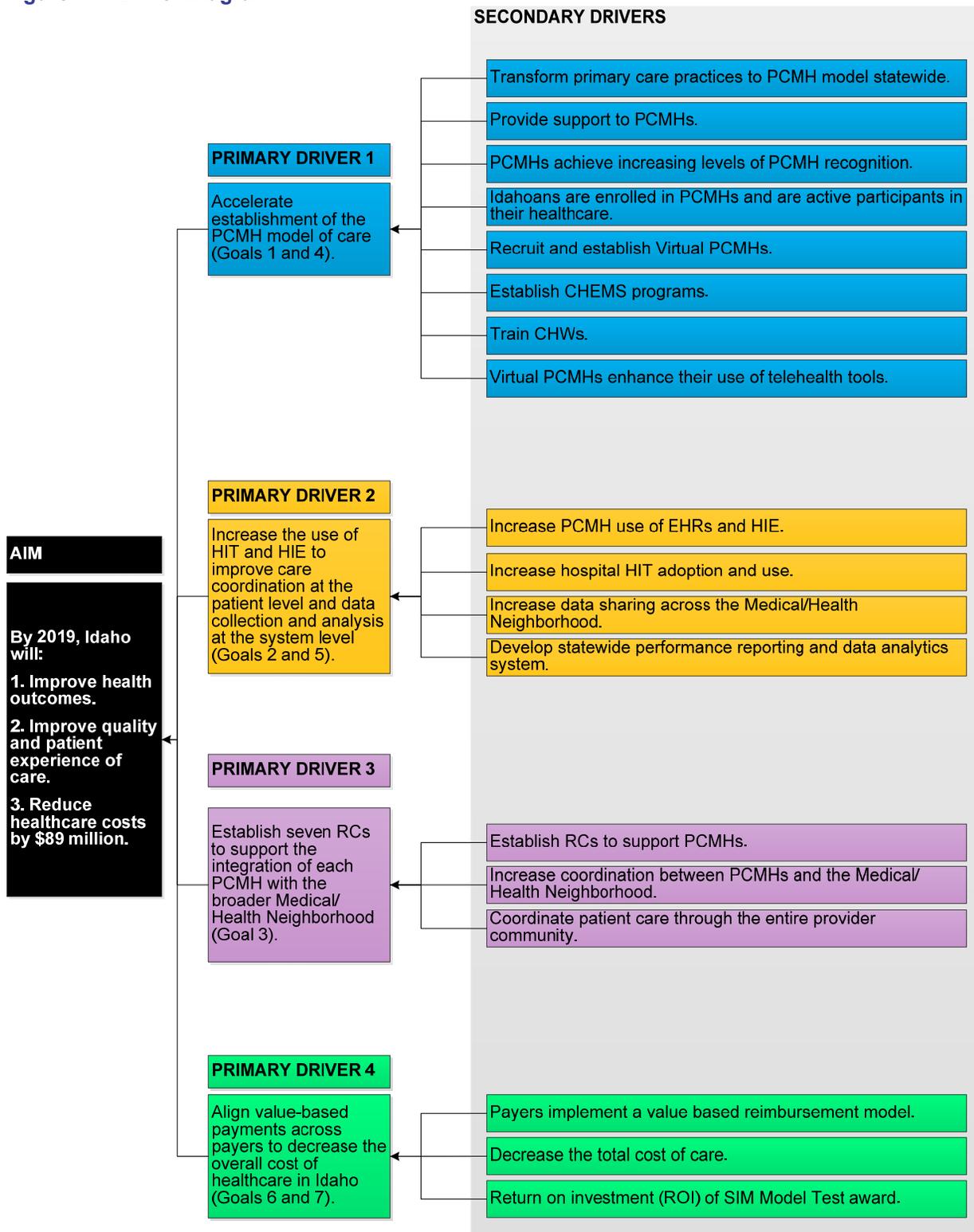


Figure 2 — Metrics for Primary Driver 1

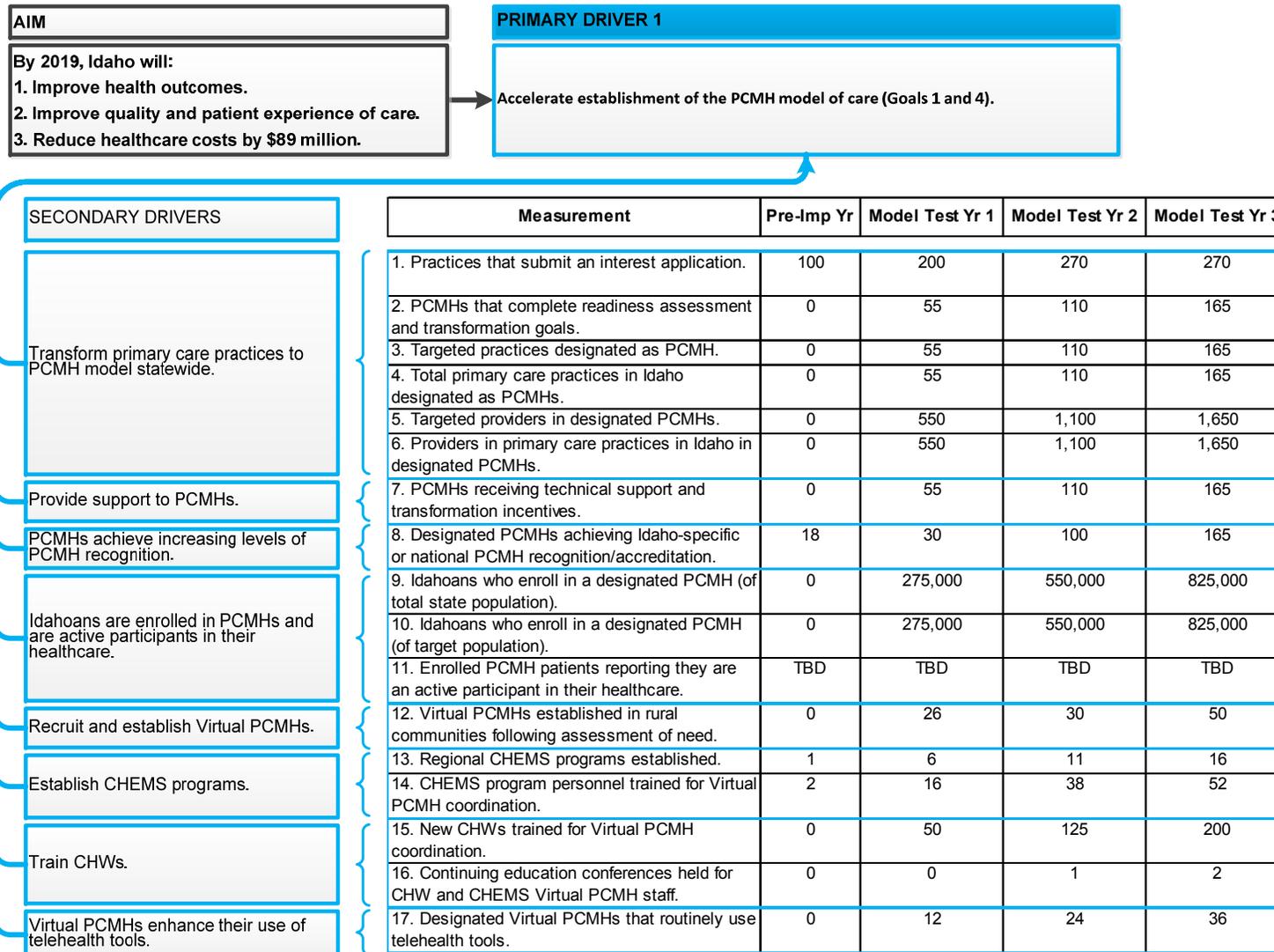


Figure 3 — Metrics for Primary Driver 2

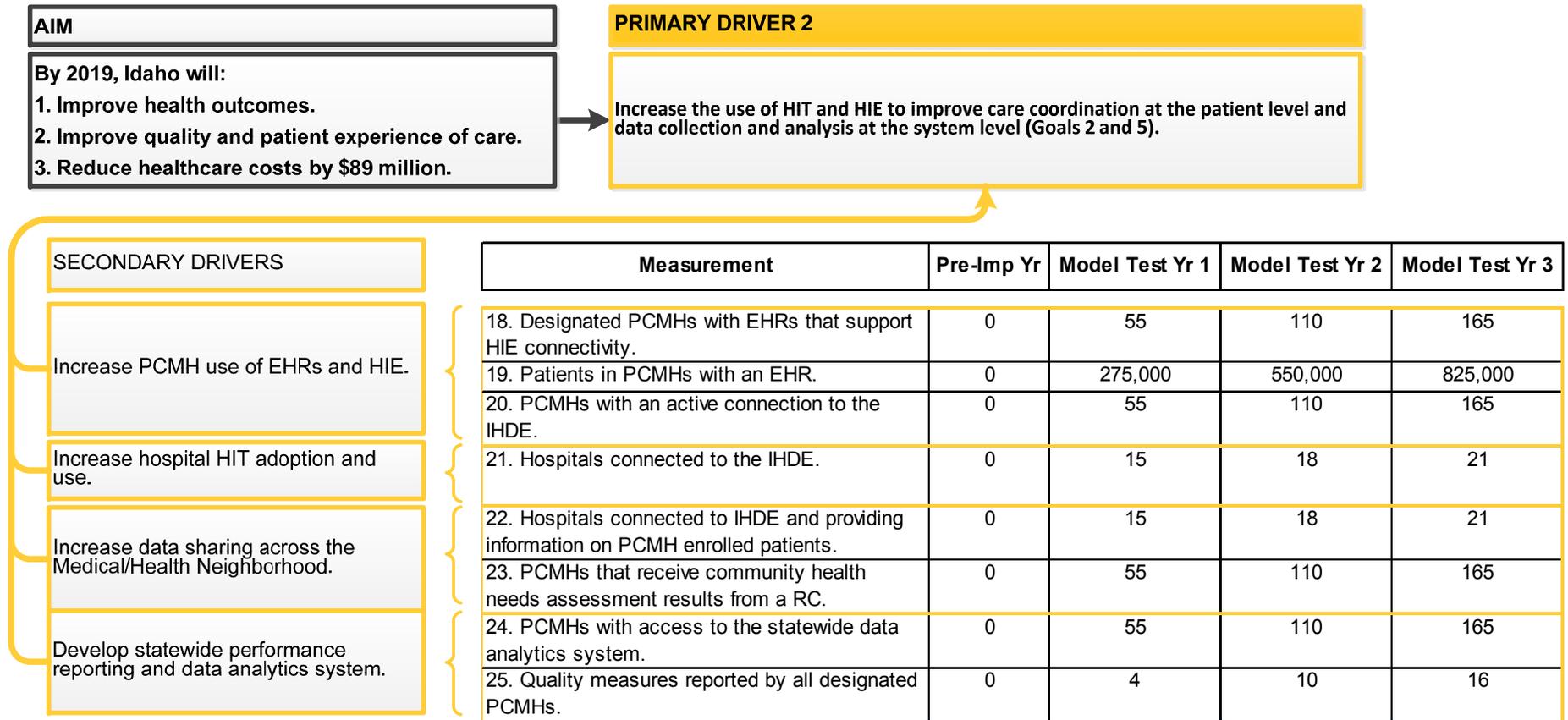


Figure 4 — Metrics for Primary Driver 3

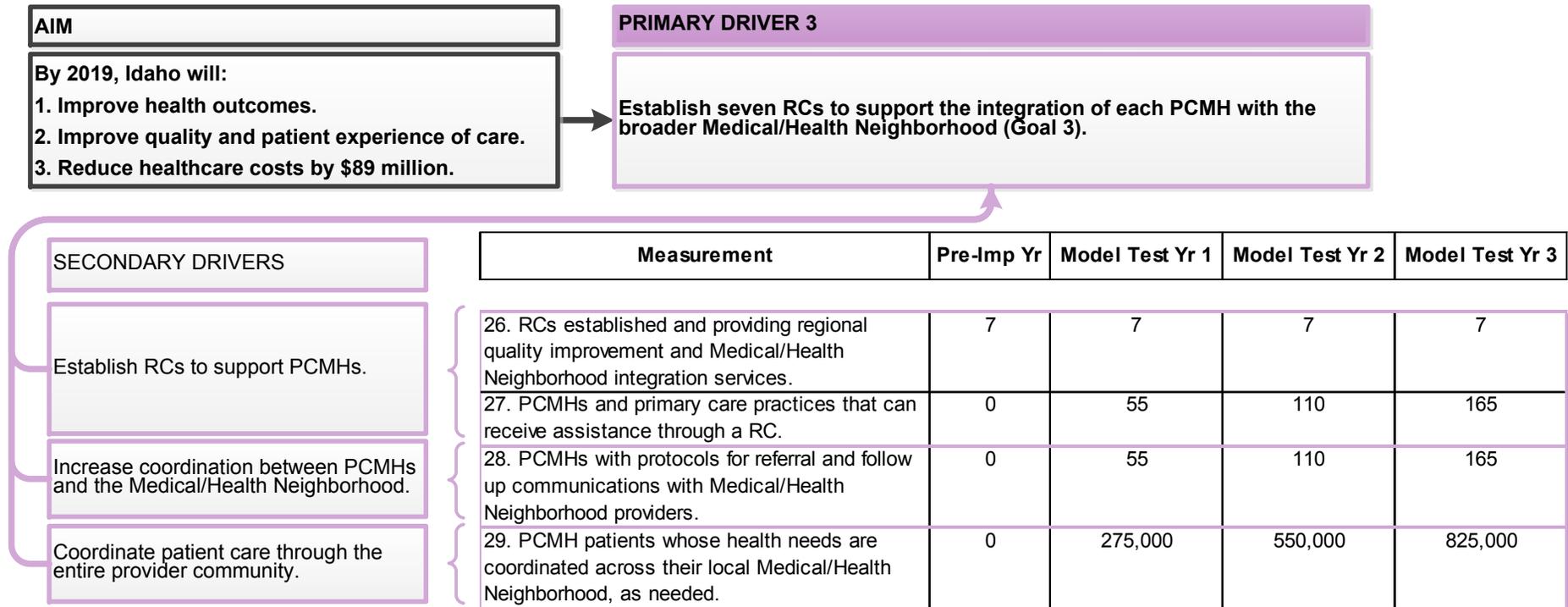
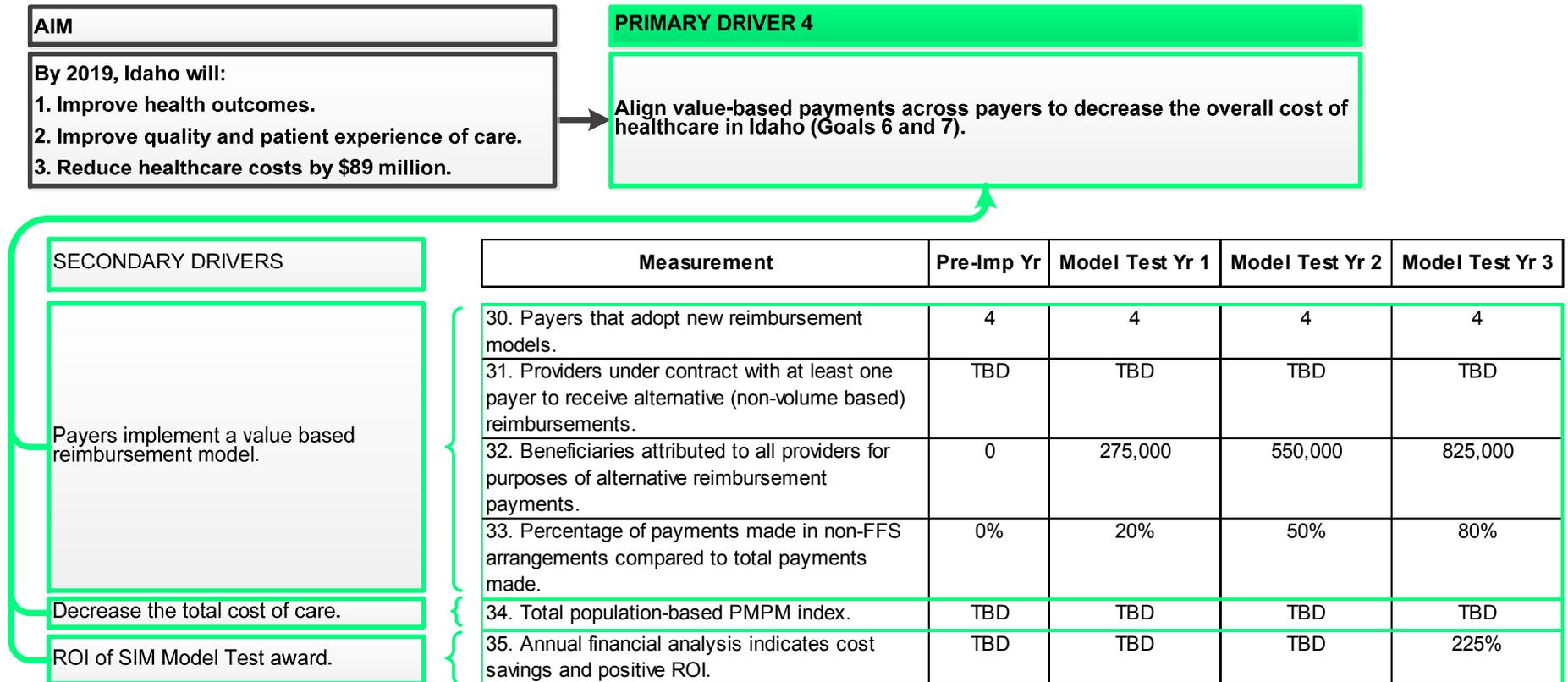


Figure 5 — Metrics for Primary Driver 4



### 1.3. Core Metrics and Accountability Targets

Idaho has established a set of metrics and accountability targets to track progress in implementing Idaho's goals for the Model Test and to monitor system transformation. The table in Appendix A specifies detailed information on Idaho's metrics and accountability targets; specifically, for each metric:

- The metric name
- Data source
- Reporting frequency
- Definition
- Numerator/denominator
- Measure population
- Measure type
- Measure value/record type
- Measure group
- National Quality Strategy priority area
- Target goals

Broadly, Idaho's metric set includes (1) performance measures to monitor population health improvement and (2) success measures for each of Idaho's seven goals.

#### Performance Measures

To align clinical quality performance measurement across public and private payers or programs, Idaho has developed an Initial Performance Measure Catalog (Catalog). Initial performance measures selected for the Catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans. The Catalog serves as the starting point for Idaho's coordinated quality reporting system and is a key milestone in the State's efforts to align measures across payers in support of population health management.

In creating the Catalog, Idaho's Model Test seeks to support cross-payer reporting methods that have shown success in the IMHC Pilot, as well as draw on the valuable lessons learned from this experience. During the Pre-Implementation Year, IDHW will contract with the State evaluator and begin working, along with the Clinical Quality Workgroup and the HIT Workgroup, to identify data pathways to establish a baseline for measures in the Catalog. Due to the lack of uniform reporting that exists today, the data pathways for the baselines and data reporting moving forward will be developed from the pockets of information that are currently available across payers and populations. IDHW and the IHC will review the baseline data to identify four core performance measures from the Catalog for all PCMHs to begin reporting in Model Test Year 1. Reported measures will be reviewed at the State and regional levels by IDHW, the IHC, and the RCs. The PHDs will provide feedback to each PCMH in their region.

RCs, in consultation with IDHW and the IHC, will identify additional performance measures to be reported beginning in Model Test Year 3 for their respective regions. Regional-specific performance measures will be identified after consideration of both initial performance results and regional health needs, as determined by community health assessments and other clinical and service data. In Model Test Year 3, PCMHs will report on the statewide performance measures and regional-specific measures.

Moving forward, IDHW and the IHC will evaluate data from multiple sources, e.g., PCMHs, hospitals, behavioral health assessments, community health needs assessments, and national trends in making any further to recommendations in terms of additional performance measures to be added to the Catalog.

### Goal Success Measures

Idaho has created success measures for each of the seven goals of the Model Test for the purpose of tracking progress towards achieving each goal. For most measures, quarterly accountability targets have been set for each success measure, and data will be collected and reviewed on a quarterly basis; some measures will be reviewed annually. Many of the goal success measures focus on critical milestones and gaps and barriers to implementation to ensure areas of risk are tracked and closely monitored. Other goal success measures reflect Idaho's commitment to expanding best practices as a fundamental value in the planned transformation. Several of Idaho's goal success measures also incorporate CMMI-required metrics.

## **1.4. Master Timeline for SIM**

### Pre-Implementation Year Activities

Idaho has accomplished a great deal in the first year of the pre-implementation period. Idaho's Pre-Implementation Year activities included accomplishing the following:

- Developing requirements:
  - PCMH requirements and standards, the incentive structure, and PCMH Mentoring Program.
  - Virtual PCMH requirements.
  - Community Health Worker (CHW) and Community Health Emergency Medical Services (CHEMS) standards and certification requirements.
  - RCs' roles and responsibilities, standards, and expectations.
  - RC stakeholder advisory groups' role, expectations, and leadership, known as the RC Executive Leadership Committees (RCEs).
  - Requirements for contractor contracts.
  - PCMH payment structure — enrollment and attribution processes.
  - Initial agreement among payers regarding data sharing and initiating formal aggregate data-sharing agreements.
  - Process and mechanism for distributing financial incentives to support practice transformation.
  - Statewide data analytics vendor responsibilities and expectations.
- Began engaging contractors:
  - IDHW entered into contracts with:
    - Project Management and Financial Analysis Contractor (Mercer).
    - PCMH Contractor, including Incentive Distribution Contractor and PCMH Technical Assistance, Training, and Coaching Contractor (Briljent, Myers and Stauffer, and Health Management Associates [HMA]).
  - IDHW plans to engage a State Evaluator by January 31, 2016.
  - IDHW developed and published a request for proposal (RFP) for the Data Analytics Contractor. An award is anticipated to occur by January 2016.
- Engaged stakeholders:
  - Expanded IHC membership to broaden stakeholder representation.

- Identified three advisory Workgroups to provide subject-matter expertise in the areas of telehealth, community health workers, and community health EMS.
- Established a Behavioral Health – Physical Health Integration Stakeholder Workgroup.
- Developed plan for communicating with external stakeholders including a toolkit to facilitate consistent, effective communication.
- Completed ramp-up activities:
  - Established RCs in each of Idaho’s seven PHDs by July 1, 2015.
  - Began PCMH recruitment by identifying and reaching out to practices, including developing an Application of Interest distributed statewide.
  - Received over 100 final applications from clinics for the first PCMH cohort.
  - Provided PCMH outreach, education, and technical assistance to practices desiring to become PCMHs.
  - Hired staff to support grant activities.
  - Conducted a population health assessment.
  - Developed Idaho’s Population Health Plan, *Get Healthy Idaho*.

### 1.5. Budget Summary Table

The table below provides a summary of Idaho’s projected funding needs for each SIM initiative component for the upcoming funding period (Model Test Year 1). Also shown are the primary drivers associated with each projected funding area. As demonstrated in the table below, each funding area contributes directly to one or multiple primary drivers of Idaho’s health system transformation. In addition, several metrics are associated with each funding area. Regular monitoring of these metrics will be an important component of Idaho’s proper stewardship of SIM Model Test funds.

**Table 1 — SIM Budget Summary, Year 2 (Model Test Year 1)**

SIM Budget Summary, Year 2 (Model Test Year 1)			
SIM Component/Project Area	Projected Expenditure	Primary Driver	Metrics
IDHW Personnel/Fringe Benefits	\$657,719	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
PCMH Contractor Contract	\$1,241,563	1	Metrics # 1–17 as numbered in Driver Diagram.
PCMH Transformation Incentives	\$1,010,000	1	Metrics # 1–17 as numbered in Driver Diagram.
CHWs and CHEMS Staff Training Contract	\$182,641	1	Metrics # 1–17 as numbered in Driver Diagram.
Telehealth Training/TA Contract	\$84,713	1	Metrics # 1–17 as numbered in Driver Diagram.
Contracts with PHDs to Establish RCs	\$1,907,562	3	Metrics # 26–29 as numbered in Driver Diagram.

## SIM Budget Summary, Year 2 (Model Test Year 1)

SIM Component/Project Area	Projected Expenditure	Primary Driver	Metrics
Idaho Health Data Exchange (IHDE) Contract	\$1,142,314	2	Metrics # 18–25 as numbered in Driver Diagram.
Data Collection and Analytics Contract(s)	\$1,591,420	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
Project Management/ Financial Analysis Contract	\$762,870	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
IDHW Telehealth Equipment	\$212,782	1	Metrics # 1–17 as numbered in Driver Diagram.
Travel	\$29,183	1 through 4	Metrics # 135 as numbered in Driver Diagram.
Staff supplies and Misc	\$7,116	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
Other: IHC member travel/meeting costs	\$18,624	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
State Evaluator	\$750,000	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
IDHW Indirect	\$60,708	1 through 4	Metrics # 1–35 as numbered in Driver Diagram.
<b>Total</b>	<b>\$9,659,215</b>		

## 2. Detailed SIM Operational Plan

### Overview

Idaho has developed seven goals to achieve the Triple Aim through their SIM Model Test. Each of these goals is an operational component of Idaho's SIM Model Test. This section of the Operational Plan provides, for each goal, a narrative summary of the goal, a goal summary table, and a description of the risk assessment and mitigation strategies that have been developed for that goal.



The information in the sections that follow is reflective of a collaborative effort between Model Test stakeholders and Workgroups/advisory groups. Workgroups and advisory groups developed project charters to capture their roles and responsibilities in the Model Test. The information in the Workgroup/advisory charters was used to align activities of the Workgroups and advisory groups to the activities required to achieve each Model Test goal.

### 2.1. Goal 1: Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices (a practice is operationally defined as a clinic site).

#### 2.1.1. Narrative Summary of Goal 1

##### In Model Test Year 1, Idaho will...

- Provide technical assistance to PCMHs.
- Assess PCMHs against HIT requirements.
- Distribute financial incentives to qualifying practices and implement fraud/abuse protections for Model Test Year 1.
- Revise (as needed for Model Test Year 2) financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections and obtain any necessary approvals.

As described in the Project Summary, Idaho's Model Test is centered on transforming the way that care is delivered throughout the State. Idaho's Goal 1 is to accelerate the establishment of the PCMH model of care as the foundation for all primary care services throughout the State and deliver integrated, coordinated services to all individuals, regardless of health status, through this model. By the end of the SIM Model Test, Idaho will have accelerated the State's selected model by building 165 PCMH primary care practices (a practice is operationally defined as a clinic site).

PCMH models are designed to produce better outcomes, improved access to care, and reduced costs. An important benefit of the PCMH model is that patient care is coordinated and provided through a person-centered, team-based approach. Each PCMH team member is allowed to practice at the top of their license, thus creating efficiencies by delivering care at the appropriate level. Physicians are able to focus their time on clinical care requiring physician-level intervention; while other staff, such as nurses and CHWs, provides care within the appropriate scope of their practice. Given that Idaho's extreme healthcare professional workforce

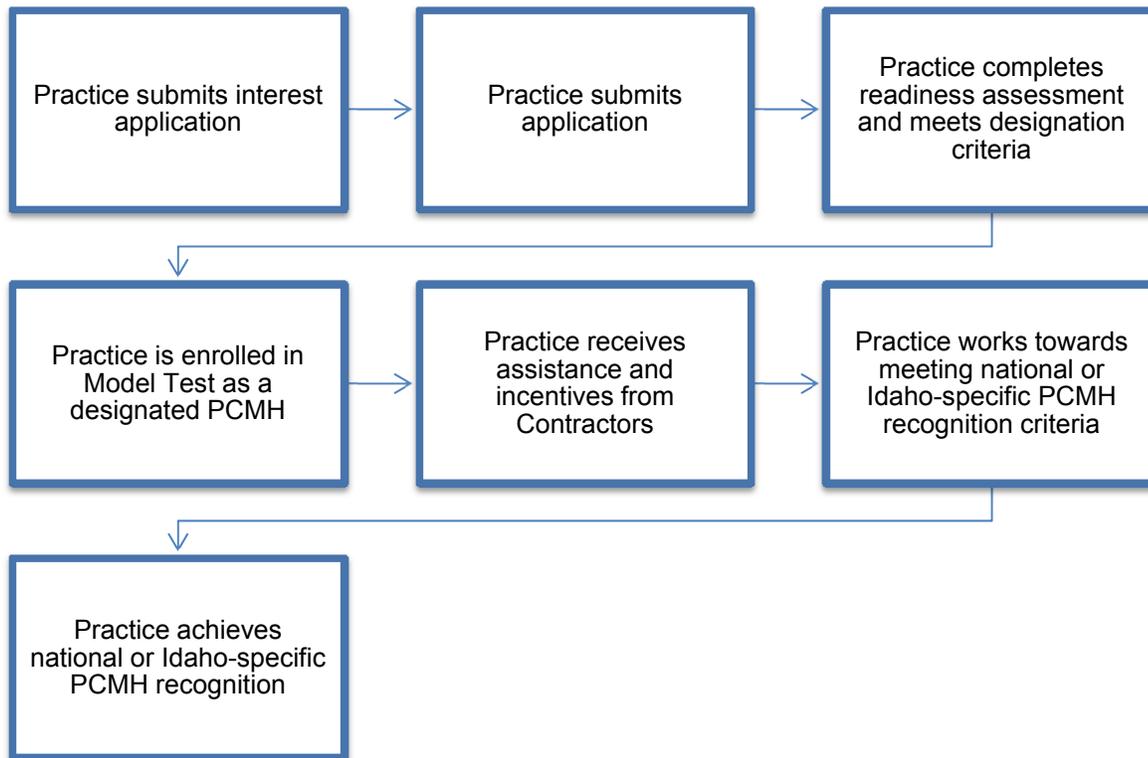
shortages significantly impacts access to care for many Idahoans, this component of the PCMH model is critically important.

Idaho's PCMHs will be integrated into a larger Medical/Health Neighborhood of specialists, hospitals, behavioral health professionals, long-term care providers, other ancillary care services, and non-medical community-based organizations. The integration of PCMHs in the Medical/Health Neighborhood will facilitate coordinated patient care, another key objective of Idaho's model, through the entire provider community. Idaho's seven PHDs are in the process of convening RCs to assist with developing Medical/Health Neighborhoods and to support the integration of PCMHs practices within these innovative, multi-sector, and regional networks. See the description of Goal 3 in Section 2.3 of this Operational Plan for more details on PCMH and Medical/Health Neighborhood integration.

Goal 1 activities will build on the Idaho Medical Health Collaborative's (IMHC) successful medical home pilot project, which began in January 2013 and concluded in 2015. Through the SIM Model Test, Idaho seeks to expand the number of PCMH primary care practices beyond those that participated in the pilot, and expand care coordination and other enhancements in the PCMH model to all patients, not just those with chronic conditions, which was the focus of the IMHC Pilot. IDHW drew upon IMHC's final report from the medical pilot project to inform the specifics of the proposed model to ensure that efforts moving forward are based on the solid foundation established during the pilot.

During the Pre-Implementation Year, Idaho has laid the groundwork for the PCMH transformation efforts that will take place during the Model Test. Idaho has successfully procured a PCMH Contractor (detailed below). With IHC approval, IMHC has also developed and implemented a PCMH interest application to identify practices that will seek PCMH designation in Model Test Year 1. The IMHC received 134 responses to the application of interest, demonstrating that practices have a high level of interest in the PCMH model. IDHW also distributed the final application to practices. Over 100 practices have submitted a final application to participate in Cohort 1. The IMHC developed Idaho-specific criteria for designating practices as PCMHs, and the IHC approved the PCMH designation criteria (described later in this section) in August 2015. The PCMH Contractor will begin readiness reviews of designated practices in January 2016. By February 1, 2016, 55 practices will be designated to participate in the Year 1 Model Test cohort.

Figure 6 — PCMH Enrollment Process



### PCMH Contractor and Subcontractors

Through the Goal 1 activities, and supported by SIM funding, Idaho will expand the existing infrastructure to support practices in becoming a PCMH and achieving increasing levels of national PCMH recognition. The new PCMH Contractor will have primary responsibility for designating PCMHs using Idaho-specific criteria, distributing grant-funded PCMH incentive payments, and supporting practices through technical assistance, training, and mentoring.

During the Pre-Implementation Year, IDHW published an RFP to procure a PCMH Contractor. In September 2015, IDHW selected Briljent, LLC to become the PCMH Contractor for the SIM Model Test. The contract was signed in October 2015. Briljent will use two subcontractors to perform other PCMH-related functions. The consulting firm Health Management Associates (HMA) will serve as the PCMH Technical Assistance Subcontractor and the certified public accounting (CPA) firm Myers and Stauffer will serve as the PCMH Incentives Subcontractor. Briljent will manage all activities for the two subcontractors, including building all of the subcontractors' tasks and associated work efforts into a cohesive project plan. Throughout the Model Test, the subcontractors will report to the Briljent Project Manager. IDHW has assigned a staff member(s) to oversee Briljent's work and ensure coordination between Briljent and its subcontractors, the RCs, the IHC and its Workgroups, and other contractors such as the Project Management Contractor.

Additional information related to Briljent, HMA, Myers and Stauffer, and how IDHW will oversee their performance during the Model Test, can be found in Section 3.1 of this Operational Plan.

### PCMH Designation Criteria

During the Pre-Implementation Year, the IMHC developed the Idaho-specific criteria that will be used to designate primary care practices as PCMHs. These are separate from the PCMH recognition criteria, which are described later in this section. The designation criteria are unique to Idaho and build on the IMHC's experience conducting the medical home collaborative. IDHW and the IHC approved the Idaho-specific designation criteria below in September 2015.

**Table 2 — Idaho's PCMH Designation Criteria**

Designation Criteria	Description
<p><b>Intent and vision of the clinic is aligned with SHIP goal to “transform primary care providers across the State into the PCMHs.”</b></p>	<ul style="list-style-type: none"> <li>• Organization and/or clinic administration (medical and financial) required to attend “PCMH in-service education and informational session” either in person (regionally) or remotely (webinar/VCE) to ensure the SHIP goals and magnitude of effort is fully understood</li> <li>• Recommend in-service provided by SHIP team to include PCMH consultant, IDHW SHIP staff, and PHD SHIP staff.</li> <li>• In-service followed up by “welcome packet, ” to include:               <ul style="list-style-type: none"> <li>○ SHIP/PCMH Transformation overview information</li> <li>○ Readiness Assessment</li> <li>○ Transformation Business Plan Template</li> <li>○ Resources and contact information</li> </ul> </li> <li>• Interested clinics to start completion of required documents for each site.</li> <li>• Currently recognized clinics may not be required to attend “PCMH in-service”. Discretion can be considered for larger healthcare systems with multiple locations, allowing flexibility to meet in-service requirement.</li> </ul>
<p><b>Engaged physician leadership champion, clinic administration engagement, and a dedicated transformation team is imperative for successful transformation and sustainability. Validation of Clinic PCMH Transformation team members to occur during face-to-face — see #3.</b></p>	<ul style="list-style-type: none"> <li>• Roles of Clinic PCMH Transformation Team for each site include:               <ul style="list-style-type: none"> <li>○ Physician (recommended) or other provider Leadership Champion should be instrumental in implementing the long-term changes/vision and continues to encourage other physicians/providers who might be unsure if they want to participate.</li> <li>○ Office Manager — imperative to keep informed and ensure buy-in for smooth transition of daily operations.</li> <li>○ PCMH change agent or project lead (if different from Office Manager) — knowledgeable, enthusiastic, and supported by leadership/management.</li> </ul> </li> </ul>
<p><b>Face-to-face onsite clinic interview to be</b></p>	<ul style="list-style-type: none"> <li>• Opportunity to address clinic questions/concerns and identify any “red flags”.</li> </ul>

Designation Criteria	Description
<p><b>conducted with Clinic PCMH Transformation Team and PCMH consultant, SHIP Team and PHD SHIP staff.</b></p>	<ul style="list-style-type: none"> <li>• Assist clinic in completing readiness assessment, if necessary.</li> <li>• Review of required components of Business Plan to ensure clinic has adequate resources to transform. Template provided to the clinic to include: <ul style="list-style-type: none"> <li>○ Practice type</li> <li>○ Panel size</li> <li>○ Staff structure — team meetings, etc.</li> <li>○ Staff resources dedicated to PCMH transformation.</li> <li>○ Timeline to achieve the PCMH recognition requirements within timeframe determined.</li> <li>○ Identification of current participation in PCMH initiatives.</li> <li>○ Budget — including estimated revenue and expenses to transform. Budget template to be provided to clinics along with input available from payers specific to anticipated PCMH revenue.</li> </ul> </li> <li>• Following interview, deadline identified for clinic to return readiness assessment, to include transformation business plan and self-attestation for participation.</li> <li>• Discretion can be considered for larger healthcare systems with multiple locations, allowing flexibility to meet face-to-face interview requirement, such as “train the trainer” approach to be provided within the organization. However, recommend SHIP team meet with each site PCMH Transformation Team at some point.</li> </ul>
<p><b>Adequate and effective HIT capabilities are critical to support the PCMH model.</b></p>	<ul style="list-style-type: none"> <li>• Clinic has an effective emergency medical response with care coordination capabilities (e.g., registry functionality, referral tracking) <b>OR</b> proof of workflow/system capabilities to execute care coordination functions.</li> <li>• Disease Registry capability for population health management <b>OR</b> proof of workflow/system capabilities to execute disease registry functions (e.g., report quality measures).</li> <li>• Capability to electronically exchange data with providers and intent to enroll and use enhanced communication features of the Idaho Health Data Exchange (IHDE). Consider specific IHDE training as a component of the in-service and require practice agreement to connect (SHIP incentive).</li> </ul>
<p><b>Evidence of quality improvement (QI) activities or defined plans for QI structured activities is critical to implementing and</b></p>	<ul style="list-style-type: none"> <li>• Current QI policies and procedures <b>OR</b> outline of plan to implement QI policy and procedures.</li> <li>• Evidence of QI activities.</li> </ul>

Designation Criteria	Description
<b>sustaining the PCMH model.</b>	

### PCMH Readiness Assessment and Enrollment

As previously mentioned, practices that are interested in becoming an Idaho PCMH will express their interest by filling out an interest application. The first cohort of interest applications were sent to practices in August 2015. IDHW received 134 responses to the interest application.

The SHIP staff will be responsible for sending each practice interested in participation in cohort one a PCMH application and readiness assessment. The purpose of the PCMH application will be to gather additional information about the practice that will be used for clinic selection by the evaluation committee. The purpose of the readiness assessment will be to evaluate the practice's competencies, commitment, and readiness to change, as well as their qualifications for participating in the SIM Model Test. As the PCMH Technical Assistance Subcontractor, and with their subject-matter expertise in the PCMH model of care, HMA will be responsible for developing and conducting the readiness assessments of primary care practices to evaluate and verify clinic readiness for change and likelihood of successful transformation. The review of the first cohort of clinics' readiness assessments will be conducted during the months of December 2015 and January 2016. The readiness assessment will identify each practice's strengths and gaps against the PCMH designation criteria. Practices will be grouped into three categories:

1. Transformation Under Way
2. Ready for Transformation
3. Approaching Readiness for Transformation

HMA will use the results of the readiness assessment to validate the selected clinics for participation in the year one cohort. IDHW will select and approve each Model Test year PCMH cohort in concert with HMA readiness assessment findings. The IHC approved the general selection criteria and process that IDHW will utilize in accordance with Idaho Code § 59-704 and § 18-1361A. By February 2016 (the beginning of Model Test Year 1), Idaho plans to enroll 55 or more PCMH practices. An additional 55 practices will be selected and enrolled using the same process for Model Test Years 2 and 3. In total, 165 practices will be enrolled over the course of the Model Test.

Upon enrolling in the Model Test, a practice will sign an agreement to facilitate the flow of incentives to the clinic (see more detail below). In the Memorandum of Understanding (MOU), practices will also agree to maintain the support of the identified champion/champion team, support the champion team with weekly protected time to engage in project activities, participate in coaching sessions, send the champion team to learning sessions, and participate in ongoing assessment of the effectiveness of the Model Test, including submitting data on a monthly basis.

### PCMH Financial Incentives

Several incentives are proposed to assist primary care practices in the demanding process of transforming to a PCMH. The amount of the incentive payments has been reduced since the submission of the original Model Test Proposal due to the reduction in Idaho's overall grant funding. However, Idaho does not anticipate that these reductions will have a significant impact on practice participation in the model, as Idaho's primary care providers have indicated that although the one-time

incentives are helpful for practice transformation to PCMH, the real incentive will be payment reform that reimburses them for outcomes rather than volume of service.

One-time incentives to encourage practice transformation to a PCMH will be financed through Model Test grant funding to support a practice's transformation costs, which include development of patient registries, HIT system changes, adjusting clinic flow and staffing patterns, and time spent out of clinic training and coaching team members. Following the readiness assessment that identifies specific practice gaps and development of a specific practice transformation plan, the practice will be awarded a one-time incentive of \$10,000.

To encourage practices to achieve higher levels of PCMH recognition, PCMHs will be reimbursed costs up to or equal to NCQA 2014 accreditation cost. Clinics with an existing accreditation will also be reimbursed on a one-time basis their reapplication fee up to or equal to NCQA 2014 reaccreditation costs. These incentive funds will reimburse practices for the costs associated with meeting recognition requirements.

During the Model Test, up to 50 PCMHs will also be identified to participate in the Virtual PCMH model, which will test the provision of PCMH services in very rural communities (described in Goal 4 in Section 2.4 of this Operational Plan). Practices participating in the Virtual PCMH program may receive an additional \$2,500 incentive payment upon meeting certain criteria in Model Test Year 2 or later. The purpose of this incentive payment will be to provide financial assistance to the practice to cover the additional costs related to building Virtual PCMH capacity.

As the PCMH Incentives Subcontractor for the PCMH Contractor, Myers and Stauffer will have primary responsibility for issuing and tracking the incentive payments. Myers and Stauffer proposes using a web-based payment accounting system to calculate, track, and report on the incentive payments. Through this system, Myers and Stauffer will be able to:

1. Track practices that qualify for incentive payments.
2. Calculate the incentive payment amount based on the parameters described above.
3. Document how the incentive amount was calculated.
4. Track distribution of incentives to practices.
5. Reconcile incentive payments.
6. Track correspondence with practices about the incentives.
7. Provide reports to IDHW on the distribution of incentives.

#### PCMH Training and Technical Assistance

PCMHs will receive training and technical assistance as they work to become PCMHs and expand their PCMH capacity according to their transformation goals. HMA will provide training and technical assistance through a two-year training program that will both meet practices where they are and support practices in an ongoing capacity throughout their transformation journey.

The two-year training program will begin upon a practice's designation by IDHW into the Model Test cohort. HMA coaches will work with the practice to develop a tailored transformation plan. The transformation plan will lay out the activities and timelines for the practice to address any gaps identified in the readiness assessment.

HMA will offer a variety of training and technical assistance opportunities to practices to make sure that each practice receives enough interaction with subject-matter experts to progress in their transformation goals. For the Model Test Year 1 cohort, the two-year training program will include:

- **Onsite Learning Collaboratives** to bring together the entire practice team three times during the first year to review topics such as: change management, performance improvement, access to care, team-based care, population health management, care management, care coordination and transitions of care, and behavioral health integration.
- **Topic-Specific Regional Video Conferences** to provide additional training on a PCMH-related topic. HMA anticipate offering six video conferences between the onsite learning sessions. Each will be delivered four times, to groups of up to 14 practices per video call.
- **Monthly Coaching** for each practice so that the practice team will have contact with a trainer between the video conferences. Coaching will focus on common aims set by the practices at the learning sessions. Coaches will assist the practices in overcoming barriers and challenges to change.

The PCMH training program will also pay particular attention to rural practices, and especially to the challenges they face in adopting and successfully utilizing Electronic Health Records (EHRs) and other Health Information Technology (HIT) tools. HMA will help rural practices develop practice-specific plans and strategies to successfully leverage HIT tools, and will provide these practices with technical assistance and best practice standards to help the practices build HIT capacity.

In implementing the training program, HMA will take steps to build capacity among Idaho's PHDs to continue providing training after the Model Test period. Building this capacity is an important part of Idaho's sustainability plan to ensure that Idaho stakeholders have the ability to carry forward the model in later years. PHD staff will participate in the training efforts, including traveling to practice sites to participate in the coaching.

### PCMH Recognition

Stakeholders agreed that encouraging practices to achieve increasing levels of national PCMH recognition should continue to be a goal of the Model Test, but national PCMH recognition should not be a requirement. Stakeholders felt that requiring national accreditation or recognition would deter providers from participating in the model, because obtaining a national level of recognition (from the NCQA, Joint Commission, AAAHC) would stretch provider resources and would represent significant additional administrative burden. As a result, Idaho will also offer practices the option of pursuing Idaho-specific PCMH recognition by meeting criteria unique to Idaho's requirements for primary care transformation. As IDHW, the IHC, and other stakeholders continue working to refine elements of the model, the Idaho-specific PCMH recognition criteria will be developed, approved by the IHC, and implemented. The addition of an Idaho-specific recognition track represents a change in the model from the Model Design phase.

### PCMH Mentoring for Year 2/Year 3 Cohorts

Idaho believes that a crucial element of PCMH transformation is the peer-level support that practices can offer to each other. Creating a strong network of "champion" practices that can serve as mentors to other practices is an important part of the model. Before the end of each of Model Test Years 1 and 2, HMA and PHD staff will recruit up to three practices to serve as champions to the practices in the next year. These practices will participate in the learning collaboratives the following year to share their experiences and to encourage new practices. PHD staff will facilitate site visits from novice practices to more sophisticated practices within their regions for additional peer-to-peer learning.

### Year 2 Training and Technical Assistance for the First Cohort

The training program will continue in Model Test Year 2 for the Model Test Year 1 cohort. In the second training year, HMA will meet with PHD staff and IDHW to make any needed changes to the training program. HMA anticipates that Year 2 training opportunities for the year one cohort will include topics such as improving care transitions in the Medical/Health Neighborhood and concepts of behavioral health integration. In this way, future cohorts will also continue their learning process in the second year of their participation in the model.

#### **2.1.2. Goal 1 Summary Table**

The desired outcomes for establishing 165 PCMH practices in Idaho are: to accelerate the transformation of traditional primary care practices to the PCMH model, to improve quality of care including the patient experience, and coordinate care across the State. The table below describes key activities and metrics for this goal.

Table 3 — SIM Component/Project Area for Goal 1

<b>SIM Component/Project Area: Goal 1 — Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices.</b>					
<b>Activity/Budget Item:</b>	<b>Description of Activities</b>	<b>Lead Entity</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
PCMH recruitment plan	<ul style="list-style-type: none"> <li>• Draft PCMH recruitment plan for Year 1.</li> <li>• Feedback from stakeholders.</li> <li>• Finalize PCMH recruitment plan for Year 1.</li> <li>• Implement PCMH recruitment plan for Year 1.</li> <li>• Evaluate recruitment plan for Years 2 and 3. Make adjustments as needed and implement Year 2 and 3 recruitment plan.</li> </ul>	IDHW and Brilljent*  * Brilljent in this table refers to Brilljent and its Subcontractors: HMA and Myers & Stauffer.	\$13,860 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>• Count of primary care practices that submit an interest application to become a PCMH.</li> </ul>
PCMH designation criteria	<ul style="list-style-type: none"> <li>• IMHC develops draft PCMH designation criteria.</li> <li>• IHC approves designation criteria.</li> <li>• Publish PCMH designation criteria and process so that PCMHs are aware of the criteria.</li> </ul>	IDHW and Brilljent	\$19,865 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>• Count of practices designated PCMH of targeted number.</li> </ul>
Application of interest in PCMH designation	<ul style="list-style-type: none"> <li>• IMHC created draft PCMH application of interest.</li> <li>• IHC approved PCMH application of interest.</li> <li>• Publish PCMH application so that potential PCMHs are aware of it.</li> <li>• Practices begin to apply for PCMH designation.</li> <li>• Determine whether/how the PCMH application of interest will be used after Year 1 wave.</li> </ul>	IDHW and Brilljent	\$19,866 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>• Count of primary care practices that submit an interest application to become a PCMH.</li> </ul>

**SIM Component/Project Area:** *Goal 1 — Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
PCMH application	<ul style="list-style-type: none"> <li>IMHC and IDHW create draft PCMH application.</li> <li>IHC approves PCMH application.</li> <li>Practices that submit interest application are given the PCMH application.</li> <li>Practices begin to apply for PCMH designation.</li> <li>Determine process for receiving/processing applications for Wave 1 and moving forward.</li> </ul>	IDHW and Briljent	\$38,868 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of practices designated PCMH of targeted number.</li> </ul>
PCMH readiness assessment	<ul style="list-style-type: none"> <li>Briljent develops PCMH readiness assessment.</li> <li>IDHW reviews the readiness assessment process and materials.</li> <li>IHC approves the readiness assessment process and materials.</li> <li>Briljent implements the readiness assessment.</li> </ul>	Briljent	\$200,000 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of designated PCMHs that have completed a PCMH readiness assessment and goals for transformation.</li> </ul>
Procure a PCMH Contractor	<ul style="list-style-type: none"> <li>Publish RFP.</li> <li>RFP responses due.</li> <li>Finalist selected.</li> <li>Send contract to CMMI.</li> <li>CMMI approval.</li> <li>Contract start date.</li> </ul>	IDHW	\$102,457 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of practices designated PCMH of targeted number.</li> </ul>

**SIM Component/Project Area:** *Goal 1 — Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Process for distributing financial incentives to qualifying PCMHs	<ul style="list-style-type: none"> <li>Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.</li> <li>Obtain any necessary approvals of the financial distribution process.</li> <li>Complete any logistical steps needed to implement the process.</li> <li>Briljent begins distribution of financial incentives and implementation of fraud/abuse protections.</li> </ul>	IDHW and Briljent	\$408,414 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of PCMHs receiving technical support and transformation incentives.</li> </ul>
Ongoing stakeholder communications regarding PCMHs.	<ul style="list-style-type: none"> <li>Develop draft communications strategy (as part of overall communications plan).</li> <li>IHC approves communication strategy.</li> <li>Implement the communications strategy.</li> </ul>	IDHW and IHC	\$115,526 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of primary care practices that submit an interest application to become a PCMH in Model Test Year 2 and Year 3.</li> <li>Count of practices designated PCMH of targeted number.</li> </ul>
Technical support and mentoring to PCMH practices.	<ul style="list-style-type: none"> <li>Develop PCMH training program (to include onsite learning collaboratives, topic-specific regional video conferences, monthly coaching, etc.).</li> <li>Implement PCMH training program.</li> </ul>	Briljent	\$155,118 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of PCMHs receiving technical support and transformation incentives</li> </ul>
Increased use of EHRs among PCMHs.	<ul style="list-style-type: none"> <li>Provide support to PCMHs to increase use of EHRs and capacity for data collection and analysis.</li> <li>Support PCMHs in connecting to IHDE.</li> </ul>	PCMHs, Briljent, and IHDE	\$155,118 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> </ul>

**SIM Component/Project Area:** *Goal 1 — Accelerate establishment of the PCMH model of care throughout the State by building 165 PCMH primary care practices.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Patients enrolled in PCMHs are active participants in their healthcare.	<ul style="list-style-type: none"> <li>Determine data collection methodology.</li> <li>Implement data collection methodology.</li> </ul>	Data Analytics Contractor and PCMHs	\$397,855 (Model Test Year 1)	Goal 1	<ul style="list-style-type: none"> <li>Count of enrolled PCMH patients reporting they are an active participant in their healthcare.</li> </ul>
Ongoing support to designated PCMHs to assist with achieving higher levels of national or Idaho-specific PCMH recognition.	<ul style="list-style-type: none"> <li>Determine process to evaluate practice support needs.</li> <li>Evaluate practice support needs.</li> <li>Develop methods and tools to provide support.</li> <li>Implement support methods and tools.</li> <li>Develop strategy to evaluate needs moving forward.</li> <li>Modify support methods and tools based on needs evaluation.</li> </ul>	Briljent	\$155,118 (Pre-Implementation Year)	Goal 1	<ul style="list-style-type: none"> <li>Count of PCMHs receiving technical support and transformation incentives.</li> <li>Count of designated PCMHs that have achieved national PCMH recognition/ accreditation.</li> </ul>
Regular PCMH project management reports	<ul style="list-style-type: none"> <li>Develop schedule, metrics, and format of regular reports.</li> <li>IDHW approves schedule, metrics and format of regular reports.</li> <li>PCMH begins submitting regular reports to IDHW.</li> </ul>	Briljent	\$52,039 (Model Test Year 1)	Goal 1	<ul style="list-style-type: none"> <li>N/A</li> </ul>
List of designated PCMHs	<ul style="list-style-type: none"> <li>Briljent enrolls designated PCMHs and develops list of designated PCMHs.</li> <li>Briljent updates list of designated PCMHs as additional practices enroll, or if a practice terminates participation in the Model Test.</li> <li>Briljent submits list of designated PCMHs to IDHW.</li> </ul>	Briljent	\$151,052 (Model Test Year 1)	Goal 1	<ul style="list-style-type: none"> <li>Count of practices designated PCMH of targeted number.</li> </ul>

### 2.1.3. Goal 1 Risk Assessment and Mitigation Strategy

There is a high likelihood that Idaho will achieve Goal 1 of establishing 165 PCMH practices in the State. The work needed to accomplish this goal builds on existing strengths in Idaho's system. Commitment to this goal is high among key stakeholders. Even after budget decreases forced Idaho to reprioritize its resources, this goal largely remained the same, with only a small reduction in the number of practices targeted for PCMH transformation and a decrease in the amount of the financial incentives. Importantly, during the Model Design phase, Idaho was careful to ensure that sufficient support, both financial and technical, will be available to practices endeavoring to transform their care delivery and become a PCMH. For all of these reasons, Idaho believes that 165 PCMH practices can be created in Idaho during the Model Test period.

However, achieving a goal of this size and scope naturally involves risks. To better understand and plan for these risks, Idaho undertook a risk assessment and mitigation strategy planning process, using guidance provided by CMMI, and involving the major stakeholders that will be responsible for implementing and monitoring Goal 1 activities. During the planning process, stakeholders identified risk factors that, if unaddressed, could impede progress towards achieving Goal 1. Stakeholders also identified potential risk mitigation strategies that can be implemented to diminish identified risks. Using CMMI guidance, stakeholders evaluated the proposed risk mitigation strategies based on (1) their feasibility given current resources and (2) their potential impact on the project. The priority risk mitigation strategies were then assigned a lead entity and relevant Workgroups. As implementation of the project continues and the need to implement a risk mitigation strategy arises, the strategy will also be assigned a next step and timeline.

This risk planning process was not a one-time effort. On an ongoing basis, Goal 1 stakeholders will continue to use the risk planning process to identify risks and develop risk mitigation strategies. IDHW and Brilljent will both be responsible throughout the Model Test Years for continually monitoring Goal 1 progress and identifying new risks as they arise. Brilljent is responsible for submitting weekly reports to IDHW SHIP staff that detail, among other metrics, any new identified risks. Brilljent will also hold weekly meetings with IDHW SHIP staff to discuss the identified risks and evaluate proposed risk mitigation strategies. This ongoing risk planning process will ensure that stakeholders remain flexible in implementing the model, adapting activities as needed so that progress towards achieving Goal 1 stays on track.

The table below details the results of the risk assessment and mitigation strategy planning process for Goal 1.

Table 4 — Goal 1 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Rate of new PCMH designation after Year 1 of the Model Test is lower than expected.	Increase stakeholder education and recruitment activities to increase provider interest in becoming a PCMH.	1	IDHW	IHC, Briljent, Briljent Subcontractors,	Determine appropriate education and recruitment messages, audiences, and methods.	July-December 2016
	Evaluate ways to increase support for PCMHs, including leveraging the PCMH mentoring program.	2	Briljent	Briljent Subcontractors, IDHW, IHC, IMHC	Determine “priority need” areas of PCMH support.	July-December 2016
PCMH Contractor start date is later than expected.	IDHW and IHC take on additional responsibility for initial PCMH Contractor responsibilities.	1	IDHW	IHC, IMHC	Determine appropriate tasks for IDHW/IHC/IMHC.	August-October 2015
Challenges at the practice level in shifting to a coordinated PCMH model.	Identify PCMHs that achieved quick successes and created collaborations among the teams in the regions to celebrate initial successes and share “best practices.” Share attempts which were not as successful and study those efforts to understand how to achieve better results in the future.	1	Briljent	Briljent Subcontractors, IMHC	Identify successful PCMHs.	June-December 2016
	Provide incentives that support providers in making the transition in the short run.	2	Briljent	Briljent Subcontractors, IDHW, IHC, IMHC	Determine need for incentive.	June-December 2016
	Eventually, new payment methodologies will help shift the culture of FFS to a model based on quality and outcomes on a broader scale.	3	Payers		Payers begin to implement new payment methodologies.	Ongoing

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
The temptation to “check the box” on becoming a PCMH could pose a threat to true transformation at the practice level.	Briljent will implement a robust training effort paired with technical assistance to PCMHs. This includes interactive learning collaboratives, regional conferences, monthly coaching, and identification of champions.	1	Briljent	Briljent Subcontractors, IDHW, IHC, IMHC	Develop training program.	December 2015- January 2016
Incorrect distribution of PCMH incentive payments: paying the wrong practice, incorrect reporting and accounting of federal funds, and delays in payments.	Develop policies and procedures for collecting timely, accurate information from providers, including a policy for providers to notify Briljent if their information changes.	1	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015- January 2016
	Develop minimum data elements needed to compute payments and provide training to providers on reporting data needed for incentives.	2	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015- January 2016
	Establish policies and procedures for reporting incentive information.	3	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015- January 2016
	Require qualifying practices to sign an attestation as their agreement or acknowledgment that the practice is responsible for distributing funds among participating physicians.	4	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015- January 2016
	Define the process for adjudicating potential issues to avoid the appearance of, or the risk of, making arbitrary decisions.	5	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015- January 2016

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
The low level of EHR use in the State presents a risk to achieving and measuring transformation success.	Briljent and its Subcontractors will carefully assess the level of data availability at the initial phases of the project (September 1, 2015–January 31, 2016) and find solutions to compensate for the lack of EHR capacity in practices selected for participation in the first cohort of the collaborative.	1	Briljent	Briljent Subcontractors	TBD with Briljent.	December 2015– January 31, 2016
Multiple contractors requesting information could burden participating practices and threaten participation.	Before requesting information from the practices, Briljent will share the request with other contractors to ensure that information is not already being collected or planned to be collected. Briljent will also ensure that any data that is collected is reported back to the clinic so that they can use it for their improvement efforts.	1	Briljent	Briljent Subcontractors, Data Analytics Vendor	TBD with Briljent.	December 2015– January 31, 2016

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

**2.2.1. Narrative Summary of Goal 2**

**In Model Test Year 1, Idaho will...**

- Identify available funding mechanisms to support development and implementation of EHRs.
- Establish core technical standards and functions for EHRs, IHDE data exchange.
- Ensure PCMHs obtain technical assistance and training for implementation and ongoing support for EHRs.
- Encourage PCMHs to adopt and use EHRs for data exchange with IHDE.
- Define and document plan for quarterly monitoring of connections to the IHDE.

In Goal 1, Idaho aims to develop 165 PCMHs with 825 primary care providers, serving 825,000 Idahoans (50.5% of State population). As a part of practice transformation, providers will have access to training and technical assistance, including assistance regarding the adoption of technology solutions and the development of clinical protocols and strategic planning efforts around technology adoption. Goal 2 focuses on the adoption and use of EHR systems by Idaho's PCMHs and hospitals, and their downstream ability to use the IHDE to securely transmit and receive patient information. This goal lays the technological foundation for coordinating care and for statewide data analytics collection, analysis, and reporting.

The desired outcomes for Goal 2 include:

- Increased adoption and use of EHRs by PCMHs and hospitals (Idaho's targets are 165 and 21, respectively).
- Increased number of Idahoans who belong to a PCMH and have an EHR (Idaho's target is 50.5% of the population).
- Increased use of EHRs and health data connections to share information to improve care coordination — both between the PCMH and the hospital, as well as across the individual's Medical/Health Neighborhood of specialists,

behavioral health professionals, long-term care providers, and other ancillary care services.

Improving care coordination through use of HIT contributes to Idaho's ability to achieve the Triple Aim:

- **Health outcomes improve** by ensuring that key providers have real-time access to clinical information and up-to-date information on the patient's status (e.g., admissions, discharges, transfers, emergency department (ED) visits, etc.). As a result, treatment and supports can be efficiently and effectively coordinated and deployed. Overall, population health outcomes improve as providers and public health officials amass data to analyze population health assessments and to forecast and effectively respond to trends and public health threats.
- **The quality and experience of patient care improves** through efficient identification of the individual patient's health status and ongoing clinical and social support needs, and the system's streamlined ability to respond to those needs within the patient's Medical/Health Neighborhood. The individual's experience of the healthcare system is enhanced by the ability to access health information (e.g., test results, medication lists, discharge instructions, treatment reminders, etc.) in

a timely way that supports individual involvement in and management of one's own regional healthcare.

- **Healthcare costs decline** through elimination of delays and inaccurate/outdated clinical data that may result in a lack of or inappropriate treatment and elimination of redundant collection of clinical information or diagnostic testing. Outcomes data can be leveraged to improve care quality, safety, accountability, and efficiency, as well as to support opportunities to develop value-based purchasing strategies.

Deliverables associated with Goal 2 include:

- Provider access to financial incentives to improve the interoperable exchange of health data through use of EHRs and connection to the IHDE.
- Building a business, clinical, cultural, and regulatory environment in Idaho that encourages interoperability, individual empowerment in care management, and strengthening opportunities to deliver high-value care.
- Adoption of shared governance and standards to support interoperability for care coordination, with a vision for statewide HIE.
- Establishment of core technical standards and functions among EHR and HIE users, with a vision toward future national standards and interoperability.
- Adherence to privacy and security protections for health information.
- Access to technical assistance and training to implement and expand the use of EHRs.
- Certification of EHR systems to ensure interoperability.
- Ability to track the expansion and status of EHR systems and the number of individuals for whom EHRs exist.
- Ability to track the expansion of IHDE participation among PCMHs and hospitals.
- Ability to collect and analyze the quality of IHDE transactions.
- Establishment of HIT infrastructure milestones to promote and monitor data aggregation and analysis capabilities.

**Timeline and Targets:** Over the three-year Model Test period, IHDE will engage 165 PCMH-designated clinic sites and 21 hospitals to adopt and use EHR technology, and to connect to the IHDE to share health information to support care coordination. Approximately 825,000 Idahoans (50.5% of the population) will belong to a PCMH and have an EHR.

### 2.2.2. Goal 2 Summary Table

Goal 2 aims to increase adoption and use of EHRs by Idaho's PCMHs, hospitals, and other providers that participate in the Medical/Health Neighborhood, and their downstream ability to use the IHDE to securely transmit and receive patient information. The key activities and metrics for this goal are captured in the table on the following page.

Table 5 — SIM Component/Project Area for Goal 2

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Funding mechanisms are identified and secured to support statewide adoption and use of EHRs by PCMHs and hospitals	<ul style="list-style-type: none"> <li>Financial incentives to emphasize interoperable exchange of health information among provider networks at the national, state, and regional level.</li> </ul>	IHC, RCs, PCMHs, IHDE, Hospitals, and IDHW	\$102,457 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>
Supportive business, clinical, cultural and regulatory environments are addressed, defined and achieved	<ul style="list-style-type: none"> <li>Business and regulatory environments encourage interoperability. Individuals are empowered to manage their own healthcare. Providers partner with individuals to deliver high value care.</li> </ul>	IHC, RCs, PCMHs, IHDE, and Hospitals	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
IHDE participants establish rules of engagement and governance	<ul style="list-style-type: none"> <li>IHDE participants adopt a single governance framework and process to facilitate agreement on policy, operation and standards issues. IHDE participants use the common governance framework and rules for interoperability established by ONC. IHDE participants adopt shared governance of policy and standards that enable interoperability for care coordination.</li> </ul>	IHC, RCs, PCMHs, IHDE, and Hospitals	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Core technical standards and functions are established for EHRs/IHDE data exchange	<ul style="list-style-type: none"> <li>• Consistent data formats and semantics.</li> <li>• Tightly defined common clinical data set</li> <li>• Data storage</li> <li>• Data extraction</li> <li>• Consistent, secure transport techniques</li> <li>• Data load capabilities</li> <li>• Standard, secure services</li> <li>• Accurate identity matching (patient/provider attribution – standardize minimum individual attributes used for matching)</li> <li>• Reliable resource location</li> <li>• Adherence to best available national technical standards for core interoperability functions as published by ONC.</li> </ul>	IHC, RCs, PCMHs, IHDE, and Hospitals	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>• Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity..</li> <li>• Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> <li>• Count of hospitals connected to the IHDE.</li> <li>• Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Privacy and security protections for health information are in place for the IHDE and its participants	<ul style="list-style-type: none"> <li>Secure network service infrastructure</li> <li>Verifiable identity and authentication of all participants</li> <li>Consistent representation of permission to collect, share and use identifiable health information (consent management, including what may be obtained/released for TPO without written permission (computable privacy))</li> <li>Consistent representation of authorization to access health information (consent management).</li> </ul>	IHC, RCs, PCMHs, IHDE, and Hospitals	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
PCMHs obtain technical assistance and training for implementation and ongoing support for EHRs.	<ul style="list-style-type: none"> <li>Technical assistance and training is made available to PMCHs to support adoption and use of EHRs.</li> <li>PCMHs utilize technical assistance and training to adopt and use EHRs.</li> </ul>	PCMHs, RCs, HMA and Brilljent	\$151,053 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>
IHDE participants obtain certification of EHRs to assure HIT is interoperable.	<ul style="list-style-type: none"> <li>IHDE participants seek and obtain independent certification of EHRs.</li> <li>IHDE is able to confirm system certification prior to contracting with participants.</li> <li>Stakeholders are assured that HIT is interoperable.</li> </ul>	PCMHs, Hospitals, IHDE, HIT Workgroup, and IHC	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
PCMHs adopt and use certified EHRs.	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 165 PCMHs obtain and deploy certified EHRs that enable them to send, receive, find, and use a common data set.</li> </ul>	RCs and PCMHs	\$155,118 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>
PCMHs contract with IHDE.	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 165 PCMHs have contracts with IHDE to enable data exchange with hospitals and across the Medical/Health Neighborhood.</li> </ul>	IHDE	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Hospitals adopt and use certified EHRs.	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 21 hospitals obtain and deploy certified EHRs that enable them to send, receive, find, and use a common data set.</li> </ul>	Hospitals	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>
Hospitals contract with IHDE.	<ul style="list-style-type: none"> <li>By Model Test Year 3, Q4, 21 hospitals have contracts with IHDE to enable data exchange with PCMHs and across the Medical/Health Neighborhood.</li> </ul>	IHDE	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>
Quarterly list of designated PCMHs by those with certified EHRs, EHRs in process, without EHRs, and number of PCMH members who have an EHR.	<ul style="list-style-type: none"> <li>List is used to determine the universe of PCMHs and the quarterly status of EHR development, adoption, and certification.</li> <li>List should capture the type of EHRs in use, as well as Meaningful Use level and certification status.</li> <li>List should capture the number of PCMH members and the number of members who have EHRs.</li> </ul>	HIT Workgroup, IHC, IHDE, and IDHW	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Quarterly list of hospitals by those with certified EHRs, EHRs in process, and without EHRs.	<ul style="list-style-type: none"> <li>List is used to determine the universe of hospitals and the quarterly status of EHR development, adoption, and certification. List should capture the type of EHRs in use, as well as MU level and certification status.</li> </ul>	HIT Workgroup, IHC, IHDE, and IDHW	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>
Quarterly list of IHDE Participants.	<ul style="list-style-type: none"> <li>List of PCMHs contracting with the IHDE.</li> <li>List PCMHs by volume of executed transactions within the IHDE.</li> <li>List of hospitals contracting with the IHDE.</li> <li>List hospitals by volume of executed transactions with the IHDE.</li> </ul>	HIT Workgroup, IHC, IHDE, and IDHW	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Quarterly list of IHDE Participants and IHDE transaction success/failure rates.	<ul style="list-style-type: none"> <li>List of all PCMHs and hospitals that contract with the IHDE.</li> <li>List of all transaction attempts by participant.</li> <li>List of transaction failures by participant and reason (if available).</li> </ul>	IHDE	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>

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

Activity/Budget Item	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Report of phased in HIT infrastructure goals that provide aggregation and analytic support to facilitate Idaho’s population health management functions.	<ul style="list-style-type: none"> <li>Recommended HIT infrastructure milestones that are agreed upon and delivered over the Model Test Year 1, Model Test Year 2, and Model Test Year 3 periods.</li> </ul>	HIT Workgroup, IHC, IHDE, and IDHW	\$87,870 (Model Test Year 1)	Goal 2	<ul style="list-style-type: none"> <li>Count of designated PCMH practices (sites) with EHR systems that support HIE connectivity.</li> <li>Count of patients in designated PCMHs (sites) that have an EHR.</li> <li>Count of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.</li> <li>Count of hospitals connected to the IHDE.</li> <li>Count of hospitals connected to the IHDE that provide information on PCMH enrolled patients.</li> </ul>

### 2.2.3. Goal 2 Risk Assessment and Mitigation Strategy

Idaho intends to achieve Goal 2 through the multi-pronged strategy that includes:

- Governance of the State HIT plan by the IHC, monitored by IDHW, to provide solid statewide oversight of state HIT plan implementation.
- Increasing provider adoption and use of EHRs through provision of technical assistance, financial incentives, and PCMH payment requirements. Model Test incentives will be provided in addition to incentives paid through the Medicaid EHR Adoption Incentive Program.
- Expanding the current IHDE infrastructure and including remote provider groups who are not yet connected or who have marginal ability to connect. Again, financial incentives will be offered to participating PCMHs to pay vendor and IHDE connection fees.
- Focusing on practices participating in the IMHC Pilot not already connected to IHDE, and leveraging their association with more experienced PCMH providers.
- Leveraging, to the extent possible, technologies championed by LINK Idaho, a federally-funded internet broadband initiative addressing connectivity issues for the expansion of IHDE.
- Working with the Medicaid Management Information System to develop plans for enhancements that can support the future environment.
- Leveraging the existing Washington & Idaho Regional Extension Center, and its experience helping primary care providers adopt and use EHRs.

Despite setting a strong foundation, Idaho recognizes and has considered several potential risks as well as developed mitigation strategies for those risks. Idaho will continue to monitor these risks, as outlined below.

Table 6 — Goal 2 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
State lacks resources to support data collection and reporting.	Hire additional resources or outsource collection and reporting activities.	1	IDHW	IHDE, Mercer, HIT Workgroup	<ul style="list-style-type: none"> <li>Identify checkpoints for monitoring adequacy of resources to support data collection and reporting.</li> <li>Monitor resource levels as part of overall project management.</li> </ul>	October 2015–December 2016
Statewide HIT Contractors not in place by selected deadlines.	HIT Workgroup will monitor timeline for selection process.	1	IDHW	IHDE	Review selection and contracting progress at monthly HIT meetings.	October 2015– March 2016
Statewide agreement on technology standards cannot be reached.	IHC makes decisions on standards.	1	IDHW	IHDE	<ul style="list-style-type: none"> <li>Monitor progress of reaching agreement on statewide standards.</li> <li>Report progress to IHC and escalate, as necessary.</li> <li>Develop contingency plan.</li> </ul>	November 2015–May 2016
Statewide HIT connections not in place by selected deadlines.	HIT Workgroup will monitor HIT connections across the State.	1	IDHW	IHDE	Review progress at monthly HIT meetings.	October 2015–December 2016
Anticipated data sources unavailable or inadequate to meet	Seek alternative data sources.	1	IDHW	Data Analytics Contractor	Identify alternative data sources for reporting needs.	February 2016–December

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
reporting needs.						2018
PCMHs or IHDE lack resources to support data collection and reporting.	Hire additional resources or outsource collection and reporting activities.	1	IDHW	Briljent, Briljent Subcontractors, IHDE	<ul style="list-style-type: none"> <li>Regular monitoring of IHDE staffing levels against performance with contract standards.</li> <li>HMA provides guidance to PCMHs on potential workarounds.</li> </ul>	January 2016–December 2018

**2.3. Goal 3: Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood.**

**2.3.1. Narrative Summary of Goal 3**

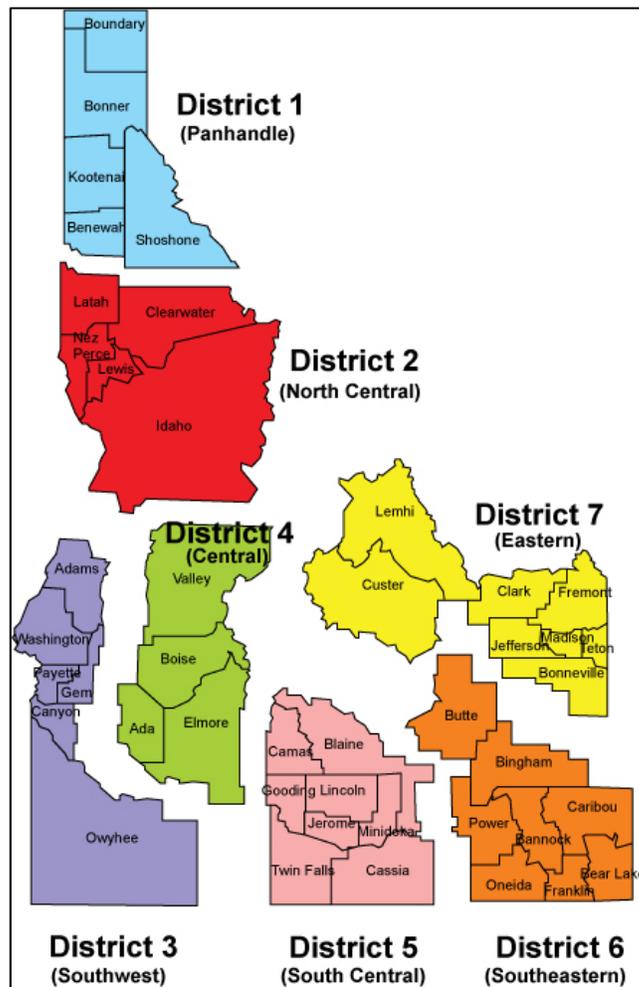
**In Model Test Year 1, Idaho will...**

- Establish seven RCs.
- Evaluation plan to ensure RCs provide regional quality improvement and Medical/Health Neighborhood integration services within service level requirements.
- Identify participants in the Medical/Health Neighborhood in each region.
- Begin the process of creating a Sustainability Plan.

Key to the success of the Model Test is the development of the RCs, which will bring local area expertise to ensure that the model is responsive to community and regional needs and characteristics.

At the local level, Idaho’s seven PHDs have been designated as the conveners of the RCs and will serve as the main facilitators of the regional effort to achieve Idaho’s goals of healthcare system transformation.

**Figure 7 — Idaho's PHDs**



Through local knowledge and expertise, RCs will link the PCMHs to the broader Medical/Health Neighborhood to facilitate coordinated patient care through the entire provider community and with other services needed to support the whole person. This broader care coordination is essential to improving quality of care, reducing errors and duplication of services, and ultimately controlling costs.

In addition to convening and supporting the RCs, PHDs will assess, promote, and monitor activities that improve the health of the broader regional population. These activities include specific targeted populations, such as individuals with diabetes or children needing immunizations, as well as broad population health initiatives promoting healthy lifestyle activities. This link with public health promotion through the seven PHDs will significantly spread the impact of the Idaho Model Test to Idahoans (825,000 by the end of the Model Test). The PHDs will leverage regional resources and expertise and will work with local providers and non-health organizations to conduct regional health needs assessments and, with support from the IHC, implement regional quality improvement and wellness initiatives.

RCs have been established for each region and will have a general membership comprised of PCMHs and the key participants of the Medical/Health Neighborhood. RCs will also have a Regional Collaborative Executive Leadership Committee (RCE) that includes a Chair, Co-Chair, the PHD Director, and the SHIP Manager (described below) to lead the RCs' efforts and communicate with the IHC to share information about each region.

Three staff members will be hired by the PHDs to work solely on the Model Test. These individuals will be a key factor in helping PCMHs get the transformation assistance they need, providing support to the RCs and RCE, and in communicating with the provider community. PHD SHIP Staff will include:

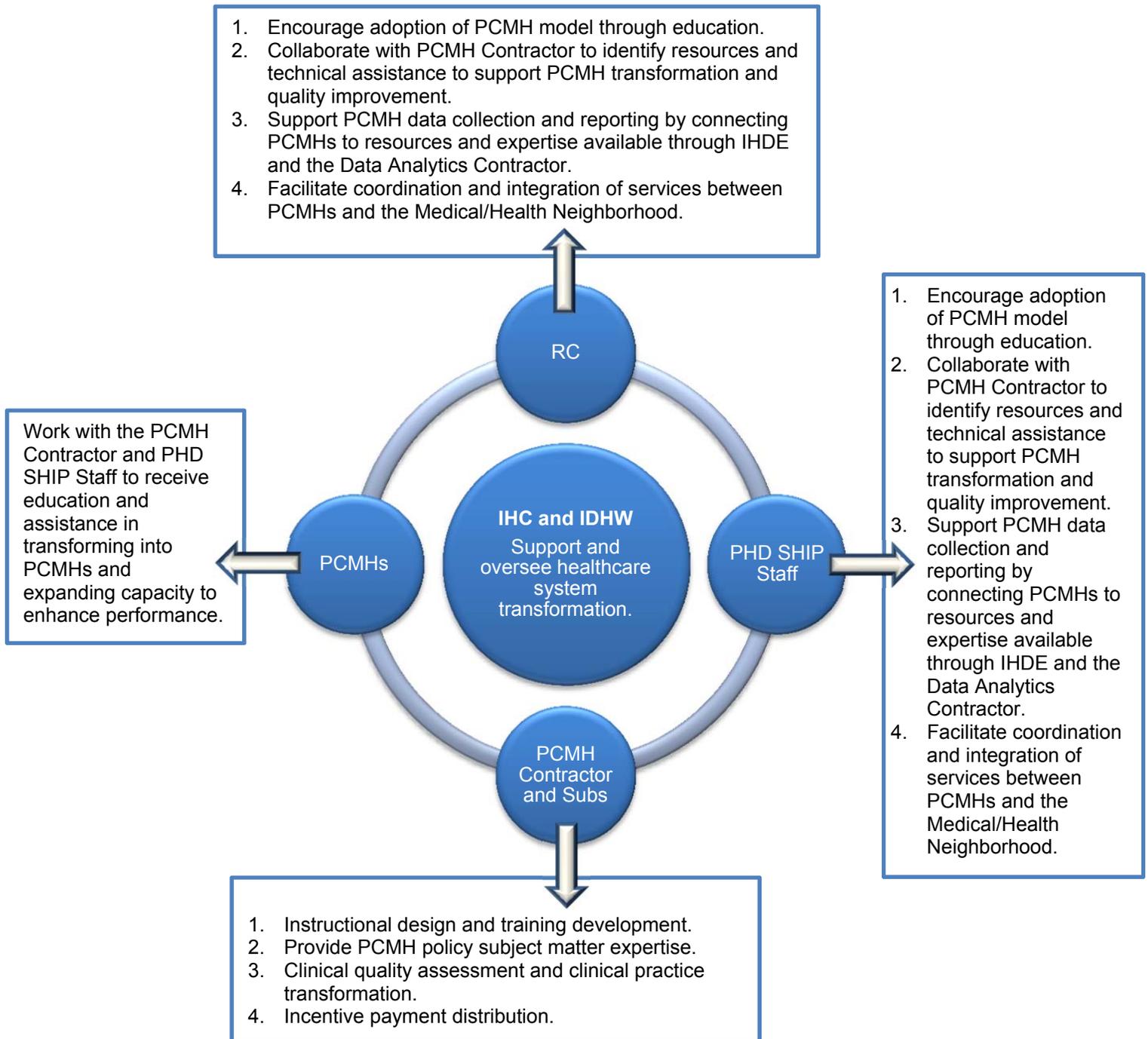
1. A SHIP Manager (RN or equivalent) who is responsible for the overall leadership and direction of the RC. The SHIP manager is also responsible for convening the RC. Other duties include directing RC efforts around quality measurement by assisting PCMHs in collection of quality data, and reviewing aggregated quality data for region; providing support to local primary care clinics in both pre-PCMH transformation and actual PCMH transformation; coordination of PCMH technical assistance with primary care practices and the PCMH Contractor; and continued support of PCMHs in subsequent years of the Model Test .
2. A Quality Assurance/Quality Improvement (QA/QI) Specialist (RN or equivalent) is responsible for providing QA/QI consultation to providers working toward PCMH transformation. Consultation activities will include PCMH project development, implementation, evaluation, and outcome reporting. Additional responsibilities will include: providing professional staff support to the RC, working with healthcare stakeholders to develop the RC group membership, work plan and meeting agendas, etc.; working with regional healthcare stakeholders to develop the Medical/Health Neighborhood; providing connections and support to both the transforming PCMHs and other service providers in the region; and working closely with the IDHW Project Manager for RCs to coordinate the RC work with that of other regions and with state level activities.
3. An Administrative Assistant who provides administrative support to the RC team members as well as to the RC Advisory Committee. The Administrative Assistant's tasks include typical staff support activities, as well as RC Advisory Committee meeting logistics, and administrative support to participating PCMHs in the region.

Together with IDHW, the IHC, and HMA, RCs will support the PCMHs in activities to transform and improve the system. RCs will work closely with PHD SHIP Staff and HMA to implement support

activities in the region, but ultimately PHD SHIP Staff will serve as the liaison between PCMHs and RCs and SHIP staff.

Below is an illustrative representation of the collaboration between the IHC, IDHW, RCs, PHD SHIP Staff, Brilljent and its subcontractors, and PCMHs.

**Figure 8 — Collaboration between Key Participants of the Model Test**



RCs will advise and provide guidance for each region as it relates to collecting data required to monitor and establish performance targets, regional and PCMH-level performance feedback, identifying and spreading evidence-based clinical practice, and providing ongoing resources and support to achieve the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lower costs of care for all Idahoans. Given Idaho's diverse geographic differences, it is expected that the levels and types of assistance required by primary care practices will vary. HMA, the PCMH Training and Technical Assistance Subcontractor, will be responsible for helping primary care practices identify gaps in their practice and providing the assistance needed to facilitate the transformation process. HMA will also assist established PCMHs as they endeavor to enhance their capacity within the model.

PHDs will have completed the process of developing RCEs and hiring PHD SHIP Staff by February 1, 2016. On November 5, 2015 an RC kickoff was held in Boise attended by RCE members, PHD SHIP staff, SHIP staff, CMMI project officers, Technical Assistance Contractors, and other stakeholders. The kickoff included strategic planning and toolkit creation to assist RCs in their development and operational efforts. On or before April 30, 2016, each of Idaho's seven PHDs will have established RCs available to provide support to PCMHs.

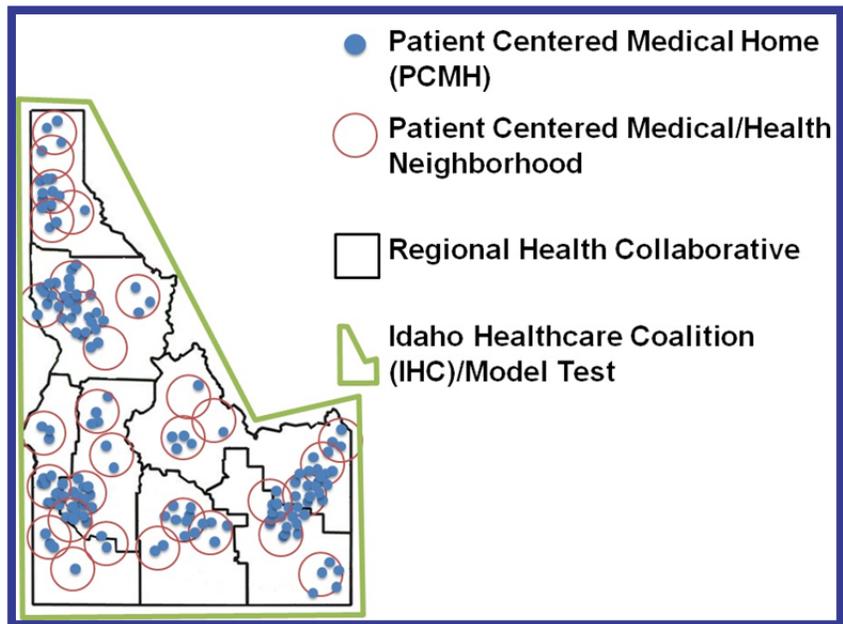
PHDs will serve as the public health/physical health integrator in local communities. Key functions of the PHDs will be to support practices and the PCMH model through a variety of activities and partners, including the following:

1. Establish RCs (including RCEs) comprised of regional representatives from PCMHs and the Medical/Health Neighborhood. Additional stakeholders will serve on the RC to expand the local expertise on regional healthcare needs. The RCs will work closely with the IHC, advising on regional issues, and providing feedback on regional Model Test progress.
2. Assist local PCMHs by establishing formal referral and communication protocols within the broader Medical/Health Neighborhood to facilitate coordinated care, support local innovation, and expand evidence-based practices. RCs, with the assistance of PHD SHIP Staff and HMA, will play a critical role in establishing referral and communication protocols between the PCMH and other providers in the Medical/Health Neighborhood, e.g., specialty care, hospitals, behavioral health, Indian Health Services (IHS) and tribal programs, elder care services, social service organizations.
3. Practices in under-resourced areas will receive additional supports from PHD SHIP Staff and HMA, including providing direct resources for critical components of the model such as care coordination, arranging for after-hours care, and behavioral health specialty consultation.
4. Facilitate implementation and accreditation of the PCMH by providing resources and supports through PHD SHIP Staff and HMA, such as trained facilitators, to guide practices through the transformation process.
5. Ensure ongoing success of the PCMHs by supporting regional and practice-level data gathering and analytics using systems and reports created at the IHC.
6. Partner with local public health experts to conduct the periodic community needs assessment using the CDC's Community Health Assessment and Group Evaluation tool. Use assessment results to identify additional activities, services, and practice improvements that are needed to improve the community's health. At the RC level, the representatives of the local provider community, community organizations, and public health authorities will collaborate in reviewing community health needs assessments, reporting to the IHC on local PCMH and public health

activities, and advising the IHC on how to improve collaboration at the State and regional levels.

7. Advise the IHC on effective quality initiatives for their region and PCMHs based on local knowledge of communities and cultures.
8. Provide on-the-ground assistance to the PCMHs through PHD SHIP Staff and HMA, or secure the technical assistance from the IHC on behalf of the region, in order to attain improved quality care and achieve good health outcomes within the region.
9. Advise PHD SHIP Staff and HMA regarding activities to facilitate coordination and integration of services through strengthening relationships between the PCMHs and the Medical/Health Neighborhood.
10. Provide support through PHD SHIP Staff and HMA, for under-resourced practices that need help in fulfilling the requirements of a PCMH.
11. Guide PHD SHIP Staff in encouraging adoption of the PCMH model through physician and Medical/Health Neighborhood education.

**Figure 9 — Visual Example of Medical/Health Neighborhood**



### 2.3.2. Goal 3 Summary Table

The desired outcomes for establishing RCs to support the integration of each PCMH within the local Medical/Health Neighborhood are to establish a support system for PCMHs in each region, increase patient care coordination between PCMHs and the Medical/Health Neighborhood, and promote regional quality improvement and population health management. The table on the following pages describes key activities and metrics for this goal.

Table 7 — SIM Component/Project Area for Goal 3

<b>SIM Component/Project Area:</b> <i>Goal 3 — Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood.</i>					
<b>Activity/Budget Item:</b>	<b>Description of Activities</b>	<b>Lead Entity</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
Establish RCs.	<ul style="list-style-type: none"> <li>Negotiate sub-grant.</li> <li>Execute contracts with PHDs.</li> <li>Hire SHIP PHD Staff.</li> <li>Convene RCE and RC general membership.</li> </ul>	IDHW and PHDs	\$715,336 (Pre-Implementation Year)	Goal 3	<ul style="list-style-type: none"> <li>Count of designated PCMHs and primary care practices that can receive assistance through an RC.</li> <li>Count of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.</li> </ul>
List of designated PCMHs.	<ul style="list-style-type: none"> <li>Recruit practices.</li> <li>Conduct readiness assessment.</li> <li>Enroll PCMH practices.</li> <li>Ensure that other stakeholders receive list of designated PCMHs as needed.</li> <li>Update list of designated PCMHs with each Model Test year.</li> </ul>	Briljent and its Subcontractors	\$151,053 (Model Test Year 1)	Goal 3	<ul style="list-style-type: none"> <li>Count of designated PCMHs and primary care practices that can receive assistance through an RC.</li> </ul>
RCs provide regional quality improvement and Medical/Health Neighborhood integration services.	<ul style="list-style-type: none"> <li>Define services provided by RCs.</li> <li>Develop plan (charter).</li> <li>Implement plan.</li> <li>Submit status report.</li> </ul>	RCs, PHDs, and IDHW	\$635,854 (Model Test Year 1)	Goal 3	<ul style="list-style-type: none"> <li>Count of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.</li> </ul>

**SIM Component/Project Area:** *Goal 3 — Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Evaluation plan to ensure RCs provide regional quality improvement and Medical/Health Neighborhood integration services within service level requirements.	<ul style="list-style-type: none"> <li>Develop plan.</li> <li>Review/revise plan.</li> <li>Finalize plan.</li> <li>Implement plan.</li> </ul>	IDHW	\$107,143 (Model Test Year 1)	Goal 3	<ul style="list-style-type: none"> <li>Count of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.</li> </ul>
Communication from RCs to practices regarding availability of services.	<ul style="list-style-type: none"> <li>Develop communication.</li> <li>Review/revise communication.</li> <li>Finalize communication.</li> <li>Initial communication with practices.</li> <li>Ongoing communication with practices.</li> </ul>	RCs	\$115,526 (Model Test Year 1)	Goal 3	<ul style="list-style-type: none"> <li>Count of designated PCMHs and primary care practices that can receive assistance through an RC.</li> </ul>
Established Medical/Health Neighborhoods.	<ul style="list-style-type: none"> <li>Define Medical/Health Neighborhood.</li> <li>Identify participants in the Medical/Health Neighborhood.</li> <li>Submit list of participants to RC Report to the IHC the status of establishing Medical/Health Neighborhoods.</li> </ul>	RCs, PHDs, and IDHW	\$953,781 (Pre-Implementation Year), \$635,854 (Model Test Year 1)	Goal 3	<ul style="list-style-type: none"> <li>Count of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood as needed.</li> <li>Count of designated PCMHs who are using established protocols for referrals and follow-up communications with service providers in their Medical/Health Neighborhood.</li> </ul>

**SIM Component/Project Area:** *Goal 3 — Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Sustainability Plan.	<ul style="list-style-type: none"> <li>• Begin the process of creating a Sustainability Plan.</li> <li>• Submit Sustainability Plan.</li> </ul>	PHDs and RCs	\$635,854 (Model Test Year 1 )	Goal 3	<ul style="list-style-type: none"> <li>• Count of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.</li> <li>• Count of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood as needed.</li> </ul>

### **2.3.3. Goal 3 Risk Assessment and Mitigation Strategy**

Idaho is confident that Idaho's seven PHDs, who have already entered into contract with IDHW, will fulfill the functions of RCs. The PHDs are already established in each region, and the scope of work that is expected of them is aligned with their current efforts in improving population health. Nonetheless, there are some risk factors that can impact the success of fully establishing RCs as a support resource for PCMHs and as an integrator of the Medical/Health Neighborhood. As RCs are established and begin sharing information and building the infrastructure necessary for the SIM Model Test, more risks may be identified and there will be a need to develop additional a risk mitigation strategies. Refer to the table on the following page for risk and mitigation strategies.

Table 8 — Goal 3 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
RCs are not established in order to provide quality improvement and integration services to PCMHs in each region.	Ongoing monitoring by IDHW SHIP Project Manager and PHD staff to determine each RC's capacity to support PCMHs.	1	IDHW	IHC, RCE, PHD Staff	<ul style="list-style-type: none"> <li>RC kick-off meeting.</li> <li>Develop standard status report guidelines.</li> </ul>	November 2015-December 2015
	Effective communication pathways between IHC and RCs.	2	IDHW	IHC, RCE, PHD Staff	Define and establish standard protocol for ongoing communication between IHC and RCs.	November 2015-December 2015
	Clear coordination between RCs and Brilljent.	3	IDHW	IHC, RCE, PHD Staff, Brilljent, Brilljent Subcontractors	Establish standardized communication between Brilljent, IHC, RCs, and PHD staff.	November 2015-December 2015
	Clear guidance on expectations of RCs.	4	IDHW	IHC, RCE, PHD Staff	Define the expectations and limitations of RCs.	November 2015-December 2015

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Clinical and broader public and social health providers do not follow established protocols for referrals and follow-up communication.	Participation of Medical/Health Neighborhood participants in development process of communication protocols.	1	RCE	RCE, PHD SHIP Staff, Briljent, Briljent Subcontractors, Medical/Health Neighborhood participants, Population Health Workgroup, IMHC	<ul style="list-style-type: none"> <li>Begin collecting information about communication capabilities of potential Medical/Health Neighborhood participants.</li> <li>Review lessons learned from IMHC and other states that have taken a similar approach to creating.</li> </ul>	November 2015-April 2016
	Clear definition of Medical/Health Neighborhood and key participants. Consistent use of definition.	2	RCs	RCE, PHD SHIP Staff, Briljent, Briljent Subcontractors, and Medical/Health Neighborhood participants, Population Health Workgroup, IMHC	<ul style="list-style-type: none"> <li>Define a Medical/Health Neighborhood.</li> <li>Identify critical participants engaging in the Medical/Health Neighborhood initiative.</li> </ul>	November 2015
	Effective communication process for Medical/Health Neighborhood participants to raise concerns.	3	RCs	RCE, PHD SHIP Staff, Briljent, Briljent Subcontractors, and Medical/Health Neighborhood participants, Population Health Workgroup, IMHC	Based on information collected, establish a standardized communication protocol for all participants in a Medical/Health Neighborhood.	November 2015

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
<p>Misaligned timelines and duplicative efforts among Brilljent and its Subcontractors, IHDE, and Data Analytics Contractor.</p>	<p>Establish communication protocols for all contractors assisting with PCMH transformation, quality improvement, and data exchange efforts.</p>	<p>1</p>	<p>IDHW</p>	<p>Mercer, Brilljent, Brilljent Subcontractors, IHDE, and Data Analytics Contractor, HIT Workgroup, CQI Workgroup, and RCs</p>	<p>Establish regular meetings for contractors to share information with one another.</p>	<p>Following executed contracts with all contractors. Completed no later than March 31, 2016.</p>
	<p>Contractor timelines should be aligned.</p>	<p>2</p>	<p>IDHW</p>	<p>Brilljent, Brilljent Subcontractors, IHDE, Data Analytics Contractor, HIT Workgroup, CQI Workgroup, and RCs</p>	<p>Compare various contracts to ensure alignment across all agencies.</p>	<p>Following executed contracts with all contractors. Completed no later than March 31, 2016.</p>

**2.4. Goal 4: Improve patient access to PCMH-based care in geographically remote areas of Idaho by supporting a Virtual PCMH Model through provider incentives and training community health workers, as well as integrating Telehealth into HIT plans for these areas.**

**2.4.1. Narrative Summary of Goal 4**

**In Model Test Year 1, Idaho will...**

- Recruit practices to become Virtual PCMHs.
- Begin incentive payments for Virtual PCMHs meeting criteria.
- Develop training curriculum for CHEMS.
- Contract for CHW training.

The Virtual PCMH model is a unique service delivery approach to developing PCMHs in Idaho's rural, medically underserved communities. The creation of Virtual PCMHs in Idaho will test the impact of the core components of the Virtual PCMH — telehealth technology, CHWs, and CHEMS personnel — in extending the PCMH care coordination model. Idaho's Virtual PCMHs will include the delivery of one or more of the following services: a) telehealth services including specialty care, behavioral healthcare, and or mobile EMS units; b) trained CHEMS personnel within participating EMS agencies; and c) trained CHW personnel within the PCMH and other community based organizations. These

services will be housed in or affiliated with established PCMHs in Idaho's rural communities. Care coordination by Virtual PCMHs will go beyond those of a traditional bricks and mortar primary care office.

RCs will work with Medical/Health Neighborhoods and communities at large to determine the need for a Virtual PCMHs within the region. Community needs assessments and clinical data will be used to determine service gaps in the community, and will be important data sources in determining a community's need for a Virtual PCMH practice. HMA will assist IDHW in selecting Virtual PCMHs based on need and interest to integrate one of the virtual component services listed above into the PCMH environment, considering access to behavioral health, virtual care coordination, connection to community resources to address social determinants, and access to specialty care.

HMA will support the PCMHs as they interface with the core components of virtual care delivery system. HMA will provide technical assistance to Virtual PCMHs that will include:

- Development of clinical applications and pathways.
- HIPAA and security issues.
- Appropriate coding and billing.
- Establishment of administrative and clinical policies and procedures.
- Development of team roles, job descriptions, and training.

RCs working on CHWs and CHEMS infrastructure will report regularly to IDHW and the IHC. Technical assistance related to the alignment of data needs and processes will be coordinated by the HIT Workgroup, and may include additional support from HMA, IHDE, and the Data Analytics Contractor to support participating Virtual PCMHs and RCs in ensuring that infrastructure can meet capacity.

Recruitment of practices to become designated as Virtual PCMHs will begin in Model Test Year 1. Practices that become Virtual PCMHs may receive an additional \$2,500 incentive payment starting in Model Test Year 1 upon meeting criteria established by IDHW. During the Model Test Years 1–3,

Idaho intends to create 50 Virtual PCMHs out of the total of 165 PCMHs that will be developed statewide.

### CHEMS and CHWs

A key component of the Virtual PCMH model is to expand the care delivery service to include trained CHWs and CHEMS professionals. The CHEMS model is based upon current, successful Idaho programs that have demonstrated a reduction in unnecessary ED visits, improved medication reconciliation, and increased vaccination rates through the deployment of CHEMS personnel in community health settings. The addition of CHEMS and CHWs to the PCMH delivery model will help in several key ways. In general, CHWs and CHEMS will:

1. Provide services for persons with chronic disease.
2. Perform health education and outreach.
3. Become an extension of the primary care team to increase self-management supports and assist in care coordination for chronic conditions.

During the Model Test, the integration of the CHEMS model will enable EMS personnel to function outside their usual roles of emergency response; activities may include providing in-home monitoring or follow-up with the goal of reducing inappropriate ED use. CHEMS personnel will also provide health education and disease management. CHEMS will potentially be able to assist persons in home environment and conduct fall risk assessment, medication education, and assisting the patient in accessing needed services. Their care coordination activities can also include providing information about area resources, such as mental health programs, dental services, and nutritional programs.

The specific role of CHWs and CHEMS will vary at each Virtual PCMH practice. Within each practice, staff will use community needs assessments and clinical data to determine the specific role of the CHWs and CHEMS in that particular practice, so that their role can be tailored and optimized at the practice level.

### CHEMS and CHW Training

IDHW will contract with training agencies to provide training to community paramedic staff to become a CHEMS professional. During the Model Test Year 1, the CHEMS Training Contractor will develop the training curriculum with input from the CHEMS Task Force. Prior to the trainings, outreach events will be conducted to educate stakeholders about CHEMS and to advertise the training opportunities. The trainings will begin in Model Test Year 1. Moving forward, Idaho's goal is to train four CHEMS professionals in three new regions in each year of the Model Test, for a total of 52 CHEMS professionals in 13 rural communities by the end of the Model Test period. Program fees for the trainings will be waived for participants during the Model Test period, and will be paid for by the grant funds. In Model Test Years 2 and 3, a one-day continuing education conference will be held for trained CHEMS staff.

IDHW will contract with training agencies to provide CHW training. During the Model Test Year 1, the Training Contractor will develop the training curriculum. Idaho's proposed CHW training program is a blended learning program consisting of in-person trainings offered statewide and online sessions. CHW training will begin as a two-day, in-person training with support from the RCs at seven locations per year, in order to train up to 200 CHWs by the end of the Model Test. In Model Test Years 2 and 3, one-day continuing education conferences will be held for CHW trained staff, in conjunction with the CHEMS continuing education conference.

### Telehealth and other Advanced Health Technologies

Another cornerstone of Goal 4 is integrating telehealth and other advanced health technologies into the Virtual PCMH practices in Model Test Year 3. IDHW will contract with a Telehealth Contractor to help expand telehealth technology in Virtual PCMHs, including training and technical assistance. SIM Model Test funds will also be used to establish and deploy telehealth technology, although budget reductions in the SIM Model Test have yielded reductions in the amount of proposed equipment to be purchased to support telehealth in Virtual PCMHs. Telehealth technology will be a particularly important tool in integrating behavioral health services, so that patient access to these services can be expanded. Idaho is a 100% federally designated mental health shortage area. The use of telehealth will enable individuals, particularly in very rural areas, to access behavioral health services not available locally. Telehealth technology will also expand access to other specialty services limited across the State.

The SIM Model Test will also encourage Virtual PCMHs to expand the use of other advanced health technologies, such as EHRs, patient portals, and clinical decisions tools. The use of these technologies at the patient level will reduce access barriers for Idaho's rural residents. These technologies will also improve provider collaboration and coordination and increase patient engagement. From a statewide perspective, the use of these technologies in rural Virtual PCMHs will also create a mechanism for practices to submit data, so that these areas are well represented in statewide datasets that will inform population health improvement initiatives.

#### **2.4.2. Goal 4 Summary Table**

The desired outcomes for developing Virtual PCMHs are to spread the PCMH model to rural communities, introduce new roles in primary care for EMS professionals and CHW, and expand use of telehealth tools by Virtual PCMHs. The table on the following pages describes key activities and metrics for this goal.

Table 9 — SIM Component/Project Area for Goal 4

<b>SIM Component/Project Area:</b> <i>Goal 4 — Improve rural patient access to PCMH by developing 50 Virtual PCMHs.</i>					
<b>Activity/Budget Item:</b>	<b>Description of Activities</b>	<b>Lead Entity</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
Virtual PCMH requirements, standards, designation criteria, and recruitment plan.	<ul style="list-style-type: none"> <li>Collect information to build the Virtual PCMH recruitment plan.</li> <li>Develop requirements, standards, and designation criteria.</li> <li>Draft Virtual PCMH recruitment plan.</li> <li>Implement Virtual PCMH recruitment plan.</li> <li>Evaluate recruitment plan periodically and make adjustments as needed.</li> </ul>	IDHW and IHC	\$41,666 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of Virtual PCMHs established in rural communities following assessment of need.</li> <li>Count of CEMS program personnel trained for Virtual PCMH coordination.</li> <li>Count of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients.</li> </ul>
Financial incentives for qualifying PCMHs.	<ul style="list-style-type: none"> <li>Hire PCMH Contractor (and Incentive Distribution Contractor).</li> <li>Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.</li> <li>Obtain any necessary approvals of the financial distribution process.</li> <li>Complete any logistical steps needed to implement the process.</li> </ul>	IDHW and Myers and Stauffer	\$408,414 (Pre-Implementation Year)	Goal 4	<ul style="list-style-type: none"> <li>Count of Virtual PCMHs established in rural communities following assessment of need.</li> <li>Count of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients.</li> </ul>

<b>SIM Component/Project Area:</b> <i>Goal 4 — Improve rural patient access to PCMH by developing 50 Virtual PCMHs.</i>					
<b>Activity/Budget Item:</b>	<b>Description of Activities</b>	<b>Lead Entity</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
Virtual PCMH mentoring program.	<ul style="list-style-type: none"> <li>Identify potential mentors.</li> <li>Gather program requirements.</li> <li>Develop Virtual PCMH mentoring program.</li> <li>Comments/feedback on Virtual PCMH peer mentoring program.</li> <li>Launch mentoring program.</li> </ul>	HMA	\$155,118 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of Virtual PCMHs established in rural communities following assessment of need.</li> <li>Count of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients.</li> </ul>
Training program for CEMS agencies and CHWs participating in Virtual PCMHs.	<ul style="list-style-type: none"> <li>Identify CEMS standards and certification requirements.</li> <li>Execute contract with training vendor to provide CEMS trainings.</li> <li>Establish CEMS Workgroup and identify CEMS subcommittee leads.</li> <li>Identify CEMS program for basic life support (BLS) and intermediate life support (ILS) agencies.</li> <li>Identify CHW standards and certification requirements.</li> <li>Contract with training vendor to provide CHW trainings.</li> <li>Establish CHW Workgroup and identify CHW subcommittee leads.</li> <li>Collect best practice resources and policies for program implementation.</li> <li>Identify required metrics and reporting process.</li> </ul>	IDHW	\$20,000 for CEMS (Pre-Implementation Year) \$63,000 (Pre-Implementation Year) \$29,000 for CHW (Pre-Implementation Year) \$14,000 CEMS Instructor Training (Pre-Implementation Year) \$133,141 for CEMS (Model Test Year 1) \$49,500 for CEMS (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of regional CEMS programs established.</li> <li>Count of CEMS program personnel trained for Virtual PCMH coordination.</li> <li>Count of continuing education conferences held for CHW and CEMS Virtual PCMH staff.</li> <li>Count of new CHWs trained for Virtual PCMH coordination.</li> </ul>

<b>SIM Component/Project Area:</b> <i>Goal 4 — Improve rural patient access to PCMH by developing 50 Virtual PCMHs.</i>					
<b>Activity/Budget Item:</b>	<b>Description of Activities</b>	<b>Lead Entity</b>	<b>Expected Expenditures</b>	<b>Primary Driver</b>	<b>Metric</b>
Technical assistance program.	<ul style="list-style-type: none"> <li>Develop transformation support program.</li> <li>Develop "how-to" guide or coaching manual to address educational needs (BLS, ILS, and ALS).</li> </ul>	HMA	\$20,000 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of CEMS program personnel trained for Virtual PCMH coordination.</li> <li>Count of new CHWs trained for Virtual PCMH coordination.</li> <li>Count of continuing education conferences held for CHWs and CEMS Virtual PCMH staff.</li> <li>Count of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients.</li> </ul>
Implement new CEMS telehealth program.	<ul style="list-style-type: none"> <li>Establish criteria for participation.</li> <li>Conduct readiness assessment and selection.</li> <li>Write and release RFP.</li> <li>Procure telehealth equipment.</li> <li>Telehealth go-live.</li> </ul>	CEMS Workgroup and Telehealth Council	\$57,472 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of regional CEMS programs established.</li> <li>Count of CEMS program personnel trained for Virtual PCMH coordination.</li> </ul>
Telehealth implementation plan.	<ul style="list-style-type: none"> <li>Research other state telehealth standards.</li> <li>Collect input from key stakeholders on draft telehealth standards.</li> <li>Develop draft telehealth standards.</li> <li>Obtain feedback as needed.</li> <li>Finalize telehealth standards.</li> </ul>	Telehealth Council	\$84,713 (Pre-Implementation Year) \$84,713 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>Count of designated Virtual PCMH practices that routinely use telehealth tools to provide specialty and behavioral services to rural patients.</li> </ul>

**SIM Component/Project Area:** *Goal 4 — Improve rural patient access to PCMH by developing 50 Virtual PCMHs.*

Activity/Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Sustainability plan for CHEMS and CHWs.	<ul style="list-style-type: none"> <li>• Collect information/feedback from CHEMS agencies.</li> <li>• Solicit stakeholder input.</li> <li>• Develop proposed plan.</li> <li>• Implement plan.</li> </ul>	CHEMS and CHW Workgroups	\$60,230 (Model Test Year 1) \$41,667 (Model Test Year 1)	Goal 4	<ul style="list-style-type: none"> <li>• Count of CHEMS program personnel trained for Virtual PCMH coordination.</li> <li>• Count of new CHWs trained for Virtual PCMH coordination.</li> <li>• Count of continuing education conferences held for CHWs and CHEMS Virtual PCMH staff.</li> </ul>

### 2.4.3. Goal 4 Risk Assessment and Mitigation Strategy

The overall likelihood of achieving Goal 4 is medium to high. Goal 4 activities were created by stakeholders during the Model Test and are built on existing strengths in Idaho's healthcare system to expand capacity in underserved rural areas.

Through the risk assessment and mitigation strategy planning process, Goal 4 stakeholders were able to identify several dependencies and risks associated with Goal 4 activities. Achieving Goal 4 is dependent upon a successful launch of Goal 1 (building statewide PCMHs) and Goal 2 (HIE) and the implementation of three distinct programs — CHWs, CHEMS, and telehealth — which all carry their own associated risks related to procuring hardware and systems, recruiting local agencies, and hiring and training new staff. Integrating these three new programs into the existing PCMH model in order to form Virtual PCMHs will not be without its challenges in establishing new partnerships and relationships for providers. HMA and RCs, along with IHDE and the Data Analytics Contractor, will need to serve as information conduits in facilitating these relationships to enable true practice transformation.

Risk mitigation planning for Goal 4 will continue throughout the Model Test Years. Goal 4 stakeholders will continue to use the risk planning process to identify risks and develop risk mitigation strategies. IDHW, Mercer, and Brilljent and its Subcontractors will all be responsible throughout the Model Test Period for continually monitoring Goal 4 progress and identifying new risks as they arise.

The table on the following page summarizes the risk factors identified during the risk assessment and mitigation strategy planning process.

Table 10 — Goal 4 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Inability to integrate CEMS data reporting with IHDE reporting requirements.	Assure communication between CEMS and HIT Workgroup.	1	IDHW	CEMS and HIT Workgroups	Convene cross-workgroup subcommittee to develop data dictionaries and identify potential system issues and limitations.	Calendar year 2016
Newly trained CEMS professionals do not remain engaged with EMS agencies.	Address in the contract/MOUs with EMS agencies.	1	IDHW	CEMS Workgroup	Identify contract language to include in the contract/MOU with EMD agencies.	July–December 2016
Lack of sustainability plan for CHW training.	Integrate CHW program with RC sustainability planning.	1	IDHW	CHW Workgroup	Ensure CHW Workgroup develops sustainability plan per charter by target date of February 2017.	July–December 2016
Limited CHW model adoption by PCMHs.	Increase outreach coordination with medical home collaborative and RCs.	1	IDHW	CHW Workgroup, IMHC Workgroup, Briljent, Briljent Subcontractors	<ul style="list-style-type: none"> <li>Engage Briljent and its Subcontractors to identify obstacles or resistance from PCMHs.</li> <li>Provide education and outreach to PCMHs about benefits to provider and patient's health outcomes.</li> </ul>	July–December 2017
Lack of student participation in training.	Align with CHW outreach committee to assure appropriate information distribution to stakeholders and potential CHWs.	1	IDHW	CHW Workgroup	Engage RCs in areas containing Virtual PCMHs to develop recruitment plans.	January–December 2017

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

### 2.5.1. Narrative Summary of Goal 5

#### In Model Test Year 1, Idaho will...

- Identify cost and quality performance measures at the patient, regional, and statewide levels (resides in Data Analytics System).
- Design reports and reporting schedule.
- Identify performance metrics for tracking and ongoing evaluation of improvements in patient care, regional population health, and overall statewide performance based on the PCMHs response to community health needs assessment results provided by the RCs.

Idaho's HIT Plan calls for the development and/or expansion of EHR and IHDE technology to support Goal 5, the development of statewide data analytics. In October 2015, IDHW released an RFP for a Data Analytics Contractor to build a structure to collect, analyze, and report on selected clinical and cost data at the individual practice level, county level, regional level, and state level. This RFP is anticipated to be awarded January 2016. Idaho's vision includes collecting statewide data on defined quality and cost measures from multiple sources, including payment, clinical, and patient portal data. Idaho payers have agreed to share data on specific quality and cost indicators identified in Idaho's SHIP.

Goal 5 builds on the increased clinic HIT capacity and data exchange pathways that are the outcomes of Goal 2, and contributes to Idaho's ability to achieve the Triple Aim. Goal 5 activities will contribute to the Triple Aim through the following mechanisms:

- **Health outcomes will improve** by establishing performance and quality standards at a statewide level, and measuring quality of care at the practice level, population

health at the regional level, and statewide quality of care. Results identify opportunities for improvement, as well as best practices and evidence-based practice guidelines to adopt across Idaho's healthcare landscape.

- **The quality and experience of patient care will improve** through using data analytics to assess how clinical quality affects patient satisfaction and the patient's experience of healthcare, and to implement change to support this goal.
- **Healthcare costs will decline** through Idaho's ability to use data analytics to establish value-based payments. Industry studies show that the most expensive care is not necessarily the best care. Data analytics will allow Idaho to identify variations in the cost and quality of care and take steps to reduce those variations, such as standardizing best practices and tracking improvements and cost savings over time.

**Timeline and Targets:** HMA, the PCMH Training and Technical Assistance Subcontractor, will provide education and technical assistance for performance reporting capacity to ensure that 55 practices are prepared to report on identified measures in the second year of the Model Test, up to 110 practices in the third year, and 165 practices by 2019. HMA, the Data Analytics Contractor, and RCs will need to coordinate efforts in this endeavor. In Year 2 of the Model Test, the RCs will conduct regional needs assessments and will develop strategies and activity recommendations to address regional improvement. The Data Analytics Contractor will collect and analyze selected quality and cost data for the baseline and each subsequent year through the Model Test. The Data Analytics Contractor will provide data analytics feedback at the practice level for improving the care of the patient population: at the county level, at the regional level for identification of quality indicators to

focus on at the regional level, and at the State level to provide direction in evaluating the overall success of the Model Test.

### **2.5.2. Goal 5 Summary Table**

Goal 5 aims to achieve the establishment of a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide level. The table below describes key activities and metrics for this goal.

**Table 11 — SIM Component/Project Area for Goal 5**

**SIM Component/Project Area:** *Goal 5 — Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional and State levels. This will provide critical feedback at the practice, regional and State levels.*

Activity/ Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
<p>Reports to analyze quality and cost data. Periodic reporting that compares quality and cost data against a baseline and for each subsequent year throughout the Model Test.</p>	<ul style="list-style-type: none"> <li>• Create and track regular reports that assess quality and cost improvements across all levels (patient, regional, and statewide).</li> </ul>	IHDE, IDHW, and IHC	\$397,855 (Model Test Year 1)	Goal 5	<ul style="list-style-type: none"> <li>• Count of designated PCMHs (sites) with access from the Data Analytics Contractor to the analytics system that provides dashboards and reporting.</li> <li>• Count of designated PCMH practices (sites) that receive community health needs assessment results from an RC.</li> </ul>
<p>Identify ongoing evaluation and tracking of performance metrics for community health needs assessment results to monitor improvement of:</p> <ul style="list-style-type: none"> <li>• Care of the patient population at the practice level.</li> <li>• Population health at the regional level.</li> <li>• Overall statewide performance.</li> </ul>	<ul style="list-style-type: none"> <li>• Create and track agreed upon performance metrics for community health needs assessment results among all IHC Workgroups.</li> </ul>	Clinical Quality Measures Workgroup, Population Health Workgroup, HIT Workgroup, IHDE, and IDHW	\$397,855 (Model Test Year 1)	Goal 5	<ul style="list-style-type: none"> <li>• Count of designated PCMHs (sites) with access from the Data Analytics Contractor to the analytics system that provides dashboards and reporting.</li> <li>• Count of designated PCMH practices (sites) that receive community health needs assessment results from an RC.</li> </ul>

**SIM Component/Project Area:** *Goal 5 — Build a statewide system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional and State levels. This will provide critical feedback at the practice, regional and State levels.*

Activity/ Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Ensure Brilljent and its Subcontractors are reaching contractual technical assistance and training milestones.	<ul style="list-style-type: none"> <li>Ongoing monitoring of Brilljent contract milestones.</li> </ul>	IDHW	\$397,855 (Model Test Year 1)	Goal 5	<ul style="list-style-type: none"> <li>Count of designated PCMHs (sites) with access from the Data Analytics Contractor to the analytics system that provides dashboards and reporting</li> </ul>

### **2.5.3. Goal 5 Risk Assessment and Mitigation Strategy**

Expert technical assistance, the contributions of the IHDE and the engagement of a Data Analytics Contractor will assist Idaho in achieving Goal 5, and the activities achieved through the other goals described earlier set the stage to support it. Nevertheless, Idaho recognizes, and has considered several potential risks as well as mitigation strategies. Idaho will continue to monitor these risks, as outlined on the following page.

Table 12 — Goal 5 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Statewide HIT Contractors not in place by selected deadlines.	HIT Workgroup monitoring of Contractor selection process.	1	IDHW	IHDE	Review selection and contracting progress at monthly HIT meetings.	October 2015- March 2016
Workgroup approval of metrics that track performance at all levels is not timely.	Clinical Quality Measures Workgroup establishes strong communication protocols with all IHC Workgroups.	1	IDHW	Data Analytics Contractor	Monitor approval process against established timeline.	October 2015- March 2016
Data Analytics Contractor not in place by selected deadline.	HIT Workgroup monitoring of Contractor selection process.	1	IDHW	Data Analytics Contractor	Review selection and contracting progress at monthly HIT meetings.	October 2015- March 2016
IDHW lacks resources to conduct monitoring of Data Analytics Contractor.	Restructure responsibilities of IDHW SHIP Team to allow for monitoring of activities.	1	IDHW	Data Analytics Contractor	IDHW project manager provides regular reports on capacity to monitor the Data Analytics Contractor.	February 2016- December 2016
State lacks resources to collect and report data.	Hire additional resources or outsource monitoring activities.	1	IDHW	IHDE	Identify checkpoints for monitoring adequacy of resources to support data collection and reporting.	October 2015- December 2016

## 2.6. Goal 6 Test transformation from a FFS system to one that incentivizes value, rather than volume, by aligning value-based payment mechanisms across payers.

### 2.6.1. Narrative Summary of Goal 6

#### In Model Test Year 1, Idaho will...

- Determine member attribution method.
- Determine quality measures.
- Determine minimum reporting requirements for projections.
- Create Financial Analysis Report Template.

As part of the Triple Aim, Idaho will move from a FFS payment model that rewards volume of service to new value-based payment models to incentivize better models of care and lower overall medical costs. This statewide payment transformation will involve a variety of approaches on the part of Idaho's major payers, including commercial payers, Medicare and Medicaid. Idaho recognizes the importance of offering flexibility to payers in defining how they will support payment reform. For example, one payer is incenting providers through an accountable care organization model with shared, upside risk, expecting to evolve to a full risk model in the future.

Within this broader statewide payment model transformation, several of Idaho's major payers have committed to alternative payment arrangements with SIM Model Test PCMHs. These new payment models will incentivize, support, and reward the improved care given through the PCMH model, which will reduce high-cost care through patient management, including lowering ED utilization, hospital admissions and re-admissions, reduce neo-natal intensive care use, and increase the use of generic prescription medication. It is anticipated that these trends will decrease the cost of healthcare in the State.

To initiate this payment shift during the Model Test period, Idaho anticipates that at least four major payers will implement value-based reimbursement models with SIM PCMHs. Idaho's target is that all PCMH practices will contract with payers under alternative payment arrangements.

The payment transformation, both at a statewide level and in support of the SIM PCMHs, will not occur immediately. Transforming payment requires negotiations and contracting between the payers and providers. To avoid anti-trust, each payer must negotiate separately with each provider. Commercial payers have demonstrated their commitment to negotiations that will lead to value-based payment arrangements with providers within their network that advance the goals of Idaho's healthcare system transformation goals.

### 2.6.2. Goal 6 Summary Table

The table below describes key activities and metrics for this goal.

Table 13 — SIM Component/Project Area for Goal 6

<b>SIM Component/Project Area:</b> Goal 6 — Test transformation from a FFS system to one that incentivizes value, rather than volume, by aligning value-based payment mechanisms across payers.					
Activity/ Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Report the number of payers participating in non-FFS that link payment to value.	<ul style="list-style-type: none"> <li>Count of payers and collection of methods used by each payer to determine if they are using non-FFS payment methods.</li> </ul>	Mercer	\$25,614 (Model Test Year 1)	Goal 6	<ul style="list-style-type: none"> <li>Count of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.</li> </ul>
Report the number of accredited PCMH practices with contracts to receive non-volume-based reimbursement	<ul style="list-style-type: none"> <li>Collect data from accredited PCMH practices to see if they have payers who contracted using non-FFS payment methods.</li> </ul>	Mercer	\$25,614 (Model Test Year 1)	Goal 6	<ul style="list-style-type: none"> <li>Count of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements.</li> </ul>
Report the number of beneficiaries whose payments fall into contracts that are non-volume-based reimbursements.	<ul style="list-style-type: none"> <li>Collect data from payers to identify the number of attributed beneficiaries to non-FFS contracts.</li> </ul>	Mercer	\$25,614 (Model Test Year 1)	Goal 6	<ul style="list-style-type: none"> <li>Count of beneficiaries attributed to all providers for purposes of alternative reimbursement payments.</li> </ul>
Report the percentage of payments to providers from all payers in FFS alternatives that link payment to value.	<ul style="list-style-type: none"> <li>Collect data from payers to identify the amount of payments made in non-FFS reimbursements compared to total reimbursements.</li> </ul>	Mercer	\$25,614 (Model Test Year 1)	Goal 6	<ul style="list-style-type: none"> <li>Percentage of payments made in non-FFS arrangements compared to total payments made.</li> </ul>

### **2.6.3. Goal 6 Risk Assessment and Mitigation Strategy**

The risk of failure for goal 6 is low, because payers have already begun negotiating performance-based contracts with providers. In fact, payers for Medicaid, Medicare advantage, and the four largest commercial insurance companies have already committed to variations of payment transformation above. The biggest risk of failure is for payers failing to attribute enough beneficiaries to a given provider to qualify for incentive-based payments for each payer, thereby delaying the payment transformation. Attribution is limited by several payers to select diagnoses initially to ensure the models do, in fact, reduce overall expenses. Increasing the diagnoses allowed for attribution after proven results should allow additional beneficiaries to attribute, thereby qualifying for incentive-based payments.

Table 14 — Goal 6 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Enough beneficiaries fail to attribute to each provider for each payer, making risk arrangements unfeasible.	Lower minimum threshold for beneficiary attribution and institute risk corridors to minimize risk for both payer and providers.	1	Payers	Multi-Payer Workgroup, IDHW, IHC, PCMHs	Identify PCMH's and primary care provider's levels of attribution by payers to determine if thresholds should be adjusted.	December 2016

## 2.7. Goal 7 Determine the cost savings and return on investment of the model, and progress toward meeting implementation goals throughout the Model Test period, as well as health outcomes predicted by the Model.

### 2.7.1. Narrative Summary of Goal 7

#### In Model Test Year 1, Idaho will...

- Receive data to conduct cost savings analysis.

The goal of achieving \$89 million in cost savings, and a return on investment of 225% are contingent on the successful implementation of all other goals. By implementing a value-based model, Idaho expects to save \$89 million through reductions in ED utilization for non-emergent episodes, inpatient admissions, inpatient re-admissions, admissions to the neo-natal intensive care unit

(NICU), and through increases in the generic fill rate for prescribed pharmaceuticals.

This goal includes the need to measure overall costs to determine a true cost savings. Therefore, the primary deliverable for this goal is to project the overall cost savings by implementing the SIM Model Test and comparing actual results to the projected savings. The actuarially certified projection creates a cost savings estimate to compare to actual results during the Model Test period. It contributes to the Triple Aim by creating financial goals to lower overall costs.

To complete the projection, historical data is used to project costs during the testing periods with and without implementation of the model. Historical data is projected forward using trend information to determine overall medical costs without implementing the model. Cost-saving assumptions are used to offset additional costs needed to implement the model to determine the overall medical costs with implementation of the model. The difference between the projections is the cost savings. Annually, payers will report summarized costs to compare to the projections to measure progress. Data from Idaho Medicaid, Medicare FFS, Medicare Advantage, and commercial payers will be summarized to calculate the total cost with and without model intervention.

Data will be gathered prior to, during, and immediately following the Model Test period from each payer. During the Pre-Implementation Year, recent data will be used to calculate the projections described above. Annually during the testing period, summarized financial data will be collected and compared to the cost savings projection. Immediately following the Model Test period, final summary data will be polled from each payer to calculate the overall cost savings during the Model Test and to calculate the return on investment for CMMI. As costs savings are identified through reductions in price and volume, payers are expected to attribute more members to providers partaking in the payment transformation listed in Goal 6.

### 2.7.2. Goal 7 Summary Table

Measurement of cost-savings is long term, and the true impact of implementing the SIM Model Test will be measured annually through the Model Test period and subsequently after the Model Test period to allow for claims run-out.

Data will be categorized by beneficiary into the payer groups shown in the table below.

Medicaid/Children's Health Insurance Program (CHIP)				Commercial/Private/Other		Medicare		
Adult	Child	Dual Eligibles (Only)	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	FFS/Non-Duals (Parts A and B)	Medicare Advantage Part C

Claims expenses will then be classified into the following categories of service.

- Inpatient Hospital
- ED
- Urgent Care
- Outpatient Hospital
- Professional Primary Care
- Professional Specialty Care
- Diagnostic Imaging/X-Ray
- Laboratory Services
- Durable Medical Equipment
- Dialysis Procedures
- Professional Other (e.g., Physical Therapy, Occupational Therapy)
- Skilled Nursing Facility
- Home Health
- Custodial Care
- Intermediate Care Facilities for Individuals with Mental Retardation
- Home and Community-Based Services
- Other costs not described elsewhere
- Behavioral Health
- Prescription Drugs (Outpatient)

Additionally, payers will report members per month on an annual basis. Cost data will be summed from up from each payer into the respective categories of service and payer group and divided by the number of member months to calculate a total cost per member per month (PMPM). These costs will be compared to the projected cost PMPM to monitor whether or not the innovational model is contributing to reduced costs.

Table 15 — SIM Component/Project Area for Goal 7

<b>SIM Component/Project Area:</b> Goal 7 — Determine the cost savings and return on investment of the model and progress toward meeting implementation goals throughout the Model Test period, as well as health outcomes predicted by the Model.					
Activity/ Budget Item:	Description of Activities	Lead Entity	Expected Expenditures	Primary Driver	Metric
Implementation of PCMH.	<ul style="list-style-type: none"> <li>Establish PCMH and/or primary care practice sites.</li> <li>Payers contract with practices using alternative payment arrangements.</li> <li>Beneficiaries attribute to PCMHs or primary care.</li> </ul>	Mercer	\$60,230 (Model Test Year 1)	Goal 7	<ul style="list-style-type: none"> <li>Total population-based PMPM index.</li> <li>SIM Model Test return on investment (ROI).</li> </ul>
Implementation of alternative payment arrangements.	<ul style="list-style-type: none"> <li>Payers contract with practices using alternative payment arrangements.</li> </ul>	Mercer	\$60,230 (Model Test Year 1)	Goal 7	<ul style="list-style-type: none"> <li>Total population-based PMPM index.</li> <li>SIM Model Test ROI.</li> </ul>
Cost saving projection.	<ul style="list-style-type: none"> <li>Data is received to conduct cost savings analysis by October 5, 2015.</li> </ul>	Mercer	\$60,230 (Model Test Year 1)	Goal 7	<ul style="list-style-type: none"> <li>Total population-based PMPM index.</li> <li>SIM Model Test ROI.</li> </ul>

### 2.7.3. Goal 7 Risk Assessment and Mitigation Strategy

The risk of failure to achieve the \$89 million in cost savings and 225% return on investment stems from the risk of failure to implement the PCMH model and from the risk of not implementing payment reform. To achieve the goal, at least 165 practices must become designated as PCMHs, contract with payers, and establish reimbursement based on outcomes rather than volume.

1. Upon implementing those steps, there are also risks that the care model will fail to achieve the following cost-saving assumptions: ED utilization for non-emergent episodes: the availability and use of primary care physicians (PCPs) is expected to provide an effective alternative to the ED.
2. Hospital admissions: admissions to the hospital are expected to decrease because of the use of evidence-based practices designed to prevent complications for beneficiaries with chronic conditions.
3. Hospital re-admissions: Care provided and directed by the PCP is proven to reduce hospital re-admissions by providing beneficiaries with transitional care designed to avoid complications and prevent symptom relapses and complications with chronic condition beneficiaries.
4. Decreased use of neo-natal intensive care: Increased early periodic screening and developmental testing, and increased monitoring of pregnant Medicaid beneficiaries should reduce the need for neo-natal intensive care.
5. Increased use of generic pharmaceuticals over brand pharmaceuticals: Primary care teams are expected to prescribe generic drugs where available to reduce costs, especially when incented by shared-savings or gain-sharing agreements.

Each assumption includes inherent risk, including patient compliance, successful implementation of primary care, in addition to unforeseen epidemics or acute care needs. Patient compliance remains difficult to incent. Monitoring and follow-up calls by the PCMH care team should help hold patients accountable for following prescribed treatment plans. The successful implementation of primary care is imperative to meeting the cost savings assumptions. This step requires availability and access to all necessary specialists and providers included in the primary care team and PCMH. Finally, the cost-saving model does not account for unforeseen epidemics that may regionally cause increases in utilization or acute care needs as a result of accidental injury or illness.

Additionally, to fully understand the progress toward achieving Goal 7, reporting of actual expenditures and utilization must occur. To create the report, payers must provide actual cost and utilization data. There is an additional risk of not receiving accurate or timely data from the payers. This risk has been mitigated through communication and through keeping the data request summarized to ensure the data does not divulge proprietary secrets such as per-unit pricing between payer and provider.

Table 16 — Goal 7 Risk Mitigation Strategies

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity	Risk Mitigation Participants	Next Steps	Timeline
Failure to implement the SIM model.	Allowing additional primary care based models in lieu of PCMH practices where payments still incent outcome over volume.	1	Payers	All	Determine if there is sufficient beneficiary attribution to move to risk-based payments.	December 2016
Failure to implement alternative payment arrangements.	See Goal 6 regarding beneficiary attribution.	1	Payers, Providers	Multi-Payer Workgroup	Identify PCMH's and primary care provider's levels of attribution by payers to determine if thresholds should be adjusted.	December 2016
Failure to report financial results timely or accurately.	Identify alternative data sources that may be used in lieu of reported data	1	Mercer, IDHW SHIP Staff, Payers	Multi-Payer Workgroup	Determine if NAIC filings for commercial data and the CMS website for Medicare FFS data have adequate detail to proceed with the financial analysis.	November 2015

## 3. General SIM Operational and Policy Areas

### 3.1. SIM Governance, Management Structure and Decision-Making Authority

Idaho's SIM Model Test is part of the State's healthcare system redesign effort that began in 2007 when Idaho recognized the need to move from the State's volume-based healthcare system to a value-based system. At that time, Governor C. L. "Butch" Otter convened the Idaho Health Care Summit to evaluate Idaho's current healthcare system and recommend ways to make healthcare more affordable and accessible to Idahoans. Immediately following the Summit, Governor Otter established, through Executive Order, the Governor's Select Committee on Health Care to evaluate the recommendations that resulted from the Summit and develop additional recommendations based on further analysis of the State's healthcare system. The result was a report in 2008 that spotlighted the need for changes to the State's healthcare system and led to the development of a number of healthcare initiatives. Idaho's healthcare system transformation journey has continued since then with the establishment of the IMHC, created in 2010 via Executive Order 2010-10. The IMHC piloted the PCMH model to determine the impact of the model on improving care. Throughout the State's efforts to transform the healthcare system, Governor Otter has been at the helm, directing the State's efforts while relying on stakeholders across Idaho to advise him and other policy makers on the State's healthcare needs and strategies for successful transformation.

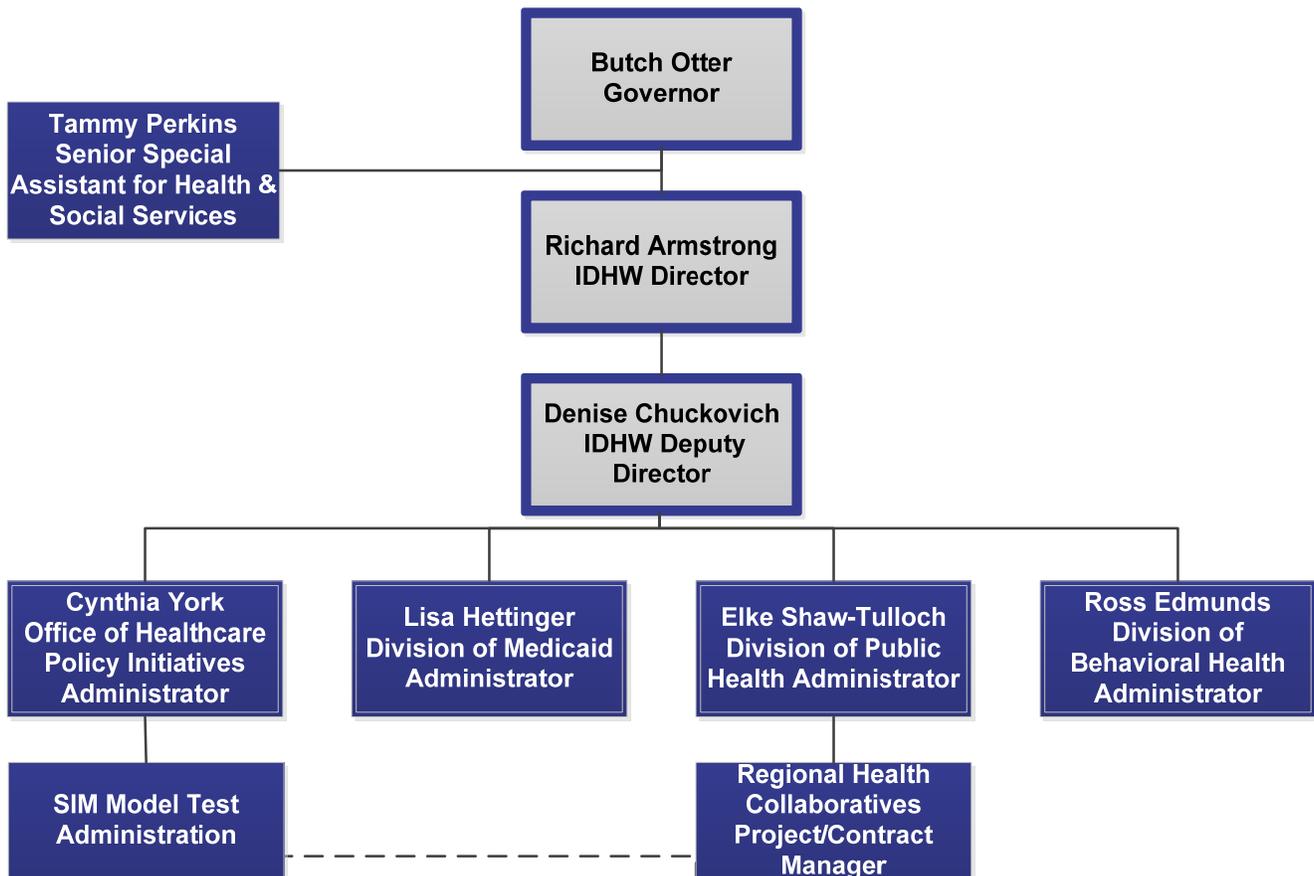
As with the previous healthcare initiatives, Governor Otter has and will continue to play a key role in the operational and policy direction of the SIM Model Test. In 2014, Governor Otter signed Executive Order 2014-02, which established the IHC for the purpose of guiding the transformation of the State's healthcare system from its siloed delivery system to a comprehensively integrated care model that focuses on health outcomes. The IHC is charged with implementing the SHIP, which was designed during the SIM Model Design period in 2013 and serves as the blueprint for Idaho's healthcare system transformation. The IHC is comprised of a diverse group of stakeholders from across the State who have been working to identify changes needed to the State's healthcare system and strategies that will lead to better health outcomes, improved patient experience of care, and reduced healthcare costs.

The SIM grantee is the IDHW, or the Department, which is led by the Governor's appointee, Director Richard Armstrong. Director Armstrong is a strong leader in the State's overall healthcare system transformation efforts and is directly involved in the SIM Model Test activities. Director Armstrong reports directly to Governor Otter and provides regular updates to the Governor on the progress of SIM Model Test activities. Additionally, Tammy Perkins from the Governor's Office serves on the IHC and provides operational and policy guidance from the Governor's Office to the IHC.

IDHW is Idaho's umbrella agency for all health and welfare programs and is responsible for an annual budget of \$2.5 billion dollars including management of \$1.6 billion in federal funds. Within the Department are the Divisions of Medicaid, Public Health, and Behavioral Health, and the Office of Healthcare Policy Initiatives, all of which are directly engaged in Idaho's healthcare system transformation. The Medicaid program is a major healthcare purchaser in Idaho and one of the key payers in Idaho's multi-payer model. The Public Health Division provides leadership in developing and monitoring Idaho's Population Health Plan, and its seven PHDs will convene and support the RCs to facilitate transformation at the local level (see sections below on RCs). The Division of Behavioral Health is facilitating the discussion on expanding behavioral health and physical health integration within the PCMH model. The three Administrators for these Divisions report directly to IDHW Deputy Director and IHC Co-Chair, Denise Chuckovich, who is responsible for ensuring coordination between the IHC and IDHW. Administrators of the Medicaid, Public Health, and Behavioral Health Divisions

serve on the IHC and are responsible for coordinating staff and programs within their Divisions with SIM Model Test activities. The Administrator of the Office of Healthcare Policy Initiatives, who also reports to Ms. Chuckovich, is responsible for administering the SIM Model Test grant and is a member of the IHC.

**Figure 10 — SIM Governance: Governor Butch Otter’s Management Structure**



### Idaho Healthcare Coalition

The IHC is the driving force of Idaho’s healthcare system transformation and, along with Governor Otter, is a key decision-making body. First formed in 2013 under the SIM Model Design grant and then officially established on February 25, 2014 through Executive Order 2014-02, the IHC has grown from 31 members to 46 members to further ensure diverse and broad stakeholder participation in the State’s overall transformation and the SIM Model Test activities specifically.

The IHC meets monthly and is co-chaired by Dr. Ted Epperly, a practicing Idaho family physician, and Denise Chuckovich, IDHW Deputy Director. The agenda for each monthly meeting is set by the co-chairs and focuses on directing and monitoring SIM Model Test activities to advance the implementation of the Idaho SHIP. Agenda items and meeting documents are distributed to IHC members five business days in advance of the meeting so IHC members can prepare for the

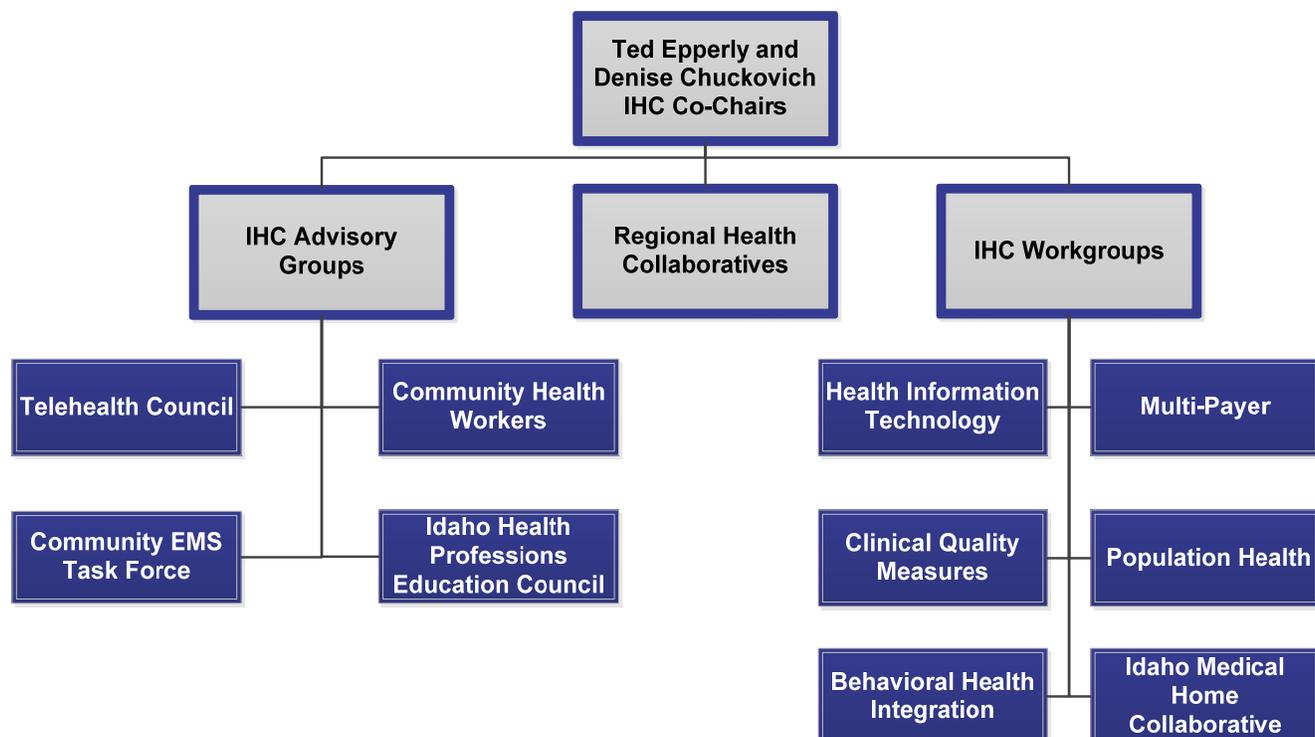
discussion. Decision items that require action, including approval of items as determined by voting, are identified in advance on the agenda.

The IHC membership, noted in Appendix C, demonstrates that the right stakeholders, in terms of both subject matter expertise and diversity, are directing healthcare system transformation in Idaho. The membership reflects the commitment of healthcare providers, public and private payers, policy makers, and community-based organizations to creating innovative, sustainable changes to the healthcare system.

#### IHC Workgroups and Advisory Groups

Six Workgroups have been established by the IHC and four existing advisory groups have been recruited to assist the IHC in carrying out the immense amount of work that must be completed to achieve Idaho's seven goals. Each Workgroup and advisory group has a charge related to implementing the SHIP goals in Idaho, and project charters that identify specific activities, milestones, deliverables, and timeframes that each Workgroup is responsible for to support the IHC in achieving the goals have been created. The IHC, with support of IDHW, monitors the State's healthcare system transformation and, as needed, assists the Workgroups with making adjustments to their project charters to maintain alignment with the overall transformation goals. The Workgroup chairs serve on the IHC and bring recommendations from the Workgroups to the IHC for consideration and final decisions.

**Figure 11 — SIM Governance: IHC Management Structure**





## RCs

The IHC has recognized the model must be responsive to local needs and characteristics and thus chartered RCs to advance and support key principles of the SHIP. Idaho's PHDs have been designated the convener of the RCs and will serve as the main facilitators of the regional effort to achieve Idaho's seven healthcare system transformation goals.

RCs will:

- Bring local area expertise to strengthen care coordination opportunities between the PCMH and Medical/Health Neighborhood, such as identifying local healthcare resources and drawing upon community needs assessments.
- Facilitate development of the Medical/Health Neighborhoods to strengthen patient care coordination.

PHDs will:

- Assist and support primary care practices as they transform to the PCMH model by engaging PHD SHIP Staff to connect practices to Technical Assistance Contractors lead the integration of public health and population health management into the Model.
- Provide support in gathering regional and practice-level data to ensure that local data, including community needs assessments, are used to both identify local health population and system needs and design solutions to address those needs.
- Convene and support the RC and the RCE to evaluate and address specific regional population health and delivery system concerns and needs.

The PHDs are independent, quasi-governmental entities that collaborate with the IDHW Division of Public Health. Through contractual arrangements, each PHD has agreed to perform duties related to supporting the RCs; as identified by IDHW, directed by the IHC and detailed in a contractual scope of work. The PHDs are also in the process of hiring staff dedicated to implementation of the Model at the regional level. A portion of the SIM Model Test grant funding has been used to create three full-time employee positions within each of the seven PHDs, for a total of twenty-one new staff positioned across the State to support achieving Idaho's healthcare system transformation goals. Each PHD will hire:

1. SHIP Manager who is the RC team lead and responsible for the overall leadership and direction of the RC.
2. QA/QI Specialist who is responsible for providing QA/QI consultation to providers working toward PCMH transformation and facilitating connections between PCMHs and the Medical/Health Neighborhood.
3. Administrative Assistant to support both the RC team and the local RCE.

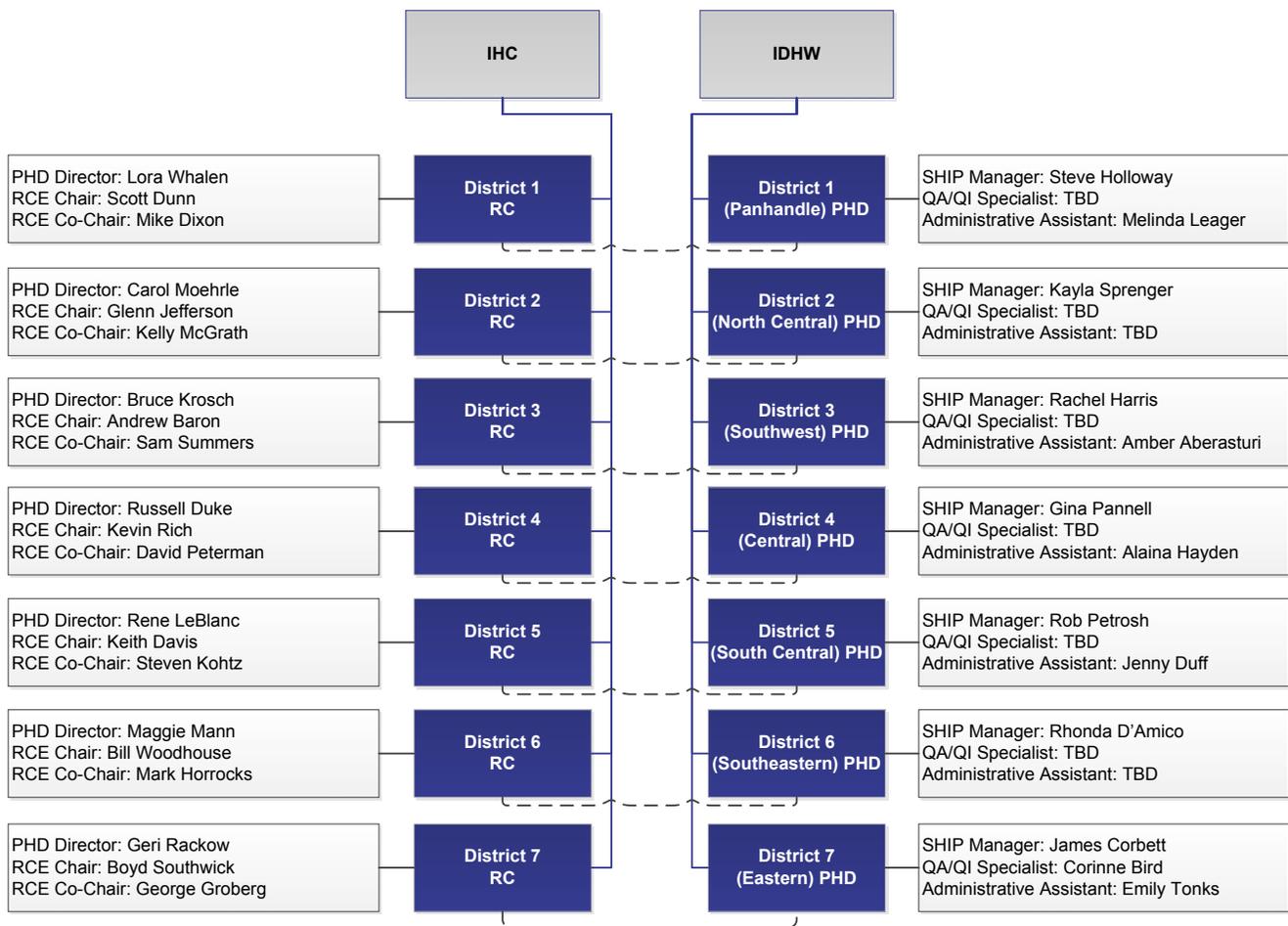
At the local level, PHD SHIP staff report to the PHD Director, who collaborates with Elke Shaw-Tulloch, IDHW Public Health Division Administrator at the statewide level. Ms. Shaw-Tulloch and the seven PHD Directors are members of the IHC.

Each RC is comprised of regional representatives from PCMHs and the Medical/Health Neighborhood. Additional stakeholders serving on the RC may include local county officials, patient advocacy organizations, and others relevant to regional healthcare needs. The RC leadership committee, known as the RCE is co-chaired by local physicians who, along with the PHD Director and SHIP Manager, are charged with:

1. Advising the IHC on issues and initiatives within the region and seeking programmatic support to address challenges, as needed.
2. Providing status reports on project progress and population health improvement strategies.
3. Seeking resources through the IHC to address unmet technical assistance needs and resources for PCMHs and the Medical/Health Neighborhood through the IHC.

A project charter developed for each RC includes activities, milestones, and deliverables for the RCE to help local stakeholders understand their role and tasks in supporting the IHC and Idaho’s healthcare system transformation across their region.

**Figure 12 — SIM Governance: IHC, IDHW, and RC Management Structure**



**IDHW Office of Healthcare Policy Initiatives**

The IDHW Office of Healthcare Policy Initiatives is responsible for the administration and management of SIM Model Test activities. Staff dedicated to the SIM Model Test grant activities are

referred to as the “IDHW SHIP Team” and all but one staff are housed in the Office of Healthcare Policy Initiatives. Responsibilities of the IDHW SHIP Team include:

- Project management of all SIM Model Test grant activities.
- Carrying out the day-to-day operations of SIM Model Test grant activities.
- Developing, managing, and monitoring the State’s Operational Plan for healthcare system transformation.
- Ensuring compliance with SIM grant requirements, including all budgetary and reporting requirements.
- Procuring and overseeing contracts that support SIM Model Test activities.
- Providing staff support to the IHC and Workgroups.
- Serving as the liaison between IDHW and other state agencies contributing to and impacted by healthcare system transformation.
- Ensuring inter-agency communication and linkages between the SIM Model Test grant activities and relevant activities in the IDHW Divisions of Medicaid, Public Health, and Behavioral Health.
- Working with the CMMI project officer and other federal agency staff regarding all areas of grant activities, including data collection and reporting and program monitoring and evaluation.

As noted previously, Cynthia York is the Administrator of the Office of Healthcare Policy Initiatives and reports directly to Denise Chuckovich. To directly support healthcare system transformation activities across the State, including SIM Model Test grant activities, IDHW created seven new positions, six of which are housed within the Office of Healthcare Policy. The seventh position, RC Project/Contractor Manager, is a member of the IDHW SHIP Team but reports directly to the Bureau Chief of Rural Health and Primary Care in the Public Health Division. New IDHW SHIP Team positions are captured in the table below.

**Table 17 — New IDHW SHIP Team Positions**

IDHW SHIP Team Position	Responsibilities
Operations Project Manager	Responsible for overseeing the operations of SIM Model Test grant activities, in particular related to project management of the healthcare system transformation, implementation of the PCMH model, and the HIT and data analytics support needed to ensure Model success; Ensuring that adequate professional staff support is provided to IHC Workgroups from the IDHW SHIP Team, including researching and sharing best practices and implementation strategies relevant to the Model; Coordinating communication among and between the Workgroups and the Technical Assistance Contractors; Overseeing staff responsible for monitoring the work and activities for SIM Model Test grant contracts; Working in cooperation with the IHDE to enhance the overall healthcare system capacity for patient data sharing through the adoption and use of EHRs and connection to IHDE; Supporting data collection and analytics for targeted metrics and performance reporting.

IDHW SHIP Team Position	Responsibilities
Grants and Contract Officer	Responsible for contract and grant compliance and reporting for the CMMI SHIP Model Testing grant. Provide progress and audit reporting to federal grantor and develop responses to resolve audit findings. Works with SHIP team to update quarterly accountability targets for all contracts. Identifies funding deficiencies and surpluses ensuring funding availability for all contract activities. Analyzes reports to determine program progress, quality and quantity of service, and compliance with contract. Assists in the development of Request for Proposals (RFPs), agreements, and contracts. Is responsible for contract management of a State Evaluator to perform evaluation activities and coordinates resources internally at IDHW to perform all other grant management activities.
Administrative Support (Two FTE)	Performs complex secretarial, office administration, and public relations assignments. Coordinates administrative activities requiring frequent contact with executives, the public, other agencies, and governmental officials. Researches, analyzes, and compiles information to prepare reports, budgets, handles complaints, or resolves problems. Responsible for financial transactions such as reconciling credit card purchases and other bookkeeping records. Purchase and order supplies and other inventory needed. Taking minutes following established standards on a reoccurring basis Supporting maintenance and upkeep of program website and resource.
PCMH Project/Contract Manager	Responsible for monitoring the work and activities of the PCMH Technical Assistance Contractor and ensuring quarterly accountability targets and thresholds are met; Researching best practices regarding the PCMH model and transformation strategies, analyzing for applicability and sharing researching findings with Workgroups and IHC.
HIT Data Analytics and Payment Redesign Project/Contract Manager	Responsible for monitoring the work and activities for contracts related to the HIT and data analytics contracts, ensuring quarterly accountability targets and thresholds are met; Participating in the HIT and Data Analytics Workgroup and supporting data collection and analytics for targeted metrics and performance reporting.
Regional Health Collaborative Project/Contract Manager	Assigned to the Bureau of Rural Health and Primary Care at the Division of Public Health. Responsible for contracts monitoring and coordination with the seven PHDs to establish the RCs, telehealth services development and training, and the Community Health Emergency Medical Services (CHEMS) and CHW training and deployment.

The Department has filled all positions except the HIT Data Analytics and Payment Redesign Project/Contract Manager. This position is expected to be filled by the start of the Model Test year. The State of Idaho utilizes a competitive hiring process and interested applicants must complete an online exam to demonstrate minimum qualifications. The exam allows the applicants to provide supporting documentation in order for the State to verify the education and/or experience required of the position. All applications are scored by a Subject Matter Expert (SME), someone who has either been in that position or supervised such and who is not involved in the hiring process. The selected candidate must have been an applicant who scored within the top 25 ranked applicants.

Upon completion of recruitment activities, all new hires must complete standard training courses that include, but are not limited to the courses listed in the table below.

**Table 18 — IDHW Standard Training Courses**

Title	Format
New Employee Orientation	Classroom
IDHW Employee Benefits for New and Current Staff	Online
Respectful Workplace for New Employees	Classroom
Privacy and Confidentiality Course	Online
IDHW Strategic Plan Orientation	Online
IDHW Customer Service Plan	Online
Region IV Programs and Services Orientation	Classroom
Emergency and Evacuation Procedures	Online
User and Approver I-Time Training	Online
Securing the Human	Online

In addition to the required training courses listed above, new hires working on the SIM Model Test must complete SIM-related training to gain an understanding of the SHIP, SIM Model Test, and key participants in the transformation process. The required courses are listed in the table below.

**Table 19 — Required Training Courses for IDHW Staff Working on SIM Model Test**

SHIP Core + Supplemental Learning Course	IHC Core + Supplemental Learning Courses
<ul style="list-style-type: none"> <li>• Contract Monitoring</li> <li>• Contracting 101</li> <li>• Contracting 102</li> <li>• Statewide Healthcare Innovation Plan Orientation</li> <li>• DNN Website (Super Users)</li> <li>• PCMH Transformation</li> <li>• CMMI Learning Collaborative (topics vary)</li> <li>• HIT Roadmap</li> <li>• Technology Enhancement Course (e.g., Word, Excel)</li> <li>• Communications Plan Orientation</li> <li>• SHIP Branding 101</li> <li>• CHEMS/CHW Orientation</li> <li>• Legislation &amp; Rulemaking 101</li> </ul>	<ul style="list-style-type: none"> <li>• Statewide Healthcare Innovation Plan Orientation</li> <li>• HIT Roadmap</li> <li>• PCMH Transformation</li> <li>• Communications Plan Orientation</li> <li>• CHEMS/CHW Orientation</li> </ul>

### Contractors

The use of contractors will help expand the Department's organizational capacity to implement and monitor SIM Model Test activities. Each contractor is managed by a member of the IDHW SHIP Team. Below is a description of each contractor that will support the Department in implementing the SIM Model Test.

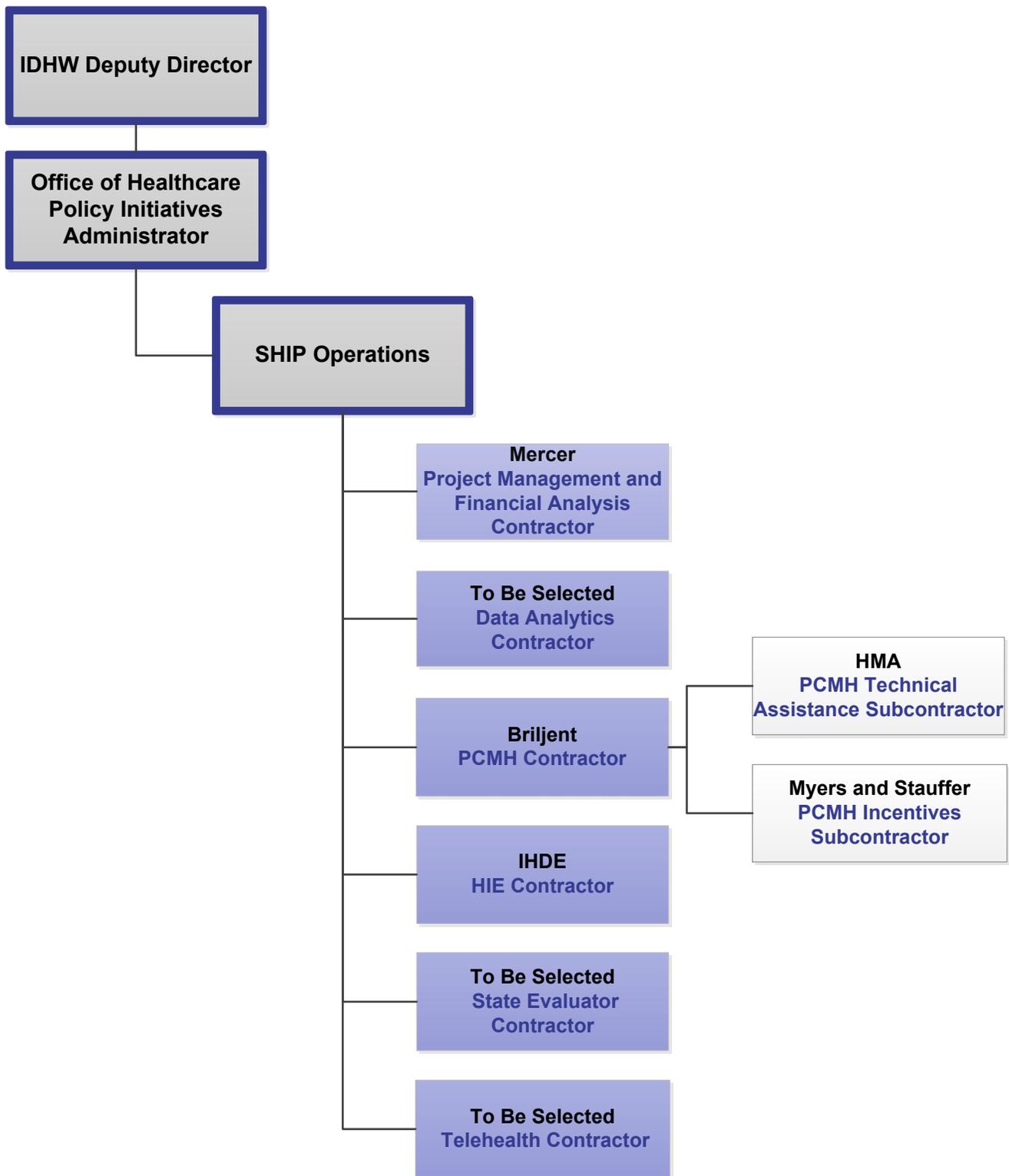
**Table 20 — IDHW’s Contractors for the Model Test**

Contractor	Responsibilities
Project Management and Financial Analysis	In June 2015, the Department completed the procurement process and engaged Mercer to help refine the Operational Plan for submission to CMMI and assist with managing the activities necessary to complete the SIM Model Test. Mercer is responsible for ensuring fidelity between the Operational Plan approved by CMMI and Model Test activities and will report directly to the Operations Project Manager.
PCMH Contractor	In October 2015, the Department completed the procurement process for engaging the Contractor responsible for assisting practices with practice transformation and performance reporting activities. Briljent, LLC was awarded the contract as PCMH Contractor and is responsible for providing technical assistance and developing mechanisms and controls to ensure proper distribution of start-up, expansion and recognition incentives to practices. Briljent will be supported by Health Management Associates, responsible for PCMH technical assistance, and Myers and Stauffer for activities related to incentive distribution.
Statewide Data Analytics Contractor	The Department is in the process of finalizing the RFP for the Data Analytics Contractor and expects to complete the procurement by the end of the calendar year. The Data Analytics Contractor will assist with developing the infrastructure for collecting and analyzing data for performance reporting.
State Evaluator	The Department will engage the State Evaluator by the end of the Pre-Implementation Year. The State Evaluator will monitor and evaluate SIM activities to support continuous quality improvements efforts of the State using core metrics and accountability targets.

The IDHW SHIP Team will monitor the Contractor’s performance against their contracts. Over the course of the Model Test, the IDHW SHIP Team and other staff will also work closely with contractors in the performance of their functions. For example, PHD SHIP staff will work closely with HMA in providing technical assistance to practices transforming to PCMHs. The close collaboration between PHD SHIP staff and HMA will help PHD SHIP staff gain the knowledge and experience to support practices in a way that sustains the Model.

The organizational chart below displays contractor relationships within the Office of Healthcare Policy Initiatives.

Figure 13 — Contractor Relationships within the Office of Healthcare Policy Initiatives



### 3.2. Stakeholder Engagement

Positive and successful health transformation begins with active stakeholder engagement. Idaho has exemplified this philosophy throughout its healthcare system transformation process which first began in 2007 when Governor Otter convened stakeholders as part of a Idaho Health Care Summit to evaluate the State's healthcare system and recommend ways to make healthcare more affordable and accessible for Idahoans. Since then and throughout the SIM Model Design phase, Idaho has continued to foster collaboration and partnerships with stakeholders across public and private sectors and continues to do so today. In fact, Idaho believes its most important principle, and the key to the State's success thus far, is the value and commitment it places on a stakeholder led process. Words such as "stakeholder driven" and "partnership" that are echoed by so many states have real meaning and action in Idaho.

The commitment to a stakeholder driven process works in Idaho because stakeholders around the State care about the health of Idaho's residents and are willing to devote time and resources to improving the State's healthcare system and the populations' health. Evidence of this fact is seen in stakeholders' continued volunteer work without support of federal grant funding, since the completion of the Model Design Phase that has enabled them to be ready to implement relevant components of the SIM Model on day one of the Model Test launch.

To further propel engagement and collaboration throughout the SIM Model Test and the State's overall healthcare transformation, Idaho recruited additional stakeholders to participate in the planning and implementation of the model to ensure that the right representation of stakeholder subject matter expertise, geographic diversity, and broad healthcare system perspectives are driving and overseeing the transformation. Additional stakeholders have been added to the IHC membership and Workgroups since the Model Design phase, and three stakeholder advisory groups now provide topic-specific subject matter expertise.

#### Payers and Providers

While all stakeholders have been instrumental to the progress made to date, the work of participating payers and healthcare providers deserves special recognition because of both their contribution to the pending changes and the impact of those changes on their work.

Public and private payers in Idaho are engaged and committed to new models of healthcare delivery and payment models that advance and reward the value, rather than volume, of healthcare services. Payers have worked collaboratively to ensure that, when Idaho launches its Model Test implementation in early 2016, payers will begin the process of moving to value-based payment approaches that include FFS alternatives that link payment to value. In Idaho, Medicaid has agreed to provide a PMPM to practices reaching certain national recognition levels to support ongoing PCMH activities, including care coordination, health promotion, and patient management. The Multi-Payer Workgroup has worked closely with the Clinical Quality Measures Workgroup to arrive at the Initial Performance Measure Catalog to be used during the Model Test. The collection of quality data and assessment of regional and statewide healthcare system performance will be made possible through the willingness of payers to enter into data-sharing agreements. Idaho's private and public payers have agreed to share data needed to standardize quality metrics reporting, evaluate the impact of the PCMH model on the health of Idaho's population, and provide information needed to support Idaho's contribution to CMMI's national evaluation of innovative delivery and payment models.

Throughout discussions and deliberations with Idaho's healthcare providers, their dedication and resolve to improve the health of their patients, community, and overall State population has helped

address challenges and barriers to healthcare transformation. Primary care doctors, nurse practitioners, hospitals, nurses, social workers, behavioral health professionals, and other specialists and ancillary providers together are the driving force of Idaho's innovation. Their willingness to contribute their expertise, share their experience, and volunteer their time to improving Idaho's health is a true testimony to the integrity and value of Idaho's healthcare workforce. It is also anticipated that this collaboration will help address barriers and challenges moving forward.

Many of Idaho's providers are ready to test the model and, at the same time, are working to recruit other providers. Medicaid currently has 364 primary care providers servicing 49 locations throughout the State who participate as Medicaid Health Homes. There are 279 primary care providers servicing 33 locations throughout the State participating in an existing Idaho Medical Home Collaborative. The majority, if not all, of these practices may be part of the initial model participants in Model Test Year 1. An "Application of Interest" was issued in August 2015 to determine additional primary care practices' interest in transformation to a PCMH model; this generated 134 responses. By the end of the SIM Model Test period, Idaho will have 165 practices around the State transformed from a traditional primary care practice to a well-integrated, coordinated PCMH model supported by value-based payment models.

### Communication Plan

A communication plan that maps internal and external communication has been developed to meet stakeholders' needs for accurate and consistent messages and updates regarding the transformation. Broadly, the communication plan identifies relevant stakeholder groups, appropriate modes of communication, outlines audience-specific information on Idaho's SHIP model, and establishes a timeframe for communication with stakeholders.

The plan outlines an engagement roadmap for internal and external stakeholders. Groups identified as internal stakeholders include:

- IHC Members
- IHC Workgroup Members
- IHC Advisory Committees
- RCs
- RCEs
- IDHW leadership
- PHD Directors
- PHD SHIP Staff
- IDHW SHIP staff
- Technical Assistance Contractors
- State Evaluator
- CMMI

Groups identified as external stakeholders are classified in six categories: patients and community members, payers, primary care providers, RCs, Medical/Health Neighborhood participants, and policymakers.

- **Patients and community members** are Idaho residents who will be impacted by the SIM Model Test.
- **Payers** are the public and commercial health insurers in Idaho that will participate in the SIM Model Test by adopting value-based payment arrangements.

- **Primary care providers** are those who have agreed to participate or have been engaged to participate in the PCMH model.
- **RCs** are regional based entities that coordinate the Medical/Health Neighborhood and are supported by PHDs.
- **Medical/Health Neighborhood participants** are specialty practices and community-based organizations that will contribute to PCMH patient care and promote health.
- **Policymakers** are members of legislative and executive bodies who have been or will be involved in State health initiatives.

The communication plan reflects a broad spectrum of stakeholder communication tools to engage the aforementioned stakeholder groups. An Idaho SHIP website, [www.ship.idaho.gov](http://www.ship.idaho.gov), has been launched and regularly updated with comprehensive information on the Model Design and upcoming Model Test. Beyond the website, other broad-based communication tools identified in the communication plan include opinion editorials in statewide newspapers, press releases on notable Idaho healthcare transformation milestones, social media updates, town hall-style presentations, and updates to a stakeholder email lists. While these tools are intended to reach a wide audience, the communication plan also targets specific stakeholder communications to foster continued participation and motivation in implementing the SHIP model in Idaho.

A toolkit consisting of a variety of communication platforms ranging from white papers, presentation slides, fact sheets, testimonials, to talking points, is under development for each stakeholder group. The communication toolkit for each stakeholder group is being tailored with relevant messages on the SIM Model Test, formatted in the most effective communication platforms. The toolkit is intended to package a consistent, accurate, and effective message to educate and engage stakeholders in the SIM Model Test. The toolkits will be available to a multitude of groups that will facilitate stakeholder engagement, ranging from the IDHW to provider organizations, which will multiply the reach of messaging on the model. The communication plan also identifies existing external stakeholder communication resources as a means for deeper engagement. Existing stakeholder communication resources identified in the communication plan include trade association newsletters, such as the Idaho Hospital Association Newsletter, Idaho Academy of Family Physicians Newsletter, and Family Medicine Residency Newsletter to name a few. Other external resources include trade association websites, meetings, and conferences.

As mentioned, communication will be tailored for each stakeholder group. Tailored communication goals and messages are intended to sustain interest, education, and active participation of stakeholders in the SHIP Model Test. For patients, the communication goal is to increase awareness and understanding of the benefits that they may see in their care from the PCMH model. Specific messages to patients will include information on what improvements they may see in their care and what opportunities they may have to participate in their own care. For payers, the communication goal is to improve understanding of the role and benefits of the PCMH in public and private payer models. Communication to payers, including Medicaid and private commercial payers in the self and fully-insured markets, will focus on education, including how the model will transform Idaho's healthcare system and the important role of payers in the State's healthcare transformation. Specific messages to payers will emphasize that transformation must occur across the payer spectrum to effectively test the SHIP Model and improve health, which will eventually generate cost savings. Communication will also be developed for payers that have yet to be incorporated in the PCMH model, including Medicare and commercial payers.

For primary care providers, the communication goal is two-tiered based on the audience. For primary care providers who have already engaged in the SHIP model, the goal is to increase understanding of

the SHIP model and its implementation. For primary care providers who have not been engaged in the process, the goals are to increase understanding of the model and to recruit their participation and commitment to the model. The specific message to primary care providers will include how the SHIP model will benefit their practice and patients, and those resources and supports will be available to them to help them as they transition to the PCMH model. Messages will also focus on the fact that Idaho is testing a model that has been chosen based on experience with the PCMHs in the State.

For Medical/Health Neighborhood participants, the communication goal reflects the same goals for primary care provider communication: to increase understanding of the model and to recruit their participation. Communication to Medical/Health Neighborhood participants will convey an educational message, including what constitutes a Medical/Health Neighborhood and the role the participants will serve in the PCMH. Again, specific messages to the Medical/Health Neighborhood participants will include how the SHIP model will benefit their practice by making sure that the right patients will come to them for the right reasons and at the right time. Messages will also be tailored to helping non-medical community organizations understand how the model will benefit them and their clients. Messages will include the fact that Idaho is testing a model that has been chosen based on experience with the PCMH in the State.

For RCs, the communication goal is to increase understanding of the model and the RC's role in the Model Test. Specific messages to the RCs will relay the fact that in order to be sustainable and effective, Idaho's healthcare system transformation must evolve at the community level. Other messages will reiterate that the RCs will play a critical role in identifying local health needs, resources and supports, and improving and monitoring the health of the region. Additionally, the communication plan underscores available resources and supports to assist in carrying out the charge of improving health locally.

For policymakers, the communication goal is to increase understanding of the model. Specific messages to policymakers will focus on how the Model Test will benefit their constituencies, general improvements to community and population health, and cost savings generated from the model.

To ensure that the communication plan is effectively engaging stakeholders, communications will be monitored, and modifications to the plan will be made based on stakeholder feedback. The monitoring process identifies communication distribution, including types, frequency, and recipients of communication. In sum, the monitoring process tracks what communication is transmitted, who has received the information, and measures the impact of the communication based on stakeholder feedback. If gaps in stakeholder engagement are identified from the monitoring process, the communication plan includes a process to modify the communication plan so that it better reflects the feedback from stakeholder groups. As the message(s) evolve or new messages are identified for specific target groups, the communication plan includes a process for reviewing, assessing, and approving these changes or additions to the plan.

As illustrated, the stakeholder engagement work in Idaho has prepared the community for implementation of the PCMH Model Test. Past stakeholder collaboration will also root future engagement, which will propel Idaho's SHIP goals and strategies next year and further in the future.

### **3.3. Plan for Improving Population Health**

Idaho's healthcare system transformation is built on the premise that the State's current health system must do better to provide effective and efficient healthcare delivery through a patient-centered coordinated care approach, while ultimately producing better outcomes for Idahoans. Idaho faces many challenges in improving the health of the State's population, but the creation of Idaho's

Population Health Plan, *Get Healthy Idaho*, is a crucially important beginning in outlining a strategy to improve and manage health of the population statewide.

*Get Healthy Idaho* consists of two integral parts:

1. A statewide, comprehensive population health assessment that provides a foundation for understanding the health of Idahoans and communities.
2. A population health improvement plan that focuses public health efforts to address specific priority areas.

To conduct the population health assessment, data were gathered from a variety of sources. The IDHW Division of Public Health developed a Leading Health Indicators document to serve as the framework for the core data of the assessment. The Leading Health Indicators document offers a consistent approach to assess the health of Idahoans and provides a way to determine if health status is changing and/or improving over time.

**Table 21 — Idaho’s Leading Health Indicators**

Topic Area	Leading Health Indicators
<b>Overweight/Obesity</b>	<ul style="list-style-type: none"> <li>• Percentage of adolescents overweight/obese (source: YRBS) (HP2020 Reference: NWS-10).</li> <li>• Percentage of Idaho adults who are overweight/obese (BRFSS) (NWS-9).</li> </ul>
<b>Tobacco Use</b>	<ul style="list-style-type: none"> <li>• Percentage of adolescents who currently smoke (YRBS) (TU-2.2).</li> <li>• Percentage of Idaho adults who are current smokers (BRFSS) (TU 1.1).</li> <li>• Percentage of Idaho adults who use smokeless tobacco (BRFSS) (TU 1.2).</li> </ul>
<b>Immunization</b>	<ul style="list-style-type: none"> <li>• Percentage of 19–35 month olds who received 4+doses of DTAP(NIS) (IID-7.1).</li> <li>• Percentage of adolescents aged 13–15 years reported having been vaccinated with three or more doses of the HPV vaccine (NIS) (IID 11.4).</li> <li>• Annual incidence of pertussis (Reportable diseases) (IID - 1.6 (&lt;1 yr) and 1.7 (11–18 yrs) ).</li> </ul>
<b>Infectious Disease</b>	<ul style="list-style-type: none"> <li>• Annual incidence rate of enteric diseases reportable to public health (cryptosporidiosis, shigellosis, listeriosis, salmonellosis, STEC, giardiasis). (RD) (FS- 1.1 &amp; 1.4).</li> <li>• Annual incidence of STDs (does not include HIV, chlamydia, gonorrhea, or syphilis). (RD)(STD-1, STD-2, STD-6, &amp; STD-7)</li> </ul>
<b>Perinatal Care</b>	<ul style="list-style-type: none"> <li>• Percentage of Idaho mothers who received adequate prenatal care. (VS) (MCH-10.2)</li> <li>• Percentage of Idaho resident live births with low birth weight. (VS) (MCH-8.1,8.2)</li> <li>• Percentage of Idaho resident live births with pre-term delivery. (VS) (MCH-9.1)</li> </ul>
<b>Injury/Suicide</b>	<ul style="list-style-type: none"> <li>• Percentage of adolescents who have attempted suicide. (YRBS) (MHMD-2)</li> <li>• Suicide death rates. (VS) (MHMD-1)</li> <li>• Injury fatalities ages 1–44. (VS) (IVP-1)</li> </ul>
<b>Chronic Disease</b>	<ul style="list-style-type: none"> <li>• Coronary heart disease prevalence. (BRFSS) (HDS-2)</li> <li>• Coronary heart disease rate of death. (VS)(n/a)</li> <li>• Stroke prevalence. (BRFSS) (HDS-3)</li> <li>• Stroke death rates. (VS)(n/a)</li> <li>• Diabetes prevalence. (BRFSS) (D-15)</li> </ul>

Topic Area	Leading Health Indicators
<b>Health Status/Behaviors</b>	<ul style="list-style-type: none"> <li>Percentage of Idaho adults who consume five or more servings of fruits and vegetables a day. (BRFSS) (Under-Dev.)</li> <li>Percentage of Idaho adults aged 50–75 years of age who receive colorectal cancer screening based on the most recent guidelines. (BRFSS) (C-16)</li> <li>Percentage of women aged 50–74 who receive a breast cancer screening based on the most recent guidelines.(BRFSS)(C-17)</li> <li>Percentage of Idaho adults with no leisure time physical activity. (BRFSS) (PA-1)</li> <li>Percentage of Idaho adults who have not visited the dentist in the past 12 months.(BRFSS) (OH-7)</li> </ul>
<b>Access/Systems</b>	<ul style="list-style-type: none"> <li>Percentage of Idaho adults without healthcare coverage. (BRFSS) (AHS-1)</li> <li>Percentage of Idaho adults without a usual healthcare provider. (BRFSS) (AHS-2)</li> <li>Number of active PCPs per 100,000. (AMA)(AHS-3)</li> </ul>
<b>Reproductive Health</b>	<ul style="list-style-type: none"> <li>Adolescent pregnancy rates ages 15–17. (VS) (FB 8.1)</li> <li>Percentage of adolescents that had sexual intercourse for the first time at 15 years old or younger. (YRBS) (FP9.3)</li> </ul>

Community-level data in the format of local public health and hospital community health needs assessments, other health assessments, such as the Maternal and Child Health (MCH) Five Year Needs Assessment and the Primary Care Needs Assessment, were collected and summarized. Issues and outcomes were arranged and grouped to align with the seven local PHD jurisdictions across Idaho. The Public Health Accreditation Board standards also informed the data refining process. The Public Health Accreditation Board (PHAB) identifies what it considers core public health programs and, as data were assessed, only data that fell within the framework of PHAB were prioritized to move forward for consideration in the health improvement plan.

The *Get Healthy Idaho* population health assessment was conducted during the summer and fall of 2014 and relied heavily on both stakeholder input and analysis of multiple data sets. An in-person meeting of stakeholders was held in November, 2014 to review the data and obtain stakeholder input on which State health issues warranted priority focus.

The top four major population health concerns identified by Idaho stakeholders to target as improved outcomes include:

- Access to care
- Adult and childhood obesity
- Tobacco use
- Diabetes

Measures addressing each of the four priority areas are included in Idaho's Initial Core Performance Measure Catalog. Additionally, it should be noted that the identified areas of concern reflect an overlap in contributing factors. One common underlying theme is the lack of patient-centered care as a key contributor to inequities in the health system and poor health outcomes. Idaho's measures tracking the transformation from traditional primary care models to the PCMH model will help the IHC assess the impact of the new delivery system model on population health across the four priority areas.

Outlined below are strategies that Idaho has identified to help alleviate identified areas of concern.

### Access to Care

According to the US Census Bureau, Idaho is ranked the 11th largest state in the country with a population size of about 1.6 million. Among Western states, Idaho is vastly rural and picturesque. However, the predominantly rural environment has created challenges for the healthcare system in guaranteeing Idahoans access to quality care and promoting positive health outcomes. Addressing the gaps within the healthcare delivery system, specifically in patients' access to care, will be accomplished through a multi-faceted approach. Identifying the medically underserved areas and their respective needs will serve as the first step in increasing Idahoans access to care. Idaho's lack of PCPs is a contributing factor in access to care; the rate of PCPs in Idaho is significantly less than national trends at 70 physicians per 100,000 Idahoans, compared to 98 physicians per 100,000 residents nationally. In order to account for the lack of physicians, Idaho has recognized that it is critical to restructure the primary care model through the implementation of team-based primary care. The development of the CHEMS and the CHW programs will be implemented to alleviate the barrier in access to care by increasing the primary care prevalence in Idaho through team-based primary care. Members of the CHEMS and CHW programs will undergo standardized training and certification and serve as care coordinators to Idahoans, providing individualized care. Furthermore, the transformation of existing practices to a PCMH will promote the patient-centered care model through the integration of comprehensive services.

### Tobacco Use

The leading preventable cause of death in Idaho was identified by Stakeholders as tobacco use. Currently, the rate of tobacco use in Idaho falls slightly below the national trend at 17.2%, compared to 18.1% nationally. In an attempt to reduce tobacco consumption in Idaho, it is imperative to focus on the adult smokers populations who have attempted to quit smoking in the past 12 months. The strategy to mitigating tobacco consumption in Idaho is two-fold; (1) Increase the rate of tobacco use assessments and; (2) Increase the referral rate to tobacco cessation services such as QuitLine, QuitNet and/or other cessation interventions. Additionally, tobacco use can be alleviated by leveraging nicotine replacement therapy for qualifying individuals enrolled in cessation services.

### Obesity

Idaho mirrors national trends in terms of increasing obesity rates; currently, 29.6% of the adult population in Idaho is obese. The childhood obesity rate in Idaho falls below the national average at 27.8% compared to 31.3% nationally. In order to reduce the complex burden of obesity in Idaho, it is critical to incorporate health promotion programs for both adults and children. Childcare providers should be required to engage in health promotion efforts, such as 'Let's Move' trainings. A paradigm shift within school curriculums should include mandating obesity/weight screenings and health promotion programs. Additionally, adopting healthy food guidelines and nutritional standards within schools and workplaces will aide in reducing the rate of obesity. Promoting physical activity for adults and children alike will convert the sedentary lifestyle to one that is healthier and dynamic. In terms of preventative measures, an effort in reducing the risk of obesity amongst children is for mothers to continue to breastfeed until six months post-partum.

### Diabetes

In comparison to national trends, diabetes prevalence in Idaho falls slightly below the national average at 8.4% compared to 9.7% nationally. In order to combat the diabetes burden in Idaho, it is crucial to increase the number of diabetes interventions such as the CDC-recognized Diabetes Prevention Programs, or the American Diabetes Association/American Association of Diabetes Educators-recognized Diabetes Self-Management Education programs. Subsequently, providers will

need to identify and refer qualifying patients to respective diabetes interventional programs. Comprehensive diabetes care, including health assessments, obesity screenings, and lifestyle management education, will allow for Idahoans with diabetes to be engaged in their health and lead a healthier life.

Idaho's plan for improving population health seeks to create a more integrated, collaborative, and efficient approach to healthcare that promotes patient-centered care and produces better outcomes for Idahoans. The plan includes measures and processes that will enable population health assessment and management at the community, regional, and statewide level.

The RCs, supported by PHD, will work to assess local health needs and make recommendations to the IHC regarding community-specific and regional population health targets. PHDs will ensure that the RCs, Medical/Health Neighborhoods, and IHC have a comprehensive understanding of the data and information that describes regional needs and will work with stakeholders and the Medical/Health Neighborhood to develop appropriate strategies to improve health. Tracking health needs and interventions at the local level will help the IHC determine if the model is making a difference in population health improvement at the community, regional, and statewide level.

The PCMH model and its relationship with the larger Medical/Health Neighborhood is a major component of Idaho's strategy to improve population health. The social determinants of health have a significant impact on health-related issues such as access to healthy choices and access to healthcare. Non-healthcare sector partners, i.e., worksites, schools, community organizations, public health, etc., often address and provide system resources and environmental supports that can prevent people from falling into poor health. These, along with ancillary healthcare providers, are the partners comprising the Medical/Health Neighborhoods. The work they do and the policies they create impact what is being done in the Medical/Health Neighborhoods that support the success of the local PCMHs and the RCs. A component of the testing of Idaho's new PCMH delivery system model will determine how population health is impacted by the model's increased focus on the whole person and improved coordination of care between primary care and the Medical/Health Neighborhood.

### **3.4. Health Care Delivery System Transformation Plan**

Idaho will test a statewide model to transform the healthcare delivery system. In doing so, Idaho will demonstrate that the State's entire healthcare system can be transformed through effective care coordination between PCMHs and integrated Medical/Health Neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services. Idaho's proposed Model Test will impact the health and healthcare of all Idahoans, through a variety of strategies that are described in the program goals below. Ultimately, Idaho will achieve the Triple Aim of improved health, improved healthcare, and lower costs for Idahoans by reaching its delivery system goals.

The table below provides a crosswalk between Idaho's Model Test goals and CMMI's healthcare delivery system transformation characteristics (as described in the Round 2 Model Test Awardee Operational Plan Guidance). As shown, each of Idaho's Model Test goals is broad and far-reaching, and will impact several of CMMI's healthcare delivery system transformation characteristics.

**Table 22 — Crosswalk between Idaho Model Test Goals and CMMI Health Care Delivery System Transformation Characteristics**

Idaho Model Test Goal	CMMI Health Care Delivery System Transformation Characteristics
<b>Goal 1:</b> Transform primary care practices across the State into PCMHs.	<ul style="list-style-type: none"> <li>• Population health measures are integrated into the delivery system.</li> <li>• Providers perform at the top of their license and board certification.</li> <li>• There is an adequate healthcare workforce to meet State residents' needs.</li> <li>• There is a high level of patient engagement and quantifiable results on patient experience.</li> <li>• Every resident of the State has a primary care provider who is accountable both for the quality and for the total cost of their healthcare.</li> </ul>
<b>Goal 2:</b> Improve care coordination through the use of EHRs and health data connections among PCMHs and across the Medical/Health Neighborhood.	<ul style="list-style-type: none"> <li>• Providers leverage the use of health information technology to improve quality.</li> <li>• Care is coordinated across all providers and settings.</li> </ul>
<b>Goal 3:</b> Establish seven RCs to support the integration of each PCMH with the broader Medical/Health Neighborhood.	<ul style="list-style-type: none"> <li>• Providers across the State and across the care continuum participate in integrated or virtually integrated delivery models.</li> </ul>
<b>Goal 4:</b> Improve rural patient access to PCMHs by developing Virtual PCMHs.	<ul style="list-style-type: none"> <li>• Population health measures are integrated into the delivery system.</li> <li>• Providers perform at the top of their license and board certification.</li> <li>• There is an adequate healthcare workforce to meet State residents' needs.</li> <li>• There is a high level of patient engagement and quantifiable results on patient experience.</li> <li>• Every resident of the State has a primary care provider who is accountable both for the quality and for the total cost of their healthcare.</li> </ul>
<b>Goal 5:</b> Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.	<ul style="list-style-type: none"> <li>• Data is used to drive health system processes</li> <li>• Performance in quality and cost measures is consistently high.</li> </ul>
<b>Goal 6:</b> Align payment mechanisms across payers to transform payment methodology from volume to value.	<ul style="list-style-type: none"> <li>• Over 80% of payments to providers from all payers are in FFS alternatives that link payment to value.</li> <li>• Performance in quality and cost measures is consistently high.</li> </ul>
<b>Goal 7:</b> Reduce overall healthcare costs.	<ul style="list-style-type: none"> <li>• Over 80% of payments to providers from all payers are in FFS alternatives that link payment to value.</li> <li>• Performance in quality and cost measures is consistently high.</li> </ul>

Detailed information related to how each goal will contribute to healthcare delivery system transformation can be found in Section 2 of this Operational Plan. Section 2 describes the specific activities that will be implemented in order to accomplish each goal individually, as well as the responsible parties for those activities and how progress will be monitored and reported.

But Idaho's Model Test is bigger than achieving seven individual, separate goals. Idaho will only achieve the true system transformation envisioned by stakeholders in the Model Design phase **by accomplishing all seven goals together**. For example, if Idaho achieves Goal 1 of building 165 PCMH practices, but these practices are not integrated with the broader Medical/Health Neighborhood (Goal 3), then the overall system transformation will be limited. Likewise, if PCMHs successfully expand their use of EHRs (Goal 2), but a statewide data analytics system is not built to track progress on quality measures at the regional and statewide level, then Idaho will have missed an opportunity to use data on a system-level to improve population health.

All goals are equally important to the success of the Model Test. Each goal has key interdependencies with activities in other goals, such that the implementation of all activities must be well coordinated. For example, Goal 4 activities related to building Virtual PCMHs are dependent on the care delivery platform for all PCMH practices that will be built through Goal 1.

As such, activities for each goal will not occur in a silo. Instead, IDHW and the IHC will continually monitor the overall progression of the model, including the achievement of key milestones in each goal, but also more broadly how each goal is fitting together and contributing to progress in reaching the other goals.

### 3.5. Payment and/or Service Delivery Model(s)

Idaho's Model Test outlines an ambitious plan to transform both payment and service delivery models in the State by moving payments from volume to value and by spurring the development statewide of the PCMH team-based model of care. With the commitment of commercial payers and Medicaid, the Model Test will move Idaho from a system that rewards the volume of services to a system that rewards the value of services (through quality incentives, shared savings, etc.). Payment methods will incentivize providers to spread best practices of clinical care and achieve improved health outcomes for patients and communities. The end goal of this transformation is to create a system that promotes practice advancement under the PCMH model while respecting the long-standing culture in Idaho of provider and payer autonomy.

The activities that stakeholders will undertake to transform the payment and service delivery models are organized into seven goals, described in detail in Section 2 of this Operational Plan. What follows is a brief overview of Idaho's plans to transform payment and service delivery in Idaho

#### Care Delivery Model

Idaho's Model Test will be centered on building a robust statewide primary care system through the delivery of services in a PCMH model of patient-centered, team-based, coordinated care. Care will be integrated and coordinated across all healthcare services in the State, yielding cost efficiencies and improved population health.

Idaho's PCMH model will achieve a two-pronged transformation. At the patient level, the model will improve individuals' health by delivering all primary care services through a PCMH. Patient-centered care through the medical home will begin with a broad, comprehensive patient assessment that takes into account the individual's behavioral health and socioeconomic needs. The plan of care will reflect

cultural knowledge and sensitivity, respect the individuals' rights and responsibilities in shared decision-making, and be built upon evidenced-based clinical practice. Recognizing the power of individuals to improve their health, the model will promote patient engagement, education, and self-management. The patient's team of healthcare professionals will be held accountable for coordinating care across the larger Medical/Health Neighborhood of specialists, hospitals, behavioral health, long-term care services, and supports as well as social support providers. EHRs and other HIT tools will be used to support care coordination through efficient, effective and timely communication, and the exchange of patient health data to inform clinical decisions.

The care delivery transformation that will take place through Idaho's Model Test will also include a strong behavioral health component that will better equip the primary care community to prevent and treat co-morbid physical and behavioral health conditions. Integration of behavioral health in the new PCMH model will require PCMHs to focus on four essential strategies: (1) conducting a comprehensive needs assessment, (2) documenting individual needs planning, (3) developing communication tools and monitoring programs, and (4) facilitating access to needed services. The PCMHs will be supported in this work by the IHC, and the Behavioral Health Integration Workgroup, which is leading the discussion on strategies to expand behavioral health integration in the PCMH. The Workgroup is identifying screening and assessment tools for PCMH use and training and resources to the PCMHs to advance the integration of physical and behavioral healthcare in the model.

At the system level, the model changes the foundation of healthcare delivery in the State by establishing PCMHs as the vehicle for delivery of primary care services and integrating PCMHs into the larger healthcare delivery system. The model will impact, to varying degrees, all healthcare providers, e.g., primary care providers, specialists, allied practitioners across all disciplines, hospitals and other acute care facilities, nursing homes, federally qualified health centers (FQHCs), and rural health clinics. By aligning payments, performance targets, data collection, and other practice policies, Idaho will transform from a disease-focused system of care to a patient-centered, coordinated system that provides all Idahoans access to quality care that will improve health outcomes and lower healthcare costs in the State.

Transformation will be achieved at the patient and the system levels through oversight and supports provided by the IHC and RCs. The IHC will support and oversee the transformation of practices to the PCMH model and the evolution of statewide population health management. Additionally, the IHC will collaborate with other State and federal efforts to improve the delivery system.

### Payment Model

Idaho will move from a FFS payment model that rewards volume of service to new models that incorporate FFS alternatives that incentivize value over volume.

Most payers will use a phased approach to implement their payment model. Medicaid will be implementing a PMPM model in Year One of the Model Test. Commercial payers have committed to implementing value-based payment models, and have begun working to implement these models. The target population for new payment models for PCMHs is all Idahoans enrolled in PCMHs statewide, including Idahoans enrolled in Virtual PCMHs in rural areas. Idaho will collect data to evaluate progress in implementing payment models, including:

- The percentage of beneficiaries impacted.
- Participating providers.
- Participating provider organization.

- Payers participating in PCMH payment and/or delivery models.
- Total cost of care per beneficiary per month.

Payers will report the count of beneficiaries included in alternative payment arrangements, total count of beneficiaries, and summarized costs per year by category of service, which can then be used to calculate an overall system cost.

### 3.6. Leveraging Regulatory Authority

Over the past ten years, Idaho has taken key regulatory and legislative actions that have played an important role in launching and/or supporting components of healthcare system transformation. This action has helped solidify a foundation for healthcare system transformation in the State by formalizing a direction, structure, and process for transformation to occur and ensuring stakeholders' critical role in the design and implementation of healthcare changes.

As noted previously, Governor Otter has used executive orders to provide a formalized process and to create a structure for stakeholders to plan, design, implement, and oversee healthcare system transformation. Below is a summary of Governor Otter's key executive orders that have helped advance the transformation of Idaho's healthcare system.

**Table 23 — Governor Otter's Key Executive Orders Supporting Healthcare System Transformation**

Date	Executive Order	Title	Summary
09/28/2007	Executive Order No. 2007-13	Establishing the Governor's Select Committee on Health Care	Creates the Governor's Select Committee on Health Care to evaluate Idaho's healthcare needs and make recommendations to improve the healthcare system and encourage public and private sector partnerships for providing healthcare services in Idaho.
02/04/2009 and 02/26/2009	Executive Order No. 2009-04 and Executive Order No. 2009-07	Establishing the Behavioral Health Transformation Workgroup and the Health Professions Education Council	Creates a Workgroup that is charged with developing a plan for a coordinated, efficient State behavioral health infrastructure, and creates the Idaho Health Professions Education Council to assess workforce issues and develop strategies to address healthcare provider shortages.
9/03/2010	Executive Order No. 2010-10	Establishing the Idaho Medical Home Collaborative (IMHC)	Creates the IMHC and embodies the purpose and policy set forth in the State's Health Planning Act. The Executive Order also carries out legislative direction established through HB 260. The IMHC was tasked with making recommendations to the Governor and the Department of Insurance (DOI) regarding policies and activities necessary to transform Idaho's healthcare delivery system to a PCMH model.
12/14/2010	Executive Order	Establishing the	Creates the Governor's Idaho Health Care Council

Date	Executive Order	Title	Summary
	No. 2010-15	Governor's Idaho Health Care Council	and Workgroups to effectuate the implementation of the State's healthcare initiatives.
<b>01/27/2011</b>	Executive Order No. 2011-01	Establishing the Behavioral Health Interagency Cooperative	Creates the Behavioral Health Interagency Cooperative to form recommendations and facilitate transformation of the State's behavioral health system.

While each of the above executive orders have significantly contributed to creating processes and forums for advancing improvements to Idaho's healthcare system, special note needs to be made of the creation of the Idaho Health Education Professions Council in 2009. The shortage of healthcare professionals across the State has been a major barrier to Idaho's goals to improve health outcomes for its 1.6 million residents. This shortage of professionals, coupled with the rural nature of the State, contributes to the severe unequal distribution of healthcare resources across the State and many under-served areas. Since Governor Otter's creation of the Health Education Professions Council in 2009, the Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions. Additional information related to the Health Education Professions Council's activities and role in the Model Test can be found in Section 3.9 of this Operational Plan.

Another executive order enacted by Governor Otter that merits special notation is the creation of the Idaho Medical Home Collaborative (IMHC) in 2010 (Executive Order 2010-10). The IMHC piloted the PCMH model, providing an opportunity to preliminarily test whether the PCMH model was an appropriate model for Idaho to improve the delivery of primary care services and advance care coordination. The IMHC was created as a collaboration of PCPs, private health insurers, Medicaid, and healthcare organizations. Following an application process, a pilot project began in January 2013 involving 36 primary care practices, 9,000 patients, and four payers — Blue Cross of Idaho, Pacific Source, Regence Blue Shield, and Idaho Medicaid. The IMHC issued a final report and recommendations on May 29, 2015.

Idaho's Health Data Exchange (IHDE) (i.e. HIE) is a non-profit 501(C)(6) organization, specifically an "independent body corporate and politic." It is governed by a 19-member board, including two non-voting ex officio members: the Director of the Department of Insurance and the Director of the Department of Health and Welfare. The Governor appoints fourteen members of the board, the Speaker of the House appoints a member of the House of Representatives, the President pro tempore appoints a member of the Senate, and minority leadership appoints a member of the legislature representing the minority party. Members appointed by the Governor serve four-year terms. The legislation specifies that the Board should collectively offer expertise in health benefits administration, healthcare finance, health plan purchasing, healthcare delivery system administration, public health, and health policy issues related to small business and individual markets and the uninsured. A majority of the board may not collectively represent health carriers and producers. Additional information about IDHE can be found at <http://www.idahohde.org/about-us/>.

### State Plan Amendment to Implement the PCMH Model for Medicaid and CHIP

The Idaho Medicaid program will participate in the model by implementing an alternative payment model to support PCMHs. Medicaid's participation in the SIM Model Test will not require any additional federal authority in the form of a state plan amendment.

### Plans for Leveraging Regulatory Authority Moving Forward

Today, Idaho's healthcare transformation is guided by the IHC. The public-private leadership that has been evident since Idaho began its healthcare transformation journey and that continues today leads the State to question whether additional regulatory or legislative action is needed. As noted in the IMHC recommendations, healthcare professionals that are most critical to the model's success value their autonomy and can be better engaged through support rather than directives. While the IHC, which includes key members of the legislature and the Governor's office, will consider regulatory and legislative opportunities to support, advance, and sustain healthcare transformation, it will be done judiciously and only with the full support of Idaho's stakeholders. No specific legislative or regulatory action is being considered at this time.

### **3.7. Quality Measure Alignment**

During the SIM Model Design phase, it was underscored that no standardized data collection or performance reporting across payers or populations currently exists in Idaho. While performance measurement data is collected by IDHW, commercial payers, Medicare, and the seven PHDs, measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes across Idaho. As stated by Goal 5, a major element of Idaho's healthcare system transformation is to "build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide level."

To align clinical quality performance measurement across public and private payers or programs, Idaho has developed an Initial Measure Catalog (Catalog). Initial performance measures selected for the Catalog were targeted because they represent the areas with the most need for health improvement across all Idahoans. The Catalog serves as the starting point for Idaho's coordinated quality reporting system and is a key milestone in the State's efforts to align measures across payers in support of support population health management. The creation of the Catalog was possible due to agreement across payers that an alignment of measurement requirements in the healthcare transformation process will make population health management efforts more attainable for practices who must work with multiple payers.

Idaho recognizes the value of collecting common data across the Model Test states to compare the impact of models across the nation and, as such, is working with CMMI to align the Idaho's metrics with federal metrics. Idaho's Catalog is closely aligned with CMMI's federal metrics pertaining to population health and clinical issues. Idaho's metrics that track cost and utilization are also very similar to the federal metrics with some slight differences. Finalization of Idaho's metrics will occur following discussions with the CMMI Project Office and prior to the start of Model Test Year 1.

Listed below, the Catalog includes both preventive and chronic healthcare and outcome metrics.

Idaho's Initial Performance Measure Catalog		
Measure Name (and Source)	Measure Description	Rationale for the Measure
Screening for clinical depression.	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	<p>In Idaho, 22.5% of persons aged 18 or older had a mental illness and 5.8% had SMI in 2008–2009 while 7.5% of persons aged 18 or older had a major depressive episode (MDE).</p> <p>During the period 2005–2009, 9% of persons aged 12–17 had a past MDE.</p> <p>Suicide is the second leading cause of death for Idahoans aged 15–34 and for males aged 10–14. This measure aligns with Healthy People 2020.</p>
Measure pair: (a.) Tobacco use assessment. (b.) Tobacco cessation intervention (SIM)	<p>Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period.</p> <p>Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.</p>	<p>In Idaho, 16.9% of the adult population were smokers in 2010 (&gt;187,000 individuals).</p> <p>Idaho ranks fifteenth in the country in prevalence of adult smokers and its smoking-attributable mortality rate is ranked eighth in the country.</p>
Asthma ED visits.	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	While asthma prevalence (those with current asthma) in Idaho was 8.8% in 2010, reduction of emergency treatment for uncontrolled asthma is a reflection of high-quality patient care and patient engagement.
Acute care hospitalization (risk-adjusted).	Percentage of patients who had to be admitted to the hospital.	While Idaho has one of the country's lowest hospital admission rates (81/1000 in 2011), this measure is held as one of the standards for evaluation of utilization and appropriate use of hospital services as part of an integrated network.

Idaho's Initial Performance Measure Catalog		
Measure Name (and Source)	Measure Description	Rationale for the Measure
Readmission rate within 30 days.	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	Data currently unavailable. Metric will be used to establish baseline.
Avoidable emergency care without hospitalization (risk-adjusted).	Percentage of patients who had avoidable use of a hospital ED.	While Idaho has one of the country's lowest hospital ED utilization rates (327/1000, 2011), this measure is still held as one of the standards for evaluation of utilization and appropriate use of emergency services, as well as a reflection of quality and patient engagement in primary care related to avoidable treatment.
Elective delivery.	Rate of babies electively delivered before full-term.	Data currently unavailable. Metric will be used to establish baseline.
Low birth weight rate (PQI 9).	This measure is used to assess the number of low birth weight infants per 100 births.	While Idaho's percentage of low birth weight babies is low compared to the national average, the opportunity to improve prenatal care across settings is an indicator of system quality. 1,355 babies in Idaho had low birth weights in 2011, compared to 1,160 in 1997.
Adherence to antipsychotics for individuals with psychotic diagnoses.	The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	Idaho has a 100% shortage of mental health providers statewide. Without these critical providers, there is little or no support for patient engagement and medication adherence.  Improved adherence may be a reflection of improved access to care and patient engagement.
Weight assessment and counseling for children and adolescents (SIM measure).	Percentage of children, two through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	In 2011, 13.4% of children were overweight as defined by being above the 85th percentile, but below the 95th percentile for BMI by age and sex, while 9.2% were obese, i.e., at or above the 95th percentile for BMI by age and sex.

Idaho's Initial Performance Measure Catalog		
Measure Name (and Source)	Measure Description	Rationale for the Measure
Comprehensive diabetes care (SIM measure).	The percentage of patients 18–75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD with the intent of preventing or reducing future complications associated with poorly managed diabetes.	Adult diabetes prevalence in 2010 was 8.0%. Overall, this represented one in 12 people in Idaho had diabetes.
Access to care.	Members report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).	Idaho has a critical access shortage of primary care providers, behavioral health providers, and dentists across the State which impedes access to the appropriate level of care.
Childhood immunization status.	Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	While there have been significant improvements in immunization rates, Idaho ranks 43rd in the nation with an immunization rate of 87.33% in 2012.  This measure aligns with Healthy People 2020.
Adult BMI Assessment.	The percentage of members 18–74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	In 2010, 62.9% of adults in Idaho were overweight, and 26.9% of adults in Idaho were obese.
Non-malignant opioid use.	Percent of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	From 2010–2011, Idaho had the fourth highest non-medical use of prescription pain relievers in the country among persons aged 12 or older at 5.73%.

### Quality Measure Timeline

The timeline for developing a baseline and establishing performance reporting developed by the IHC to achieve statewide quality measurement is outlined below. The timeline has been updated from the original proposal submitted in the December 2013 version of the SHIP based on feedback from providers and payers and reflects realistic activities and timetable for Idaho's assessing statewide quality across payers.

#### *Model Test Year 1*

- The IHC will establish a baseline for each of these measures in Year 1 of Model Testing. Due to the lack of uniform reporting that exists today, the IHC will develop a baseline from the pockets of information that are currently available across payers and populations. An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline by the end of Year 1
- During this first year, the IHC will also analyze the current system capabilities and constraints regarding statewide data collection and reporting and establish a statewide data analytics vendor. By the end of Year 1, decisions regarding construction of the statewide database and protocols for PCMHs to report on performance measures will have been developed. The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho.

#### *Model Test Year 2*

- IDHW and the IHC will review the baseline data to establish performance targets for reporting in Year 2 of the Model Test. Reported measures will be reviewed at the State and regional levels by IDHW, the IHC, and RCs. The RCs will provide feedback to each PCMH in their regions. Quality initiatives will be identified and implemented to improve individual and regional PCMH performance. RCs, in consultation with IDHW and the IHC, may identify additional performance measures to be reported in Year 3 for their respective regions. Regional-specific performance measures will be identified after consideration of both initial performance results and regional health needs as determined by community health assessments and other clinical and service data.

#### *Model Test Year 3*

- In Year 3, PCMHs will report on the statewide performance measures and potential regional-specific measures. IDHW and IHC's quality committee will evaluate data from multiple sources, e.g., PCMHs, hospitals, behavioral health assessments, community health needs assessments, and national trends to identify additional performance measures to be added to the Catalog. The IHC will review performance results and select statewide performance reporting requirements from the expanded Catalog.

As noted previously, the creation of the Catalog and establishment of realistic timelines for data collection, analysis, and reporting are only possible because Idaho's payers (1) are committed to population health management, and (2) recognized the difficulty of achieving that due to the significant administrative burden that providers experience from the numerous and differing quality reporting requirements across multiple payers. In addition, payers were able to hear and respond to providers' frustration that the benefits of collecting and reporting the data are often not fully realized, as the data is siloed across payers. The IHC created the opportunity for providers and payers to exchange ideas and collectively develop a realistic strategy for a coordinated, statewide quality reporting system. Throughout the Model Test Years, the IHC will monitor the State's progress in

aligning quality measures and providing useful, relevant information to providers and payers to manage population health.

### 3.8. SIM Alignment with State and Federal Initiatives

Idaho's model of healthcare delivery and payment reform both builds off existing state and national healthcare initiatives and partners with those efforts to elevate their impact on the population. Idaho will not use federal funds for duplicative activities or to supplant current federal or state funding.

The primary method of ensuring ongoing coordination between the SIM Model Test and other State and Federal Initiatives will be the collaborative stakeholder engagement occurring throughout the Model Test period. Representatives of other state and federal initiatives have an active seat at the SIM table through their participation in the IHC and its Workgroups. Representatives of other related federal programs operating in Idaho (e.g., other CMS and the Department of Health and Human Services initiatives) are mostly IDHW division staff that have regular communication with SHIP staff, including weekly one hour meetings plus ad hoc communications as issues arise. Working together on a regular basis, these teams will ensure that the development and continued implementation of the SIM Model Test will be well coordinated with other state and federal initiatives.

Specific areas of coordination between the SIM Model Test and other state and federal initiatives will include:

1. The Idaho Medical Home Collaborative will advise the IHC on PCMH model and spread.
2. The Idaho Telehealth Task Force/Council will advise the IHC on telehealth standards/training.
3. The Idaho Oral Health Strategic Plan will guide the participation of oral health providers in Medical/Health Neighborhoods.
4. The Idaho Workforce Professions Education Council will advise the IHC on healthcare workforce education and development.
5. Representatives of the Children's Health Improvement Coalition along with the IHC will coordinate PCMH development with the Children's Healthcare Improvement Collaboration model for special needs children.
6. National public health campaigns will be engaged through the Division of Public Health, and will be coordinated to promote alignment with Healthy People 2020, the Million Hearts Campaign, the National Prevention Strategy, and the National Quality Strategy.
7. Local nonprofit hospitals will partner with RCs and the IHC to conduct community needs assessments and identify regional differences in population health outcomes.
8. The Idaho Health Quality Planning Commission will advise the IHC regarding quality initiatives and measures at the State level.

### 3.9. Workforce Capacity

Idaho's health system transformation is geared at achieving the Triple Aim of improved health outcomes, improved quality and patient experience of care, and lowered healthcare costs by addressing barriers and filling gaps in the current system. Primary among these barriers, as identified by the stakeholders in the Model Design process and noted in the SHIP, are severe workforce shortages in Idaho across professions and across geographic regions of the State that must be addressed in order to truly transform healthcare in Idaho. One hundred percent of Idaho is a federally-designated shortage area in mental healthcare, and 96.7% of Idaho is a federally-designated shortage area in primary care. Recognizing the access barriers presented by this shortage, Idaho has

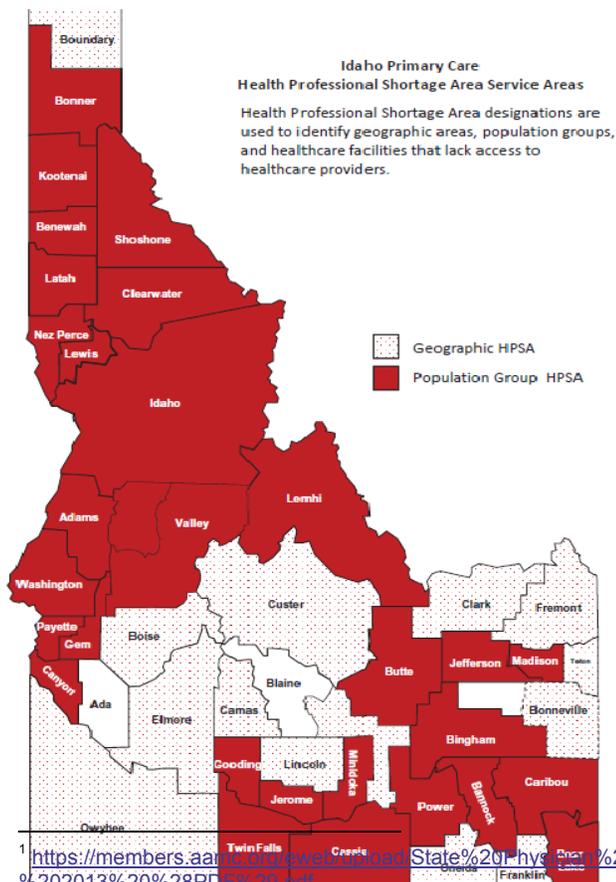
designed a model that maximizes the current workforce while designing comprehensive strategies to increase practitioners of all types throughout the system.

### Current Workforce Capacity

In the SHIP, Idaho provided data on its workforce capacity as of 2013. Since that time, more updated information on Idaho's healthcare workforce has become available. The new data shows that Idaho's workforce continues to face many of the same challenges and shortages.

#### *Physicians*

According to the Association of American Medical College's 2013 State Physician Workforce Data Book, there were 2,938 active physicians in Idaho in 2012 (184.1 physicians per 100,000 residents), including 2,611 Doctors of Medicine (MDs) and 327 Doctors of Osteopathic Medicine (DO).<sup>1</sup> This reflects a slight increase from the physician workforce in 2010 when the SHIP was published, and at that time there were 2,873 active physicians in the State (184.2 physicians per 100,000 residents), including 2,610 MDs and 263 DOs.<sup>2</sup> However, despite modest increases in number of physicians from 2010 to 2012, Idaho's rank as the 49th state in the nation in terms of physician to patient ratios has remained unchanged.



#### *Primary Care*

There was also a slight increase between 2010 and 2012 in the number of active patient care PCPs. In 2010, there were 987 active patient care PCPs, and as of 2012 there were 1,048.

As of 2014, there were 12 FQHCs providing care to over 156,000 patients in Idaho.<sup>3</sup> Services provided by FQHCs include medical, dental, mental health, substance abuse, and other services, and often function as safety-nets in their community. There is also one FQHC "look-alike" in Idaho that served 220 patients in 2014.<sup>4</sup>

Additionally, there are 48 Rural Health Clinics (RHCs) operating throughout Idaho.<sup>5</sup> RHCs are family medicine clinics that provide outpatient primary care health services, including diagnostic and laboratory services. These clinics are staffed by mid-level practitioners 50% of the time the clinic is open.<sup>6</sup> RHCs are certified by the IDHW Division of Medicaid's Bureau of Facility Standards. To be certified as an RHC, a clinic must be located in a non-urban area as defined by the US Census Bureau

<sup>1</sup> <https://members.aamc.org/Downloads/DownloadState%20Physician%20Workforce%20Data%20Book%202013%20%28PDF%20-%20.pdf>

<sup>2</sup> <https://www.aamc.org/download/263512/data/statedata2011.pdf>

<sup>3</sup> <http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=ID&compare=Nat>

<sup>4</sup> <http://bphc.hrsa.gov/uds/lookalikes.aspx?q=&bid=10E00721&state=ID&year=2014>

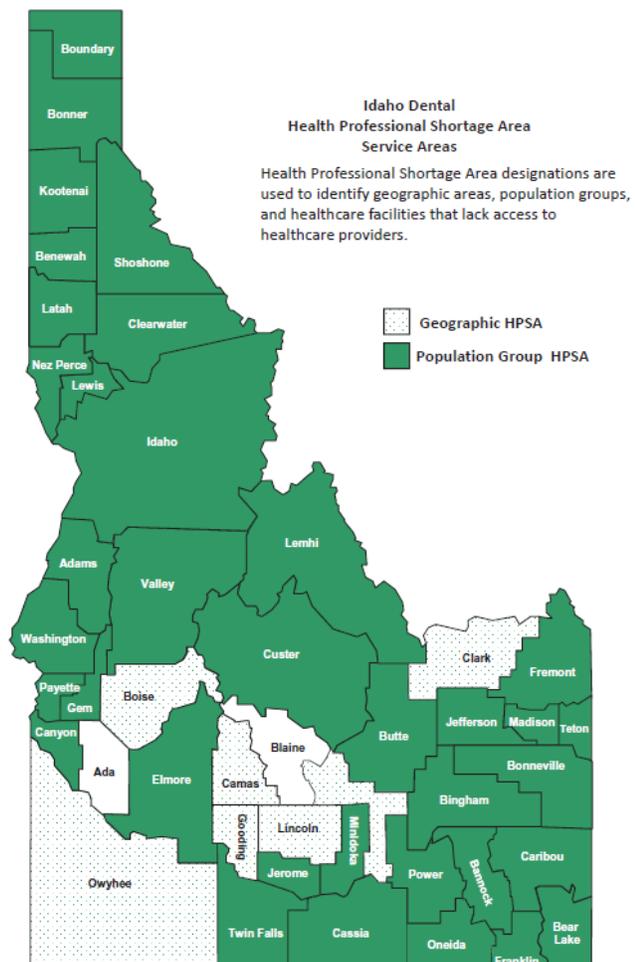
<sup>5</sup> <http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RRHC.pdf>

<sup>6</sup> <http://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RRHC.pdf>

and a federally-designated medically-underserved area (or a governor-designated shortage area) or serve a designated population group or geographic HPSA.

Nurses (RNs), Nurse Practitioners (NPs), and Physician Assistants (PAs) are important participants in Idaho's team-based PCMH model. As of December 2013, The Idaho Department of Labor reports that there were 18,763 with active licenses in Idaho in 2013.<sup>7</sup> However, only 61% of RNs reported that they are currently working in the State. The same study found that, as of December 2013, there were 3,937 Licensed Practical Nurses (LPNs) with active licenses, but only 61% are working as nurses in Idaho.<sup>8</sup> The latest information from the Kaiser Family Foundation shows that there are currently 752 NPs and 659 professionally active PAs in Idaho.<sup>9</sup>

An important source of updated primary care workforce information in Idaho is the State's population health improvement plan, *Get Healthy Idaho*, published by IDHW's Division of Public Health. The plan reports that, using 2013 data from U.S. Department of Health and Human Services, CQ Press ranks Idaho 13th nationally in percent of population lacking access to primary care services at 17.4%, 6.5% greater than the national average (SAGE Publications, Inc., 2013). There are 43 Primary Care HPSA designations for geographic areas and population groups across the State of Idaho. These designations cover 96.36% of the State's total land area: approximately 60.54% of Idaho's geography is designated as a population group HPSA, while 35.82% is designated as a geographic HPSA in the primary care discipline.



### Dental Health

Get Healthy Idaho reported that there are 43 HPSA designations for geographic areas and populations across the State of Idaho. These designations cover a total of 97.01% of the State's land area: approximately 78.18% of Idaho's geography is designated as a population group HPSA, while 18.83% is designated as a geographic HPSA in the dental discipline.

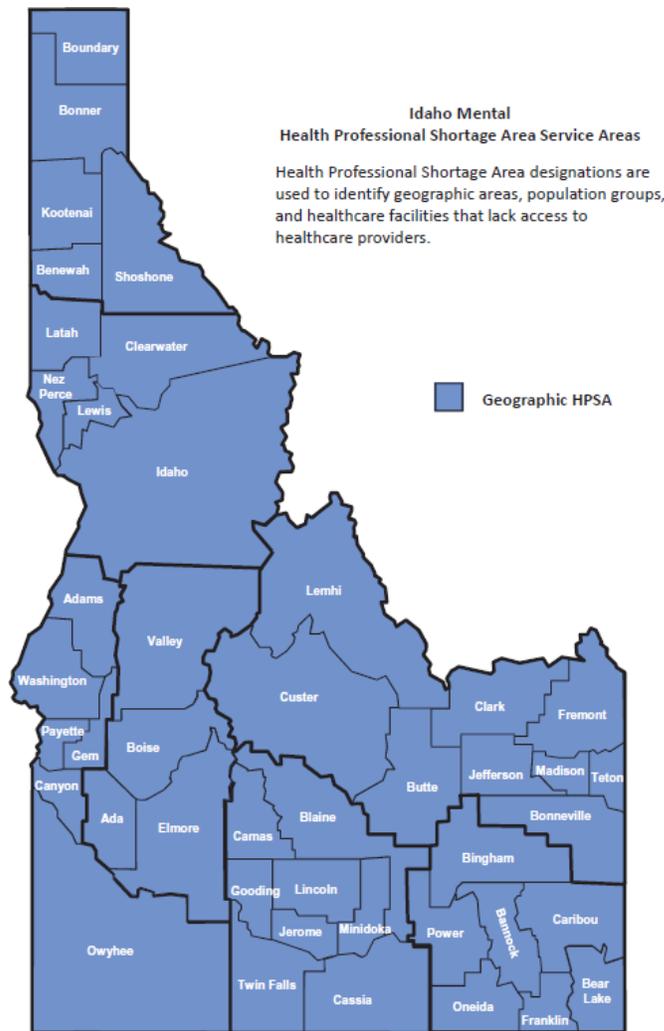
### Behavioral Health

The shortage of behavioral health professionals in Idaho creates substantial barriers for Idahoans with mental health conditions and substance abuse disorders. Due to the severe shortage of mental health

<sup>7</sup> <http://labor.idaho.gov/publications/NursingOverview2015.pdf>

<sup>8</sup> <http://labor.idaho.gov/publications/NursingOverview2015.pdf>

<sup>9</sup> <http://kff.org/other/state-indicator/total-physician-assistants/?state=ID>



professionals across the State, the Idaho Primary Care Office reviews the State's geography on a regional basis. In 2014, there were 36 Mental Health Professional Shortage Areas (MHPSAs) in Idaho. A MHPSA, as recognized by the Health Resources Services Administration (HRSA), is a geographic area where the population to mental health professional ratio is 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community).<sup>10</sup> These mental health designations encompass 100% of Idaho's land area and population.

Based on data from the Idaho Board of Alcohol/Drug Certification, there were 451 substance abuse counselors with active certifications in September, 2015.<sup>11</sup>

In September, 2015, there were 3,787 social workers with active licenses from the Idaho Board of Social Work Examiners.<sup>12</sup> There were 416 psychologists with active licenses from the Idaho Board of Psychologist Examiners.<sup>13</sup>

#### Ongoing Sources of Workforce Capacity Data

There are a number of data sources that Idaho has used and will continue use as resources to document and track workforce capacity development during the Model Test. At the national level, these resources include:

- The Association of American Medical Colleges, including the Annual State Physician Workforce Data Book.
- Publications from HRSA.
- Publications from Kaiser Family Foundation, including State Health Facts reports.
- Publications of other relevant trade associations, which track workforce capacity closely.

Local sources will also be important to track workforce development during the Model Test. The Idaho Health Professions Education Council (IHPEC), composed of healthcare organizations, Idaho colleges and universities, and the public, has primary responsibility in Idaho for publishing

<sup>10</sup> <http://kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/>

<sup>11</sup> [http://www.ibadcc.org/new\\_web/search/search\\_list.shtml](http://www.ibadcc.org/new_web/search/search_list.shtml)

<sup>12</sup> <https://secure.ibol.idaho.gov/elBOLPublic/LPRBrowser.aspx>

<sup>13</sup> <https://secure.ibol.idaho.gov/elBOLPublic/LPRBrowser.aspx>

Idaho-specific data on the status of the healthcare workforce, and for making recommendations to address workforce capacity gaps. As documented in the IHPEC's most recent public meeting minutes from June 2015, the Council is in the process of finalizing the 2014–2015 Annual Report to the Governor, which should provide valuable information on the current and projected state of Idaho's healthcare workforce. Once published, Idaho will use the report to enhance ongoing workforce objectives of the Model Test.

### Current Health Workforce Capacity Programs

Chief among current health workforce capacity programs are the existing medical education programs located in Idaho. The State's medical education programs are uniquely suited to the State's expansive geography and frontier areas. The residents in these programs are being trained in the PCMH model. Additionally, Idaho's medical education programs provide physician residents with opportunities to experience their curriculum within practices throughout the State and translate value-based tenets into the reality of diverse practice settings. This bi-directional education helps to shape curriculum, assists in updating clinical practices, and supports graduates in the practical application of value-based care.

Moving forward, Idaho's Model Test supports the expansion of this delivery model of the future in a rural and frontier state. It inspires the graduates of our training programs to stay and be a part of that future.

Idaho has a number of additional collaborative initiatives underway to increase the number of primary care providers in the State. These efforts are supported by the governor's office, legislature, universities, residency programs, and include coordinated, active engagement by stakeholder organizations statewide. Strategies include:

- Expansion of family medicine residency programs: the successful expansion of existing family medicine residency programs and the establishment of a new program. Idaho increased the number of family medicine residency program graduates by 71% over the last four years by expanding the size of existing programs and adding a new family medicine residency program this year.
- New internal medicine residency programs: Idaho previously had zero internal medicine residency programs and within the past three years two new residencies were established. These two programs produce 14 internal medicine graduates per year. Within the past three years, Idaho also established a psychiatry residency which trains three residents per year in years three and four of their residency.
- Increase in state-supported medical school seats at the University of Washington and University of Utah: Idaho's Governor, legislature, and board of education support access to medical school education for residents by providing state funding for medical school seats. Over the past four years, ten new state supported medical school seats have been added with plans to continue to grow these programs annually.
- PCP workforce summit on September 17, 2014: the purpose of the summit is to identify gaps in current and future workforce needs, develop strategies to improve recruitment and retention, and create an action plan to increase Idaho's PCP workforce. The event is sponsored by the Division of Public Health, Idaho Academy of Family Physicians, and Idaho Primary Care Association, and participants include leadership from residency programs, University of Washington and University of Utah medical schools, Idaho Department of Health and Welfare, State Board of Education, and various stakeholder organizations with workforce expertise.
- Idaho Health Professions Education Council: this governor-appointed Workgroup includes leadership from State universities, residency programs, and the Idaho Department of Labor, and

makes recommendations for funding appropriations and healthcare program growth. The council's recommendations are based in the context of evidence-based evolving workforce needs in Idaho, use of technology, curricular, and field changes of key providers, within the overall strategy for care delivery by healthcare teams. The strategies are designed to address efficient and effective use of health professionals, with input from educational institutions, to plan for Idaho's future workforce needs.

- Rural Training Tracks: Idaho has two well-recognized and successful Rural Training Track (RTT) residency programs to train physicians for rural practice. A high proportion of RTT graduates provide healthcare in designated shortage areas for underserved populations and at least half of graduates remain in rural areas after graduation.
- Expansion of PA and NP training programs: these university-based programs continue to grow to help meet the increasing primary care needs of Idaho residents. This workforce is particularly critical in rural and underserved communities to staff Rural Health Clinics and Federally Qualified Health Centers.

### Stakeholder Engagement and Plans to Build Workforce Capacity

Recognizing the critical need to build on existing workforce capacity initiatives to support the PCMH care delivery system envisioned in Idaho's Model Test, Idaho's stakeholders worked together during the Model Design phase to develop strategies to make the best use of Idaho's current workforce, and increase the future supply of needed health professionals.

During the Model Test, key stakeholders have begun to actively partner with the IHC and IDHW to determine the best path forward in implementing these critical workforce capacity efforts. Chief among these key stakeholders is the IHPEC. The IHPEC is composed of groups central to Idaho's healthcare workforce development goals, including healthcare organizations, colleges, and universities. This composition of stakeholders will reinforce Idaho's workforce trends and priorities in the Model Test phase. Since 2009, the Council has been working to develop healthcare workforce objectives for the State and recommend strategies to address healthcare shortage across a range of professions.<sup>14</sup> During Idaho's Model Design phase, stakeholders recommended that many of the Council's recommendations be incorporated into the Idaho SHIP strategies for workforce improvement.

To implement this recommendation, IDHW and the IHC have begun to work more closely with the Council to ensure that SHIP activities, such as training opportunities for primary care practices and new data sharing arrangements, align with the Council's workforce development strategies and support their efforts wherever possible. The Chair of IHPEC is now an active member of the IHC. The IHPEC is enthusiastic about advising the IHC on workforce education topics and is actively working to identify key topics and strategic initiatives in this area.

Throughout the Model Test, the Council will continue to advise the IHC on healthcare workforce education and development. The soon to be released 2014–2015 IHPEC Annual Report to the Governor will also serve as a guide to further build workforce capacity in Idaho. And, to emphasize the collaboration with IHPEC in the Model Test phase, discussion at the June 2015 Council meeting focused, in part, on the role of the IHPEC in implementing SHIP and the PCMH model.<sup>15</sup>

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<sup>14</sup> See the Idaho Health Professions Education Council, 2013 Annual Report to Governor C. L. "Butch" Otter, submitted August 13, 2013 available at <http://gov.idaho.gov/HealthCare/PDF/2013%20IHPEC%20Annual%20Report.pdf>

<sup>15</sup> <https://labor.idaho.gov/dnn/wia/StateCouncil/IdahoHealthProfessionsEducationCouncil.aspx>

While collaboration with IHPEC is just one example, other stakeholder engagement activities will help build healthcare workforce capacity. For example, the Bureau of Rural Health & Primary Care has been an internal stakeholder throughout the Model Design process. The Bureau partners with external stakeholders, including trade associations and educational institutions, to strengthen workforce recruitment and retention efforts in Idaho. Collaboration with the Bureau leverages the agency's work and expertise in building Idaho's healthcare workforce capacity, as well as its network of stakeholders in the SHIP Model Test.

### CHW and CHEMS

Because of the rural nature of the State, Idaho's Model Test proposes new workforce development initiatives that are aimed at increasing the healthcare workforce in rural areas. These workforce development initiatives will specifically focus on building capacity around two types of professionals — CHWs and CHEMS. By developing a strong workforce of CHWs and CHEMS, and helping primary care practices in rural areas become Virtual PCMHs that integrate CHWs and CHEMS in their healthcare team, Idaho's Model Test will amplify primary care efforts in rural areas and ensure the highest level of care as close to home as possible for Idahoans.

Through the Model Test, Idaho proposes training over 250 CHWs and CHEMS. Details related to this training effort can be found in the Goal 4 narrative summary in Section 2 of this Operational Plan. Proposed CHW and CHEMS training programs will include staff training and onsite technical assistance to assure successful integration of these staff into the PCMH team. Through the Model Test, Idaho will evaluate the effectiveness of CHW and CHEMS personnel in rural communities with very limited resources.

### **3.10. Health Information Technology**

Health Information Technology (HIT) is a critical component underpinning the overall SIM Model Test and is a primary driver of Idaho's healthcare system transformation. The HIT Plan describes the State's plans to establish the data and analytical capability to support PCMHs and other organizations in improving coordination and delivery of care, exchanging clinical information, and improving the health of the population.

The full HIT Plan, developed in accordance with CMS' "Health IT Plan: Supplemental Guide for Model Test", can be found in Appendix D of this Operational Plan.

#### Idaho's HIT Plan

During the Model Design phase, Idaho's stakeholders identified limited opportunities in the existing landscape to coordinate data collection and analysis across payers and populations. These limitations have historically prevented Idaho from fully developing the capacity to collect and analyze statewide data.

Idaho's SIM Model Test HIT Plan provides a pathway to increasing this capacity. The HIT Plan describes how Idaho will build capacity across the system and sets a strong foundation for implementing increasingly robust HIT solutions as the PCMH model evolves. The HIT Plan aims to support a successful PCMH model in Idaho by building a platform for Model Test participants to collect and share data for purposes of patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics.

Idaho's HIT Plan also promotes the use of advanced health technology, such as telehealth, EHRs, patient portals, and clinical decision tools to:

- Reduce barriers to access for those living in rural areas.
- Improve provider collaboration and coordination.
- Increase patient engagement.
- Increase training and specialized care in geographically isolated areas of the State.
- Gather statewide data that informs the activities needed to improve the quality of care, control healthcare costs, and achieve improved health outcomes.

The key components of Idaho's HIT plan are to:

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| <p><b>1. Use technology, such as EHRs and remote patient-based monitoring systems, to coordinate care over time and across settings.</b></p>   | <p>Over the three-year Model Test period, the IHDE will engage 165 PCMH clinic sites statewide to both adopt and use EHR technology and to connect to the IHDE. As the model matures, IDHW and the IHC will determine the most appropriate ongoing HIT infrastructures to provide data aggregation and analytic support to facilitate Idaho's population health management. Idaho's SIM Model Test also supports improving rural patient access to a PCMH by developing 50 virtual PCMHs and integrating telehealth into these practices to support both physical healthcare and the integration of behavioral health and other specialty services.</p>   |
| <p><b>2. Use technology to support maintaining a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations and other providers of services and suppliers.</b></p> | <p>Idaho's seven PHDs will establish and support the RCs, which serve to support practices as they transform to a PCMH and continue to expand their capabilities. RCs will also link PCMHs to the broader Medical/Health Neighborhood to coordinate patient care throughout the provider community. Connectivity via the IHDE for PCMHs, hospitals, and other organizations will allow for rapid electronic exchange of information and facilitates communications that cement lasting relationships among the patient's circle of supports. Under Idaho's SIM Model Test, PCMHs will use HIT to receive community health needs assessment results from the RCs; these results will help drive healthcare strategic planning within the PCMH and across Idaho's healthcare landscape.</p> |
| <p><b>3. Use technology to enable a team-based approach to interventions, such as comprehensive care assessments, care planning and self-management coaching.</b></p>  | <p>Broad-based care coordination, facilitated by the RCs and PCMHs and realized through HIT, will be essential for improving care quality, reducing errors and redundant services, keeping costs down, and promoting a patient-centric approach to healthcare in Idaho in which the patient is empowered to manage his or her healthcare.</p>   |
| <p><b>4. Use technology to enable service</b></p>  | <p>Idaho's first step in setting the technological foundation for coordinating care is the adoption and use of EHRs by 165 PCMHs</p>  |
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**providers and suppliers to share information with patients, caregivers, and other service providers on a real-time basis.**

and 21 hospitals, and ensuring their capability to use the IHDE to securely transmit and receive patient information. Over time, as Idaho further defines and develops its HIT infrastructure, additional users across the Medical/Health Neighborhood, specifically patients, will have access to real-time information sharing.

**5. Use technology to create an effective link with other public sector or private sector payers.**

RCs will promote public health campaigns to improve regional population health, such as targeting populations segments susceptible to specific health threats (smoking, diabetes, immunization status, etc.) and promote healthy lifestyles. PCMHs will have access to a statewide data analytics system and will report quality measures related to these and other health issues. In addition to the inherent link with public health, Idaho's HIT plan is designed to provide the data and analytical capability to support provider practices, hospitals (and eventually, other organizations, including private sector payers), in improving care coordination and delivery, exchanging real-time clinical information, and improving population health.

### HIT Plan Implementation

Governance of the HIT Plan will be tightly linked to IDHW's overall SIM Model Test Operational Plan, and aligned with efforts to achieve nationwide interoperability. To this end, IDHW will work to ensure that efforts are implemented in concert with other local, state, and national HIT initiatives. IDHW is well aware of the Office of the National Coordinator's (ONC's) recently issued shared nationwide interoperability roadmap, and the 2016 Interoperability Standards Advisory. IDHW recently hosted representatives from the ONC in a joint onsite discussion of the Idaho HIT roadmap.

Idaho will continue to meet with its stakeholders to assess the levels and quality of data available. Steps are already underway to assess data currently available and map data pathways, so that improvements supporting Idaho's HIT efforts and strategic goals can be introduced. Improvements will include recommendations for standardizing data elements, formats, usage, and content so that information is collected, stored, and used in a consistent manner with the support of the data analytics solution. This will be done utilizing the national technical standards for core interoperability functions as published by the ONC.

In addition to assisting PCMHs in implementing successful EHRs, ongoing support will continue to improve EHR functionality and the quality of shared information. Aligning EHR usage with consistent data definitions allows Idaho to build a statewide system capable of collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels. The IHDE will begin working with the PCMHs early in Model Test Year 1 to implement EHRs capable of sharing clinical information in a consistent manner that supports reporting.

Concurrent with EHR implementation activities, the IHDE will partner with a data analytics vendor to create reporting mechanisms that assess quality and identify potential cost improvements across all levels (patient, clinic, county, region, and statewide). As the reporting infrastructure is built, IHDE

technical staff will participate in all development activities so that support and ongoing development activities can be performed by the IHDE, as opposed to outside vendors. Initial reports will be delivered by the end of the first quarter 2016 and will be used as the basis for further development.

Stakeholder collaboration continues to be an extremely important and valuable component of Idaho's Model Test, particularly in the HIT activities. IDHW and the IHC will continue working to implement the HIT Plan in collaboration with stakeholders to ensure that statewide solutions are viable and acceptable to the different communities in Idaho, and that system enhancements support interoperability and align with regulatory requirements.

### 3.11. Program Monitoring and Reporting

#### Measures and Accountability Targets for Program Evaluation

Monitoring and evaluating the progress and impact of Idaho's SIM Model Test is critical to determining the success of Idaho's healthcare system delivery transformation. Idaho's strategy for monitoring the SIM Model Test will involve regularly gathering and analyzing data to determine Idaho's performance on a comprehensive set of quality, cost, and model implementation measures. The full set of measures proposed for Idaho's SIM Model Test can be found in Appendix A: Core Metrics and Accountability Targets.

The first component of the comprehensive measure set is Idaho's Initial Performance Measure Catalog (Catalog). Idaho developed these measures, discussed in full detail in Section 3.7, during the SIM Model Design phase with broad input from local expert stakeholders. The clinical and population health measures were chosen because they reflect Idaho's priorities for improving population health outcomes in specific areas that currently present barriers to health in the state. During the SIM Model Test Pre-Implementation Year, IDHW worked with stakeholders to modify these measures to incorporate the clinical measures required by CMMI. These measures will be reported annually.

The second component of the comprehensive measure set is cost measures. An important goal of Idaho's SIM Model Test is to reduce the overall cost of healthcare in the State and provide a positive return on investment of SIM Model Test funds. IDHW will report on the cost measures required by CMMI plus one Idaho-specific cost measure. These measures will be reported annually.

The third component of the comprehensive measure set is the model implementation measures. In collaboration with stakeholders and advisors, IDHW has developed a robust set of measures to track the progress of implementing each of the model's seven goals. The majority of these measures are structural measures to track changing behaviors across the system on the part of payers, provider organizations (including PCMHs), providers, and patients. Performance on these measures will provide Idaho and CMMI a comprehensive picture of how Idaho's Model Test implementation is working to improve care coordination, increase access to care in rural areas, promote the use of health information technology, and move payment for healthcare services to alternative reimbursement methodologies. The majority of these measures will be monitored and reported quarterly.

With input from stakeholders, IDHW has developed accountability targets for each measure in the comprehensive measure set. Achieving each accountability target will be a "reach" for the system, but is realistic and will show the State's stepwise progress towards healthcare transformation. IDHW has not established accountability targets yet for the clinical measure catalog. As discussed in Section 3.7, IDHW will establish accountability targets for these measures after a State Evaluation Contractor is

procured and baseline data can be established. IDHW anticipates this work happening in Model Test Year 1.

### Program Evaluation Process

IDHW and its stakeholders have laid the groundwork for regular reporting on the program measures during the Model Test as well as regular program evaluation. During the Pre-Implementation Year, IDHW has worked to refine the performance measures by ensuring that the CMMI-required measures are incorporated, establishing working definitions for each measure's numerator and denominator, and identifying baselines where possible. IDHW anticipates continuing to work with CMMI through the remainder of the Pre-Implementation Year to produce the final measure set.

Where known, IDHW has also identified preliminary data sources for the measures. Idaho anticipates engaging the State Evaluator Contractor, the Data Analytics Contractor, the PCMH Contractor, and payers in Model Test Year 1 to finalize data sources for each measure. In doing so, IDHW will seek to reduce any administrative burden associated with reporting, which will help ensure that data reporting is complete and timely.

Performance measure data will be collected, analyzed, and reported quarterly and annually, depending on the measure. The process will also vary by measure. Data collection and analysis for some measures will be completed internally at IDHW (for example, on the measure: CUM # (%) of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services. Data collection and analysis for other measures will be the responsibility of the State Evaluator Contractor, the Data Analytics Contractor, the PCMH Contractor, or others. IDHW will engage with the State Evaluator Contractor during Model Test Year 1 to finalize the data collection, analysis, and reporting process for each measure. IDHW and the State Evaluator will also finalize data validation processes to ensure that the data gathered is accurate and complete.

Throughout the Model Test, IDHW will be responsible for reporting performance measure data to CMMI on quarterly and annual progress reports. The IDHW SHIP Team will also share quarterly performance results with stakeholders to promote awareness of performance and progress, to maintain a high level of support and engagement in transforming Idaho's healthcare delivery system transformation, and to discuss and implement changes to the Model as needed.

### Regular Program Monitoring

In addition to reporting on the Model Test performance measures as described above, IDHW and its partners will regularly monitor the Model Test as part of the day-to-day practice of implementing the model. The program monitoring process will focus on ensuring a common understanding of the Model Test goals by all workgroups, advisory groups, and contractors and establishing communication pathways for sharing data and information regarding potential or anticipated issues with Model implementation. Idaho views monitoring as a continuous, iterative process that serves as an early warning system to detect potential changes relevant to the Model. Idaho will monitor the implementation through:

1. Regular status meetings with contractors.
2. Monthly workgroup and advisory group meetings.
3. Regular status reports from workgroups, advisory groups, contractors, and RCs.
4. Review of progress towards meeting quarterly accountability targets.
5. Review of performance against Idaho's performance measure catalog.

Idaho's Project Management Contractor, Mercer, will assist IDHW in monitoring the Model Test Implementation. Mercer will work with the Department, IHC, workgroup facilitators, and other Technical Assistance Contractors in a multi-faceted capacity to support the Model Test. Mercer will provide project management services for implementing and monitoring the Model Test to ensure there is a high level of coordination and cohesion between the different components of the Model Test. Mercer's project management plan describes the how the Model Test will be monitored and managed as it relates to risks, schedule, scope, quality, communication, and resources. Mercer will work with IDHW to finalize the project management plan and ensure that an adequate amount of monitoring and reporting is in place to achieve the goals of the SIM Model Test.

### **3.12. Data Collection, Sharing and Evaluation**

IDHW has worked during the Model Test Pre-Implementation Year to continue refining its plans for data collection, sharing, and evaluation, which includes supporting CMMI and its contractors in the federal SIM evaluation. During the Model Design phase, IDHW and its stakeholders prepared an initial plan for data collection and analysis to track progress in implementing the SHIP and in achieving the aims of the SHIP. At the completion of the Model Design phase, Idaho had not fully developed the capacity to collect and analyze statewide data, largely due to the limited opportunities to coordinate data collection and analysis across payers and populations. At that time, further analysis was needed to finalize the approach.

During the Model Test Pre-Implementation Year, IDHW has further reviewed current system capabilities and constraints regarding statewide data collection and reporting. Through the HIT Workgroup and the Multi-Payer Workgroup, IDHW and the IHC have engaged stakeholders in this process to ensure that a statewide solution is viable and acceptable to the different communities in Idaho. While much work has been done, the data collection and reporting processes continue to be fluid plans that will change and expand over time based on work plan objectives, accomplishments, and expectations.

In further refining the statewide data collection, analysis, and reporting processes, IDHW and the IHC have placed high priority on creating mechanisms that will promote close coordination between the State and the federal evaluation. This involves creating pathways for data exchange and regular communication to avoid unnecessary duplication of evaluation efforts and to ensure that evaluations are not hindering each other. Much work remains to be done on this front, and IDHW looks forward to partnering with CMMI in this effort.

#### Providing Data for Federal Evaluation

Idaho will provide data to enable CMMI and its contractors to evaluate the extent to which Idaho's health system transformation plan was implemented and the results of the model. This will include, but is not be limited, to providing qualitative and quantitative data as requested, including baseline and historical data as well as current data as the Model Test implementation proceeds.

Regarding baseline and historical data, IDHW has partnered with Model Test participating payers (Idaho Medicaid, Idaho Blue Cross, PacificSource of Idaho, and Regence Select Health) through the Multi-Payer Workgroup to develop a process for gathering baseline and historical data for three years prior to the Model Test Project Period (i.e., 2013, 2014, and 2015). Participating payers are engaged in this process to obtain data and implement ongoing financial analysis. Data requests were submitted to payers in September, 2015. IDHW will continue to work with participating payers to gather remaining information needed to complete the baseline and fulfill the historical data requests. IDHW

anticipates working with CMMI to delineate the timing and format of sharing this information with CMMI and its Federal Evaluation Contractor.

#### Beneficiary Indicator

IDHW has initiated conversations related to the possibility of creating an identifier for all patients affected by Idaho's Model Test, regardless of payer.

#### Beneficiary Information

IDHW is committed to working with CMMI to meet the objectives of the SIM evaluation in an ethical and appropriate manner. Regarding the provision of identifying and contact information for beneficiaries who receive services under Idaho's SIM Model, Idaho will work with CMMI up-front to create a process that meets CMMI's needs, is HIPAA-compliant, and respects the privacy of Idahoans. Where needed and appropriate, IDHW will work with CMMI to coordinate and facilitate data collection on behalf of CMS.

#### Cooperating with Primary Data Collection Efforts

IDHW also anticipates cooperating with CMMI and federal evaluators in the primary collection of qualitative information regarding the Model Test implementation. This includes, but is not limited to, surveys, focus groups, and key informant interviews. IDHW will work directly with CMMI and federal evaluators on these requests to ensure a smooth and efficient process and, wherever possible, to prevent duplicative efforts between the State and federal evaluation activities. IDHW SHIP Staff will continue to be the primary point of contact for these and all other data requests.

#### Legal Mechanisms for Data Delivery

IDHW will ensure that the necessary legal mechanisms, authorities, and/or agreements are in place to ensure timely delivery of data to CMS and/or CMS contractors. If potential barriers to data delivery arise, IDHW will work with its local and federal partners to the greatest extent possible to overcome these barriers. During the SIM Model Design phase, stakeholders rejected the idea of changes to the law impacting payer data collection and reporting. Stakeholders were clear in stating that mandates and penalties do not work in Idaho, but that real change could occur through cooperation. Therefore, no mandate for data collection has been issued. Instead, payer data collection and reporting is being coordinated through the Multi-Payer Workgroup.

#### Coordination with Federal Evaluation Contractor

IDHW understands the importance of SIM evaluation at the federal level, and will coordinate with the Federal Evaluation Contractor and CMS for any other needs/requirements to support the evaluation. IDHW agrees to not receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.

### **3.13. Fraud and Abuse Prevention, Detection, and Correction**

Fraud and abuse prevention, detection, and correction will continue to be a focus of Idaho's Model Test. Payers have committed to participating in the Model Test by moving their payment methodologies towards value-based payment. These new payment models will vary by payer). At the individual payer level, a key component of this work will be ongoing fraud and abuse prevention, detection, and correction activities.

Primary care provider use of the medical information exchange adds an additional layer of review onto payer controls already in place for identifying fraud, waste, and abuse.

To date, Idaho has not identified any existing fraud and abuse protections that may pose barriers to implementing the proposed innovation model. Moving forward, if Idaho does identify any fraud and abuse protections that may pose a barrier to the Model Test, Idaho will plan to obtain necessary waivers from the Office of the Inspector General and CMS.

#### PCMH and Virtual PCMH Incentive Payment Controls

The PCMH Contractor, Brilljent, and the PCMH Incentives Subcontractor, Myers and Stauffer, have considerable experience in fraud and abuse detection and prevention. To ensure that incentive payments are used by PCMHs and Virtual PCMHs in accordance with funding conditions, the Brilljent and Myers and Stauffer team will develop a plan to monitor, track, prevent, and address, if needed, the improper distribution or expenditure of incentive payments. The Myers and Stauffer team will use an incentive payment accounting system to distribute the incentives to qualifying practices. IDHW and IHC will review and approve the plan before implementation. The Myers and Stauffer team will have primary responsibility for implementing program controls to ensure the right incentives are distributed to qualifying practices in a timely manner and for the appropriate activities. They will also be responsible for identifying issues or potential red flags related to the incentive payments.

## 4. Appendix A: Core Metrics and Accountability Targets

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Screening for clinical depression.	TBD in Model Test Year 1	Annual	Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	TBD in Model Test Year 1	CMMI Numerator	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	16 ,17	TBD in Model Test Year 1			

<sup>16</sup> During the Model Design phase, IDHW and stakeholders developed a set of clinical metrics (the Initial Core Performance Measurement Catalog) that reflect population health improvement priorities of importance and value to Idaho. Payers have committed to contributing data on these metrics in support of the Model Test. During Model Test Year 1, IDHW, the Clinical Quality Workgroup and the HIT Workgroup will identify the data pathways to set a baseline for each metric; these data pathways will also be leveraged moving forward for ongoing data reporting. IDHW, the Clinical Quality Workgroup and the HIT Workgroup will also develop annual target goals for each metric starting in January 2016.

<sup>17</sup> The denominators for the Initial Core Performance Measurement Catalog reflect Idaho’s vision for improving quality of care through the PCMH model. The target population for each measure will be the target number of enrollees in PCMHs participating in the Model Test.

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Measure pair: (a.) Tobacco use assessment. (b.) Tobacco cessation intervention (SIM).	TBD in Model Test Year 1	Annual	a. Percentage of patients who were queried about tobacco use one or more times during the two-year measurement period. b. Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.	TBD in Model Test Year 1	CMMI Numerator	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Asthma ED visits.	TBD in Model Test Year 1	Annual	Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Acute care hospitalization (risk-adjusted).	TBD in Model Test Year 1	Annual	Percentage of patients who had to be admitted to the hospital.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Readmission rate within 30 days.	TBD in Model Test Year 1	Annual	Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Avoidable emergency care without hospitalization (risk-adjusted).	TBD in Model Test Year 1	Annual	Percentage of patients who had avoidable use of a hospital ED.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Elective delivery.	TBD in Model Test Year 1	Annual	Rate of babies electively delivered before full-term.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Low birth weight rate (PQI 9).	TBD in Model Test Year 1	Annual	This measure is used to assess the number of low birth weight infants per 100 births.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Adherence to antipsychotics for individuals with psychotic diagnoses.	TBD in Model Test Year 1	Annual	The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Weight assessment and counseling for children and adolescents.	TBD in Model Test Year 1	Annual	Percentage of children, 2–17 years of age, whose weight is classified based on BMI, who receive counseling for nutrition and physical activity.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Comprehensive diabetes care	TBD in Model Test Year 1	Annual	The percentage of patients 18–75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Access to care.	TBD in Model Test Year 1	Annual	Members report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Childhood immunization status.	TBD in Model Test Year 1	Annual	Percentage of children two years of age who had four DtaP/DT, three IPV, one MMR, three H influenza type B, three Hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Adult BMI assessment.	TBD in Model Test Year 1	Annual	Percentage of members 18–74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Non-malignant opioid use.	TBD in Model Test Year 1	Annual	Percentage of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	TBD in Model Test Year 1	TBD in Model Test Year 1	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Hospital Consumer Assessment of Health Care Providers and Systems Survey (HCAHPS).	TBD in Model Test Year 1	Annual	<p>The HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS, also known as the CAHPS® Hospital Survey, is a 32-item survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.</p> <p>This measure captures patient ratings of health systems and providers across a number of areas. A commonly reported summary measure is the percentage of survey respondents rating their hospital a 9 or 10 on a scale of 0 to 10 (10 being best).</p>	TBD in Model Test Year 1	CMMI Numerator	825,000	Model Test PCMH enrollees	Outcome	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Controlling high blood pressure.	TBD in Model Test Year 1	Annual	Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	TBD in Model Test Year 1	CMMI Numerator	825,000	Model Test PCMH enrollees	Process	Percentage	Clinical	TBD	None	TBD in Model Test Year 1			
Goal 1: PCMH interest application.	IDHW	Quarterly	CUM # (%) of primary care practices that submit an interest application to become a PCMH.	0	Primary care practices that submit an interest application	270 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	100 (37%)	200 (74%)	270 (100%)	270 (100%)
Goal 1: PCMH readiness assessment.	PCMH Contractor	Quarterly	CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation.	0	Designated PCMHs that have completed a PCMH readiness assessment and goals for transformation	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 1: Designated PCMHs (of target).	PCMH Contractor	Quarterly	CUM # (%) of targeted practices designated as PCMH.	0	Practices designated PCMH	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 1: Designated PCMHs (of total primary care practices).	Numerator: PCMH Contractor, Denominator: Idaho Medicaid, Idaho Medical Association, Idaho Academy of Family Physicians.	Quarterly	CUM # (%) of total primary care practices in Idaho designated as PCMH.	0	Practices designated PCMH	500 (estimate of total primary care practices in Idaho)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (11%)	110 (22%)	165 (33%)
Goal 1: Providers in designated PCMHs (of target).	PCMH Interest Application	Quarterly	CUM # (%) of targeted providers participating in designated PCMHs.	0	Providers in designated PCMHs. Providers = staff employed at/represented by PCMHs, including licensed clinicians, other licensed professionals and allied health professionals	1,650 (estimate of total number of providers in 165 PCMHs)	Providers	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	550 (33%)	1110 (67%)	1650 (100%)

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 1: Providers in designated PCMHs (of total providers).	PCMH Interest Application	Quarterly	CUM # (%) of providers in primary care practices in Idaho participating in designated PCMHs.	0	Providers in designated PCMHs. Providers = staff employed at/represented by PCMHs, including licensed clinicians, other licensed professionals and allied health professionals	5,000 (estimate of total number of providers in primary care practices in Idaho)	Providers	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	550 (11%)	1110 (22%)	1650 (33%)
Goal 1: PCMHs receiving technical support and incentives.	PCMH Contractor	Quarterly	CUM # (%) of PCMHs receiving technical support and transformation incentives.	0	PCMHs receiving technical support and transformation incentives	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 1: PCMHs achieving national PCMH recognition/accreditation.	PCMH Contractor	Quarterly	CUM # (%) of designated PCMHs that have achieved Idaho-specific or national PCMH recognition/accreditation.	0	PCMHs that achieve national PCMH recognition/accreditation	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	18 (11%)	30 (18%)	100 (61%)	165 (100%)
Goal 1: Idahoans enrolled in a designated PCMH (of total state population).	PCMHs	Quarterly	CUM # (%) of Idahoans who enroll in a designated PCMH (of total state population).	0	Idahoans enrolled in a designated PCMH	1.634 million (total state population in 2014)	Statewide population	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	275,000 (17%)	550,000 (34%)	825,000 (50.5%)

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 1: Idahoans enrolled in a designated PCMH (of target population).	PCMHs	Quarterly	CUM # (%) of targeted population who enroll in a designated PCMH (of target population).	0	Idahoans enrolled in a designated PCMH	825,000 (estimated members in 165 PCMHs)	Target population	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Goal 1: PCMH patients who are active participants in their healthcare.	PCMHs	Quarterly	CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	0	TBD	TBD	Target population	Structure	Count/Percentage	Performance	N/A	None	TBD	TBD	TBD	TBD
Goal 2: PCMHs with active EHRs.	PCMHs	Quarterly	CUM # (%) of designated PCMHs (sites) with EHR systems that support HIE connectivity.	0	PCMHs with EHR connectivity	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	18	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 2: PCMH members with EHRs.	PCMHs	Quarterly	CUM # (%) of patients in designated PCMHs (sites) that have an EHR.	0	PCMH members with EHRs	825,000 (estimated members in 165 PCMHs)	Target population	Structure	Count/Percentage	Performance	N/A	19	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Goal 2: PCMHs connected to IHDE and utilizing the clinical portal.	IHDE	Annual	CUM # (%) of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.	0	PCMHs that sent/received IHDE transactions for the purpose of care coordination	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	20	0 (0%)	55 (33%)	110 (67%)	165 (100%)

<sup>18</sup> Will also be tracked in Goal 1

<sup>19</sup> Will also be tracked in Goal 1

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Goal 2: Hospitals connected to IHDE.	IHDE	Quarterly	CUM # (%) of hospitals connected to the IHDE.		Hospitals that are connected to the IHDE	21 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	15 (71%)	18 (86%)	21 (100%)
Goal 2: Hospitals providing information to PCMHs.	IHDE	Quarterly	CUM # (%) of hospitals connected to IHDE that provide information on PCMH enrolled patients.		Hospitals sending transactions via the IHDE	21 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	15 (71%)	18 (86%)	21 (100%)
Goal 3: Established/operational RCs.	IDHW	Quarterly	CUM # (%) of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.	0	PHDs that have established RCs	7	PHDs	Structure	Count/Percentage	Performance	N/A	None	7 (100%)	7 (100%)	7 (100%)	7 (100%)
Goal 3: PCMHs receiving assistance through an RC.	RCs	Quarterly	CUM # (%) of designated PCMHs and primary care practices that can receive assistance through an RC.	0	PCMHs that received communication from RC about how to get assistance	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)

<sup>20</sup> Will also be tracked in Goal 1

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 3: PCMHs using protocols with Medical/Health Neighborhood providers, including hospitals.	PCMH Contractor	Quarterly	CUM # (%) of designated PCMHs who have established protocols for referrals and follow up communications with service providers in their Medical/Health Neighborhood.	0	PCMHs using protocols for referrals and follow up	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 3: Patients with coordinated health needs.	TBD in Model Test Year 1	Quarterly	CUM # (%) of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood, as needed.	0	Patients in PCMHs whose health needs are coordinated	825,000 (estimated members in 165 PCMHs)	Target population	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Goal 4: Established Virtual PCMHs.	IDHW	Quarterly	CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	0	Established virtual PCMHs	50 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	15 (30%)	30 (60%)	50 (100%)
Goal 4: Established CEMS programs.	IDHW	Quarterly	CUM # (%) of regional CEMS programs established.	0	Established CEMS programs	16 (Model Test target)	CEMS programs	Structure	Count/Percentage	Performance	N/A	None	1 (6.25%)	6 (38%)	11 (69%)	16 (100%)
Goal 4: Trained CEMS personnel.	IDHW	Quarterly	CUM # (%) of CEMS program personnel trained for Virtual PCMH coordination.	0	Trained CEMS program personnel	52 (Model Test target)	Providers	Structure	Count/Percentage	Performance	N/A	None	2 (4%)	16 (31%)	38 (73%)	52 (100%)

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Goal 4: New trained CHWs.	IDHW	Quarterly	CUM # (%) of new CHWs trained for Virtual PCMH coordination.	0	Trained CHWs	200 (Model Test target)	Providers	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	50 (25%)	125 (63%)	200 (100%)
Goal 4: Continuing education for CHWs and CHEMS.	IDHW	Quarterly	CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff.	0	Continuing education conferences	2 continuing education conferences (Model Test target)	Continuing education conferences	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	0 (0%)	1 (50%)	2 (100%)
Goal 4: Virtual PCMH use of telehealth.	IDHW	Quarterly	CUM # (%) of designated Virtual PCMHs that routinely use telehealth tools to provide specialty and behavioral health services to rural patients.	0	Virtual PCMHs using telehealth tools to provide specialty and behavioral health services	36 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	12 (33%)	24 (67%)	36 (100%)
Goal 5: PCMHs with access to the analytics system.	PCMH reporting (or Data Analytics Subcontractor reporting)	Quarterly	CUM # (%) of designated PCMH (sites) with access from the Data Analytics Vendor to the analytics system that provides dashboards and reporting.	0	PCMHs that have access to data analytics system	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 5: PCMH quality measure reporting.	Data Analytics Subcontractor reporting	Quarterly	CUM # (%) of quality measures that are reported by all designated PCMHs.	0	PCMHs that report identified measures	16 (Model Test target)	Quality measures	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	4 (25%)	10 (63%)	16 (100%)

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 5: PCMHs that receive community health needs assessment results.	PCMH reporting (or RC reporting)	Quarterly	CUM # (%) of designated PCMHs (sites) that receive community health needs assessment results from an RC.	0	PCMHs that receive results from an RC	165 (Model Test target)	Provider organizations	Structure	Count/Percentage	Performance	N/A	21	0 (0%)	55 (33%)	110 (67%)	165 (100%)
Goal 6: Payer adoption of new reimbursement models.	Payers	Annual	CUM # (%) of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.		Payers that adopt new reimbursement models	4 (Model Test target)	Payers	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	4 (100%)	4 (100%)	4 (100%)
Goal 6: Providers participating in value-based purchasing and alternative payment models.	Payers	Annual	CUM # (%) of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements.		Providers participating in any value-based purchasing and alternative payment model	Total number of providers in the State	Providers	Structure	Count/Percentage	Performance	N/A	None	TBD	TBD	TBD	TBD

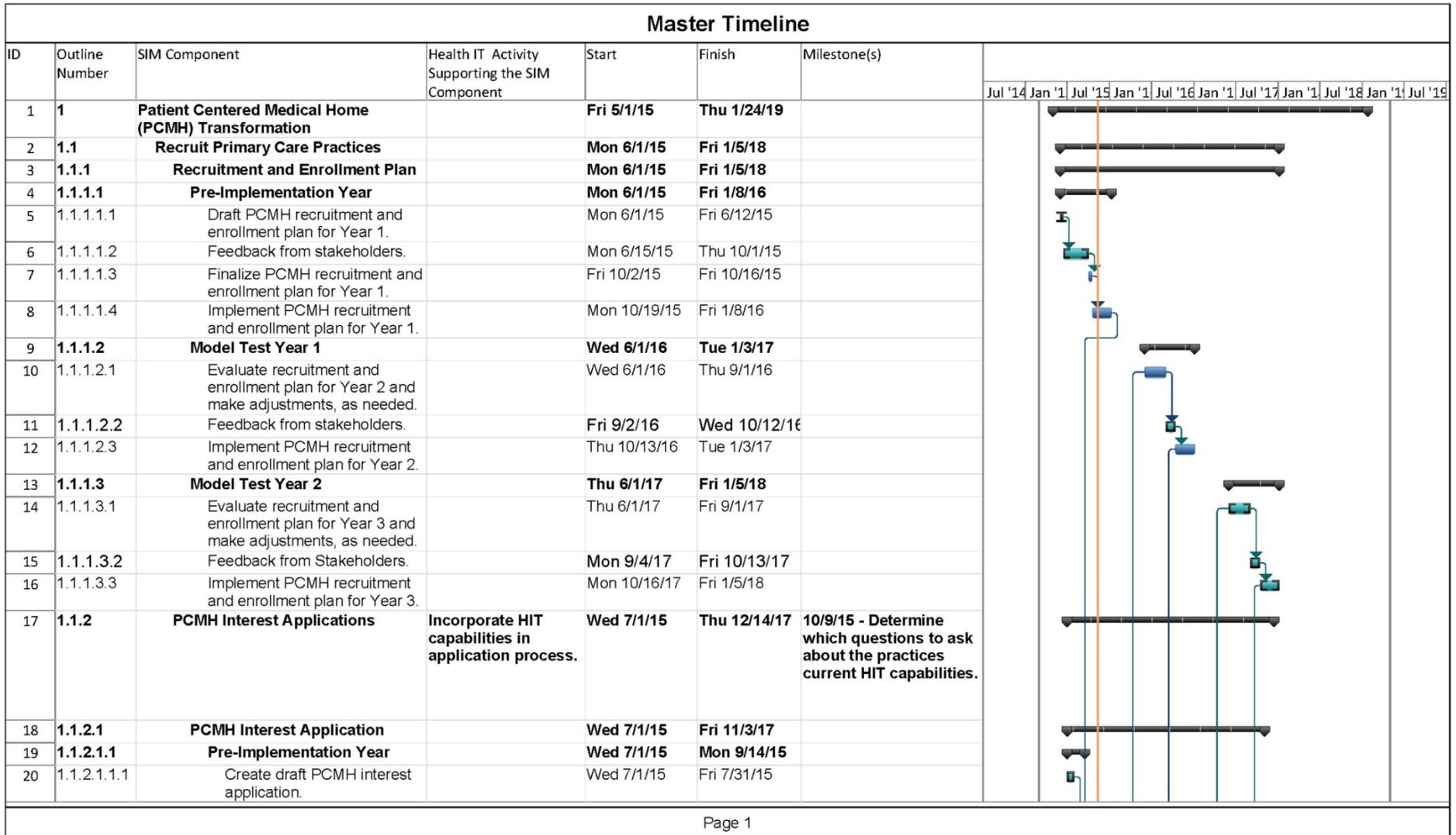
<sup>21</sup> Will also be tracked in Goal 1

Metric Title	Data Source	Reporting Frequency (How often will the data be submitted to CMMI? Quarterly, Annual, Biannual)	Definition	Baseline	Numerator Definition	Denominator Definition	Measure Population (e.g., Statewide Population, Providers, Patient Group)	Measure Type (Process, Outcome, Structure, Balance, Composite)	Measure Value/Record Type (Currency, Percentage, Binary (Y/N), Date, Count)	Measure Group (Performance, Clinical, Cost/Utilization)	National Quality Strategy Priority Area	Notes	Target Goal by end of Project Year 1	Target Goal by end of Project Year 2	Target Goal by end of Project Year 3	Target Goal by end of Project Period (January 2019)
Goal 6: Individuals receiving care through value-based purchasing and alternative payment models.	Payers	Annual	CUM # (%) of beneficiaries attributed to all providers for purposes of alternative reimbursement payments.		Beneficiaries (individuals) receiving care through any value-based purchasing and alternative payment model	Total State population	PCMH enrollees	Structure	Count/Percentage	Performance	N/A	None	0 (0%)	275,000 (33%)	550,000 (67%)	825,000 (100%)
Goal 6: Percentage of non-FFS payments	Payers	Annual	Percentage of payments made in non-FFS arrangements compared to total payments made.		Total dollar amount of payments made in non-FFS arrangements	Total dollar amount of all payments made	Payments	Structure	Percentage	Performance	N/A	None	10%	20%	50%	80%
Goal 7: PMPM cost.	Mercer	Annual	Total population-based PMPM index, defined as the total cost of care divided by the population risk score.		Total cost of care	Population risk score	PMPM index	Structure	Index	Cost/Utilization	N/A	None	TBD	TBD	TBD	TBD
Goal 7: Return on investment (ROI).	Mercer	Annual	Annual financial analysis indicates cost savings and positive ROI. Target ROI is 197%.		Total cost savings	Annual SIM Model Test award amount	ROI	Structure	Percentage	Cost/Utilization	N/A	None	TBD	TBD	TBD	197%

## 5. Appendix B: Master Timeline for SIM

Below is the legend that accompanies the timeline in the following pages. Key milestones are highlighted in yellow.

Idaho SIM Master Project Management Plan & Timeline	Task		External Tasks		Manual Task		Finish-only	
	Split		External Milestone		Duration-only		Deadline	
	Milestone		Inactive Task		Manual Summary Rollup		Progress	
	Summary		Inactive Milestone		Manual Summary			
	Project Summary		Inactive Summary		Start-only			



Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
21	1.1.2.1.1.2	Approve PCMH interest application.		Fri 7/31/15	Fri 7/31/15	
22	1.1.2.1.1.3	Send PCMH interest applications to practices.		Mon 8/3/15	Mon 8/3/15	
23	1.1.2.1.1.4	Primary care practices submit PCMH interest application for Model Test Year 1 cohort.		Mon 8/3/15	Mon 9/14/15	
24	<b>1.1.2.1.2</b>	<b>Model Test Year 2</b>		<b>Wed 6/1/16</b>	<b>Wed 11/2/16</b>	
25	1.1.2.1.2.1	Determine whether/how the PCMH interest application will be used.		Wed 6/1/16	Thu 9/1/16	
26	1.1.2.1.2.2	Implement interest application, as appropriate.		Thu 10/13/16	Wed 11/2/16	
27	<b>1.1.2.1.3</b>	<b>Model Test Year 3</b>		<b>Thu 6/1/17</b>	<b>Fri 11/3/17</b>	
28	1.1.2.1.3.1	Determine whether/how the PCMH interest application will be used.		Thu 6/1/17	Fri 9/1/17	
29	1.1.2.1.3.2	Implement interest application, as appropriate.		Mon 10/16/17	Fri 11/3/17	
30	<b>1.1.2.2</b>	<b>PCMH Application</b>		<b>Tue 9/1/15</b>	<b>Thu 12/14/17</b>	
31	1.1.2.2.1	Create draft PCMH application.		Tue 9/1/15	Fri 10/9/15	
32	1.1.2.2.2	Incorporate IMHC feedback on PCMH application.		Mon 10/5/15	Fri 10/9/15	
33	1.1.2.2.3	Approve PCMH application.		Wed 10/14/15	Wed 10/14/15	
34	1.1.2.2.4	Create online application.		Thu 10/15/15	Thu 11/5/15	
35	1.1.2.2.5	Primary care practices submit PCMH application for Model Test Year 1 cohort.		Fri 11/6/15	Mon 11/30/15	
36	<b>1.1.2.2.6</b>	<b>Model Test Year 2</b>		<b>Thu 11/3/16</b>	<b>Mon 12/5/16</b>	
37	1.1.2.2.6.1	Primary care practices submit PCMH application for Model Test Year 2 cohort.		Thu 11/3/16	Mon 12/5/16	
38	<b>1.1.2.2.7</b>	<b>Model Test Year 3</b>		<b>Mon 11/13/17</b>	<b>Thu 12/14/17</b>	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
39	1.1.2.2.7.1	Primary care practices submit PCMH application for Model Test Year 3 cohort.		Mon 11/13/17	Thu 12/14/17	
40	1.2	<b>Select and Enroll Primary Care Practices</b>		Fri 5/1/15	Thu 1/24/19	
41	1.2.1	<b>Develop PCMH Designation Criteria</b>	<b>Incorporate HIT requirements in designation process.</b>	Mon 6/1/15	Wed 10/14/15	10/14/15 - Establish HIT requirements that must be met to be designated as a PCMH in Idaho.
42	1.2.1.1	Develop draft PCMH designation criteria.		Mon 6/1/15	Wed 10/14/15	
43	1.2.1.2	Approve PCMH designation criteria.		Wed 10/14/15	Wed 10/14/15	
44	1.2.2	<b>Hire a PCMH Contractor</b>		Fri 5/1/15	Thu 12/3/15	
45	1.2.2.1	Publish RFP.		Fri 5/1/15	Sun 5/31/15	
46	1.2.2.2	Select finalist.		Mon 6/1/15	Mon 8/31/15	
47	1.2.2.3	Federal approval of contract.		Tue 9/1/15	Thu 10/15/15	
48	1.2.2.4	Contract start date.		Tue 10/20/15	Tue 10/20/15	
49	1.2.2.5	<b>Regular PCMH Project Management Reports</b>		Wed 11/4/15	Thu 12/3/15	
50	1.2.2.5.1	Develop schedule, metrics, and format of regular reports.		Wed 11/4/15	Wed 12/2/15	
51	1.2.2.5.2	Approve schedule, metrics, and format of regular reports.		Wed 11/4/15	Wed 12/2/15	
52	1.2.2.5.3	Begin submitting regular reports to Idaho Department of Health and Welfare (IDHW).		Thu 12/3/15	Thu 12/3/15	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
53	1.2.3	<b>PCMH Readiness Assessment</b>	<b>Assess PCMHs against HIT requirements.</b>	Wed 11/4/15	Thu 1/25/18	11/30/15 - Identify activities to assess PCMH readiness as it pertains to HIT.
54	1.2.3.1	<b>Readiness Assessment for Model Test Year 1 Cohort</b>		Wed 11/4/15	Thu 1/28/16	
55	1.2.3.1.1	Develop readiness assessment process and tools.		Wed 11/4/15	Wed 12/2/15	
56	1.2.3.1.2	Approve readiness assessment process and tools.		Thu 12/17/15	Thu 12/17/15	
57	1.2.3.1.3	Conduct readiness assessment.		Fri 12/18/15	Thu 1/28/16	
58	1.2.3.2	<b>Readiness Assessment for Model Test Year 2 Cohort</b>		Tue 10/25/16	Tue 1/31/17	
59	1.2.3.2.1	Revise readiness assessment, as appropriate.		Tue 10/25/16	Wed 12/7/16	
60	1.2.3.2.2	Conduct readiness assessment.		Thu 12/8/16	Tue 1/31/17	
61	1.2.3.3	<b>Readiness Assessment for Model Test Year 3 Cohort</b>		Fri 11/3/17	Thu 1/25/18	
62	1.2.3.3.1	Revise readiness assessment, as appropriate.		Fri 11/3/17	Thu 11/30/17	
63	1.2.3.3.2	Conduct readiness assessment.		Fri 12/1/17	Thu 1/25/18	
64	1.2.4	<b>Select and Enroll Primary Care Practices</b>		Wed 12/2/15	Thu 1/24/19	
65	1.2.4.1	<b>Model Test Year 1 Cohort</b>		Wed 12/2/15	Wed 1/18/17	
66	1.2.4.1.1	Identify first cohort of clinics for enrollment in the State Innovation Model (SIM) Model Test.		Wed 12/2/15	Thu 12/10/15	
67	1.2.4.1.2	Review results of readiness assessment.		Fri 12/18/15	Wed 1/20/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
68	1.2.4.1.3	Designate primary care practices using PCMH criteria for Model Test Year 1.		Thu 1/21/16	Wed 1/18/17	2/1/2016 - Public announcement of selection.
69	1.2.4.1.4	Generate list of designated PCMHs and submit to IDHW.		Thu 1/21/16	Wed 1/18/17	
70	<b>1.2.4.2</b>	<b>Model Test Year 2 Cohort</b>		<b>Wed 11/30/16</b>	<b>Wed 1/24/18</b>	
71	1.2.4.2.1	Identify second cohort of clinics for enrollment in the SIM Model Test.		Wed 11/30/16	Thu 12/8/16	
72	1.2.4.2.2	Review results of readiness assessment.		Thu 12/8/16	Tue 1/24/17	
73	1.2.4.2.3	Designate primary care practices using PCMH criteria for Model Test Year 2.		Wed 1/25/17	Wed 1/24/18	2/1/2017 - Public announcement of selection.
74	1.2.4.2.4	Generate list of designated PCMHs and submit to IDHW.		Wed 1/25/17	Wed 1/24/18	
75	<b>1.2.4.3</b>	<b>Model Test Year 3 Cohort</b>		<b>Fri 12/1/17</b>	<b>Thu 1/24/19</b>	
76	1.2.4.3.1	Identify third cohort of clinics for enrollment in the SIM Model Test.		Tue 12/5/17	Wed 12/13/17	
77	1.2.4.3.2	Review results of readiness assessment.		Fri 12/1/17	Wed 1/24/18	
78	1.2.4.3.3	Designate primary care practices using PCMH criteria for Model Test Year 3.		Thu 1/25/18	Thu 1/24/19	2/1/2018 - Public announcement of selection.
79	1.2.4.3.4	Generate list of designated PCMHs and submit to IDHW.		Thu 1/25/18	Thu 1/24/19	
80	<b>1.3</b>	<b>Technical Assistance and Incentives for Primary Care Practices</b>	<b>Provide technical assistance to PCMHs.</b>	<b>Tue 10/20/15</b>	<b>Mon 12/31/18</b>	<b>1/15/16 - Determine the type of HIT-related technical assistance will be provided to practices.</b>
81	<b>1.3.1</b>	<b>Financial Incentives Distribution</b>		<b>Tue 11/3/15</b>	<b>Mon 12/31/18</b>	
82	<b>1.3.1.1</b>	<b>Model Test Year 1</b>		<b>Tue 11/3/15</b>	<b>Tue 1/31/17</b>	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
83	1.3.1.1.1	Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.		Tue 11/3/15	Wed 12/2/15	
84	1.3.1.1.2	Obtain any necessary approvals of the financial distribution process.		Thu 12/3/15	Sun 1/31/16	
85	1.3.1.1.3	Distribute financial incentives to qualifying practices and implement fraud/abuse protections for Model Test Year 1.		Mon 2/1/16	Tue 1/31/17	
86	<b>1.3.1.2</b>	<b>Model Test Year 2</b>		<b>Wed 11/2/16</b>	<b>Wed 1/31/18</b>	
87	1.3.1.2.1	Revise (as needed for Model Test Year 2) financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections and obtain any necessary approvals.		Wed 11/2/16	Tue 1/31/17	
88	1.3.1.2.2	Distribute financial incentives to qualifying practices and implement fraud/abuse protections for Model Test Year 2.		Thu 2/2/17	Wed 1/31/18	
89	<b>1.3.1.3</b>	<b>Model Test Year 3</b>		<b>Wed 11/1/17</b>	<b>Mon 12/31/18</b>	
90	1.3.1.3.1	Revise (as needed for Model Test Year 3) financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections and obtain any necessary approvals.		Wed 11/1/17	Wed 1/31/18	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
91	1.3.1.3.2	Distribute financial incentives to qualifying practices and implement fraud/abuse protections for Model Test Year 3.		Thu 2/1/18	Mon 12/31/18	
92	<b>1.3.2</b>	<b>Technical Support and Mentoring to PCMH Practices</b>		<b>Tue 10/20/15</b>	<b>Fri 12/14/18</b>	
93	1.3.2.1	Develop methods and tools to provide support and mentoring to PCMH practices in topics related to transformation (PCMH training program).		Tue 10/20/15	Tue 1/19/16	
94	1.3.2.2	Implement digital platform for PCMH transformation support.		Wed 1/20/16	Fri 12/14/18	
95	1.3.2.3	Implement support methods and tools (training program).		Wed 1/20/16	Fri 12/14/18	
96	1.3.2.4	Modify support methods and tools (training program), as needed.		Wed 1/20/16	Fri 12/14/18	
97	<b>1.3.3</b>	<b>Increased Use of Electronic Health Records (EHRs) Among PCMHs</b>		<b>Mon 2/1/16</b>	<b>Mon 12/31/18</b>	
98	1.3.3.1	Provide support to PCMHs to increase use of EHRs and capacity for data collection and analysis.		Mon 2/1/16	Mon 12/31/18	
99	1.3.3.2	Support PCMHs in connecting to Idaho Health Data Exchange (IHDE).		Mon 2/1/16	Mon 12/31/18	
100	<b>2</b>	<b>Develop Health Information Technology (HIT) Infrastructure</b>		<b>Mon 9/28/15</b>	<b>Fri 5/20/16</b>	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
101	2.1	<b>Funding mechanisms are identified and secured to support statewide adoption and use of EHRs by PCMHs and hospitals.</b>	<b>Identify available funding mechanisms to support development and implementation of EHRs.</b>	Fri 1/1/16	Mon 4/11/16	3/28/16 - Execute funding plan.
102	2.1.1	Identify the EHR status of designated PCMHs and hospitals.		Fri 1/1/16	Fri 1/15/16	
103	2.1.2	Identify available funding mechanisms to support development and implementation of EHRs.		Mon 1/11/16	Fri 1/15/16	
104	2.1.3	Determine/document the extent to which potential funding has been secured by designated PCMHs and hospitals.		Mon 1/11/16	Mon 1/25/16	
105	2.1.4	Conduct gap analysis to identify further opportunities for securing funding.		Mon 1/11/16	Mon 2/1/16	
106	2.1.5	Draft plan to close identified gaps.		Tue 2/2/16	Fri 2/12/16	
107	2.1.6	Feedback from stakeholders.		Tue 2/2/16	Mon 2/29/16	
108	2.1.7	Finalize Funding Plan.		Mon 3/7/16	Mon 3/21/16	
109	2.1.8	Execute Funding Plan.		Tue 3/22/16	Mon 3/28/16	
110	2.1.9	Conduct follow-up activities as needed to ensure maximum use of available funding mechanisms.		Tue 3/29/16	Mon 4/11/16	

Master Timeline																						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)	Timeline															
							Jul '14	Jan '15	Jul '15	Jan '16	Jul '16	Jan '17	Jul '17	Jan '18	Jul '18	Jan '19	Jul '19					
111	2.2	<b>Supportive business, clinical, cultural and regulatory environments are addressed, defined and achieved.</b>	<b>Define information and information sources needed to assess progress toward the desired results. Refine Assessment Plan based on stakeholder input.</b>	Mon 1/4/16	Fri 4/29/16	4/29/16 - Execute improvement activities.																
112	2.2.1	Define information and information sources needed to assess progress toward the desired results.		Mon 1/4/16	Fri 1/8/16																	
113	2.2.2	Define and document Assessment Plan.		Mon 1/18/16	Fri 1/22/16																	
114	2.2.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16																	
115	2.2.4	Refine Assessment Plan based on stakeholder input.		Tue 1/26/16	Mon 2/1/16																	
116	2.2.5	Collect information.		Tue 2/2/16	Fri 2/19/16																	
117	2.2.6	Analyze information.		Mon 2/22/16	Mon 2/29/16																	
118	2.2.7	Design results deliverable.		Tue 3/1/16	Mon 3/14/16																	
119	2.2.8	Draft deliverable.		Tue 3/15/16	Mon 3/21/16																	
120	2.2.9	Obtain peer review.		Tue 3/22/16	Mon 3/28/16																	
121	2.2.10	Finalize deliverable.		Tue 3/29/16	Fri 4/15/16																	
122	2.2.11	Identify follow-up activities to improve results, as needed.		Mon 4/18/16	Fri 4/22/16																	
123	2.2.12	Execute improvement activities.		Mon 4/25/16	Fri 4/29/16																	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
124	2.3	<b>Core technical standards and functions are established for EHRs, IHDE data exchange.</b>	<b>Define information and information sources needed to assess progress toward the desired results. Refine Assessment Plan based on stakeholder input.</b>	Fri 1/1/16	Fri 5/6/16	5/6/16 - Execute improvement activities.
125	2.3.1	Define information and information sources needed to assess progress toward the desired results.		Fri 1/1/16	Mon 1/11/16	
126	2.3.2	Define and document Assessment Plan.		Tue 1/12/16	Fri 1/15/16	
127	2.3.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16	
128	2.3.4	Refine Assessment Plan based on stakeholder input.		Tue 1/26/16	Fri 2/5/16	
129	2.3.5	Collect information.		Mon 2/8/16	Fri 2/19/16	
130	2.3.6	Analyze information.		Mon 2/22/16	Mon 2/29/16	
131	2.3.7	Design results deliverable.		Fri 3/4/16	Mon 3/14/16	
132	2.3.8	Draft deliverable.		Tue 3/15/16	Mon 3/28/16	
133	2.3.9	Obtain peer review.		Tue 3/29/16	Mon 4/4/16	
134	2.3.10	Finalize deliverable.		Tue 4/5/16	Fri 4/15/16	
135	2.3.11	Identify follow-up activities to improve results, as needed.		Mon 4/18/16	Fri 4/22/16	
136	2.3.12	Execute improvement activities.		Mon 4/25/16	Fri 5/6/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
137	2.4	<b>Privacy and security protections for health information are in place for the IHDE, PCMHs and its consumer participants.</b>	<b>Define information and information sources needed to assess progress toward the desired results. Refine Assessment Plan based on stakeholder input.</b>	Mon 9/28/15	Fri 4/29/16	10/5/15 - Execute remediation activities to close gaps.
138	2.4.1	Define information and information sources needed to assess progress toward the desired results.		Mon 1/4/16	Fri 1/8/16	
139	2.4.2	Define and document Assessment Plan.		Mon 1/18/16	Fri 1/22/16	
140	2.4.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16	
141	2.4.4	Refine Assessment Plan based on stakeholder input.		Tue 1/26/16	Mon 2/1/16	
142	2.4.5	Collect information.		Tue 2/2/16	Fri 2/19/16	
143	2.4.6	Conduct gap analysis.		Fri 2/26/16	Fri 3/4/16	
144	2.4.7	Identify steps to remediate gaps.		Fri 2/26/16	Fri 3/4/16	
145	2.4.8	Design assessment results deliverable.		Mon 3/7/16	Mon 3/14/16	
146	2.4.9	Draft deliverable.		Tue 3/15/16	Mon 3/28/16	
147	2.4.10	Obtain peer review.		Tue 3/29/16	Fri 4/15/16	
148	2.4.11	Finalize deliverable.		Mon 4/18/16	Fri 4/22/16	
149	2.4.12	Identify remediation activities, as needed.		Mon 4/25/16	Fri 4/29/16	
150	2.4.13	Execute remediation activities to close gaps.		Mon 9/28/15	Mon 10/5/15	



Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
165	2.6	IHDE participants obtain confirmation of EHRs to assure HIT is interoperable.	Define information and information sources needed to assess progress toward the desired results. Refine Assessment Plan based on stakeholder input.	Mon 1/4/16	Mon 5/16/16	5/16/16 - Execute remediation activities to close gaps.
166	2.6.1	Define information and information sources needed to assess progress toward the desired results.		Mon 1/4/16	Fri 1/8/16	
167	2.6.2	Define and document Assessment Plan.		Mon 1/18/16	Fri 1/22/16	
168	2.6.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16	
169	2.6.4	Refine Assessment Plan based on stakeholder input.		Tue 1/26/16	Mon 2/1/16	
170	2.6.5	Collect information.		Tue 2/2/16	Fri 2/19/16	
171	2.6.6	Conduct analysis to identify interoperability gaps.		Fri 2/26/16	Fri 3/4/16	
172	2.6.7	Identify steps to remediate gaps.		Fri 2/26/16	Mon 3/14/16	
173	2.6.8	Design assessment results deliverable.		Mon 3/7/16	Mon 3/14/16	
174	2.6.9	Draft deliverable.		Tue 3/15/16	Mon 3/28/16	
175	2.6.10	Obtain peer review.		Tue 3/29/16	Fri 4/15/16	
176	2.6.11	Finalize deliverable.		Fri 4/15/16	Mon 4/18/16	
177	2.6.12	Identify remediation activities, as needed.		Fri 4/22/16	Fri 4/29/16	
178	2.6.13	Execute remediation activities to close gaps.		Mon 5/2/16	Mon 5/16/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
179	2.7	<b>PCMHs adopt and use EHRs for data exchange with IHDE.</b>	<b>Define information and information sources needed to assess progress toward the desired results (e.g., designated PCMHs with certified EHRs, EHRs in process, and without EHRs, and number of PCMH members who have an EHR). Collect PCMH information each qtr.</b>	Fri 1/1/16	Fri 5/20/16	5/20/16 - Execute remediation activities to close gaps.
180	2.7.1	Define information and information sources needed to assess progress toward the desired results (e.g., designated PCMHs with certified EHRs, EHRs in process, and without EHRs, and number of PCMH members who have an EHR).		Fri 1/1/16	Mon 1/11/16	
181	2.7.2	Define and document Assessment Plan for quarterly monitoring of progress.		Tue 1/12/16	Fri 1/15/16	
182	2.7.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16	
183	2.7.4	Refine Assessment Plan based on stakeholder input.		Tue 1/26/16	Fri 2/5/16	
184	2.7.5	Collect PCMH information each quarter.		Mon 2/8/16	Fri 2/19/16	
185	2.7.6	Conduct analysis to identify gaps.		Mon 2/22/16	Mon 2/29/16	
186	2.7.7	Identify steps to remediate gaps.		Fri 3/4/16	Mon 3/14/16	
187	2.7.8	Design assessment results deliverable.		Tue 3/15/16	Mon 3/28/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
188	2.7.9	Draft deliverable.		Tue 3/29/16	Mon 4/4/16	
189	2.7.10	Obtain peer review.		Tue 4/5/16	Fri 4/15/16	
190	2.7.11	Finalize deliverable.		Mon 4/18/16	Fri 4/22/16	
191	2.7.12	Identify remediation activities, as needed.		Mon 4/25/16	Fri 5/6/16	
192	2.7.13	Execute remediation activities to close gaps.		Mon 5/9/16	Fri 5/20/16	
193	<b>2.8</b>	<b>Hospitals adopt and use EHRs capable of exchanging data with IHDE.</b>	<b>Define information and information sources needed to assess progress toward the desired results (e.g., quarterly list of hospitals with certified EHRs, EHRs in process, and without EHRs). Collect hospital information each quarter.</b>	<b>Mon 1/4/16</b>	<b>Fri 4/22/16</b>	<b>4/22/16 - Execute remediation activities to close gaps.</b>
194	2.8.1	Define information and information sources needed to assess progress toward the desired results (e.g., quarterly list of hospitals with certified EHRs, EHRs in process, and without EHRs).		Mon 1/4/16	Fri 1/8/16	
195	2.8.2	Define and document Assessment Plan for quarterly monitoring of progress.		Mon 1/18/16	Fri 1/22/16	
196	2.8.3	Seek stakeholder feedback.		Mon 1/18/16	Mon 1/25/16	
197	2.8.4	Refine Assessment Plan based on stakeholder input.		Mon 1/25/16	Mon 2/1/16	
198	2.8.5	Collect hospital information each quarter.		Mon 2/1/16	Fri 2/19/16	



Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
218	2.9.12	Identify remediation activities, as needed.		Mon 4/18/16	Fri 4/29/16	
219	2.9.13	Execute remediation activities to close gaps.		Mon 5/2/16	Fri 5/20/16	
220	<b>2.10</b>	<b>Hospitals contract with IHDE.</b>	<b>Define information and information sources needed to assess progress toward the desired results. Collect IHDE hospital contracting information each quarter.</b>	<b>Mon 1/4/16</b>	<b>Mon 5/16/16</b>	<b>5/16/16 - Issue quarterly deliverable comparing progress to quarterly goals.</b>
221	2.10.1	Define information and information sources needed to assess progress toward the desired results.		Mon 1/4/16	Fri 1/8/16	
222	2.10.2	Consult with IHDE and IDHW to determine funding.		Mon 1/18/16	Fri 1/22/16	
223	2.10.3	Assist IHDE in designing draft deliverables, providing support, and consultation.		Mon 1/18/16	Mon 1/25/16	
224	2.10.4	Define and document plan for quarterly monitoring.		Tue 1/26/16	Mon 2/1/16	
225	2.10.5	Seek stakeholder feedback.		Tue 2/2/16	Fri 2/19/16	
226	2.10.6	Refine monitoring plan based on stakeholder input.		Mon 2/29/16	Fri 3/4/16	
227	2.10.7	Collect IHDE hospital contracting information each quarter.		Mon 2/29/16	Mon 3/14/16	
228	2.10.8	Design quarterly monitoring deliverable.		Mon 3/7/16	Mon 3/14/16	
229	2.10.9	Draft deliverable.		Tue 3/15/16	Mon 3/28/16	
230	2.10.10	Obtain peer review.		Tue 3/29/16	Fri 4/15/16	
231	2.10.11	Finalize deliverable design.		Thu 4/14/16	Mon 4/18/16	
232	2.10.12	Conduct quarterly monitoring.		Fri 4/22/16	Fri 4/29/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
233	2.10.13	Issue quarterly deliverable comparing progress to quarterly goals.		Mon 5/2/16	Mon 5/16/16	
234	2.10.14	Identify remediation activities, as needed.		Mon 5/2/16	Fri 5/6/16	
235	2.10.15	Execute remediation activities to close gaps.		Mon 5/9/16	Fri 5/13/16	
236	<b>3</b>	<b>Regional Health Collaboratives (RCs)</b>		<b>Fri 5/1/15</b>	<b>Thu 1/31/19</b>	
237	<b>3.1</b>	<b>Establish RCs</b>		<b>Fri 5/1/15</b>	<b>Fri 4/1/16</b>	
238	3.1.1	Negotiate sub-grant (contracts)		Fri 5/1/15	Tue 6/30/15	
239	3.1.2	Execute contract with seven Public Health Districts (PHDs).		Wed 7/1/15	Fri 7/31/15	7/31/15 - Execute contracts with PHDs.
240	3.1.3	Hire SHIP PHD staff (SHIP Manager, Quality Improvement/Quality Assurance (QI/QA) Specialist).		Mon 8/3/15	Sat 10/31/15	
241	3.1.4	Identify RC Executive Leadership Committee (RCE).		Mon 11/2/15	Mon 11/30/15	
242	3.1.5	Convene RCE.		Mon 11/2/15	Mon 11/30/15	
243	3.1.6	Establish RC general membership.		Tue 12/1/15	Fri 4/1/16	
244	<b>3.2</b>	<b>RCs provide Regional Quality Improvement and Medical/Health Neighborhood Integration Services to PCMHs</b>		<b>Wed 7/1/15</b>	<b>Mon 12/31/18</b>	
245	3.2.1	Define quality improvement and Medical/Health Neighborhood integration services to be provided by RCs.		Wed 7/1/15	Fri 7/31/15	
246	3.2.2	Develop plan (charter) for providing quality improvement and Medical/Health Neighborhood integration services.		Tue 12/1/15	Sun 1/31/16	
247	3.2.3	Implement plan to provide quality improvement and Medical/Health Neighborhood integration services.		Mon 2/1/16	Mon 12/31/18	
248	3.2.4	Submit status report.		Mon 2/1/16	Mon 12/31/18	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
249	<b>3.2.5</b>	<b>Initial Communication from RCs to practices regarding availability of services</b>		<b>Tue 12/1/15</b>	<b>Mon 2/29/16</b>	
250	3.2.5.1	Develop communication.		Tue 12/1/15	Thu 12/31/15	
251	3.2.5.2	Review/revise communication.		Tue 12/1/15	Thu 12/31/15	
252	3.2.5.3	Finalize communication.		Fri 1/1/16	Sun 1/31/16	
253	3.2.5.4	Initial communication with practices.		Mon 2/1/16	Mon 2/29/16	
254	<b>3.3</b>	<b>Evaluation plan to ensure RCs provide regional quality improvement and Medical/Health Neighborhood integration services within service level requirements</b>		<b>Tue 12/1/15</b>	<b>Fri 4/29/16</b>	
255	3.3.1	Develop plan.		Tue 12/1/15	Thu 3/31/16	
256	3.3.2	Review/revise plan.		Tue 12/1/15	Thu 3/31/16	
257	3.3.3	Finalize plan.		Fri 4/1/16	Fri 4/29/16	
258	3.3.4	Implement plan.		Fri 4/29/16	Fri 4/29/16	
259	<b>3.4</b>	<b>Establish Medical/Health Neighborhoods</b>		<b>Sat 8/1/15</b>	<b>Thu 1/31/19</b>	
260	3.4.1	Define Medical/Health Neighborhood.		Sat 8/1/15	Mon 11/30/15	
261	3.4.2	Identify participants in the Medical/Health Neighborhood in each region.		Tue 12/1/15	Tue 5/31/16	
262	3.4.3	Submit list of Medical/Health Neighborhood participants to IDHW.		Wed 6/1/16	Thu 1/31/19	
263	3.4.4	Report to the IHC the status of establishing Medical/Health Neighborhoods.		Tue 12/1/15	Thu 1/31/19	
264	<b>3.5</b>	<b>Sustainability Planning</b>		<b>Wed 6/1/16</b>	<b>Mon 12/3/18</b>	
265	3.5.1	Begin the process of creating a Sustainability Plan.		Wed 6/1/16	Wed 6/1/16	
266	3.5.2	Submit Sustainability Plan.		Mon 12/3/18	Mon 12/3/18	
267	<b>4</b>	<b>Virtual PCMHs</b>		<b>Sat 8/1/15</b>	<b>Wed 2/1/17</b>	
268	<b>4.1</b>	<b>Recruit Virtual PCMHs</b>		<b>Sun 11/1/15</b>	<b>Mon 2/1/16</b>	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
269	4.1.1	<b>Virtual PCMH Requirements, Standards, and Designation Criteria</b>		Sun 11/1/15	Wed 1/13/16	
270	4.1.1.1	Develop requirements, standards, and designation criteria.		Sun 11/1/15	Mon 11/30/15	
271	4.1.1.2	Present to IHC for approval.		Wed 1/13/16	Wed 1/13/16	
272	4.1.2	<b>Virtual PCMH Recruitment Plan</b>		Mon 11/2/15	Mon 2/1/16	
273	4.1.2.1	Collect information to build the Virtual PCMH recruitment plan.		Mon 11/2/15	Fri 11/13/15	
274	4.1.2.2	Draft Virtual PCMH recruitment plan.		Mon 11/2/15	Tue 12/1/15	
275	4.1.2.3	Feedback from stakeholders.		Wed 12/2/15	Fri 1/1/16	
276	4.1.2.4	Finalize Virtual PCMH recruitment plan.		Mon 1/4/16	Fri 1/29/16	
277	4.1.2.5	Implement Virtual PCMH recruitment plan.		Mon 2/1/16	Mon 2/1/16	2/1/16 Implement Virtual PCMH recruitment plan.
278	4.2	<b>Technical Assistance and Incentives for Virtual PCMHs</b>		Mon 11/2/15	Tue 1/31/17	
279	4.2.1	<b>Financial Incentives for Qualifying PCMHs</b>		Mon 11/2/15	Tue 1/31/17	
280	4.2.1.1	Develop financial incentive distribution process, including criteria for practices to receive the incentive and fraud/abuse protections.		Mon 11/2/15	Sun 1/31/16	
281	4.2.1.2	Obtain any necessary approvals of the financial distribution process.		Sun 1/31/16	Sun 1/31/16	
282	4.2.1.3	Complete any logistical steps needed to implement the process.		Tue 1/5/16	Sun 1/31/16	
283	4.2.1.4	Begin distribution of financial incentives.		Tue 2/2/16	Tue 1/31/17	2/2/16 - Begin distribution of financial incentives.

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
284	4.2.2	<b>Virtual PCMH Mentoring Program</b>		Wed 6/1/16	Tue 1/31/17	
285	4.2.2.1	Identify potential mentors.		Wed 6/1/16	Thu 6/30/16	
286	4.2.2.2	Gather program requirements.		Wed 6/1/16	Thu 6/30/16	
287	4.2.2.3	Develop Virtual PCMH mentoring program.		Fri 7/1/16	Mon 1/2/17	
288	4.2.2.4	Comments/feedback on Virtual PCMH peer mentoring program.		Tue 1/3/17	Tue 1/31/17	
289	4.2.2.5	Launch Virtual PCMH mentoring program.		Tue 1/31/17	Tue 1/31/17	1/31/17 - Launch Virtual PCMH mentoring program.
290	4.2.3	<b>Technical Assistance Program</b>				
291	4.2.3.1	Begin developing transformation support program.		Mon 1/4/16	Mon 1/4/16	
292	4.2.3.2	Develop "how-to" guide or coaching manual to address educational needs (ILS).		Tue 1/5/16	Tue 2/2/16	
293	4.2.3.3	Develop "how-to" guide or coaching manual to address educational needs (BLS and ALS).		Mon 1/2/17	Tue 1/31/17	
294	4.3	<b>Virtual PCMH Staff training Program for Community Health Workers (CHW)</b>	<b>Identify required metrics and reporting process.</b>	Sat 8/1/15	Thu 3/10/16	3/10/16 - Identify required metrics and reporting process.
295	4.3.1	Establish CHW workgroup and identify CHW subcommittee leads.		Sat 8/1/15	Mon 8/31/15	
296	4.3.2	Collect best practice resources and policies for program implementation.		Fri 1/1/16	Sun 1/31/16	
297	4.3.3	Identify CHW standards and certification requirements.		Fri 1/1/16	Sun 1/31/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
298	4.3.4	Contract with training vendor to provide CHW trainings.		Mon 2/1/16	Mon 2/29/16	2/29/16 - Contract with training vendor to provide CHW trainings.
299	4.3.5	Identify required metrics and reporting process.		Tue 3/1/16	Thu 3/10/16	
300	4.4	<b>Virtual PCMH Staff Training Program for Community Health EMS (CHEMS) Agencies</b>	<b>Identify required metrics and reporting process.</b>	<b>Sat 8/1/15</b>	<b>Mon 1/2/17</b>	<b>2/29/16 - Identify required metrics and reporting process.</b>
301	4.4.1	Establish CHEMS workgroup and identify CHEMS subcommittee leads.		Sat 8/1/15	Sun 8/30/15	
302	4.4.2	Identify CHEMS standards and certification requirements.		Fri 1/1/16	Sun 1/31/16	
303	4.4.3	Execute contract with training vendor to provide CHEMS trainings.		Fri 1/1/16	Sun 1/31/16	1/31/16 - Execute contract training with vendor to provide CHEMS trainings.
304	4.4.4	Collect best practice resources and policies for program implementation.		Fri 1/1/16	Sun 1/31/16	
305	4.4.5	Identify required metrics and reporting process.		Mon 2/1/16	Mon 2/29/16	
306	4.4.6	Identify CHEMS program for basic life support (BLS) and intermediate life support (ILS) agencies.		Thu 12/1/16	Mon 1/2/17	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
307	4.5	<b>Implement New CHEMS Telehealth Programs</b>	<b>Establish criteria for participation. Procure telehealth equipment.</b>	Mon 2/1/16	Wed 2/1/17	2/1/17 - Telehealth go-live.
308	4.5.1	Establish criteria for participation.		Mon 2/1/16	Wed 3/2/16	
309	4.5.2	Conduct readiness assessment and selection.		Sun 5/1/16	Wed 6/1/16	
310	4.5.3	Write and release RFP.		Mon 8/1/16	Thu 9/1/16	
311	4.5.4	Procure telehealth equipment.		Sat 10/1/16	Tue 1/31/17	
312	4.5.5	Telehealth go-live.		Wed 2/1/17	Wed 2/1/17	2/1/17 - Telehealth go-live
313	4.6	<b>Telehealth Implementation Plan</b>	<b>Research other state telehealth standards. Develop draft telehealth standards.</b>	Tue 9/1/15	Wed 12/2/15	1/31/16 - Finalize telehealth standards.
314	4.6.1	Research other state telehealth standards.		Tue 9/1/15	Thu 10/1/15	
315	4.6.2	Collect input from key stakeholders on draft telehealth standards.		Fri 10/2/15	Mon 11/2/15	
316	4.6.3	Develop draft telehealth standards.		Fri 10/2/15	Mon 11/2/15	
317	4.6.4	Obtain feedback, as needed.		Tue 11/3/15	Wed 12/2/15	
318	4.6.5	Finalize telehealth standards.		Tue 11/3/15	Wed 12/2/15	
319	5	<b>Build Statewide Data Analytics System</b>		Fri 1/1/16	Fri 6/10/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
320	5.1	<b>Reports to analyze quality and cost data. Periodic reporting that compares quality and cost data against a baseline and for each subsequent year throughout the Model Test.</b>	<b>Identify cost and quality performance measures at the patient, regional, and statewide levels (resides in Data Analytics System). Design reports and reporting schedule.</b>	Fri 1/1/16	Fri 4/15/16	3/11/16 - Execute Analytics reports.
321	5.1.1	Identify cost and quality performance measures at the patient, regional, and statewide levels (resides in Data Analytics System).		Fri 1/1/16	Thu 1/7/16	
322	5.1.2	Determine method and process for data collection and collection roles and responsibilities.		Fri 1/1/16	Fri 1/15/16	
323	5.1.3	Test data collection process.		Mon 2/1/16	Mon 2/15/16	
324	5.1.4	Refine process, as necessary.		Tue 2/16/16	Fri 2/19/16	
325	5.1.5	Determine point in time for capturing data.		Mon 2/22/16	Mon 2/29/16	
326	5.1.6	Design reports and reporting schedule.		Mon 3/7/16	Tue 3/15/16	
327	5.1.7	Define plan of action for hospitals/PCMHs that refuse/fail to report data or that report unacceptable levels.		Mon 2/1/16	Tue 3/1/16	
328	5.1.8	Collect data.		Wed 3/2/16	Tue 3/15/16	
329	5.1.9	Execute Analytics reports.		Mon 3/7/16	Fri 3/11/16	
330	5.1.10	Analyze results.		Mon 3/14/16	Fri 3/25/16	
331	5.1.11	Implement plans of action for failure to report data or reporting data that does not meet quality standards, as needed.		Mon 3/28/16	Fri 4/1/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
332	5.1.12	Execute follow up activities, as needed.		Mon 4/4/16	Fri 4/15/16	
333	<b>5.2</b>	<b>Identify ongoing evaluation and tracking of performance metrics for community health needs assessment results to monitor improvement of: care of the patient population at the practice level, population health at the regional level, and overall statewide.</b>	<b>Identify performance metrics for tracking and ongoing evaluation of improvements in patient care, regional population health, and overall statewide performance based on the PCMHs response to community health needs assessment results provided by the RCs.</b>	<b>Mon 1/4/16</b>	<b>Fri 6/10/16</b>	<b>2/19/16 - Establish method for monitoring performance against milestones.</b>
334	5.2.1	Identify performance metrics for tracking and ongoing evaluation of improvements in patient care, regional population health, and overall statewide performance based on the PCMHs response to community health needs assessment results provided by the RCs.		Mon 1/4/16	Fri 1/8/16	
335	5.2.2	Obtain consensus on performance metrics among all SHIP Workgroups.		Mon 1/18/16	Fri 1/22/16	
336	5.2.3	Document performance metrics using Analytics System.		Mon 1/18/16	Mon 1/25/16	
337	5.2.4	Document milestones for Model Test Years 1-3.		Tue 1/26/16	Mon 2/1/16	
338	5.2.5	Establish method for monitoring performance against milestones.		Tue 2/2/16	Fri 2/19/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
339	5.2.6	Define data collection method and collection roles and responsibilities.		Mon 2/29/16	Fri 3/4/16	
340	5.2.7	Test data collection process.		Mon 2/29/16	Mon 3/14/16	
341	5.2.8	Refine process, as necessary.		Mon 3/7/16	Mon 3/14/16	
342	5.2.9	Determine point in time for capturing data.		Tue 3/15/16	Mon 3/28/16	
343	5.2.10	Design report and reporting schedule.		Tue 3/29/16	Fri 4/15/16	
344	5.2.11	Collect data.		Mon 4/18/16	Fri 4/22/16	
345	5.2.12	Execute reports.		Mon 4/18/16	Fri 4/22/16	4/22/16 - Execute reports.
346	5.2.13	Analyze results.		Mon 4/25/16	Fri 4/29/16	
347	5.2.14	Define plan of corrective action for failure to meet established milestone(s).		Mon 5/2/16	Fri 5/6/16	
348	5.2.15	Implement plans of corrective action, as needed.		Mon 5/9/16	Fri 6/10/16	
349	<b>5.3</b>	<b>Ensure Data Analytics Contractor is reaching the contractual and educational access requirements for PCMHs.</b>	<b>Define data collection method and collection roles and responsibilities. Test data collection process.</b>	<b>Mon 1/18/16</b>	<b>Fri 5/20/16</b>	<b>4/22/16 - Execute reports.</b>
350	5.3.1	Identify contractual milestones.		Mon 1/18/16	Fri 1/22/16	
351	5.3.2	Establish method for monitoring the PCMH Contractor performance against milestones.		Mon 1/18/16	Mon 1/25/16	
352	5.3.3	Define data collection method and collection roles and responsibilities.		Tue 1/26/16	Mon 2/1/16	
353	5.3.4	Test data collection process.		Tue 2/2/16	Fri 2/19/16	
354	5.3.5	Refine process, as necessary.		Mon 2/22/16	Mon 2/29/16	
355	5.3.6	Determine point in time for capturing data.		Tue 3/1/16	Mon 3/14/16	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
356	5.3.7	Design report and reporting schedule.		Tue 3/15/16	Mon 3/21/16	
357	5.3.8	Define plan of action for vendor failure to meet contractual milestone(s).		Tue 3/22/16	Mon 3/28/16	
358	5.3.9	Collect data.		Tue 3/29/16	Fri 4/15/16	
359	5.3.10	Execute reports.		Mon 4/18/16	Fri 4/22/16	4/22/16 - Execute reports.
360	5.3.11	Analyze results.		Mon 4/25/16	Fri 4/29/16	
361	5.3.12	Implement plans of action for vendor failure.		Mon 5/9/16	Fri 5/13/16	
362	5.3.13	Execute follow up activities, as needed.		Mon 5/16/16	Fri 5/20/16	
363	<b>6</b>	<b>Test Transformation from FFS to Value-Based Payments</b>		<b>Sun 3/1/15</b>	<b>Thu 2/28/19</b>	
364	<b>6.1</b>	<b>Develop Alternative Payment Methods.</b>	<b>Determine member attribution method. Determine quality measures.</b>	<b>Sun 3/1/15</b>	<b>Mon 8/31/15</b>	<b>2/28/19 - Attribute membership.</b>
365	6.1.1	Determine alternative value based payment methodologies by payer.		Sun 3/1/15	Mon 8/31/15	
366	6.1.2	Determine member attribution method.		Sun 3/1/15	Mon 8/31/15	
367	6.1.3	Determine incentive payments.		Sun 3/1/15	Mon 8/31/15	
368	6.1.4	Determine quality measures.		Sun 3/1/15	Mon 8/31/15	
369	<b>6.2</b>	<b>Contract with PCMHs and primary care providers.</b>		<b>Sun 11/1/15</b>	<b>Thu 1/31/19</b>	
370	6.2.1	Pre-testing phase reporting		Sun 11/1/15	Mon 11/30/15	
371	6.2.2	Year 1		Fri 1/1/16	Sat 1/30/16	
372	6.2.3	Year 2		Sun 1/1/17	Tue 1/31/17	
373	6.2.4	Year 3		Mon 1/1/18	Wed 1/31/18	
374	6.2.5	Year 4		Tue 1/1/19	Thu 1/31/19	
375	<b>6.3</b>	<b>Attribute membership.</b>		<b>Tue 9/1/15</b>	<b>Thu 2/28/19</b>	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
376	6.3.1	Pre-testing phase reporting		Sun 11/1/15	Mon 11/30/15	
377	6.3.2	Year 1		Fri 1/1/16	Sat 1/30/16	
378	6.3.3	Year 2		Sun 1/1/17	Tue 1/31/17	
379	6.3.4	Year 3		Mon 1/1/18	Wed 1/31/18	
380	6.3.5	Year 4		Tue 1/1/19	Thu 1/31/19	
381	6.4	<b>Track and report payments and costs.</b>		<b>Tue 9/1/15</b>	<b>Thu 2/28/19</b>	
382	6.4.1	Pre-testing phase reporting		Sun 11/1/15	Mon 11/30/15	
383	6.4.2	Year 1		Fri 1/1/16	Sat 1/30/16	
384	6.4.3	Year 2		Sun 1/1/17	Tue 1/31/17	
385	6.4.4	Year 3		Mon 1/1/18	Wed 1/31/18	
386	6.4.5	Year 4		Tue 1/1/19	Thu 1/31/19	
387	7	<b>Cost Savings and Return on Investment Model</b>		<b>Mon 6/1/15</b>	<b>Wed 5/1/19</b>	
388	7.1	<b>Create Data Request.</b>	<b>Determine minimum reporting requirements for projections. Create connect site for payers to drop data.</b>	<b>Mon 6/1/15</b>	<b>Wed 5/1/19</b>	<b>9/30/15 - Create connect site for payers to drop data.</b>
389	7.1.1	Determine minimum reporting requirements for projections.		Mon 6/1/15	Fri 7/31/15	
390	7.1.2	Gather data specifications for categories of service.		Wed 7/1/15	Fri 7/31/15	
391	7.1.3	Distribute request and client confidentiality agreements.		Wed 7/1/15	Fri 7/31/15	
392	7.1.4	Legal review of client confidentiality agreement changes.		Wed 7/1/15	Thu 2/28/19	
393	7.1.5	Create connect site for payers to drop data.		Tue 9/1/15	Wed 9/30/15	
394	7.1.6	Find historical data as contingency for Medicare FFS and self-insured data.		Tue 9/1/15	Sat 10/31/15	

Master Timeline						
ID	Outline Number	SIM Component	Health IT Activity Supporting the SIM Component	Start	Finish	Milestone(s)
						Jul '14 Jan '15 Jul '15 Jan '16 Jul '16 Jan '17 Jul '17 Jan '18 Jul '18 Jan '19 Jul '19
395	7.1.7	Create CMS data request for Medicare FFS data.		Wed 7/1/15	Thu 2/28/19	
396	7.1.8	Informatics and legal review of CMS data request.		Tue 9/1/15	Wed 5/1/19	
397	<b>7.2</b>	<b>Create Financial Analysis Report Template.</b>		<b>Tue 9/1/15</b>	<b>Mon 11/30/15</b>	
398	7.2.1	Create Excel template to collect payer data, accumulate it, and calculate base rate PMPMs.		Tue 9/1/15	Sat 10/31/15	
399	7.2.2	Determine trend/CPI to use for projecting data.		Thu 10/1/15	Sat 10/31/15	
400	7.2.3	Verify and update cost saving assumptions.		Tue 9/1/15	Sat 10/31/15	
401	7.2.4	Apply cost savings to intervention model.		Thu 10/1/15	Mon 11/30/15	
402	7.2.5	Compare baseline model to intervention model.		Sun 11/1/15	Mon 11/30/15	
403	7.2.6	Create financial analysis report.		Sun 11/1/15	Mon 11/30/15	11/30/15 - Create financial analysis report.

## 6. Appendix C: SIM Directory

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
<b>Idaho State Staff</b>					
Strategic Direction	IDHW Director	Richard	Armstrong	208-334-5500	ArmstrongR@dhw.idaho.gov
Strategic Direction	IDHW Deputy Director and IHC Co-Chair	Denise	Chuckovich	208-334-5500	ChuckovD@dhw.idaho.gov
Administration	Office of Healthcare Policy Initiatives Administrator	Cynthia	York	208-334-5574	YorkC@dhw.idaho.gov.
Administration	Division of Behavioral Health Administrator, Behavioral Health Integration Workgroup Co-Chair	Ross	Edmunds	208-334-6997	EdmundsR@dhw.idaho.gov
Administration	Division of Medicaid Administrator	Lisa	Hettinger	208-334-5747	HettingL@dhw.idaho.gov
Administration	Division of Public Health Administrator	Elke	Shaw-Tulloch	208-334-6996	Shawe@dhw.idaho.gov
Administration	Office of the Governor, Senior Special Assistant for Health and Social Services	Tammy	Perkins	208-334-2100	Tperkins@gov.idaho.gov
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Goal 1	IDHW Project/Contract Manager - PCMH Transformation	Kymberlee	Schreiber	208-334-5577	SchreiberK@dhw.idaho.gov
Goal 3, Goal 4, Regional Health Collaboratives, CHEMS, CHW	IDHW Project/Contract Manager - Regional Health Collaboratives	Miro	Barac	208-334-5594	BaracM@dhw.idaho.gov
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Grant Management	Grants & Contract Officer	Ann	Watkins	208-334-5579	WatkinsA@dhw.idaho.gov
<b>Key Stakeholders and Advisors</b>					
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HIT and Data Analytics Workgroup	Workgroup Chair, IHDE Executive Director	Scott	Carrell	208-332-7261	Scarrell@idahohde.org

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
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Multi-Payer Workgroup	Workgroup Co-chair	David	Peterman	208-955-6500	David.peterman@primaryhealth.com
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Population Health Workgroup	Workgroup Co-chair	Geri	Rackow	208-522-0310	Grackow@phd7.idaho.gov
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Behavioral Health Integration Workgroup	Workgroup Chair	Ross	Edmunds	208-334-5726	Edmundsr@dhw.idaho.gov
Behavioral Health Integration Workgroup	Workgroup Co-Chair	Charles	Novak	208-863-7284	Sageremindsu@cs.com
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Idaho Medical Home Collaborative (IMHC)	Co-Chair	Lisa	Hettinger	208-364-1804	HettingL@dhw.idaho.gov
Telehealth Council	Telehealth Council Chair	Stacey	Carson	208-489-1401	Scarson@teamiha.org
CHEMS Advisory Group	CHEMS Advisory Group Chair	Miro	Barac	208-334-5594	Baracm@dhw.idaho.gov
CHW Advisory Group	CHW Advisory Group Chair	Ariel	Foster	208-332-7944	Fostera@dhw.idaho.gov
<b>Contractors</b>					
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PCMH Transformation	Health Management Associates (HMA) Lead, PCMH Technical Assistance Subcontractor	Lori	Wieselberg	312-641-5007	Lwieselberg@healthmanagement.com
PCMH Transformation	Myers and Stauffer Lead, PCMH Incentives Subcontractor	Jared	Duzan	317-846-9520	Jduzan@mslc.com
HIT Data Analytics	Data Analytics Contractor	TBD	TBD	TBD	TBD
SIM Model Test Evaluation	State Evaluator	TBD	TBD	TBD	TBD
CHWs and CEMS Staff Training	CHWs and CEMS Staff Training Contractor	TBD	TBD	TBD	TBD

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
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Project Management and Financial Analysis	Senior Associate, Mercer Government Human Services Consulting	Jennifer	Feliciano	954-838-3406	Jennifer.Feliciano@mercer.com
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North Central Public Health District RCE	Co-Chair (RC 2)	Kelly	McGrath	208-476-4555	Kellym@qualishealth.org
North Central Public Health District RCE	Chair (RC 2)	Glenn	Jefferson	208-746-1383	Gjefferson@valleymedicalcenter.com
North Central Public Health District	QA/QI Specialist (Region 2)	TBD	TBD	TBD	TBD
North Central Public Health District	Administrative Assistant (Region 2)	TBD	TBD	TBD	TBD

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
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Central Public Health District RCE	Co-Chair (RC 4)	David	Peterman	208-955-6500	David.peterman@primaryhealth.com
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South Central Public Health District RCE	Chair (RC 5)	Keith	Davis	208-886-2224	Docdavis@shoshone.net
South Central Public Health District RCE	Co-Chair (RC 5)	Steven	Kohtz	208-814-8000	Stevenk@slhs.org
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South Central Public Health District	Administrative Assistant (Region 5)	Jenny	Duff	208-737-5941	Jennydphd5.idaho.gov

SIM Component/Project Area Key Staff Directory					
SIM Component/Project Area	Component/Project Lead			Contact Information	
	Position/Title	First Name	Last Name	Phone Number	Email Address
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Southeastern Public Health District	QA/QI Specialist (Region 6)	TBD	TBD	TBD	TBD
Southeastern Public Health District	Administrative Assistant (Region 6)	TBD	TBD	TBD	TBD
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Eastern Idaho Public Health District RCE	SHIP Manager (Region 7)	James	Corbett	208-533-3195	Jcorbett@eiph.idaho.gov
Eastern Idaho Public Health District RCE	Chair (RC 7)	Boyd	Southwick	208-552-7700	Bsouthw@familyfirstif.com
Eastern Idaho Public Health District RCE	Co-Chair (RC 7)	George	Groberg	208-821-2893	Ggroberg@msn.com
Eastern Idaho Public Health District	QA/QI Specialist (Region 7)	Corinne	Bird	208-533-3191	Cbird@eiph.idaho.gov
Eastern Idaho Public Health District	Administrative Assistant (Region 7)	Emily	Tonks	208-533-3184	Etonks@eiph.idaho.gov

## 7. Appendix D: HIT Plan

# STATEWIDE HEALTHCARE INNOVATION PLAN

## HEALTH INFORMATION TECHNOLOGY PLAN



## IDAHO DEPARTMENT OF HEALTH AND WELFARE

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## Introduction

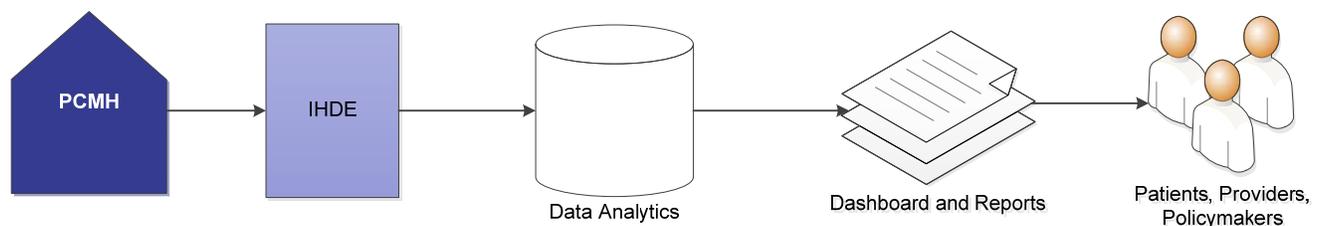
Idaho's Health Information Technology (HIT) Plan seeks to support the implementation of Idaho's State Innovation Model (SIM) Test by building a network of technology at multiple levels of Idaho's healthcare system: electronic health records (EHRs) that collect, store, and transmit health information; the Idaho Health Data Exchange (IHDE) that supports interconnectivity and communication between providers, caregivers, and patients; telehealth services for individuals in remote locations; and a statewide health data analytics system.

By using health information more effectively and efficiently throughout Idaho's health system, HIT has the potential to empower patients and their providers, make healthcare and the health system more transparent, enhance the study of care delivery and payment systems, and drive substantial improvements in care, efficiency, and population health. Details on the core elements of Idaho's HIT Plan in support of the SIM Model Test can be found in Table 24 — Health IT Support for Data/Information for Driver Diagram.

During the SIM Model Design phase, Idaho's stakeholders identified limited opportunities in the existing landscape to coordinate data collection and analysis across payers and populations. These limitations have historically prevented Idaho from fully developing the capacity to organize, collect and analyze statewide data.

Idaho's SIM Model Test HIT Plan provides a pathway to increasing this capacity. The HIT Plan describes how Idaho will build capacity across the system and sets a strong foundation for implementing increasingly robust HIT solutions as the Person Centered Medical Home (PCMH) model evolves. The HIT Plan aims to support a successful PCMH model in Idaho by building a platform for Model Test participants to collect and share data for purposes of patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics.

**Figure 144 — PCMH Data Collection and Use**



Idaho's HIT Plan also promotes the use of advanced health technology, such as telehealth, electronic health records (EHRs), patient portals, and clinical decision support tools to:

1. Reduce barriers to access for those living in rural areas.
2. Improve provider collaboration and coordination.
3. Increase patient engagement.
4. Increase training and specialized care in geographically isolated areas of the State.
5. Provide tools for population health monitoring and management

6. Gather statewide data that informs the activities needed to improve the quality of care, control healthcare costs, and achieve improved health outcomes.

The key components of Idaho's HIT plan are to:

- |  |  |
|--|--|
| <p><b>1. Use technology, such as EHRs and remote patient-based monitoring systems, to coordinate care over time and across settings.</b></p>   | <p>Over the three-year Model Test period, the IHDE will engage 165 PCMH clinic sites statewide to both adopt and use EHR technology and to connect to the IHDE. As the model matures, IDHW and the IHC will determine the most appropriate ongoing HIT infrastructures to provide data aggregation and analytic support to facilitate Idaho's population health management. Idaho's SIM Model Test also supports improving rural patient access to a PCMH by developing 50 virtual PCMHs which includes integrating a component such as telehealth into these practices to support both physical healthcare and the integration of behavioral health and other specialty services.</p>   |
| <p><b>2. Use technology to support maintaining a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations and other providers of services and suppliers.</b></p> | <p>Idaho's seven public health districts (PHDs) will support the Regional Health Collaboratives (RCs), which in turn will support practices as they transform to a PCMH and continue to expand their capabilities. RCs will convene and link PCMHs to the broader Medical/Health Neighborhood to coordinate patient care throughout the provider community. Connectivity via the IHDE for PCMHs, hospitals, and other organizations will allow for rapid electronic exchange of information and facilitates communications that cement lasting relationships among the patient's circle of supports. Under Idaho's SIM Model Test, PCMHs will receive community health needs assessment results from the RCs; these results will help drive healthcare strategic planning within the PCMH and across Idaho's healthcare landscape.</p> |
| <p><b>3. Use technology to enable a team-based approach to interventions, such as comprehensive care assessments, care planning and self-management coaching.</b></p>  | <p>Broad-based care coordination, facilitated by the RCs and PCMHs and realized through HIT, will be essential for improving care quality, reducing errors and redundant services, keeping costs down, and promoting a patient-centric approach to healthcare in Idaho in which the patient is empowered to manage his or her healthcare.</p>  |
| <p><b>4. Use technology to enable service providers and suppliers to share information with</b></p>  | <p>Idaho's first step in setting the technological foundation for coordinating care is the adoption and use of EHRs by 165 PCMHs and 21 hospitals, and ensuring their HIE capability can be leveraged to securely transmit and receive patient information through the IHDE. Over time, as Idaho further defines and develops its HIT</p>  |

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**patients, caregivers, and other service providers on a real-time basis.**

infrastructure, additional users across the Medical/Health Neighborhood, specifically patients, will have access to real-time information sharing.

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**5. Use technology to create an effective link with other public sector or private sector payers.**

RCs in collaboration with Public Health Districts will promote public health campaigns to improve regional population health, such as targeting populations segments susceptible to specific health threats (smoking, diabetes, immunization status, etc.) and promote healthy lifestyles. PCMHs will have access to a statewide data analytics system and will report quality measures related to these and other health issues. In addition to the inherent link with public health, Idaho's HIT plan is designed to provide the data and analytical capability to support provider practices, hospitals (and eventually, other organizations, including private sector payers), in improving care coordination and delivery, exchanging real-time clinical information, and improving population health.

Table 24 — Health IT Support for Data/Information for Driver Diagram

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
1. Screening for clinical depression: Percentage of patients aged 12 years and older screened for clinical depression using a standardized tool and follow-up plan documented.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	Please see Section 2 in this HIT Plan.	O: Patient flows (business operations) at the clinic level are not standardized related to screening and entry of data within EHRs. IT: Health IT interface with IHDE able to transmit specific data elements required to report this metric for the analytic solution.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
2. Measure pair: (a.) Tobacco use assessment (percentage of patients who were queried about tobacco use one or more times during the two-year measurement period), (b.) Tobacco cessation intervention (percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period).	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to cessation intervention and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.
3. Asthma emergency department (ED) visit: Percentage of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
4. Acute care hospitalization (risk-adjusted): Percentage of patients who had to be admitted to the hospital.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
5. Readmission rate within 30 days: Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
6. Avoidable emergency care without hospitalization (risk-adjusted): Percentage of patients who had avoidable use of a hospital ED.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
7. Elective delivery: Rate of babies electively delivered before full-term.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
8. Low birth weight rate (PQI 9): This measure is used to assess the number of low birth weight infants per 100 births.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Vital Statistics and hospitals collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
<p>9. Adherence to antipsychotics for individuals with psychotic diagnoses: The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.</p>	<p>RCs, PCMHs, State, patients, payers, and the Centers for Medicare &amp; Medicaid Innovation (CMMI).</p>	<p>Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.</p>	<p>O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.</p>	<p>N/A</p>	<p>O: Patient flows (business operations) at the clinic level are not standardized related to medication compliance and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.</p>

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
10. Weight assessment and counseling for children and adolescents: Percentage of children, 2–17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to counseling for nutrition and physical services and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
<p>11. Comprehensive diabetes care (SIM): The percentage of patients 18–75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c&lt;8.0%, LDL&lt;100 mg/dL, blood pressure&lt;140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.</p>	<p>RCs, PCMHs, State, patients, payers, and the Centers for Medicare &amp; Medicaid Innovation (CMMI).</p>	<p>Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.</p>	<p>O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.</p>	<p>N/A</p>	<p>O: Patient flows (business operations) at the clinic level are not standardized related to comprehensive care intervention and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.</p>

<p><b>Metric: What data will be used to track progress (how much and by when)?</b></p>	<p><b>Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.</b></p>	<p><b>What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?</b></p>	<p><b>What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?</b></p>	<p><b>Identify and explain policy levers that will be used (if applicable).</b></p>	<p><b>Identify challenges &amp; additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.</b></p>
<p>12. Access to care: Members report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).</p>	<p>RCs, PCMHs, State, patients, payers, and the Centers for Medicare &amp; Medicaid Innovation (CMMI).</p>	<p>Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.</p>	<p>O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.</p>	<p>N/A</p>	<p>P: Standardized methodology for collecting data that has been set by a statewide level entity. IT: Data collection mechanisms and pathways to the exchange O: Impact to the practice level for implementing methodology.</p>

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
<p>13. Childhood immunization status: Percentage of children two years of age who have had four DtaP/DT, three IPV, one MMR, three H influenza type B, three Hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.</p>	<p>RCs, PCMHs, State, patients, payers, and the Centers for Medicare &amp; Medicaid Innovation (CMMI).</p>	<p>Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.</p>	<p>O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.</p>	<p>N/A</p>	<p>O: Patient flows (business operations) at the clinic level are not standardized related to childhood immunization status and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.</p>

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
14. Adult BMI assessment: Percentage of members 18–74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to BMI assessment and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
15. Non-malignant opioid use: Percentage of patients chronically prescribed an opioid medication for non-cancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually).	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to non-malignant opioid use and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
<p>16. Hospital Consumer Assessment of Health Care Providers and Systems Survey (HCAHPS): The HCAHPS is a national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS, also known as the CAHPS® Hospital Survey, is a 32-item survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. This measure captures patient ratings of health systems and providers across a number of areas. A commonly reported summary measure is the percentage of survey respondents rating their hospital a 9 or 10 on a scale of 0 to 10 (10 being best).</p>	<p>RCs, PCMHs, State, patients, payers, and the Centers for Medicare &amp; Medicaid Innovation (CMMI).</p>	<p>Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.</p>	<p>O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.</p>	<p>N/A</p>	<p>N/A</p>

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
17. Controlling high blood pressure: Percentage of patients 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and IDHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to controlling high blood pressure and entry of data within EHRs. Health IT will interface with IHDE to report this metric for the analytic solution.
18. Goal 1: PCMH interest application: Cumulative (CUM) # (%) of primary care practices that submit an interest application to become a PCMH.	PCMH Contractor, State, and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
19. Goal 1: PCMH readiness assessment: CUM # (%) designated PCMHs that have completed a PCMH readiness assessment and goals for transformation.	PCMH Contractor, State, and CMS.	N/A	N/A	N/A	N/A
20. Goal 1: Designated PCMHs (of target): CUM # (%) of targeted practices designated as PCMH.	PCMH Contractor, State, and CMS.	N/A	N/A	N/A	N/A
21. Goal 1: Designated PCMHs (of total primary care practices): CUM # (%) of total primary care practices in Idaho designated as PCMH.	State and CMS.	N/A	N/A	N/A	N/A
22. Goal 1: Providers in designated PCMHs (of target): CUM # (%) of targeted providers participating in designated PCMHs.	State and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
23. Goal 1: Providers in designated PCMHs (of total providers): CUM # (%) of providers in primary care practices in Idaho participating in designated PCMHs.	State and CMS.	N/A	N/A	N/A	N/A
24. Goal 1: PCMHs receiving technical support and incentives: CUM # (%) of PCMHs receiving technical support and transformation incentives.	PCMH Contractor, State, and CMS.	IPASS database will be used to track incentives.	O: Establish process for tracking incentives. IT: Develop database.	N/A	IT: Building the Idaho portal and database that will track and monitor incentives. O: Roll-out and training PCMH participant and program staff on the use of the system
25. Goal 1: PCMHs achieving national PCMH recognition/accreditation: CUM # (%) of designated PCMHs that have achieved Idaho-specific or national PCMH recognition/accreditation.	PCMH Contractor, State, and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
26. Goal 1: Idahoans enrolled in a designated PCMH (of total state population): CUM # (%) of Idahoans who enroll in a designated PCMH (of total state population).	State and CMS.	Contractor database.	IT: Develop database.	N/A	N/A
27. Goal 1: Idahoans enrolled in a designated PCMH (of target population): CUM # (%) of targeted population who enroll in a designated PCMH (of target population).	State and CMS.	Contractor database.	IT: Develop database.	N/A	N/A
28. Goal 1: PCMH patients who are active participants in their healthcare: CUM # (%) of enrolled PCMH patients reporting they are an active participant in their healthcare.	State and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
29. Goal 2: PCMHs with active EHRs: CUM # (%) of designated PCMHs (sites) with EHR systems that support HIE connectivity.	IHDE, State, and CMS.	Data collection – EHRs at PCMHs and PCMH connectivity to IHDE. Data analysis – IHDE.	TA: To PCMHs re: EHR adoption and use. IT: EHRs at PCMH practices and connection to IHDE. O: PCMH use of EHRs and connection to IHDE.	N/A	O: Practices adjusting work flow and business processes to incorporate use of EHRs.
30. Goal 2: PCMH members with EHRs: CUM # (%) of patients in designated PCMHs (sites) that have an EHR.	State and CMS.	Data Collection – EHRs at PCMHs. Data analysis – IHDE and Data Analytics Contractor.	TA: To PCMHs re: EHR adoption and use. IT: EHRs at PCMH practices. O: PCMH use of EHRs.	N/A	None at this time.
31. Goal 2: PCMHs connected to IHDE and utilizing the clinical portal: CUM # (%) of designated PCMHs with an active connection to the IHDE and utilizing the clinical portal to obtain patient summaries, etc.	State and CMS.	Data Collection – EHRs at PCMHs. Data analysis – IHDE.	TA: To PCMHs. IT: Connection to IHDE. O: PCMH connection to IHDE.	N/A	IT: All clinics are not presently connected to IHDE so limited patient data is available.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
32. Goal 2: Hospitals connected to IHDE: CUM # (%) of hospitals connected to the IHDE.	State and CMS.	Data collection - hospital connection to IHDE. Data analysis – IHDE.	TA: To hospitals. IT: Hospital connection to IHDE. O: Hospital connection to IHDE.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
33. Goal 2: Hospitals providing information to PCMHs: CUM # (%) of hospitals connected to IHDE that provide information on PCMH enrolled patients.	State, CMS, and PCMH Contractor.	Data collection – hospital connection to IHDE. Data analysis – IHDE.	TA: To hospitals and PCMHs. IT: Hospital connection to IHDE. O: Hospital connection to IHDE.	N/A	IT: Need of notification system to alert provider when patient data is available.
34. Goal 3: Established/operational RCs: CUM # (%) of RCs established and providing regional quality improvement and Medical/Health Neighborhood integration services.	RCs, State, and CMS.	N/A	N/A	N/A	N/A
35. Goal 3: PCMHs receiving assistance through an RC: CUM # (%) of designated PCMHs and primary care practices that can receive assistance through an RC.	RCs, State, and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
36. Goal 3: PCMHs using protocols with Medical/Health Neighborhood providers, including hospitals: CUM # (%) of designated PCMHs who have established protocols for referrals and follow-up communications with service providers in their Medical/Health Neighborhood.	PCMH Contractor, State, and CMS.	N/A	N/A	N/A	O/IT: Protocols may vary from practice to practice.
37. Goal 3: CUM # (%) of patients enrolled in a designated PCMH whose health needs are coordinated across their local Medical/Health Neighborhood, as needed.	RC, State, and CMS.	N/A	N/A	N/A	N/A
38. Goal 4: Established Virtual PCMHs: CUM # (%) of Virtual PCMHs established in rural communities following assessment of need.	State and CMS.	Data collection – telehealth tools to support Virtual PCMHs.	TA: To Virtual PCMHs on using telehealth technologies. IT: Telehealth tools. O: Use of telehealth tools by Virtual PCMHs.	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
39. Goal 4: Established Community Health Emergency Medical Services (CHEMS) programs: CUM # (%) of regional CHEMS programs established.	State and CMS.	N/A	N/A	N/A	N/A
40. Goal 4: Trained CHEMS personnel: CUM # (%) of CHEMS program personnel trained for Virtual PCMH coordination.	State and CMS.	N/A	N/A	N/A	N/A
41. Goal 4: New trained Community Health Workers (CHWs): CUM # (%) of new CHWs trained for Virtual PCMH coordination.	State and CMS.	N/A	N/A	N/A	N/A
42. Goal 4: Continuing education for CHWs and CHEMS: CUM # (%) of continuing education conferences held for CHW and CHEMS Virtual PCMH staff.	State and CMS.	N/A	N/A	N/A	N/A

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
43. Goal 4: Virtual PCMH use of telehealth: CUM # (%) of designated Virtual PCMHs that routinely use telehealth tools to provide specialty and behavioral health services to rural patients.	RCs, PCMHs, State, and CMS.	Data collection – telehealth tools for Virtual PCMH.	TA: to Virtual PCMHs on using telehealth technologies. IT: Telehealth tools. O: use of telehealth tools by Virtual PCMHs.	N/A	O: Keeping data separate regarding the use of telehealth tools for primary care versus behavioral health and specialty services.
44. Goal 5: PCMHs with access to the analytics system: CUM # (%) of designated PCMH (sites) with access from the Data Analytics Contractor to the analytics system that provides dashboards and reporting.	RCs, PCMHs, State, and CMS.	Data collection – PCMH connection to Data Analytics Contractor. Data analytics – Data Analytics Contractor.	TA: to PCMHs on connection to Data Analytics Contractor. IT/O: PCMH connection to Data Analytics Contractor.	N/A	IT: Complete patient data may not be available since all providers are not yet connected to IHDE.
45. Goal 5: PCMH quality measure reporting: CUM # (%) of quality measures that are reported by all designated PCMHs.	RCs, PCMHs, State, and CMS.	Data collection – PCMH reporting. Data analytics – Data Analytics Contractor and State Evaluation Vendor.	TBD with Data Analytics Contractor and State Evaluation Vendor.	N/A	TBD

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
46. Goal 5: PCMHs that receive community health needs assessment results: CUM # (%) of designated PCMHs (sites) that receive community health needs assessment results from an RC.	RCs, PCMHs, State, and CMS.	TBD	TBD	N/A	TBD
47. Goal 6: Payer adoption of new reimbursement models: CUM # (%) of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.
48. Goal 6: Providers participating in value-based purchasing and alternative payment models: CUM # (%) of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
49. Goal 6: Individuals receiving care through value-based purchasing and alternative payment models: CUM # (%) of beneficiaries attributed to all providers for purposes of alternative reimbursement payments.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.
50. Goal 6: Percentage of non-fee-for-service (FFS) payments: Percentage of payments made in non-FFS arrangements compared to total payments made.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.
51. Goal 7: Per member per month (PMPM) cost: Total population-based PMPM index, defined as the total cost of care divided by the population risk score.	State and CMS.	N/A	N/A	N/A	N/A
52. Goal 7: Return on investment (ROI): Annual financial analysis indicates cost savings and positive ROI. Target ROI is 225%.	State and CMS.	N/A	N/A	N/A	N/A

The remainder of the HIT Plan contains detailed information for the four Health HIT Plan domains identified by CMS in its State Innovation Models Round 2 Model Test Awardee Operational Plan Guidance:

1. Governance
2. Policy
3. Infrastructure
4. Technical assistance

Within each of the sub-sections identified above, Idaho has included, as applicable, optional tables as outlined in CMS' guidance.

## 1. HIT Governance

### Organizational Structure and Decision-Making Authority Related to Health IT

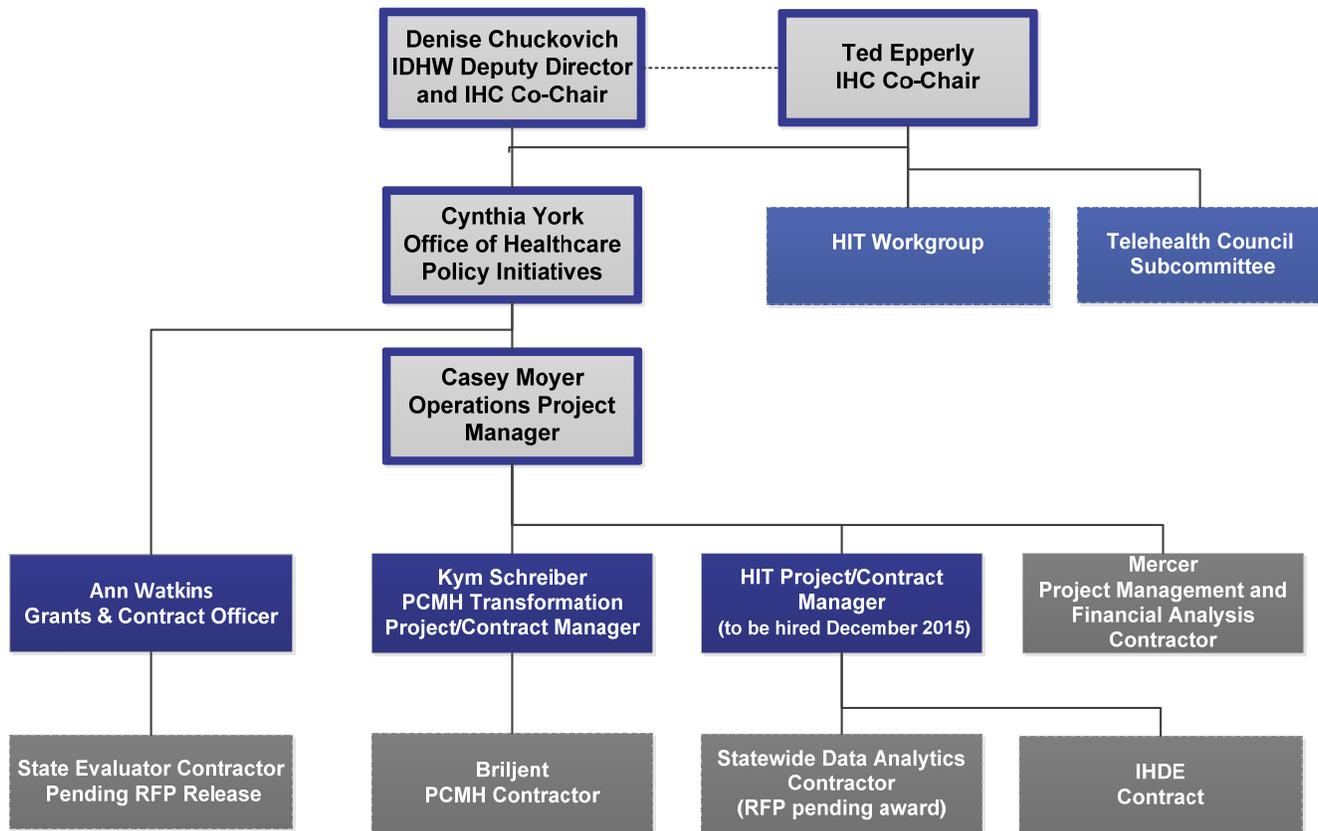
Idaho has developed an approach to overall SIM Model Test governance and, specifically, to governance of the HIT infrastructure that will support effective implementation of the plan. Governance will also promote the effective coordination of the SIM Model Test HIT Plan with concurrent HIT initiatives, so that implementation is linked to efforts to achieve nationwide interoperability and are developed in concert with the recently released ONC Shared Nationwide Interoperability Roadmap.

Idaho will implement the HIT components of the SIM Model Test under the direct management of IDHW. Several staff, hired for the full grant performance period, are responsible for facilitating HIT work teams, program development, project management, and grant and contract monitoring. The IHC advises IDHW and serves on work teams, one of which is the HIT Workgroup, under the direction of the IDHW State Health Innovation Plan (SHIP) Operations Project Manager. Idaho is in the process of hiring a HIT Project Manager that will assist in a full time capacity. The position is anticipated to be filled by the end of December, 2015.

The HIT Workgroup advises and addresses the technology needs of the SIM Model Test. The HIT Workgroup's scope includes increasing data sharing, interconnectivity, analytics, and reporting — all are essential elements to Idaho's healthcare transformation efforts.

Figure below illustrates the SIM Model Test organizational chart as it relates to the HIT Plan. This figure shows the relationship of the HIT Workgroup and the IHDE to the IDHW's overall SHIP program management. Note that the HIT Workgroup has a direct reporting relationship to both of the IHC Co-Chairs. Figure 15 also depicts a number of technical assistance vendors that are currently engaged (or are planned) to support IDHW's SIM Model Test efforts in the area of HIT.

### **Figure 15 — HIT Plan Organizational Chart**



### *HIT Organizational Capacity*

Implementation of the SIM Model Test HIT Plan provides an important opportunity for Idaho to build organizational capacity and infrastructure in this critical area. Throughout the Model Test, Idaho will continue to build its HIT organizational capacity and infrastructure through multiple sources including HIT experts, contractors, and other stakeholders. HIT-related positions are identified in Table 25. In this work, Idaho will continue to leverage the experience and expertise of its stakeholder partners, including the IHDE and the IHC's HIT Workgroup members, who have developed Idaho's SIM Model Test HIT Plan.

IDHW plans to procure contractors as part of the SIM Model Test who will bring additional resources and focus on building HIT capacity within the state. These contractors' assistance during the SIM Model Test will also contribute to ongoing sustainability of the HIT Plan activities after the Model Test has concluded. For example, the new PCMH Contractor, Briljent, and its subcontractor Health Management Associates (HMA) will provide key technical assistance to providers and Public Health District (PHD) staff related to PCMH transformation and the adoption and use of HIT. So, as PHD staff are trained to assist providers, they will be in a better position to offer support moving forward. In addition, the Data Analytics Contractor, IHDE, Briljent, and HMA will work with IDHW staff to identify data needs from the EHR level to the statewide level and will assist in developing plans for obtaining

the needed data. Through this process, IDHW staff will gain a better understanding of data collection and exchange required to further the SIM project goals and implement the statewide HIT plan.

Moving forward, Idaho will continue to make progress in expanding HIT in the state. IDHW and the IHC will retain responsibility for coordinating HIT activities related to the SIM Model Test with other private and public HIT efforts. IDHW and the IHC will continue to provide governance and strategic direction to promote the integration and alignment of HIT with relevant legislative and executive authority, and will also monitor future needs for recruiting and training staff and contractors related to HIT.

Table 25 — Health IT Related Positions

Health IT Activity	HIT Lead				Contact Information	
	Position/Title (including Government Agency)	State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)	First Name	Last Name	Phone Number	Email Address
Strategic Direction	IDHW Director	AS	Richard	Armstrong	208-334-5500	ArmstrongR@dhw.idaho.gov
Strategic Direction	IDHW Deputy Director and IHC Co-Chair	AS	Denise	Chuckovich	208-334-5500	ChuckovD@dhw.idaho.gov
Administration	Office of Healthcare Policy Initiatives Administrator	HS	Cynthia	York	208-334-5574	YorkC@dhw.idaho.gov
Administration	Division of Behavioral Health Administrator, Behavioral Health Integration Workgroup Co-Chair	AS	Ross	Edmunds	208-334-6997	EdmundsR@dhw.idaho.gov
Administration	Division of Medicaid Administrator	AS	Lisa	Hettinger	208-334-5747	HettingL@dhw.idaho.gov
Administration	Division of Public Health Administrator	AS	Elke	Shaw-Tulloch	208-334-6996	shawe@dhw.idaho.gov
Administration	Office of the Governor, Senior Special Assistant for Health and Social Services	AS	Tammy	Perkins	208-334-2100	Tperkins@gov.idaho.gov
Project Management, Goal 2, and Goal 5	Operations Project Manager – SHIP	HS	Casey	Moyer	208-334-5581	Moyerc@dhw.idaho.gov

HIT Lead					Contact Information	
Health IT Activity	Position/Title (including Government Agency)	State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)	First Name	Last Name	Phone Number	Email Address
Goal 1	IDHW Project/Contract Manager - PCMH Transformation	HS	Kymerlee	Schreiber	208-334-5577	SchreiberK@dhw.idaho.gov
Goal 3, Goal 4, Regional Health Collaboratives, CHEMS, and CHW	IDHW Project/Contract Manager - Regional Health Collaboratives	HS	Miro	Barac	208-334-5594	BaracM@dhw.idaho.gov
Goal 3 and Regional Health Collaboratives	Chief, IDHW Bureau of Rural Health and Primary Care	AS	Mary	Sheridan	208-334-0669	SheridaM@dhw.idaho.gov
Administrative Support	Administrative Assistant	HS	Kim	Thurston	208-334-0612	ThurstoK@dhw.idaho.gov
Grant Management	Grants & Contract Officer	HS	Ann	Watkins	208-334-5579	WatkinsA@dhw.idaho.gov
Strategic Direction	IHC Co-Chair	A	Ted	Epperly	208-954-8744	Ted.Epperly@fmridaho.org
HIT and Data Analytics Workgroup	Workgroup Chair, IHDE Executive Director	A	Scott	Carrell	208-332-7261	Scarrell@idahohde.org
Multi-Payer Workgroup	Workgroup Co-chair	A	Jeff	Couch	208-331-7564	Jcrouch@bcidaho.com
Multi-Payer Workgroup	Workgroup Co-chair	A	David	Peterman	208-955-6500	David.peterman@primaryhealth.com

HIT Lead					Contact Information	
Health IT Activity	Position/Title (including Government Agency)	State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)	First Name	Last Name	Phone Number	Email Address
Clinical Quality Measures Workgroup	Workgroup Co-chair	A	Andrew	Baron	208-866-5029	Abaron@trhs.org
Telehealth Council	Telehealth Council Chair	A	Stacey	Carson	208-489-1401	Scarson@teamiha.org
PCMH Transformation	Briljent Lead, PCMH Transformation Contractor	C	Grace	Chandler	317-735-3497	Gchandler@briljent.com
PCMH Transformation	Health Management Associates (HMA) Lead, PCMH Technical Assistance Subcontractor	C	Lori	Wieselberg	312-641-5007	Lwieselberg@healthmanagement.com
PCMH Transformation	Myers and Stauffer Lead, PCMH Incentives Subcontractor	C	Jared	Duzan	317-846-9520	JDuzan@mslc.com
HIT Data Analytics	Data Analytics Contractor	C	TBD	TBD	TBD	TBD
SIM Model Test Evaluation	State Evaluation Contractor	C	TBD	TBD	TBD	TBD
Project Management and Financial Analysis	Principal, Mercer Government Human Services Consulting	C	Katie	Falls	202-536-7451	Katie.Falls@mercer.com

HIT Lead					Contact Information	
Health IT Activity	Position/Title (including Government Agency)	State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)	First Name	Last Name	Phone Number	Email Address
Project Management and Financial Analysis	Senior Associate, Mercer Government Human Services Consulting	C	Jennifer	Feliciano	954-838-3406	Jennifer.Feliciano@mercer.com
Project Management and Financial Analysis	Senior Associate, Mercer Government Human Services Consulting	C	Maggie	Wolfe	202-331-2635	Maggie.Wolfe@mercer.com
IHDE Contract	IHDE	C	Scott	Carrell	208-332-7261	Scarrell@idahohde.org

Appendix B provides a comprehensive project implementation plan for the SIM Model Test HIT Plan. The project plan identifies each major project area for the SIM Model Test and its supporting HIT efforts, the timeline for HIT activities, and key milestones and due dates. Additional detail for these activities can be found in Appendix B to the Operational Plan (Master Timeline for SIM).

**Error! Not a valid bookmark self-reference.** outlines projected expenditures by project area, with the associated identification of primary drivers and metrics for each project area.

**Table 26 — Health IT Organizational Capacity – Project Management Budget Support**

SIM Budget Summary, Year 2 (Model Test Year 1)			
SIM Component/Project Area	Projected Expenditure	Primary Driver	Metrics
IDHW personnel/fringe benefits	\$82,215	1–4	Metrics # 1–35 as numbered in Driver Diagram.
PCMH Contractor contract	\$132,377	1	Metrics # 1–17 as numbered in Driver Diagram.
PCMH transformation incentives	\$0	1	Metrics # 1–17 as numbered in Driver Diagram.
CHWs and CHEMS staff training contract	\$49,500	1	Metrics # 1–17 as numbered in Driver Diagram.
Telehealth training/TA contract	\$84,713	1	Metrics # 1–17 as numbered in Driver Diagram.
RC's contract(s)	\$397,082	3	Metrics # 26–29 as numbered in Driver Diagram.
IHDE contract	\$1,142,314	2	Metrics # 18–25 as numbered in Driver Diagram.
Data collection and analytics contract(s)	\$1,591,420	1–4	Metrics # 1–35 as numbered in Driver Diagram.
Project management/financial analysis contract	\$149,186	1–4	Metrics # 1–35 as numbered in Driver Diagram.
IDHW telehealth equipment	\$212,782	1	Metrics # 1–17 as numbered in Driver Diagram.
Travel	\$5,170	1–4	Metrics # 1–35 as numbered in Driver Diagram.
Staff supplies and misc.	\$890	1–4	Metrics # 1–35 as numbered in Driver Diagram.
Other — IHC member travel/meeting costs	\$2,328	1–4	Metrics # 1–35 as numbered in Driver Diagram.
State Evaluator	\$225,000	1–4	Metrics # 1–35 as numbered in Driver Diagram.
IDHW overhead	\$759	1–4	Metrics # 1–35 as numbered in Driver Diagram.
<b>Total</b>	<b>\$4,075,736</b>		

### Health IT Stakeholder Engagement

During the SIM Model Design Phase, Idaho engaged stakeholders from every component of the healthcare system to design a new health delivery model and change the course of healthcare in Idaho. Idaho focused particular attention on soliciting stakeholder advice and input with regard to its assessment of and vision for HIT. These stakeholders included representatives from federal, state, local and tribal governments, physical health, behavioral health and public healthcare providers and systems, commercial payers/purchasers, community-based and long term support providers, and consumers.

The HIT Workgroup was formed during this time, comprised of HIT subject matter experts in Idaho who contributed their knowledge and experience to the development of Idaho's HIT plan. Today, the HIT Workgroup continues to represent statewide stakeholders, including representatives from physical health, behavioral health, and public healthcare providers/systems, commercial payers/purchasers, and state and local government.

The HIT Workgroup continues to be a core component of Idaho's SIM Model Test implementation. The HIT Workgroup meets regularly and reports to the IHC Co-Chairs. The HIT Workgroup:

- Guides the expansion of the HIT infrastructure.
- Supports integration of PCMHs that do not yet have a connection with the IHDE.
- Guides the development of infrastructure for the collection and analysis of selected quality and cost data.

### HIT Stakeholder Priorities

Idaho's HIT Plan was designed and is being implemented to reflect and incorporate key priorities identified during stakeholders during the Model Design and first year of Model Testing. For example, during the Model Design phase, the Data Analytics Workgroup, a subgroup of the HIT Workgroup, set priorities for collection and analysis of quality and cost data. The Data Analytics Workgroup identified the need for a statewide healthcare data analytics system with the capacity to provide analytics output on Idaho's Initial Performance Measure Catalog, using healthcare data within the IHDE from clinics throughout the state. As part of the process, the workgroup created a Request for Information (RFI) which included a series of questions directed towards analytics vendors. From this process, the workgroup compiled all twenty-seven responses into a single matrix. This matrix was then used to help gauge the quality and value of areas contained within the RFI; from that information the content areas of the RFP to procure the data analytics vendor was generated.

During the Model Test phase, IDHW has continued to prioritize the development of a statewide healthcare data analytics system with the feedback provided by the workgroup, an essential component in monitoring the implementation of the SHIP and the transformation of the statewide healthcare system in Idaho. The RFP has been released and the procurement process remains under way with an award anticipated in February 2016.

IDHW and the IHC will continue to seek input from key stakeholder groups and will strive to align the implementation of the HIT Plan with priorities identified by stakeholders.

Table 27 is a directory of the current HIT Workgroup members. The Data Analytics subgroup was combined with the HIT workgroup in June 2015 after the RFI was completed. Note that members of the Data Analytics Subgroup have been identified with an asterisk (\*) for historic purposes.

Table 27 — Idaho SHIP HIT Workgroup Directory

Idaho SHIP HIT Workgroup Directory		
Organization	Name and Title	Email Address
HIT Workgroup Chair		
Idaho Health Data Exchange	Scott Carrell, Executive Director, IHDE	Scarrell@idahohde.org
HIT Workgroup Members		
Benewah Medical Center	Tina Voves, Coder and Next Gen EHT Trainer	TVoves@bmc.portland.ihs.gov
Blue Cross of Idaho	Lance Hatfield, VP, Chief Information Officer *	Lhatfield@bcidaho.com
	Peter Sorensen, BlueCard Executive, FEP Plan Executive	Psorensen@bcidaho.com
IDHW	Michael Farley, IT Division Administrator *	Farleym@dhw.idaho.gov
	Lisa Hettinger, Administrator, Div. of Medicaid	Hettingl@dhw.idaho.gov
	Sheila Pugatch, Bureau Chief, Medicaid Division Financial Services	Pugatchs@dhw.idaho.gov
	Cale Coyle, Financial Specialist, Div. of Medicaid	CoyleC@dhw.idaho.gov
	Kathy Turner, Bureau Chief, Bureau of Communicable Disease Prevention, Division of Public Health	TurnerK@dhw.idaho.gov
	Rene Hughes, Bureau Chief, Div. of Medicaid	HughesR1@dhw.idaho.gov
	Cathy Libby, Deputy Division Administrator, Div. of Medicaid	LibbyC@dhw.idaho.gov
	Tom Rosenthal, Research Analyst, Supervisor Div. of Medicaid *	RosenthT@dhw.idaho.gov
Idaho Primary Care Association	Tim Heinze, Medical Home / Meaningful Use Program Manager	Theinze@idahopca.org
Kootenai Health	Michael Gaul, IT Director *	Mgaul@kmc.org
	Jon Tolley, Integration and Department Applications Manager	Jtolley@kh.org
Primary Health	Paul Castronova, Director of Information Technology	Paul.Castronova@primaryhealth.com
	Mike Evans, Network Administrator	

Idaho SHIP HIT Workgroup Directory		
Organization	Name and Title	Email Address
Qualis Health	Peggy Evans, PhD, Interim VP Quality and Safety Initiatives; Consulting Director, CPHIT; PCMH Certified Content Expert	Peggye@qualishealth.org
	Zach Hodges, Sr. Consultant, CPHIT, Certified Health Insurance Portability and Accountability (HIPAA) Professional *	Zachh@qualishealth.org
	Linda Rowe, Director, Idaho Care Transitions & Patient Safety *	Lindaro@qualishealth.org
Regence Blue Shield	Richard Rainey, MD, Executive Medical Director	Richard.rainey@regence.com
	Gregg Shibata, Manager, Accountable Health Implementation *	Gregg.shibata@regence.com
St. Alphonsus	Rick Turner, MD, Chief Medical Informatics Officer, Dept. of Data Informatics and Analytics *	Turnerrd@sarmc.org
Ascension Information Services	Jim Johnston, SD Senior Analyst	Jjohnston@sjrmc.org
St. Luke's Health System	Marc Chasin, MD, Chief Medical Informatics Officer	Chasinm@slhs.org
	Brad Erickson, Director, Informatics Integration *	Rricksob@slhs.org
	Denette Dresback, Director, Informatics Integration	Dresbacd@slhs.org
Boise VA Medical Center	Scott Smith, MD, Director, Boise VA Center of Excellence in Primary Care Education	Scott.smith2@va.gov
	Timothy Gordon, Management Analyst *	Timothy.gordon@va.gov
Deputy Attorney General		
Office of the Attorney General	Nicole McKay, Deputy Attorney General	McKayN@dhw.idaho.gov
Staff to the HIT Workgroup		
IDHW	Casey Moyer, SHIP Operations Project Manager	Moyerc@dhw.idaho.gov
	Cynthia York, SHIP Administrator	Yorkc@dhw.idaho.gov
	Kim Thurston, SHIP Administrative Assistant	ThurstoK@dhw.idaho.gov

### Leveraging Existing Assets to Align with Federally-Funded Programs and State Enterprise IT Systems

Idaho's SIM Model Test HIT Plan builds upon the platform of existing HIT in the State, including federally-funded programs and state enterprise IT systems. The largest building block for Idaho's SIM Model Test HIT Plan is the IHDE. As mentioned previously, the SIM Model Test seeks to increase provider connectivity with the IHDE as well as access to clinical data to promote improved quality and coordination of care. As of September 2015, IHDE participants included 34 provider practices with HIE connectivity; 47 participants with clinical portal (view only) connectivity; seven laboratories; 16 hospitals; and three payers. Please visit the IHDE website ([www.idahohde.org](http://www.idahohde.org)) for the most up-to-date list of participants. Also, IHDE has recently completed a platform conversion which now enables them to begin the process of connecting with more hospitals, providers and health organizations.

Existing IHDE functionality includes:

1. Connectivity to hospitals, labs, providers, regardless of EHR system.
2. Image Exchange (PACS).
3. 24/7/365 availability of lab reports, radiology images, transcription reports, etc..
4. Securely access, share, and send medical records and images with providers statewide and within the region.
5. IHDE controlled user access.
6. One-Click Access.

By the fourth quarter of SIM Model Test Year 3, Idaho aims to implement several enhancements to the IHDE in support of healthcare transformation, including:

1. Increasing participation in IHDE by adding 165 PCMHs and 21 hospitals.
2. Expanding HIE data sharing agreements to support SHIP activities.
3. Expanding IHDE capabilities and system architecture.
4. Increasing IHDE's organizational capacity.
5. Expanding EHR data integration and other functionality.
6. Advancing analytic and reporting capabilities and providing value-added data analytics and reporting services to participants, the IHC and RCs.

While the IHDE is an important asset and building block that will be leveraged for Idaho's SIM Model Test, significant barriers have prevented the development of additional HIT in the State. The use of EHRs and other advanced HIT is deficient in the State, with many providers experiencing significant barriers to adopting HIT such as connectivity issues and the high cost of HIT tools. Providers have expressed confusion and frustration with knowing how to differentiate between EHR products commercially available. Navigating the open market on their own is a challenge. As a result, data sharing is not comprehensive or complete.

The SIM Model Test will provide resources and technical assistance to practices to increase adoption and use of HIT tools. The Medicaid Provider Incentive Program has established a critical foundation for the work ahead. Additional information related to the incentive program can be found on their website (<http://healthandwelfare.idaho.gov/default.aspx?TabId=1405>). The program has been successful in providing incentives to eligible providers (EPs) and eligible hospitals (EHs) to promote meaningful use (MU) of HIT. Details on provider participation in the program are as follows:

- Total number of Medicaid MU-EPs who have received a payment with 2014 Certified System = 405 (402 unique EPs)

- Total number of Medicaid MU-EHs who have received a payment with 2014 Certified System = 17

The SIM Model Test will seek to increase HIT adoption and use, especially among PCMH practices. Another key focus area will be developing data aggregation and analytics capacity to provide timely access to information at all levels of the system. This is a key area of need in Idaho, as the current data aggregation and analytics infrastructure is minimal. At this time, Idaho does not have any less-than-Statewide HIEs, an all payer claims system or a data repository. Furthermore, there is no statewide provider directory, patient matching system, statewide, community-level or plan-level clinical notification system or shared-care plans. There are also no non-Public Health Clinical Registries in Idaho.

Furthermore, no standardized data collection or performance reporting across payers or populations exists in Idaho. While performance measurement data is collected by IDHW (including the Division of Public Health, the Division of Behavioral Health and the Division of Medicaid), commercial payers, Medicare, and the local public health districts, measures are reported in various forms and in silos that make it difficult or impossible to measure population health changes across Idaho. Repositories of statewide data exist for public health purposes (such as the vital statistics registry, immunizations registry, cancer registry, and registry of reportable diseases), but these data collection and analytics efforts only present part of the picture of health in Idaho. As such, Idaho currently has no a mechanism to conduct statewide measurement of the health of Idahoans or evaluate the performance of its healthcare delivery system.

The Statewide Health Data Analytics System, to be developed by the Data Analytics Contractor, will track, analyze, and report on individual and population health data in order to monitor health outcomes and measure performance. This system will be aimed at increasing statewide capacity to collect quality measures based on EHR data, to provide additional interfaces with needed data sources, and will build state government capacity to retain, analyze and share data with providers. The details of these activities will be determined with the Data Analytics Contractor and IHDE.

### *Leveraging and Expanding Existing Public/Private Health Information Exchanges*

At present, the IHDE is the only single statewide HIE in operation in Idaho. In the future, it is possible that a private HIE may form in part of the state to meet data exchange needs of border states, but a regional private HIE is not a solution to meet exchange needs for the Model Test. Eventually, regional HIE hubs could interface with the Statewide HIE, but there is no federated model in place at this time. Therefore, the sole HIE that will be leveraged for the SIM Model test is the IHDE, as described throughout this HIT Plan.

## **2. Policy**

### *Relevant Idaho Healthcare Policy Levers*

As described in the Operational Plan, Idaho's SIM Model Test rests on a foundation of supporting legislative and executive action that created a framework for Idaho's healthcare transformation. However, while CMS-required components related to HIT are in place among Idaho's public payers, Idaho statute does not currently include additional requirements of public or private payers related to support of expanded HIT. HIT efforts in the State have been implemented voluntarily, not as the result of statute or policy. During the Model Design phase, IDHW and the IHC worked with stakeholders to

consider additional policy levers that could further support Idaho's Model Test generally and the implementation of HIT activities in particular. For example, stakeholders discussed the importance of EHR adoption and other HIT tools to support care coordination, patient engagement, and performance reporting. However, stakeholders did not support using mandates. Instead, stakeholders recommended that it is important to understand existing and perceived barriers, and implement supports and incentives to help providers overcome barriers. As the IHC expands and collaboration in implementation of the model continues across payers, providers, communities and individuals, stakeholders may eventually identify legislative, executive and/or regulatory authorities related to HIT that would benefit and advance transformation of Idaho's healthcare delivery system. At this time, however, no such authorities are recommended, as Idaho is confident that the model can be implemented through the commitment of healthcare system stakeholders and be advanced by incentives to transform to a patient-centered, population health approach.

### 1115 Medicaid Waivers and State Plan Amendment

Idaho's Medicaid program does not currently include an operational 1115 demonstration. As such, Idaho's SIM Model Test HIT Plan does not contemplate coordination with any 1115 demonstration HIT parameters and funding. Idaho Medicaid will participate in supporting PCMHs through its existing Section 2703 state plan amendment (SPA), approved by CMS on November 21, 2012, which enabled the Idaho Medicaid program to participate in the Idaho Medical Home Collaborative PCMH pilot. Idaho Medicaid does not plan to submit an additional SPA at this time to support the SIM Model Test or the HIT Plan in particular.

As the single State agency for Medicaid administration, IDHW will continue to retain responsibility for any coordination moving forward between the SIM Model Test HIT Plan and any HIT-related requirements of federal authority under the Medicaid program.

### SIM Health IT Alignment with Other State, Federal and External Health IT Efforts

Idaho has several other statewide HIT-related initiatives underway that support the State's SIM Model Test activities. Stakeholders in the HIT Workgroup endeavored during the Model Design Phase to identify these initiatives, which include:

- The Idaho Telehealth Council.
- The Idaho HIT work group, which is a key stakeholder support for the SIM Model Test HIT Plan
- The Time Sensitive Emergency (TSE) work group, tasked with presenting a proposed legislation to develop a statewide trauma, stroke, and heart attack system.
- LINK Idaho, part of the Telehealth Taskforce, TSE, and HIT work groups, focuses on broadband access in Idaho.
- The Medicaid Provider Incentive Program.
- Changes to the Medicaid Management Information System (MMIS) to support the future environment. There will be a need for the Idaho MMIS to pass and receive data to/from other systems at the regional and State level. Potential data includes claims, recipient, and provider data, in consideration of HIPAA and other regulations. The Medicaid Decision Support System aggregates claims and pharmacy data and may feed the proposed "data hub" through a variety of mechanisms (flat file, web services, etc.). Required changes/modifications to the Decision Support System could include data filtering, data-specific aggregation, and transmission.

Coordination between these various initiatives is essential for Idaho to maximize collaboration opportunities and value across the various initiatives. IDHW and the IHC will continue to retain responsibility for identifying other state, federal and external HIT efforts that are relevant to the SIM Model Test HIT Plan. IDHW and the IHC will seek to advance the success of the HIT-related initiatives in collaboration wherever possible with the SIM Model Test HIT Plan in order to prevent duplication of effort and/or funds, and to promote an integrated HIT network in the state with common goals and objectives.

### *Methods to Improve Transparency and Encourage Innovative Uses of Data*

Idaho recognizes that transparency is an important aspect for service improvement, data quality, and productivity. To this end, Idaho will work closely with model participants to identify ways to improve transparency and at the same time encourage innovative uses of data across the state, regions, counties, payers, providers, communities, and individuals.

For example, the statewide Data Analytics Contractor will support the SIM Model Test by collecting, aggregating, analyzing, and producing reports on the Initial Core Performance Measurement Catalog. Data will be viewable at a number of levels — by PCMH, by county, region, and statewide. RCs will be able to use dashboard data to assess the healthcare climate within their local areas, and the availability of this data will offer an opportunity for both transparency and for users at various levels to apply the results toward innovative changes to drive improvements from the ground up.

### *Promotion of Patient Engagement and Shared Decision Making*

Today, the patient's experience of care is not always positive in Idaho, particularly in rural areas. Consumers report a lack of provider choices, especially in the areas of behavioral health providers and diagnostic technologies, as well as limited provider use of HIT tools, such as patient portals, that facilitate patient access to health information. Patients also experienced primary care providers being rushed or overloaded; challenges in accessing specialty care, including out-of-state travel in many situations; and limited after-hours primary care access.

Recognizing the power of individuals to improve their health, the SIM Model Test will promote patient engagement, education, and self-management. The patient's team of healthcare professionals will be held accountable for coordinating care across the larger Medical/Health Neighborhood that includes specialists, hospitals, behavioral health, and other services. EHR data and IHDE connectivity will be used to support care coordination through efficient, effective, and timely communication and the exchange of patient health data to inform clinical decisions.

The HIT Plan also seeks to create a data platform where information is collected and made available for purposes of extraction, patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics. IHDE will play a critical role in this effort to share information and engage patients. Part of the enhancement at the provider level may include having a patient portal that different providers could use. The site could also include links to health initiatives, statistics, data, etc. Patient engagement activities could also include collecting biometric data from devices. Collaboration between the practice, IHDE and the IHC will direct how advances are made in the IHDE system to promote patient engagement. Another planned component scheduled for introduction through IHDE includes a secure messaging function which will allow providers to securely communicate for the betterment of patient care and service coordination.

Through use of advanced health technology, such as telehealth, EHRs, secure messaging, and clinical decisions tools, Idaho will reduce its barriers to access for those living in rural areas, improve provider collaboration and coordination, and increase patient engagement. Patient engagement improves patients' understanding of their health and healthcare conditions, enabling them to assume a more active role in their healthcare. Specific SIM Model Test HIT Plan milestones that will promote patient engagement and shared decision making include:

#### Year 1:

- Develop policies and technologies for data sharing and reporting.
- Increase EHR adoption and expand telehealth use.
- Expand reporting and data analytics capabilities.

#### Year 2:

- Implement policies, technology, and processes to ensure data security and patient privacy.
- Expand the infrastructure for statewide data collection and reporting.
- Use the SHIP website as a mechanism to share information with consumers and providers regarding prevention, wellness, and other statewide campaigns.

#### Year 3 and ongoing:

- Continue to conduct activities to expand the use of EHR and telehealth.
- Continue to expand patient engagement activities and tools to improve the patient's experience of care.
- Serve 825,000 patients through the PCMH model.

**Table 28 — HIT Support for Patient Engagement and Shared Decision Making**

Support Element	Description
<b>Information Shared</b>	Information shared with patients under the Idaho SHIP Model includes patient access to his/her EHR data, such as the patient's plan of care, care summaries, test results, prescriptions, etc., via a patient portal provided by the PCMH or the IHDE. Individual claims data will not be available via the SHIP Model.
<b>HIT Tools</b>	HIT tools that will support patient access to information will include EHR technology; HIE support (data exchanged between providers and caregivers in the patient's Medical/Health Neighborhood); and information is shared via the SHIP website portal, which will include population health information collected and analyzed via the statewide health data analytics system. Telehealth will also facilitate direct exchange of information between provider and patient.
<b>Focus</b>	The primary focus of patient information sharing for decision making will be the individual's clinical and caregiver data; a secondary focus will be sharing results of statewide population health studies and recommendations. Access to individual information via patient portals will be implemented at the provider and IHDE level; population health and other information will be available via social media, such as the SHIP website.
<b>Cost</b>	Patients will not to bear the cost for access to information and shared decision making. The costs for providing these features are included in the costs for EHR and HIE technology and the SHIP model funding.

### *Multi-Payer Strategies to Enable and Expand the Use of Health IT*

Idaho's SIM Model Test will involve care delivery and payment model transformation across multiple payers in the State, including Medicaid, commercial payers, and Medicare. However, Idaho's statewide HIT activities to support this transformation are not payer-focused and will not require significant investment by payers at this time. HIT strategies at the payer level will largely vary depending on the payer. Table 29 below outlines multi-payer strategies to enable and expand the use of health IT.

Table 29 — Multi-payer Strategies to Enable and Expand Use of Health IT

Multi-payer Health IT Strategy	Payers	By Payer Status: (Planned, Engaged or Currently Participating)	Implementation Date (Indicate if expected date or actual date)
Implementation of HIT strategies and tools at the payer level to support alternative payment arrangements. HIT strategies will vary by payer, but in general include: <ul style="list-style-type: none"> <li>• Beneficiary attribution</li> <li>• Encounter data</li> <li>• Claims processing and payment</li> <li>• Tracking of up-front PMPM payments</li> <li>• Data collection and reporting</li> <li>• Provider HIT tools</li> </ul>	Medicaid, Medicare, Blue Cross, PacificSource, Regence, and Select Health.	Status varies by payer.	Implementation dates vary by payer.
Future plans for the IHDE include payer participation in HIE.	To be determined.	Planned	The HIT workgroup will be addressing this in Spring 2016.
Payer support for Virtual PCMH use of telehealth and advanced HIT tools.	Multiple payers are currently participating in the telehealth subcommittee.	Planned	Evaluation and planning are currently underway with an anticipated plan delivery date of May 2016.

### 3. Infrastructure

During the Model Design phase and the Model Test Pre-Implementation year, IDHW and the IHC worked with stakeholders to review and document the current state HIT environment and to identify the gaps that must be closed to develop and implement the SIM Model Test HIT Plan. Gaps include technology for increasing data collection and sharing, interconnectivity, analytics, and reporting. Based on this initial assessment, IDHW, the IHC and stakeholders will continue to develop and implement activities aimed at improving the existing infrastructure through:

1. Increasing provider (clinic) and hospital adoption and use of EHR technology.
2. Increasing the number of PCMHs and increasing PCMH and hospital participation in the IHDE.
3. Implementing a statewide health data analytics system.
4. Increasing the availability of telehealth services in rural areas.

Table 30 below outlines the Health IT tools required to achieve these objectives.

Table 30 — State Implementation of Health-IT Tools to Coordinate Care

Health IT Tools	Purpose of Analytical Tools (Identification and assessment — indicate type, coordination of care, decision support, other name)	Status (Planned, designed, implemented, operational and indicate as of date)
EHR technology	Individual clinical data collection to support coordination of care among providers, PCMHs, caregivers, and others in the Medical/Health Neighborhood, and enable patients greater access to information needed for self-management of healthcare.	Planned/operational (depending on provider)
HIE technology	System capable of receiving and transmitting clinical data, care summaries and communications between providers, PCMHs, caregivers, and others in the Medical/Health Neighborhood.	Planned/operational (depending on provider's connection to IHDE)
Clinical and claims-based data analytics system	<p>System capable of collecting and standardizing data necessary for producing quality measurements reporting. System functionality includes:</p> <ul style="list-style-type: none"> <li>• Data retrieval and standardization from multiple source types including relational databases, data warehouses, analytic databases, distributed database systems, distributed file systems, and text files in a variety of formats.</li> <li>• Producing data analytics for participating clinic level, county level, RC level, and statewide level.</li> <li>• Data dictionaries.</li> <li>• Data controls and integrity.</li> <li>• Standard reports, ad hoc reports, dashboards, and scorecards.</li> <li>• Capability to track, analyze, and report feedback to individual providers on selected performance and outcome measures to improve their practice.</li> <li>• Role-based security with access controls.</li> </ul>	Planned

Health IT Tools	Purpose of Analytical Tools ( <i>Identification and assessment — indicate type, coordination of care, decision support, other name</i> )	Status ( <i>Planned, designed, implemented, operational and indicate as of date</i> )
Statistical analysis	Initial analytical output for the following four performance measures: <ul style="list-style-type: none"> <li>• Tobacco cessation intervention.</li> <li>• Weight assessment and counseling for children and adolescents.</li> <li>• Comprehensive diabetes care.</li> <li>• Additional performance measurement — TBD (from Idaho's Catalog of Performance Measures).</li> </ul>	Planned
Predictive modeling	Identifying future utilization and projected outcomes.	Planned (dependent upon analytic vendor response)
Decision analytics	Analysis including variance measurement and statistical significance.	Planned
Telehealth technology	System capable of enabling patients in rural areas to receive healthcare services (including primary care, behavioral health, specialty evaluation, and monitoring) remotely; and to support workforce training in underserved areas.	Planned/operational (depending on provider)

### Telehealth and Remote Patient Monitoring

The SIM Model Test will encourage Virtual PCMHs to expand the use of advanced health technologies, such as telehealth, EHRs, and clinical decisions tools. Telehealth technology will also expand access, especially in rural areas, to services not available locally and to specialty services that are limited across the State. The use of these technologies will also improve provider collaboration and coordination of services for remote patients, improve patient monitoring, and increase patient engagement. From a statewide perspective, the use of these technologies in rural Virtual PCMHs will create a mechanism for practices to submit data, so that these areas are well represented in statewide datasets that will inform population health improvement initiatives.

The Idaho Telehealth Council will be a key partner in this work. Specifically, the Telehealth Council will assist IDHW in creating a plan to implement telehealth in the Virtual PCMH model. This task will include the following activities:

1. Research other state telehealth standards.
2. Collect input from key stakeholders on draft telehealth standards.
3. Develop draft telehealth standards.
4. Obtain feedback, as needed.
5. Finalize telehealth standards.

Virtual PCMH practices will receive financial incentives to provide support for investments in telehealth and other advanced HIT. In addition, the PCMH Contractor will implement a technical assistance and training program for Virtual PCMHs and RCs related to the use of telehealth and advanced HIT. The PCMH Contractor will also implement a Virtual PCMH mentoring program, which will be an important source of peer-level support.

Notably, Idaho also plans to use telehealth as a means of increasing the healthcare workforce in rural and underserved communities, particularly through the incorporation of CHWs and CHEMs in the Virtual PCMH care network. The CHEMS Workgroup of the IHC and the Telehealth Council will work with others to implement the new CHEMS telehealth program. The program will involve the provision of telehealth equipment for CHEMS agencies.

### Plans to Use Standards-Based Health IT to Enable Electronic Quality Reporting

Idaho is taking steps to collect and standardize healthcare data and develop analytical reporting capabilities to support quality measures and performance metrics. The tools being implemented will allow users to perform data analytics, ad hoc, and standard reporting, data mining, predictive modeling, and decision analytics.

Health outcomes will be improved by measuring quality of care at the practice level, population health at the regional level, and quality of care statewide. Results will identify opportunities for improvement, such as informing adoption of best practices and evidence-based practice guidelines across Idaho's healthcare landscape. Idaho expects the quality and experience of patient care to improve through using data analytics to assess how clinical quality affects patient satisfaction and the patient's experience of healthcare, and using these results as a basis to implement changes to support this goal.

Data analytics will allow Idaho to identify variations in the cost and quality of care and take steps to reduce variations, such as standardizing best practices, adopting value-based payment methods, and tracking improvements and cost savings over time.

*Public Health IT Systems Integration and Electronic Data to Drive Quality Improvement at the Point of Care*

The SIM Model Test HIT Plan will seek to integrate HIT activities in the state with public health IT systems, which are currently a backbone to data collection and health system evaluation in the state. Some of the main sources of healthcare performance data collected and used by IDHW today include Vital Records and community health surveys conducted by Idaho's providers and local PHDs using the Centers for Disease Controls' (CDCs') Community Health Assessment and Group Evaluation tool. However, because these efforts are currently siloed, Idaho is unable to produce statewide data analytics and statewide evaluation of the performance of Idaho's healthcare delivery system.

Idaho's SIM Model Test HIT Plan will focus on enlarging IHDE capacity and building a statewide data analytics system for collecting, analyzing, and reporting quality and outcome data at the PCMH, regional, and state levels. The goal of these activities is to promote access to key information across all participants in the Model Test to improve the quality and coordination of care.

The future state of the HIT system will see IHDE enlarging its capabilities and reach to include more providers and connect more systems in the state. To bring more providers into the IHDE, the first step will be to establish core technical standards and functions for EHRs/IHDE data exchange. Privacy and security protections for health information will also be established and implemented for the IHDE, PCMHs, and its consumer participants. PCMHs will obtain technical assistance and training for implementation and ongoing support for their EHR use and connection to the IHDE. IHDE will initiate technical specification and linkages, and will confirm connectivity interoperability (HIE enabled) with PCMH EHRs. PCMHs will contract with IHDE to enable data exchange. Hospitals will also adopt and use EHRs capable of exchanging data with IHDE, and will contract with the IHDE to enable data exchange.

IDHW is in the process of procuring a Data Analytics Contractor to assist with building a statewide data analytics system. Working in concert with the IDHW, the IHC, and other key stakeholders, the Data Analytics Contractor will create and track regular reports that assess quality and cost improvements across all levels (patient, clinic, county, region, and statewide). The Data Analytics Contractor will provide technical assistance to PCMHs on reporting requirements and interfaces with the data analytics system. The Model Test performance metrics will be tracked and monitored within the data analytics system as key indicators of: improvement of patient population care at the practice level, population health at the regional level and overall statewide performance. Because the Data Analytics Contractor will have primary responsibility for implementing these tasks, IDHW will ensure the Contractor is reaching their contractual and educational access requirements for PCMHs.

The outputs of the data analytics system will be available at multiple levels within the healthcare system, including IDHW, the IHC, policy makers, providers, health systems, payers, and patients. Key data recipients will also include other entities such as PHDs for community health and public health activities. IDHW and the IHC will help facilitate the collaboration between IHDE and public health as this information will also be important for the assessment of regional health needs.

### Health IT to Support Fraud and Abuse Prevention, Detection and Correction

Fraud and abuse prevention, detection, and correction will continue to be a focus of Idaho's Model Test. Payers have committed to participating in the Model Test by moving their payment methodologies towards value-based payment and implementing the corresponding fraud and abuse prevention, detection, and correction activities. Payers will implement HIT activities to support fraud and abuse prevention, detection and correction as needed, and IDHW expects that these HIT activities will vary by payer.

#### **4. Technical Assistance**

Technical assistance will be critical to implementing Idaho's SIM Model Test HIT Plan in order to increase knowledge and capacity at all levels of the system, including IDHW, the IHC and its workgroups, and PCMHs, to support overall system transformation.

Idaho is seeking or has obtained technical assistance to support development and implementation of its SIM Model Test. The scope of assistance includes:

1. Mercer Health & Benefits, LLC is providing HIT technical expertise and project management assistance to IDHW and the HIT Workgroup of the IHC, along with broader project management and consulting services to support implementation of the model test.
2. The HIT workgroup is providing technical assistance to IDHW in securing a Data Analytics Contractor. The HIT workgroup began work in March 2015 to support a Request for Information (RFI) in which interested vendors responded to general questions about analytics solutions. To ensure an equitable and fair opportunity for all interested vendors, the workgroup used a segregated, staged process to produce the RFI. In addition to the HIT Workgroup, participants in this planning process included representation from the Office of the Attorney General and IDHW Contracts and SHIP staff.
3. The PCMH Contractor (Briljent, LLC, with support from Health Management Associates and Myers and Stauffer) will provide training and technical assistance to PCMHs on topics related to PCMH transition, including HIT.
4. IDHW will help expand telehealth technology in Virtual PCMHs, including contracting with an entity to provide training and technical assistance.

Additional details regarding plans for technical assistance to providers can be found in Table 31. State Health IT Technical Assistance to Providers. Note that Idaho's SIM Model Test does not include planned efforts to extend resources to ineligible Meaningful Use incentive payment providers, such as long-term post-acute/long-term services and supports and behavioral health providers.

Table 31 — State Health IT TA to Providers

Targeted Provider Type	Health IT TA Provided	How Health IT TA Delivered (examples: web-based, on site, initial or ongoing, other-explain)	SIM Funded (Yes/No)	TA Status (Planned, Implemented, Operational)
PCMHs	Idaho has secured the services of a vendor (Briljent, LLC, with support from Health Management Associates and Myers and Stauffer) to provide PCMH training and technical assistance for the PCMH transition for the model test.	On site and online	Y	Planned
Virtual PCMHs and other providers using telehealth technology	Idaho will use telehealth technology to increase the trained workforce in underserved areas across the range of primary care and associated health professions that will comprise the virtual PCMHs. Partnerships with community, county, and State organizations with videoconference technology will be facilitated by the RCs to provide access to telehealth training.	To be determined	Y	Planned
Telehealth Contractor (yet to be selected)	IDHW plans to obtain the services of a Telehealth Contractor to help expand telehealth technology in Virtual PCMHs, including training and technical assistance.	To be determined	Y	Planned