Idaho Statewide Healthcare Innovation Plan Grant Closeout Report Success Stories

Prepared for CMMI

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Success Stories

Improved Access to Care
Challis Area Health Center (CAHC), Challis, Idaho

The Challis area of Idaho brings an entirely new meaning to the term 'rural' America. Located in Custer County in the heart of the state, Challis is the county seat. It has three roads going in or out of town and it's nestled in the heart of the Frank Church Wilderness Area – the largest wilderness area in the lower 48 states.

Custer County covers 4,938 square miles of arid desert, green valleys and rugged, rocky peaks. It has 4,087 residents with 41.8% living at or below 200% of the federal poverty level (FPL). The county's towns are Challis (1,083), Mackay (494), May (186), Ellis (88) and Clayton (7). The next closest FQHC is Community Family Clinic in Blackfoot, ID which is 139 miles away - a 2-hour and 20-minute drive (in good conditions).

The Challis Area Health Center (CAHC) is the primary medical facility for the county. In 2017, CAHC Medicaid claims were 1,709 (not unique). Their providers serve the extremely rural area both through the clinic setting and through emergency medical outreach. The clinic had just initiated expansion to include behavioral health services when they joined SHIP as a Cohort Three clinic. On November 30, 2018, Challis achieved National Committee for Quality Assurance (NCQA) 2017 patient-centered medical home (PCMH) accreditation despite the difficulties of PCMH implementation. Challis requested additional help from SHIP with integration of telehealth services under PCMH before conclusion of the SHIP grant. Challis plans to offer telepsychiatry visits within the next six months.

Quality Metric Improvement
Family Health Services, 9 locations serving South Central Idaho

Family Health Services patients have seen the quality of their care improve and the healthcare services they receive are more comprehensive and patient-centered. The organization has been able to improve healthcare measures including diabetes and hypertension control, depression and colorectal prevention screenings, immunizations, and an increased participation in the Idaho Health Data Exchange (IHDE). Seven of their eight clinics have received level II NCQA PCMH recognition.

Quality Improvement
Two Rivers Medical Clinic, Weiser, Idaho

Two Rivers Medical Clinic demonstrated success in PCMH transformation during SHIP Cohort Three after migrating to an Electronic Medical Record (EMR). The clinic attempted to participate in a PCMH pilot several years ago but discontinued because they didn't have an EMR. Two Rivers has now assigned every patient in their practice to a provider team and improved continuity of care with the assigned provider.

A small team attended the SHIP PCMH Learning Collaborative in June 2018 and following the collaborative, their PCMH physician champion began testing team huddles. The clinic also further updated their EMR to produce quality data reports for preventative and chronic condition management. They also initiated a connection to the IHDE to facilitate care coordination.

Care Management
Rehabilitative Health Services (RHS) Family Medical Clinic, Ammon, Idaho

Rehabilitative Health Services (RHS) Family Medical Clinic in Ammon, Idaho is a "reverse" integration clinic. They originally started as a behavioral health clinic and added primary care to enhance outcomes for their patients. The clinic has started the NCQA application process. One of their key successes in transformation was developing a new care management program for high-risk patients that incorporates both behavioral health and physical health elements.

Quality and Patient Experience
Kaniksu Health Services, 5 locations serving North Idaho

Kaniksu Health Services has successfully qualified all four of their clinics as level III PCMHs through the NCQA. By practicing this model of care, Kaniksu stated they have vastly improved the quality of care provided to their patients and have received national recognition from HRSA for their work in diabetes management. They are making strides towards reducing ER utilization and hospital readmissions. Kaniksu expressed that this work has prepared them to positively perform in the value-based payment model and they are regularly collecting incentive payments from their contracts with multiple payers.

PCMH Accreditation
Total Family Medicine, Idaho Falls, Idaho

As a solo physician-led practice, this team accomplished a lot with very few resources through weekly team meetings that included support from their Quality Improvement (QI) Specialist and through engaging all team members to take ownership of the process. During their SHIP cohort they successfully obtained NCQA PCMH recognition.

PCMH Accreditation
Kootenai Health, Coeur d'Alene, Idaho

Kootenai Health has achieved recognition for six of its primary care sites within nine months. A team of dedicated clinic leaders from all six sites met weekly to lead the PCMH process, then the clinic leaders and staff met with PCMH coaches monthly to build the transformational process and address culture change within the health system. Their team has committed to continue to meet at least monthly to work on a sustainability plan for their clinics and the larger system.

Population Health Management
Terry Reilly Health Services (TRHS), Melba, Idaho

A diabetes care management program was started in the Terry Reilly Health Services (TRHS) Melba clinic which has one provider. The clinic is open three days a week serving a ranching and farming community. Since Spring 2018, they have identified 80 patients with elevated hemoglobin A1Cs.

Despite staffing changes, including the departure of the clinic's nurse care manager, the office manager, and a behavioral health provider all in one month, they were able to rehire a nurse care manager. They now have over a dozen patients with several months of care management.

TRHS demonstrated several success stories of reduced Hemoglobin A1C from double to single digits and even convinced some of their more reluctant patients with diabetes to meet with one of the pharmacists for medication reviews when they were previously not willing to do so. The SHIP QI Specialist connected TRHS with public health district (PHD) experts on diabetes and they initiated the development of a diabetic nursing protocol. The clinic is also partnering with the local public health district on efforts to spread access to nutritional counseling to these patients.

Community Health Worker
Family Medicine Residency of Idaho, Boise, Idaho

"I have a patient who is on peritoneal dialysis. He became despondent because of his limited life expectancy. His Mom called me to tell me he had stopped doing his peritoneal dialysis. I called him and spent maybe 15 minutes on the phone with him trying to talk him into restarting dialysis – he refused. So, I sent a community health worker, Martha Madero, out to his house. With a longer conversation and more personal attention she was able to talk him into restarting his dialysis. To this day he is doing well."

- Ted Epperly, MD

Telehealth Pilot Program
Latah Community Health, Moscow, Idaho

As part of Community Health Association of Spokane (CHAS) Health, the Latah Community Health clinic began to investigate home-based telehealth for the Latah County community in the summer of 2016. In addition to an evaluation on patient travel distances, CHAS's telehealth needs assessment included access to broadband internet in the service area, patient access to smartphones and computers with webcams, and patient interest in telehealth. Based on the findings, CHAS formed a Telehealth Core Team comprised of clinic, finance, and IT staff. Latah Community Health piloted real-time telehealth visits using the Chiron Health platform for patients who are located at home during the time of the visit. The program targeted Medicaid and uninsured adults in Latah County, and in particular, behavioral health and diabetic patients who require regular follow-up appointments. The goals were to reduce patient transportation barriers, increase patient engagement in their own care, and expand system capacity. Program activities included a multi-faceted outreach campaign, including social media and mass mailings, workflow development for behavioral health, dietitian, and pharmacy services, and regular team meetings to drive quality improvement.

As the CHAS team continued to focus on their BH program, Health Management Associates added Dr. Marc Avery, new to HMA from the University of Washington, to the coaching team. Dr. Avery is a psychiatrist and tele-psychiatry subject matter expert. He provided specific technical assistance virtually, as well as an on-site work session with CHAS Health behavioral health team to discuss the expansion of the Latah tele-behavioral health program.

Idaho Health Data Exchange
Family Practice Physician, Boise, Idaho

“There is no question that having [IHDE] portal access to medical records has significantly improved my ability to provide care for patients. A day does not go by where I’m not accessing several patients’ records for information. Just yesterday I had a patient walk into the clinic for evaluation after being in the ER for a possible stroke. He just walked in for evaluation and records were simply not going to be faxed from the hospital in a timely fashion. I was able to view the radiology reports that indicated that a stroke had occurred and that he was still having problems. I had an incomplete note from the ER that the patient left the ER and declined admission but just got medications and left. Without immediate access to the portal I would not have been able to appreciate the seriousness of the situation; I wouldn’t have known that he was diagnosed with an actual stroke. With that knowledge, I was able to get other processes moving to help the patient back to health.”

- Geoffrey Thomas, DO