Idaho Statewide Healthcare Innovation Plan (SHIP) Final Report

Idaho SIM Grant #1G1CMS331399

4.30.2019

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Idaho Statewide Healthcare Innovation Plan (SHIP) State Innovation Model Grant Final Report

Project Period: 2/1/2015-1/31/2019

Grant Number: 1G1CMS331399

State Innovation Models: Round Two of Funding for Design and Test Assistance CMS-1G1-14-001

Required Submissions for the CMMI Final Report:

- A summary of activities and major accomplishments and milestones that occurred during the entire cooperative agreement term, including a complete discussion of project activities, analysis of the effectiveness/success of the project, lessons learned to date, and description of project activities that will be continued after the cooperative agreement activities have ceased.
- A summary of the sustainability strategies the recipient will employ to sustain SIM initiatives.
- An updated, final Metrics Report through the end of the SIM period following the same format as the Quarterly Metrics Report. Recipients should provide the most recently available data for all required reporting elements. If data are not yet available through the end of the SIM period at the time of reporting (due to data lag), the recipient should include a note in the Final Metrics Report explaining any missing/incomplete data.
- A summary of final, actual SIM expenditures across several categories, as outlined in the instructions on pages 2-3 of this guidance.
- A disclaimer that the opinions expressed are those of the recipient and do not necessarily reflect the official view of HHS or any of its agencies.

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

Executive Summary

Idaho made tremendous strides in realizing its vision of transforming the State's healthcare system to one that delivers patient-centered, effective, and coordinated primary care services through a patient-centered medical home (PCMH) model, supported and rewarded by payment models that emphasize outcomes and value. Healthcare delivery and transformation efforts continue to be refined in order to be responsive to Idaho's needs while always maintaining the patient at the center of our model.

Idaho's achievements are due to the partnership and commitment of healthcare professionals across the State, commercial and public payers, State leadership, and other stakeholders who shared their collective knowledge and experience together with the goal of achieving better care and improved health outcomes for all Idahoans. Through this partnership, the State and healthcare system stakeholders focused on Idaho's seven goals:

> Goal 1: Transform primary care practices across the State into patient-centered medical homes (PCMHs).
>
> Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.
>
> Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.
>
> Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs.
>
> Goal 5: Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.
>
> Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.
>
> Goal 7: Reduce overall healthcare costs.

Embedded in these seven goals were the core tenets of our State's vision and values. The first was that a patient-centered focus was the driving force behind all our planning, decisions, and activities. Secondly, quality healthcare is not possible without a dedicated, skilled healthcare workforce. Our goals included: a) incorporating supports at every level for clinics as they transform to the PCMH model; b) adopting new HIT technology systems and processes to support data analytics and expand telehealth; c) enhancing the understanding and use of Community Health Workers (CHW) and Community Health EMS (CHEMS); and d) working with the Regional Collaboratives (RCs), Public Health Districts (PHDs), the SHIP Team and its PCMH Transformation vendor to share best practices and expand care coordination across the Medical – Health Neighborhood to improve clinical outcomes and regional population health. The seven RCs and PHDs represented another key component of Idaho's vision as it reflected the value we placed on local expertise to lead identification of community and regional health needs and solutions.

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Another fundamental aspect of Idaho's vision was moving to payment models that incentivize and reward quality care and improved health outcomes, and in doing so ultimately contributed to bending the cost curve for healthcare costs. Idaho's public and private payers were partners in implementing payment reform. Our partnership was based on an appreciation that "one size does not fit all" when it comes to payment models that work best for diverse organizations, and that a number of alternative payment approaches could be effective in moving the State's healthcare system from rewarding volume to rewarding value. Idaho's four largest commercial payers, Medicaid, and Medicare supported the State's vision of payment reform, and annually submitted data to report on their respective organizations' advancement of alternative payment models (APMs).

Lastly, the advancement of health information technology and data exchange and reporting were critical to the implementation of our SHIP model. Idaho understood that the shift to value-based payment models, expansion of care coordination within the PCMH model, and statewide tracking and reporting of a multi-payer shared set of clinical quality measures cannot be fully realized without HIT. Like many states however, Idaho encountered challenges in creating the necessary HIT infrastructure at the pace needed to match Idaho's readiness to implement delivery and payment reform. While building the needed HIT infrastructure caused delays to full implementation of certain aspects of the SHIP model, Idaho continued to push forward HIT development as our vision for statewide healthcare delivery and payment reform was dependent upon success in this area.

The Idaho Healthcare Coalition (IHC) served a pivotal role of overseeing Idaho's transformation and it successor stakeholder organization; the Healthcare Transformation Council of Idaho (HTCI) will continue to lead the continuation of sustainability planning and implementation following the end of the SHIP grant.

A summary of our successes, opportunities and challenges throughout the four years of the SHIP is best understood by examining the progress of each goal.

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Sustainability Overview

Changing a statewide multi-payer health system requires an investment of significant financial and human resources. Since deciding to embark on this journey of healthcare transformation, Idaho has been mindful of the need to sustain both the momentum gained and the changes that will have occurred by the end of the grant period. Idaho applied for SIM grant funding knowing that this was potentially a one-time opportunity to garner financial support for transformation given that the state does not have the resources to replace federal dollars when the grant ends.

With that in mind, Idaho chose to invest its grant funds primarily in establishing and expanding the foundation upon which transformative change will occur. For example, upfront costs of HIT and data analytics infrastructure development occurring now will provide a future platform for data analytics and reporting at an affordable cost. The investment in a regional infrastructure to support PCMH transformation and population health will be sustained beyond the grant period as a result of the grant seed funds supporting new partnerships between healthcare providers, stakeholders, and the PHDs. The commitment and collaboration across payers to advance value-based payment models will help sustain improved healthcare delivery into the future.

Effective February 1, 2016, IDHW restructured its Healthy Connections and Healthy Home Program to incentivize primary care practices to expand the PCMH model. This program change has advanced implementation of the model while leveraging federal Medicaid funds to help support it. Idaho continually looks for opportunities to participate in federal funding opportunities to expand innovation and best practices across the state's health care system.

The Public Health Division and the seven PHDs in Idaho will play critical roles in the sustainability of the state's long-term funding and support for population health improvement activities. Public Health's mission focuses on improving population health by: 1) preventing disease, disability and premature death; 2) promoting healthy lifestyles; and 3) protecting the health and quality of the environment. The goal of SHIP to implement and expand delivery systems and payment models to improve population health is a natural fit with the mission of public health. Long before the SIM Model Test grant was awarded to Idaho, the PHDs were working to improve population health, and their work in this area will continue after the grant period ends.

Final Progress Report

Goal 1

Prepared for
CMMI

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Patient Centered Medical Home (PCMH) Transformation Team

Contract AC057300 Closeout Report

Idaho Statewide Healthcare Innovation Plan (SHIP)

October 20, 2015 - January 31, 2019

PCMH TRANSFORMATION TEAM

The SHIP PCMH Transformation Team is supported by Funding Opportunity Number CMS-1G1-14-001 from the US Department of Health & Human Services, Centers for Medicare & Medicaid Services.

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OVERVIEW

In August 2015, the Idaho Department of Health and Welfare (Department) selected Briljent, LLC (Briljent) to implement Patient Centered Medical Home (PCMH) training and technical assistance (TA) to support the Department's Statewide Healthcare Innovation Plan (SHIP) Model Test. On October 20, 2015, the Briljent contract with the Department was fully executed.

This report is the PCMH Transformation Team's (Team) Contract Closeout Report. This report summarizes implementation of the PCMH Training and TA Program and describes the evolution and expansion of the project work, and the value added to the SHIP PCMH transformation grant activities with SHIP clinics and the Department over the life of the Briljent contract.

Briljent Contract for PCMH Training and TA

The contract covered a Pre-Implementation period and three subsequent Award Years (also called Model Test Years). Model Test Years 1 through 3 (also known as Award Years 2 through 4) began on February 1, 2016 and continued through January 31, 2019.

The Pre-Implementation period (also known as Award Year 1) was a compressed planning period to allow the Team to plan and prepare for Model Test Year 1, when the first cohort of SHIP clinics was to begin. The initial Briljent contract was extended by one month, through February 29, 2016, to allow the Team to finish critical planning in the compressed Pre-Implementation period, while still ensuring that Model Test Year 1 began on time for SHIP and the SHIP Cohort 1 clinics.

The Briljent contract time periods and project nomenclature are outlined in Table 1. When referring to SHIP cohort clinics, the report will refer to "Model Test Year." When referring to Team deliverables in the Briljent contract, the report will refer to "Award Year."

Table 1: Contract Project Time Periods Nomenclature

Period of Performance Start Dates	End Dates	SHIP Model Test Year = SHIP Cohort Year	Contract Award Year (AY)
October 20, 2015	Extended to February 29, 2016	Pre-Implementation Period	Award Year 1
March 1, 2016	January 31, 2017	Model Test Year 1 (Cohort 1 Clinics)	Award Year 2
February 1, 2017	January 31, 2018	Model Test Year 2 (Cohort 2 Clinics)	Award Year 3
February 1, 2018	January 31, 2019	Model Test Year 3 (Cohort 3 Clinics)	Award Year 4

Per the contract, the Team's fundamental role was to help advance the Department toward the attainment of SHIP Goal 1, the first of the seven SHIP Goals set forth in the *SHIP Operational Plan*:

- **Goal 1: Transform primary care clinics across the state into Patient Centered Medical Homes (PCMHs).**
- **Goal 2:** Improve care coordination using electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.
- **Goal 3:** Establish seven Regional Collaboratives to support the integration of each PCMH within the broader medical neighborhood.
- **Goal 4:** Improve rural patient access to PCMHs by developing Virtual PCMHs.
- **Goal 5:** Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.
- **Goal 6:** Align payment mechanisms across payers to transform payment methodology from volume to value.
- **Goal 7:** Reduce overall healthcare costs.

Team Alignment to SHIP Goals

As a component of Goal 1, and to support SHIP Goals 3 and 4, the Team worked with SHIP to ensure tasks and deliverables were aligned with SHIP and set up to be accomplished successfully. The Team planned to work with Public Health Department (PHD) SHIP Quality Improvement Specialists (PHD QI Staff) and SHIP clinics to coach and provide training and TA to help clinics implement processes and policies to strive for PCMH transformation and, if they chose, toward PCMH recognition.

PCMH Team Structure and Roles

Briljent formed and led the Team, which consisted of the following three firms:

- Briljent – project management (PM) and training expertise
- Health Management Associates (HMA) – PCMH and clinical subject matter expertise
- Myers and Stauffer (MSLC) – experience in auditing and government health programs

Briljent served in the role of project manager (PM), overseeing operations of the PCMH Training and TA Program by managing the Team, as well as the project areas relating to the PCMH Transformation portal, clinic contracts and payments, and Team/project communications. Briljent's role allowed PCMH Coaches (Coaches) from HMA, subject matter experts, to focus on the key component of this contract; to coach clinics to help them transform to PCMHs.

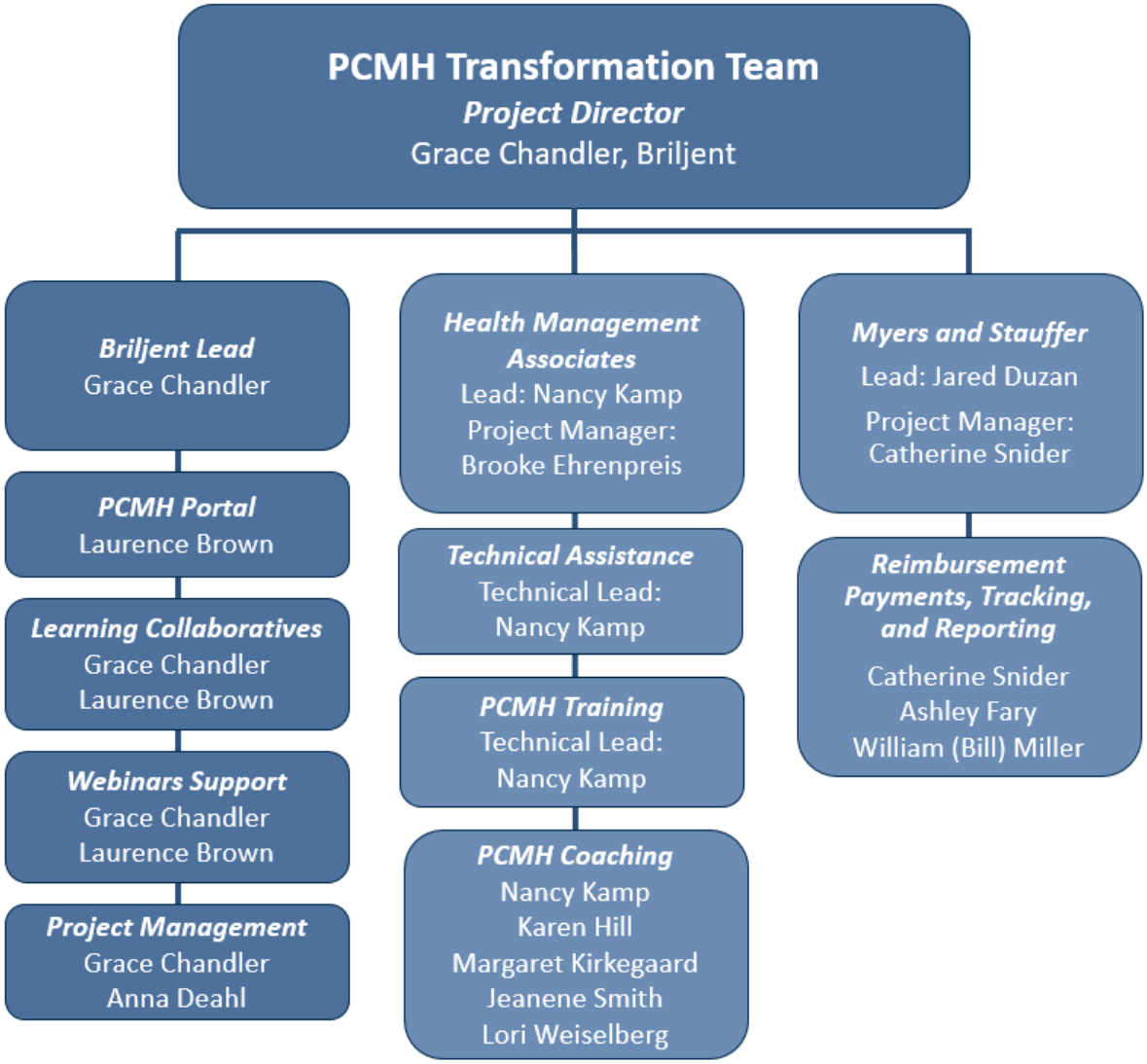
As part of the Team, HMA convened a team of consultants, each of whom served part-time in the role of a Coach who worked with one or more of the seven PHDs and with various clinics. One Coach, Nancy Jaeckels-Kamp, served as the PCMH Technical Director for a major portion

of the contract. To help Briljent manage HMA work deliverables, schedules, and travel, an HMA PM was added in Award Year 2.

Another major component of the Team was MSLC's role as a project check point. MSLC developed a methodology to review, audit, approve, and report clinic payments (These were called incentive payments for Cohort 1 and reimbursement payments for Cohort 2 and Cohort 3. The report refers to all payments, unless otherwise specified by cohort, as reimbursement payments.).

The Team's work breakdown structure is outlined in Figure 1.

Figure 1: PCMH Transformation Team



Scope of Work – General and New Requirements

Briljent and the Team developed a Project Management Plan (PMP), in consultation with the Department, to plan to conduct project activities and develop work products, schedules, and deliverables. During this agile project, the Department and Briljent negotiated and developed 17 change requests (CRs) for Scope of Work (SOW) or budget modifications, adding value and often scope or definition to the project deliverables. These CRs allowed the Team to remain nimble and flexible in adapting to the ongoing and dynamic needs of the PCMH project and to meet the needs of both the Department and clinics.

Table 2 shows the Briljent CRs by Award Year throughout the life of the project.

Table 2: Briljent Contract and CR Numbers, 2015 - 2019

Approved CR Number	Award Year	CR Topic(s)
CR 001	2	• PHD QI Staff training and support • Learning Collaborative #1 coordination and event planning • Assistance SHIP with clinic selection of Cohort 2
CR 002	2	• Evaluation of the PCMH coaching process • Evaluation of the SHIP PCMH Transformation portal • Bi-weekly status meetings with SHIP and Team
CR 003	2	• Increased time for coaching the PHD QI Staff • Additional 330 coaching calls with the clinics • Learning Collaborative Session – March 2016; added Day 2 and the World Café breakout session • Outlined recoupment process for clinic reimbursement payments
CR 004	2	• Travel to Learning Collaborative by two Briljent staff members
CR 005	2	• Portal upgrades, including increasing user features and transformation plans and developing reports related to Goal 1 success measures for the Center for Medicare & Medicaid Innovation (CMMI) • Development of portal requirements documents
CR 006	3	• Revised SOW added clinic to Cohort 2, with additional clinic support
CR 007	3	• Continuing Medical Education (CME) Credit Application to American Academy of Family Physicians (AAFP) for educational webinar series (not approved) • Learning Collaborative event coordination
CR 008	3	• Idaho PCMH Mentorship Subcommittee participation • Review of Department documentation
CR 009	3	• Mentorship webinar series

Approved CR Number	Award Year	CR Topic(s)
CR 010	3	• Team Program Enhancements (realignment of unused funds from reimbursement to training and portal) • Portal enhancements • Toolkits – Mentoring for Success, Employees New to PCMH Orientation, Onboarding Clinics New to PCMH • Sustainability Workshop for Clinics
CR 011	3	• SHIP request to amend Briljent Agreements with Cohort 1 and Cohort 2 clinics to allow clinics to apply for and receive reimbursement as approved by SHIP through the end of the SHIP grant period
CR 012	4	• Additional Mentorship webinars
CR 013	4	• PCMH Sustainability and Patient Engagement Toolkits • Best Practices Focus Group • Clinic/Patient Incubator Project • Change Management workshop sessions
CR 014	4	• Boise State University (BSU)/Goals 2 and 5 – State Evaluation Team (SET): EHR systems, clinic processes and work flows, clinical quality measures (CQM) reporting; MentorSHIP use cases; formation of affinity groups, reporting CQMs to the National Committee for Quality Assurance (NCQA), and other national accreditation organizations
CR 015	4	• Briljent Closeout Report • SHIP PCMH Portal Transition Plan to BSU • SHIP PCMH Transformation Plans and Roadmaps transition to the Department (including all files to the Department)
CR 016	4	• Organizational Change Management (OCM) Virtual Toolkit
CR 017	4	• Budget transfer from materials and travel to training, TA, and project management

PRE-IMPLEMENTATION PERIOD (OCTOBER 2015 – FEBRUARY 2016)

Planning Activities

From October 20, 2015, through January 31, 2016, the Team planned and prepared for the upcoming Award Years of the project, as well as for the first 55 SHIP cohort clinics, known as Cohort 1, which were to start on February 1, 2016 (the first Model Test Year). Due to the compressed planning time and developing policies by the Department, as

The SHIP PCMH Transformation Team implemented necessary processes and procedures in a compressed period from the contract start of October 20, 2015, and were fully prepared to help SHIP welcome SHIP Cohort 1 clinics on February 1, 2016.

well as the many processes to establish, the Department extended the Team's Pre-Implementation period to February 29, 2016. This extension allowed the Team the necessary time to execute the complex planning needed for all three Model Test Years; to fully develop the original PMP; to create and implement the first version of the SHIP PCMH Transformation Portal (portal); and to be ready to help SHIP welcome SHIP Cohort 1 clinics on February 1, 2016. During this Pre-Implementation period, the Team built the internal and external relationships and processes needed to support a project of this magnitude and complexity, with evolving requirements and numerous deliverables over multiple years.

Requirements Analysis and SHIP PHD QI Staff

Due to the compressed time for the Pre-Implementation period, on September 28, 2015, prior to the Briljent contract effective date of October 20, 2015, the Department and Team participated in a kick-off meeting to discuss the following:

- Department roles, responsibilities, and project objectives
- PCMH requirements established by the Department and the Idaho Healthcare Coalition (IHC)
- The SHIP Model Test Evaluation, used in conjunction with the Department's evaluation team, as well as the evaluation requirements associated with the contracted services

To gain a quick onboarding immersion in the SHIP project, and by invitation from SHIP, the Briljent PM and Team Project Director, Grace Chandler, traveled to Boise, Idaho, on November 5 and 6, 2015. She attended the Department's SHIP kick-off meeting, as well as the kickoff for the SHIP Regional Collaboratives (RCs).

These sessions helped inform the Team of the Department's priorities and the PHD's role in the RCs and SHIP, and facilitated requirements analysis, project planning, and development.

Project Deliverables

The Team's project deliverables are outlined in Table 3 and include add-on tasks to the original SOW.

Table 3: Team Deliverables*

Deliverables	Award Year 1 (Pre-Implementation Period)	Award Year 2 (Model Test Year 1) Clinic Cohort 1	Award Year 3 (Model Test Year 2) Clinic Cohort 2	Award Year 4 (Model Test Year 3) Clinic Cohort 3
SHIP Cohort Clinic Contracts	Y	Y	Y	Y
SHIP Cohort Clinic Contract Amendments	N/A	N/A	Y	Y
Project Management Plan and Schedule	Pre-Implementation Period Planning Activities	Y	Y	Y
Project Management Services	Y	Y	Y	Y

Deliverables	Award Year 1 (Pre-Implementation Period)	Award Year 2 (Model Test Year 1) Clinic Cohort 1	Award Year 3 (Model Test Year 2) Clinic Cohort 2	Award Year 4 (Model Test Year 3) Clinic Cohort 3
Clinic Readiness Assessment and Enrollment	Pre-Implementation Period Planning Activities	Y	Y	Y
Training and TA Plan	Pre-Implementation Period Planning Activities	Y	Y	Y
Quality Assurance Plan	N/A	Y	Y	Y
Transition Plan	N/A	Y	Y	Y
Idaho Payment and Accounting System (I-PAS) Tracking Tool	Pre-Implementation Period Planning Activities	Y	Y	Y
SHIP PCMH Transformation Portal	Y	Y	Y	Y
PHD SHIP QI Learning Sessions	Pre-Implementation Period Planning Activities	Y (2)	Y	N
Clinic Learning Collaborative, Boise, Idaho	Pre-Implementation Period Planning Activities	Y (2)	Y	Y
Clinic and PHD SHIP QI Cohort Educational Webinars	Pre-Implementation Period Planning Activities	Y (6)	Y (6)	Y (6)
PHD SHIP QI Training Webinars	N/A	Y (3)	N	N
Clinic Mentorship Webinars	N/A	N/A	Y (6)	Y (6)
PHD SHIP QI Staff Skills Assessment by PCMH Coaches	N/A	Y	Y	Y
PCMH Coaching Sessions with Clinics	N/A	Y	Y	Y
Clinic Site Visits by PCMH Coaches	N/A	Visits with Each Clinic After the Second Learning Collaborative	Y	Y
SHIP and Team Weekly Meetings	Y	Y	Y	Y
Weekly Status Reports	Y	Y	Y	Y
Monthly Progress Reports	Y	Y	Y	Y
Briljent Invoice to SHIP (Monthly)	Y	Y	Y	Y
Quarterly Expenditure Meetings – SHIP and Briljent	N/A	N/A	Y	Y
Quarterly Expense Report by Briljent	N/A	Y	Y	Y
Status Success Progress Measures Reports (Quarterly)	N/A	Y	Y	Y
PCMH Coaching Evaluation by Clinics and PHD SHIP Staff	N/A	Y	Y	Y
PHD SHIP QI Staff Evaluation by Clinics	N/A	Y	Y	N
Mentorship Webinar Summary Report	N/A	N/A	N/A	Y

Table Key:

Y = Yes, there were deliverables in this category.
N = No, there were no deliverables in this category.
N/A = This is not Applicable to this time frame.
(#) = The number in parentheses shows instances of the deliverables.

Other requirements mentioned in the Department's request for proposal (RFP) and further discussed and developed in the Briljent SOW were as follows:

- **SHIP PCMH Transformation Portal** – Briljent, along with Adaptive Systems, developed a portal and a process to serve as a single-point repository for learning resources, participation tracking, and collaboration. The portal included the SHIP PCMH Transformation Plan and allowed for MSLC to upload clinic participation progress data for transparency. The portal was ready for users at the beginning of Model Test Year 1.
- **SHIP PCMH Transformation Plan** – The Team and the Department identified and discussed the need for both a process and a tool to assist each participating clinic in developing a customized PCMH Transformation Plan. The purpose of the Transformation Plan would be for each clinic to address gaps, set measurable PCMH transformation and business goals, and chart a course of action toward achieving PCMH accreditation. The Transformation Plan was housed on the portal and provided a location for Coaches to write coaching notes, and for clinics and PHD QI Staff to log their own notes.
- **Clinic Coaching Site Visits** – The Department's RFP requested site visits to each clinic. Although the Team proposed to conduct site visits and six coaching calls with the clinics in each cohort, each year, the Team initially recommended that Coaches increase the frequency of coaching calls to monthly to provide more concentrated and focused coaching support to each of the clinics and PHD QI Staff. The Department considered this approach and negotiated with the Team to conduct annual site visits and six coaching calls with each clinic, as originally planned. See the Site Visits section for more information.
- **Learning Collaborative Events** – In Model Test Year 1 there were two Learning Collaborative events for the Team to plan and coordinate. This proved to be a challenge as the Briljent contract did not include funding to coordinate and pay for an event venue, and federal grant monies did not allow for catering expenses. Therefore, the Department secured sponsorship for venue space as well as catering costs for each Learning Collaborative. In Model Test Years 2 and 3, one Learning Collaborative event was held annually, and BSU hosted the Learning Collaborative events on their main campus. The Learning Collaboratives improved each year to comprehensively offer relevant learning opportunities such as panel discussions with third-party payers, discussions on adoption of EHRs, and moderated group learning with subject matter experts (SMEs) via a World Café setting.
- **Reimbursement Payments to Clinics** – The Department added a new requirement to the project that was not clearly established in the RFP. As a State entity, the Department was unable to pay SHIP cohort clinics their reimbursement payments, and therefore, requested Briljent be responsible for developing and monitoring clinic agreements with each cohort of clinics. Briljent's role was expanded in Model Test

Years 2 and 3 to also develop agreement amendments with prior cohort clinics who were still working toward PCMH accreditation, to allow for ongoing TA and reimbursement payments, if eligible. This task also involved making direct reimbursement payments to clinics, necessitating information on banking from clinics for electronic reimbursement payments.

- **Six New Virtual Toolkits** – Due to the various clinics and staff entering the program in each cohort year, and the need for clinics and staff to rapidly gain information and develop competencies related to PCMH, six virtual online toolkits were approved by the Department to be developed and posted on the PCMH portal. Each toolkit was designed with a visually appealing graphical user interface (GUI) and robust and engaging content, and included educational and/or resource videos, worksheets, sample templates, exercises, and real-world scenario. Each toolkit contained a virtual downloadable Notebook used concurrently with the toolkit to keep track of insights, ideas, and notes. This led adult learner users through content and activities to effectively help them grasp, track, and retain information learned from each toolkit.

  Each toolkit allowed for sequential or standalone progress through each module to help meet the needs of dynamic healthcare clinic environments and staff. Some clinics used the toolkits to conduct small group trainings. The toolkits the Team developed and posted on the portal are as follows:

  - **Clinics New to PCMH** – This toolkit was designed for clinics that are new to the PCMH concept and want to learn more. It focused on the basics of PCMH (rather than the specifics of accreditation) to help new clinic PCMH teams develop a common understanding of the PCMH model.
  - **Onboarding Employees New to PCMH** – This toolkit was designed for onboarding employees new to the PCMH concept to learn more about how their jobs may be different in the new PCMH model.
  - **Mentoring for Success** – This toolkit was designed for primary care practices interested in developing clinic-to-clinic and peer-to-peer relationships. Its purpose was to help identify clinic staff interested in serving as mentors and mentees, also known as mentoring collaborators, to other practices or staff, as well as to learn the various aspects of mentoring within the PCMH transformation context.
  - **Best Practices for PCMH Sustainability** – This toolkit was designed primarily for clinics that had already undertaken PCMH transformation and wanted to understand the best practices for sustaining the PCMH model.
  - **Best Practices in Patient Engagement** – This toolkit was designed for PCMHs and other clinics looking for strategies and resources to enhance their patient engagement efforts.
  - **Organizational Change Management** – This toolkit addressed organizational needs to support change, deal with resistance, and move people in the direction of the change. The PCMH transformation journey represented a major organizational change that impacted clinics and stakeholders, and this toolkit was designed to assist with leading OCM.

- **Workshops** – The Department requested Briljent provide additional training and TA through on-site workshops throughout Idaho and for specific identified needs. Workshops provided curated and timely content and were moderated by Briljent SMEs.
    - **PCMH Sustainability** – This dedicated workshop occurred at the end of Model Test Year 3, in January 2018, and offered Department-selected stakeholders help with assessing what was needed for ongoing PCMH sustainability, such as:
        - Where they were and where they wanted to be
        - Identifying key challenges and opportunities
        - Defining what it is to be "sustainable"
        - Gaining clarity and making decisions on key areas of focus and strategic initiatives

      The PCMH Sustainability Workshop was well-received and allowed the Department to move forward with strategic goals in time to execute them before the SHIP grant ended in January 2019.
    - **Effectively Leading Change** – These in-person workshops took place in October of Model Test Year 4 (2018) and were offered to SHIP clinic stakeholders in three sessions held statewide. A fourth session was conducted in December 2018 in Boise, Idaho, for Department staff. The workshops featured functional information related to OCM to teach leadership how to successfully support the adoption of change to advance the changes within their organizations and help transform healthcare delivery.

The Effectively Leading Change workshops were facilitated by experienced and skilled OCM professionals from Briljent and a Coach from HMA. Workshops focused on learning to lead the "people side of change."

- **Mentorship Webinars** – Following the creation of the Department's SHIP PCMH Mentorship Framework in 2017, the Team worked with the Department to initiate a series of mentorship webinars with topics directly relevant to their current work. These webinars included expanded education options for SHIP clinics in Model Test Years 2 and 3. Mentors were recruited from SHIP clinics to mentor other clinics. These webinars were optional and were open to all SHIP cohort clinic teams.
- **PHD SHIP QI Staff Coaching** – Due to the limited healthcare experience within the PHD QI Staff, the Department approved a CR in the middle of Award Year 2 for Coaches to provide targeted coaching and training with PHD QI Staff. The PHD QI Staff training and TA program was implemented with Amendment 3 of the contract, signed July 20, 2016.
- **Cohort Extended Training and TA** – In Award Year 3 (Model Test Year 2), the Department requested the Team work with SHIP clinics in Cohort 2 as well as to

continue work with clinics in Cohort 1. As a result, Cohort 1 clinics participated in an intensive intervention over two years. This necessitated Briljent to process original clinic agreements as well as amendment agreements with two cohorts of clinics. This was replicated in Award Year 4 (Model Test Year 3), with Briljent extending amendments to both Cohort 1 and 2 clinics who had not achieved PCMH recognition, allowing clinics the opportunity to apply for and receive SHIP reimbursement payments for achieving accreditation.

SHIP Cohort Clinics Selection

SHIP's goal was to enroll a total of 165 SHIP clinics or 55 clinics in each cohort or Model Test Year. SHIP selected 166 clinics over the three Model Test Years and officially enrolled 165 during the project. Of those 165 clinics, 163 remained engaged in PCMH and 94 received a SHIP reimbursement payment for PCMH recognition.

The Team's Technical Director (HMA) was asked to review SHIP cohort clinic applications and conduct a gap assessment to note questions or areas of concern that would make it difficult for the clinic to fully participate in SHIP (e.g., the clinic was implementing a new EHR that same year, the clinic was undergoing a merger or acquisition, etc.). The Team also conducted a readiness assessment with each prospective clinic to evaluate gaps in PCMH competencies, commitment, and readiness to change, and assessed each clinic's qualifications for participating in the SHIP Model Test.

To aid in this process, the Team used a Readiness to Participate/Readiness Assessment gap analysis which was sent to SHIP for recommendation for the selected clinics, per cohort.

The Team's Technical Director recommended and worked collaboratively with SHIP to revise the clinic application, including questions related to change capacity and leadership engagement. This helped support the selection committee as they developed inclusion and exclusion criteria and a scoring process for the SHIP cohort clinic applications.

As a follow-up to selected SHIP clinics, the Team's Technical Director contacted certain clinics' leadership to explore potential identified issue(s) and provided a recommendation to SHIP regarding the clinic's potential SHIP cohort enrollment. The recommendations informed the Department's selection committee to make a final decision about accepting the clinic in the SHIP cohort. In each subsequent year, the Team's Technical Director provided this readiness or gap assessment of clinics identified by SHIP as having possible risks in participation and reported to SHIP on any "pink or magenta flags" of risk or approval of readiness to participate.

Non-traditional primary care providers were also accepted into SHIP. For example, one group had several urgent care clinics that were developing longitudinal primary care. Additionally, four behavioral health clinics developing "reverse integration" with the addition of primary care services also participated.

As the PCMH project proceeded and as the Cohort 1 clinics were completing their first year, the Department also developed a Virtual PCMH program to promote creation of programs for Community Health Workers (CHWs) and Community Health Emergency Medical Services (CHEMS) as part of the SHIP Goals. These programs dovetailed and had collaborative participation with the PCMH clinics to advance the SHIP Goals in transforming health care in Idaho. To further promote the CHW and CHEMS programs, these groups presented information to the clinics during educational webinar sessions, allowing clinics to gain additional information and insight into healthcare transformation.

In Cohort 1, several clinics accepted by SHIP were already recognized or certified by a national PCMH accrediting body, and many other clinics were already on the path toward PCMH recognition. The first cohort of clinics also had participation from more of the larger, integrated medical groups or health systems. As Cohort 2 and 3 clinics were accepted, clinics were less prepared for PCMH transformation and, therefore, necessitated more intense support and coaching from Coaches and PHD QI Staff.

After each cohort's selection, SHIP notified clinics they were accepted to participate and provided a Welcome letter that included information from the Team and other SHIP contractors and partners regarding the upcoming year's training and TA activities. SHIP and the Team also conducted an introductory educational webinar at the start of each new cohort, providing an overview of the program goals, requirements, and expectations, and engaging the commitment of clinic leadership.

SHIP Clinic Agreements with Briljent

The Team executed agreements with each clinic annually for a one-year term, beginning February 1 and ending January 31 of the following year, for each of the three cohort years. The agreements required each clinic in that cohort year to be a provider of primary care, have a clinical champion/physician and a PCMH lead, and assign other team members to the Team to participate in the program, including participation at the in-person learning collaborative, six telephonic coaching sessions, one site visit, and six educational webinars.

In Model Test Year 1, the clinic agreements set forth a payment of $10,000 upon enrollment in the program. In subsequent years, clinics were required to submit a budget for approval to SHIP to be reimbursed up to the $10,000 limit. To retain this reimbursement payment, a clinic needed to have met the minimum criteria or benchmark for participation in the learning collaborative, coaching sessions, and educational webinars. The clinic agreement also included a $5,000 payment upon the Team's receipt of evidence of PCMH recognition or accreditation during the project period.

In collaboration with SHIP, Briljent developed and executed 165 clinic agreements, many of which were amended to extend the term of training and TA in subsequent years. Briljent also handled all contract administration throughout the PCMH project.

In Model Test Years 2 and 3, a new $2,500 payment was added for becoming a Virtual PCMH. To receive the payment, a clinic needed to submit an application and a budget as proof of successfully achieving one of the following Virtual PCMH programs as approved by the Department:

- Telehealth
- Community Health Workers (CHWs)
- Community Health Emergency Medical Services (CHEMS)

Readiness Assessment of SHIP Clinics

PCMH Self-Assessments

To assess the extent to which clinics were implementing a patient-centered model of care, the Team reviewed or assisted sites in conducting a self-assessment. All Cohort 1 clinics enrolled in SHIP were also in Healthy Connections (Medicaid) and most (51 of 55) had already completed a PCMH self-assessment tool, the PCMH-A, to assess patient-centered care; however, they did not assess criteria related to a PCMH recognition program. It should be noted that 51 one clinics were at a payment level with Medicaid that required them to complete the PCMH-A assessment.

Since most enrolled clinics had the intention of applying for NCQA PCMH recognition, the Team used the Primary Care Development Corporation's (PCDC's) PCMH Self-Assessment Tool, which was developed based on the NCQA PCMH 2014 Standards. This tool auto-calculated a score based on the number of PCMH attributes the clinic already had in place and provided additional information useful in identifying specific gaps related to the NCQA PCMH standards. SHIP approved clinics to utilize either tool: the PCMH-A, if already completed for Healthy Connections, or the PCDC PCMH Self-Assessment Tool (PCDC Tool). Many of the sites completed both the PCMH-A and the PCDC Tool. In addition, Coaches helped clinics address the changes to the NCQA 2017 Standards, as well as those changes in the clinic's Transformation Plans in the portal.

SHIP PCMH Transformation Portal

Portal Summary

The Idaho SHIP PCMH Transformation Portal website is an online environment that allows SHIP, the Team, PHD QI Staff, and clinic participants to collaborate on documenting transformation plan goals and activities, measuring progress, sharing information, and benefitting from education and training events, as well as coaching sessions. In addition, the SET used information from the Transformation Plans in their work, which was outside of the scope of this contract.

The portal evolved over the three cohort years based on feedback from actual usage. Its major features are:

- A Dashboard with charts that summarize percent achievement for the categories of Educational Webinars, Learning Collaboratives, and Coaching Sessions participation
- A Calendar which provided important training and TA dates such as coaching, educational and mentorship webinars, Learning Collaboratives, etc.
- A collaborative, online documentation of each clinic's Transformation Plan, organized initially into four sections, and later only 3 sections, allowing interactive updates and additions, and to print to PDF
- Upcoming events to provide awareness, one-click registration, and attendance tracking at program-sponsored events, such as educational and mentorship webinars and Learning Collaboratives
- A Resource Library to provide access to program-related documents and links to websites organized into relevant and searchable categories
- A set of online training Toolkits
- An online forum for participants to post and respond to topics of interest
- A Frequently Asked Questions (FAQ) section to provide self-service / self-help capabilities for the portal's users
- An announcements area to share news of policies and clinic successes
- An administrative area to manage portal content, events, clinics, PHDs, and users

The portal database also was a repository for SHIP and Team's internal documents, including a clinic payment tracker document. Additionally, certain content was outlined in the requirements, including a user Help Desk, and Briljent created an e-mail mailbox, PCMHID.Team@briljent.com, to respond to inquiries and send communications from an identified source.

Portal Development

Stage 1 of portal development was completed in November 2015, with the portal acting as a document repository. In December 2015, Briljent met with SHIP to gather feedback and review portal requirements. The portal was made available to users by the start of the first cohort of clinics.

During Award Year 2, Briljent subcontracted with Adaptive Systems to deliver updates to the portal. Chief among the items developed in this phase and interactive with the SHIP PCMH Transformation Plan were online events registration, and a comprehensive Resource Library (previously called the Document Library). The portal updates were presented to the IHC on May 18, 2016, and the changes were live for clinic users the next day.

The portal distributed a list of publicly available, electronic PCMH tools to clinics. The Team continued to identify, refine, and develop new tools and materials to meet the needs of SHIP as the program evolved. The Team also promoted sharing of tools and best practices among participating sites as they developed some of their own tools.

Portal Requirements

Per requirements, the portal was to serve as a single point repository for learning resources, training and TA, event participation tracking, and collaboration. The portal was based on open source applications where possible and was built using the WordPress framework, a feature-rich platform with an abundance of open source plugins that provided extended functionality.

Portal Results and Impacts

The portal was actively used throughout all three cohort years. The following are some key usage statistics as of January 4, 2019:

- 164 clinics from 74 clinic organizations (53 - 56 clinics per cohort), within 7 PHDs
- 165 appointments documented on the shared clinic calendars (for Cohort 3 only)
- 767 users, including clinic staff, PHD SHIP, SET, the Team, and SHIP staff
- 69 events with 2,663 participants
- 10,075 Transformation Plan entries were created throughout all sections of the transformation plans, averaging 61 per clinic, and 5 per clinic per month
  - 1,079 goals with 1,195 plans for change
  - 1,137 progress entries
  - 1,412 coaching calls and sessions with 2,547 attendees
  - 2,705 notes
- 375 resources organized into one or more of 46 categories
- 11 forum entries (6 topics and 5 replies)
- 14 announcements and celebrate successes entries

The portal proved to be an effective communication tool to provide visibility to and drive participation in program events, to disseminate Resource Library information, to administer training, and to document PCMH transformation progress and ongoing collaboration.

Portal Functions and Features

SHIP PCMH Transformation Plan

As stated previously, the Team and the Department identified the need for both a process and a tool to assist each participating clinic in developing a customized PCMH Transformation Plan. The purpose of the Transformation Plan would be for each clinic to address gaps, set measurable PCMH transformation and business goals, and chart their courses of action.

The PCMH Self-Assessment baseline results for each clinic were the basis for identifying gaps in comparison to NCQA PCMH Standards and Guidelines. Using this body of results, the Team assisted clinic leads in developing measurable AIMS/goals and a clinic-specific work plan (Transformation Plan) focused on achieving the level of transformation feasible and desired by the clinics throughout their participation with SHIP.

The Transformation Plan was an electronic tool embedded in the portal and was designed to reflect the domains in the NCQA Standards and Guidelines, consistent with the PCMH Self-Assessment Tool. With assistance from the PHD QI Staff, the clinics entered their AIMS/goals and plans for change in the Transformation Plan template. The Transformation Plan served as an organizational tool for clinic teams to document not only their goals and plans, but also their progress. A section in the portal was dedicated for clinics to note monthly progress, which was then used to help guide PHD QI Staff and Coaches in developing agendas for coaching calls.

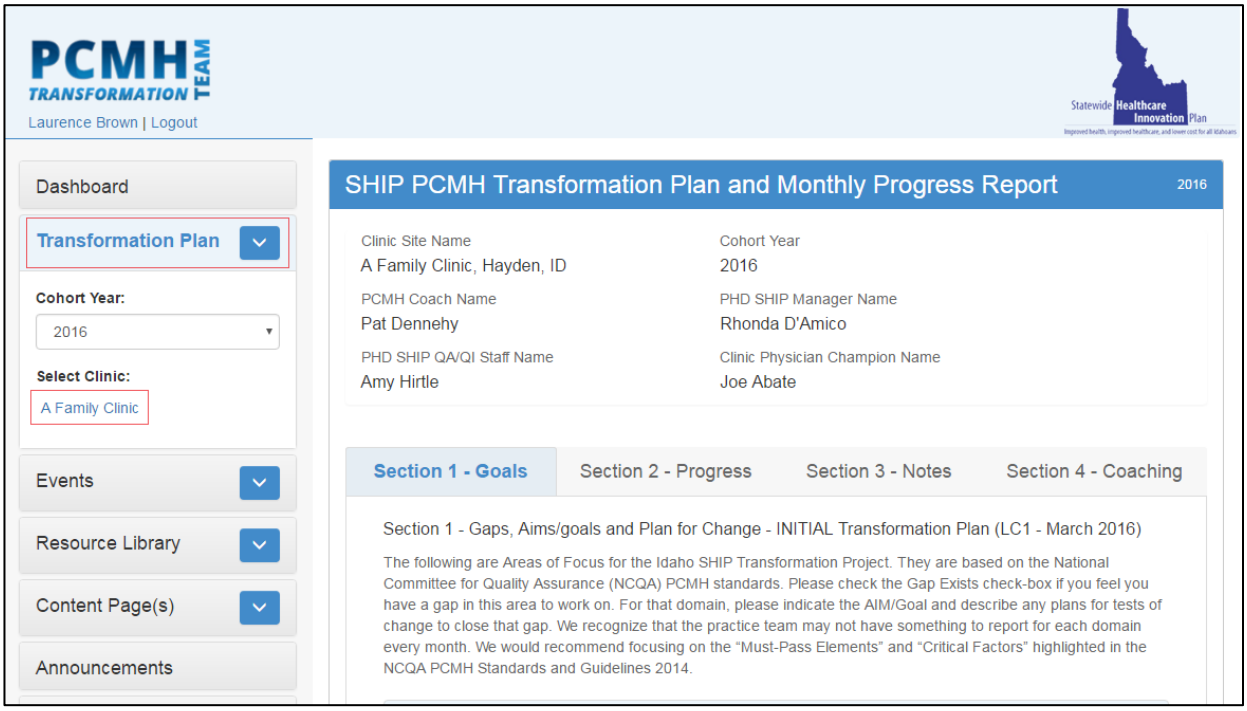
The portal enabled clinics to access only their own Transformation Plans and Progress Notes, while PHD QI Staff and Coaches had access to multiple Transformation Plans and progress for their assigned sites; the SHIP administrator and the Department had access to all. It was noted that many clinics did not fully utilize their Transformation Plans and Progress Notes as was intended. While all clinics were required to start their Transformation Plans in the portal per their agreement with Briljent, the clinic leads had personal preferences for where and how to document plans and track progress, such as by utilizing the PCMH Self-Assessment Tool. Others had pre-established methods used by their clinics to plan and track progress, while others kept a separate document with cumulative plans and progress. Coaches were flexible in working with clinics on the tools with which clinics felt most comfortable, although clinics would not always openly share those documents.

The SHIP PCMH Transformation Plan was comprised of the following four sections, as depicted in Figure 2:

- **Section 1: Goals** – This section contained tabs for each of the six Standards or Concepts in the NCQA Recognition program. Clinic team members were responsible for completing this section.
- **Section 2: Progress** – This section tracked monthly progress. Clinic teams documented their actions and plans for specific standards. It was not necessary for clinics to chart monthly on all standards, but rather only those on which the team had worked during that month.
- **Section 3: Notes** – This section pertained to coaching calls and notes from the Coaches and PHD QI Staff. Each coaching call date was entered by the Coach and discussion items and follow-ups from that call were tracked. Coaches and PHD QI Staff could enter notes in this section as needed.
- **Section 4: Coaching** – This section allowed clinics to record reflections and learning notes. It was mainly reserved for the clinic team to complete when they wanted to note a lesson learned from that month or something they wanted to share with the Coach and PHD QI Staff at the coaching call (e.g. accomplishments, barriers/efforts to overcome barriers, topics to discuss in future coaching calls, or educational or mentorship webinars, etc.).

Note: In Award Year 4, the sections were reduced to three: Goals, Coaching, and Notes.

Figure 2: Transformation Plan



Events

The Events section allowed users to learn about and register for one of the following two event types:

- **Webinars** – Registration for all webinars, including clinic Educational and Mentorship webinars, after June 21, 2016, was done exclusively through the portal once the requirements for the Events section were finalized.
- **Learning Collaborative** – Registration for the first Learning Collaborative for Cohort 1 was handled through e-mail correspondence, and registration for each Learning Collaborative thereafter was conducted through the portal.

Resource Library

Toward the end of the Pre-Implementation period, the only workable feature housed on the portal was the Document Library, a precursor to the Resource Library. Additional content, such as the Transformation Plan, coaching, educational and mentorship webinars, and Learning Collaborative events would be implemented during Model Test Year 1. With each subsequent year, the portal content and functionality were enhanced for better usability by portal users.

The Resource Library housed a selection of relevant materials that could be accessed by users. The library received significant reorganization and improvements for Cohort 3, based on user feedback. The library's categories were reorganized to align with the six NCQA Standards and two additional areas (Health Information Technology/Information Technology [HIT/IT] Capability and Patient Care [PC]/Behavioral Health Integration [BHI]). Additionally, search results were enhanced for better usability and access.

Forums

The Forums feature was available; however, attempts to improve participation by interested users were unsuccessful. Some possible reasons were that in the competitive healthcare marketplace and with the prevalence of strong safeguards to confidentiality of information, as well as the need for in-organization approval to share information, the Forums feature may have been avoided as a risk mitigation strategy by the clinics.

Progress Charts

The Team (MSLC) implemented dynamic progress charts on the Dashboard for each new cohort to allow clinics to view their participation data. Following the start of the third cohort of clinics, the Team provided static images of the final participation data to clinics in Cohorts 1 and 2, since their data was no longer updated.

Frequently Asked Questions

The Team (MSLC) was responsible for supporting clinics through the development of FAQs that were posted in the FAQ module within the portal. This document, compiled by the Team, was based on historical questions and answers approved by the Department.

Portal Access Control/Security

A hierarchical security structure was used to control access to the portal content. Other than the *Login* page, there would be no public-facing content and content could only be accessed after logging in using a user name and password assigned by the Team portal administrators. All login information was stored in an encrypted database, accessible only by portal administrators. Passwords used field-level encryption to avert a data breach.

Portal content items were assigned to one or more access categories. Initially, if a content item was assigned to a category, only logged-in users assigned to that category would be able to access the content. Per request by the Department, this changed in Award Year 4 so that any user could see all general portal items for clinics.

The following items became features of the portal access hierarchy:

- **Access Levels** – The most restricted access levels were the provider clinics. Each clinic was assigned its own access category, allowing each clinic the ability to view information specific to the clinic plus any content available to all logged-in users.
- **Access Category** – Each PHD QI Staff user was also assigned an access category. By default, a user assigned to a PHD access category had access to content specific to the district and access to content for each clinic assigned to the district. In special cases, a PHD QI Staff user could be restricted to only a few of the clinics assigned to the district. A PHD QI Staff user did not have access to clinic information for clinics that are not assigned to that user's district unless approved by the SHIP Team.
- **Shared Content** – PHD QI Staff users had access to a non-hierarchal structure which consisted of content available to all users assigned to a PHD access category but was not available to any clinic-level users. This allowed content to be shared with PHD QI Staff users outside of the hierarchy while maintaining privacy within each individual PHD structure. For example, other special access categories could be constructed if requested, such as a category that includes only the PHD SHIP managers.
- **SHIP Access** – SHIP users also had comprehensive access across all districts and clinics, as well as private content.
- **Special Access** – The Team had comprehensive access to all content on the site, including private content viewable only by members of the Team. The access system also allowed custom groupings to be created outside the hierarchy. These groupings addressed special case situations requested by SHIP to provide organization-level access if an organization had multiple participating clinics. The clinics in an organization-level hierarchy could span multiple districts, as needed.

With the above access requirements established, for each Model Test Year between January and February, Briljent created new user accounts for staff from all selected SHIP clinics, and portal login directions were sent to each user.

PCMH Idaho Payment and Accounting System

The Team was required to develop and manage the Idaho Payment and Accounting System (I-PAS) to incentivize and, later, reimburse clinics participating in the SHIP Model Test to continue the PCMH transformation process. Briljent and MSLC worked with the Department to finalize qualification requirements for reimbursement payments.

Per the SHIP cohort clinic agreement with Briljent, clinic reimbursements were to include the following:

1. **Initial PCMH Clinic Transformation Reimbursement** – A lump sum transformation incentive was provided to Cohort 1 clinics that completed a readiness assessment and developed a specific clinic Transformation Plan. For Cohorts 2 and 3, a reimbursement was paid upon completion of a Department-approved budget. The initial PCMH Clinic Transformation incentive, later called reimbursement, consisted of an amount of no more than $10,000.
2. **PCMH Transformation Recognition Reimbursements** – Payments to clinics offset the cost of applying for PCMH accreditation. The PCMH Transformation Recognition Reimbursement payment was an amount equal to $5,000.
3. **Virtual PCMH Reimbursement** – This was introduced during Model Test Year 2 for clinics implementing telehealth, CHW, or CHEMS programs as approved by the Department. The Virtual PCMH Reimbursement was an amount of no more than $2,500 and began in 2017.

The third clinic reimbursement type began in Model Test Year 2 for clinics implementing a Virtual PCMH to support SHIP's Goal 4.

Development of the PCMH I-PAS began in early 2016 with a completion date of May 31, 2016. The development process included the following: I-PAS and database testing for the Accreditation reimbursement payment; development of Dashboard requirements; and presentation of Dashboard and graphs to the IHC, which occurred on May 18, 2016.

By July 2016, the Team had received, via collaboration with clinics and the Department, a series of certificates providing proof of PCMH recognition for 17 of the 55 clinics. In that same month, and for the purposes of reporting benchmark attainment, I-PAS participation charts—created and managed by MSLC—became visible for the first time on the portal Dashboard. These Dashboard charts represented the first element portal users would see upon signing in and outlined clinics' benchmark achievement statuses for the various SHIP PCMH activities.

I-PAS Participation, Payments, and Reports

To provide reliable and consistent reimbursement payment data, MSLC established a financial accounting system with documented methodology for calculating, distributing, tracking, reporting, controlling, and reconciling reimbursement payments to clinics that met qualifications. The system tracked attainment of PCMH standards for consistent payment of amounts

Data transfer between the portal and I-PAS was tested and implemented during Model Test Year 1. This created a seamless and effective data exchange to support the goals of the project and participating clinics.

agreed upon with the Department, and Briljent submitted invoices to the Department for approval and payment.

MSLC was responsible for monitoring and tracking reimbursement funds and each clinic's payment status for accurate quarterly reporting and evaluation.

The Team developed a data transfer between the SHIP PCMH Transformation Portal and I-PAS for tracking and reporting purposes.

Cohort Participation

By the end of each cohort, participation benchmarks had to be successfully met by all clinics for them to retain reimbursement payments. Only one clinic had to return a portion of the reimbursement payment due to ending their SHIP participation mid-way through Cohort 2.

Final participation status across clinics was reflected in the I-PAS charts on the portal Dashboard for each cohort and remained visible in subsequent years. Sample Dashboard charts are represented in Figure 3 through Figure 5 for clinics and display clinic data for the cohort year.

Figure 3: Sample Educational Webinars Participation Chart

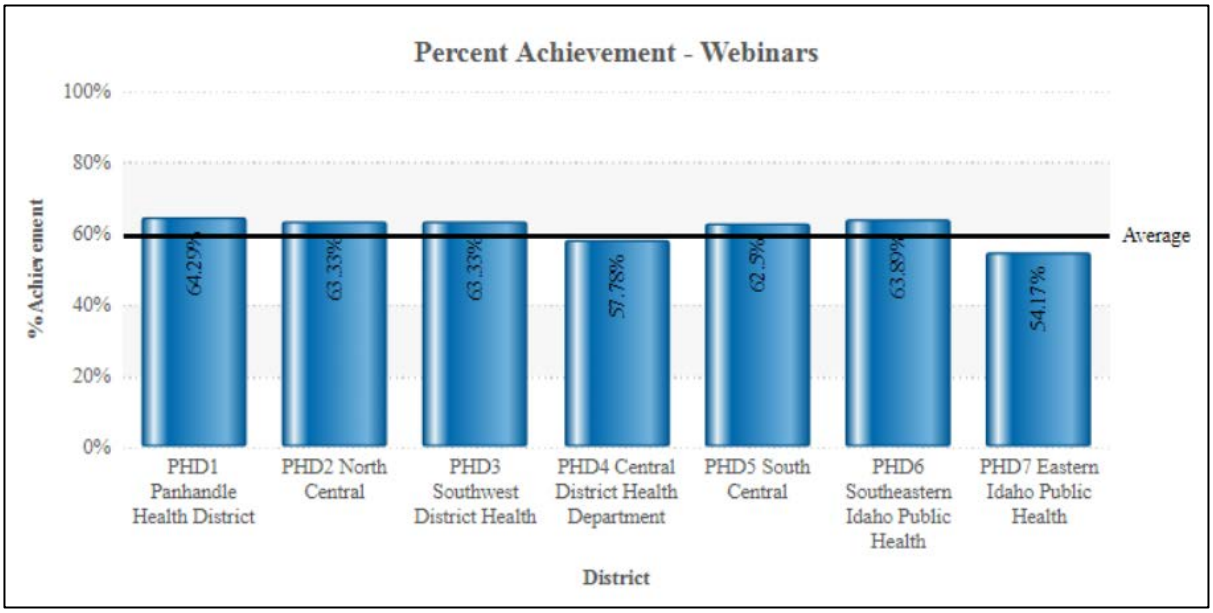


Figure 4: Sample Learning Collaborative Participation Chart

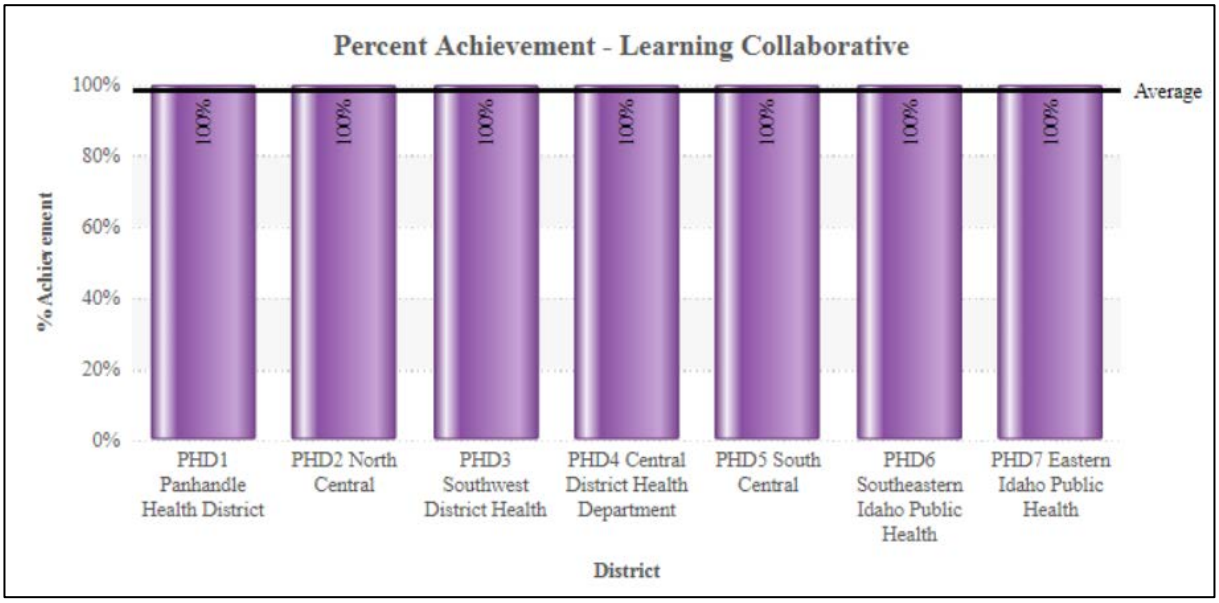
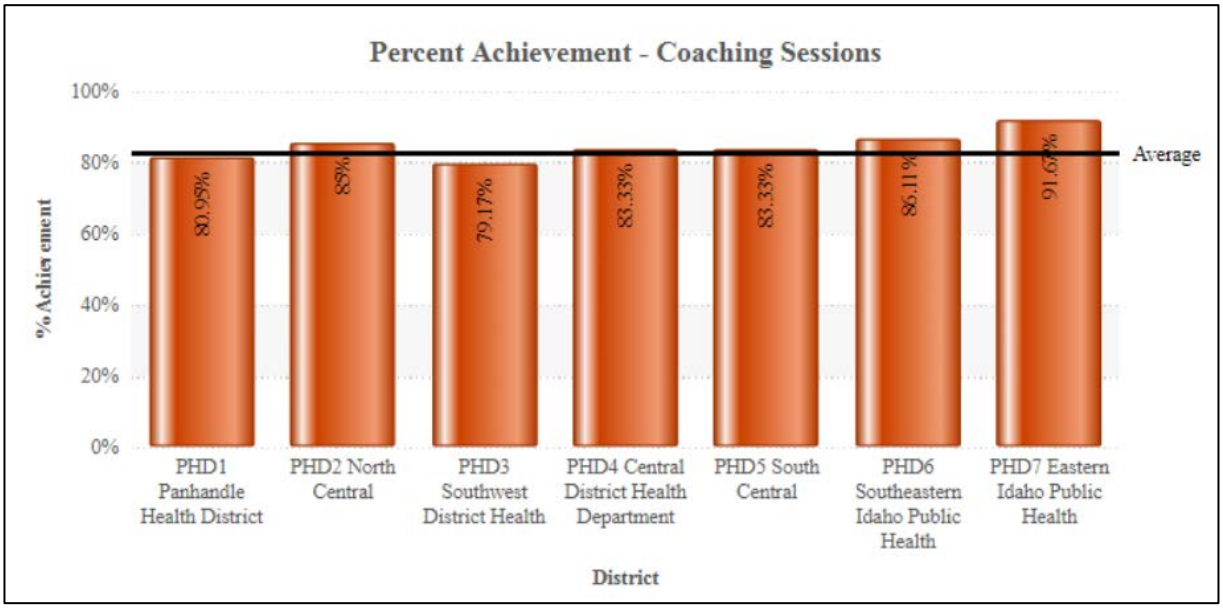


Figure 5: Sample Coaching Session Participation Chart



PCMH Training and Technical Assistance Program

PCMH Coaches

Coaches from HMA provided direct support to the clinics during their selected cohort period. The Coaches served as SMEs in the development and implementation of Learning Collaboratives, site visits, coaching calls, and educational and mentorship webinars. Coaches were either physicians, nurse practitioners, nurses, or public health professionals, all of whom had extensive experience in primary care clinic transformation.

Clinics placed high value on the coaching as they worked to transform to PCMH.

In Cohort 1, the Team included eight Coaches. During Cohort 2 and continuing in Cohort 3, five of the original eight Coaches delivered training and TA, which provided continuity to the clinics and PHD QI Staff. As the Team became more familiar with the needs of the clinics and the increased PHD QI Staff experience level, coaching was adapted and tailored to leverage efficiencies in providing targeted training and TA to clinics and supporting PHD QI Staff.

Coaching Assignments

In Cohort 1, Coaches were assigned to clinics based on clinic needs and each Coach's experience. For example, a more experienced Coach who had worked in a Federally Qualified Health Center (FQHC) might be assigned to a SHIP FQHC clinic that had already achieved PCMH recognition and wanted to refine their model. While this type of individualized matching worked well for clinic interactions, one Coach might be assigned clinics in multiple PHDs, meaning they were paired with multiple PHD QI Staff. To improve efficiency, in Cohort 2, HMA assigned each Coach to a PHD so they got to know the healthcare services and resources in that region and build a strong collaborative relationship with the QI Specialist in the region. For site visits, this helped as Coaches could limit visits within a smaller geographic region. For Cohort 3, HMA continued to assign Coaches to PHDs, with some exceptions based on expertise and clinic needs. One challenge to the assignment of Coaches by PHD was that some larger medical organizations spanned more than one PHD and required some adjustments of assignments.

Assigning PCMH Coaches to a PHD in Cohorts 2 and 3, allowed for developing deeper relationships with PHD QI Staff, resulting in increased effectiveness and efficiencies.

Site Visits

Site visits facilitated building strong relationships with Coaches, PHD QI Staff, and clinics.

Site visits were an important and invaluable part of the PCMH transformation process and promoted trust and collaborative relationships between the Coaches, clinics, and PHD QI Staff. Over the course of the first cohort year, feedback from the clinics indicated that while the Coaches had the technical and relationship skills to coach clinics, the Coaches required additional knowledge to work in depth with frontier and rural communities. To address this and add value to the clinics, the Coaches spent intensive time with clinics at the second Learning Collaborative for Cohort 1. Site visits were also offered to Cohort 1 clinics during this time. Some clinics chose to have a lengthy face-to-face meeting with their Coaches during the Learning Collaborative in Boise, and others preferred the Coach travel to their locations, while others elected to continue monthly coaching calls instead of site visits. Due to the positive feedback from clinics and Coaches, site visits were scheduled to occur earlier during each subsequent cohort year and were conducted as three-hour on-site visits to each clinic in both Cohorts 2 and 3.

The Coaches and PHD QI Staff developed strong working relationships and often traveled together to site visits. This allowed the Coaches to develop a comprehensive understanding of the local healthcare systems. Meeting clinic staff in their settings also helped Coaches better understand the framework, clinic staff, and unique healthcare delivery resources used at each clinic.

Agendas were developed for each site visit and typically focused on introductions, a brief tour of the clinic, a presentation and discussion with staff, assistance with the PCMH Self-Assessment or a review of the Assessment and the development of a Transformation Plan, and a sharing of relevant resources.

Clinic surveys included the following questions:

- What is the best thing you have gained from working with your Coach?
- What would you do to improve the coaching process?

Themes from the responses included decreasing the number of coaching calls, increasing in-person contact, and a very strong theme about the value of site visits at the beginning of the cohort year for relationship building and better understanding of how to build an effective coaching framework.

PCMH Coaching Calls

Coaching calls provided the opportunity for clinics to have focused effort supporting their teams, customizing TA to their needs. Differences in clinic type, resources, and geography required different approaches to providing TA. For example, a large, hospital-based clinic in Boise may have had different challenges and opportunities than an FQHC in Lewiston or a small private clinic in Moscow. While all clinics initially participated in the same interventions, the coaching calls were customized, building on the clinic's assets and addressing their individual needs. Some clinics had their full PCMH Transformation teams participate in the coaching calls, while others did not have the luxury of being able to release staff from the clinic for this purpose.

After the first coaching call with a Cohort 2 clinic, and based on the answers to questions, one Coach imagined the Chief Operating Officer (COO), assigned as the PCMH lead, as being in an off-site corporate setting, and thus removed from the clinic. The PCMH Coach was concerned that the COO was not involved enough in the clinic on a daily basis to serve as the PCMH lead. However, once the site visit occurred, it was obvious to the Coach that the COO was very much a part of that clinic family and that the COO's "off-site" location was actually in what staff referred to as the "Granny Cottage" within a few feet of the clinic.

The Coach organized a mutually agreeable, recurring date for these conference calls and sent invites to the clinic teams and PHD QI Staff assigned to the clinic. Coaching calls were refined and tailored over time. Additionally, the coaching guide for PCMH Coaches was refined and peer review was implemented to support Coaches. Less experienced Coaches listened in to coaching sessions facilitated by more experienced Coaches.

Coaching agenda development reflected a collaborative effort between the Coach and PHD QI Staff who met about a week prior to the upcoming coaching call to build the agenda. Agenda items were developed based on documented progress in the portal, outstanding goals in the clinic's Transformation Plan, follow-up items from the prior coaching call, portal documentation by the Coach and PHD QI Staff since the prior call, and any additional items suggested by clinics.

A typical coaching call agenda included a discussion of updates on follow-up items, current transformation activity, and challenges such as the following:

- Managing new assignments among staff
- Addressing concerns about staff engagement and team development
- Implementing Plan-Do-Study-Act (PDSA) cycles
- Improving work flows and decisions related to purchasing
- Implementing and using new technology

Other agenda items included a discussion on recent educational or mentorship webinars or Learning Collaborative sessions and strategies or development of plans to implement a new approach or activity. Coaching calls were also used to refine PCMH Self-Assessments, add to the PCMH Transformation Plans, and discuss relevant implementation strategies from the literature or other participating clinics.

Coaching Call Evaluations

Upon request from the Department, Briljent implemented a detailed evaluation of coaching calls. An electronic survey was prepared for each clinic and PHD QI Staff to answer assessment questions on their assigned Coach, with statements or questions such as the following:

- "The time spent with my Coach was productive."
- "My Coach helped me identify solutions to problems."
- "What is the best thing you have gained from working with your Coach?"
- "What would you do to improve the coaching process?"

Of high value was conducting site visits earlier in the cohort year for improving relationships and better understanding of context, which the Team implemented in Cohorts 2 and 3. Most clinic respondents also indicated that they felt that they knew how to effectively utilize their Coaches and found high value in the opportunity to participate in coaching sessions. Over 95 percent of clinics indicated that they felt they had "accomplished more in [their] transformation efforts because of the coaching calls" (see Table 4).

Note: The Summary of Coaching Evaluation table summarizes the overall responses of both the PHD QI Staff and clinic staff across all three cohorts, accounting for all Coaches. In many cases, the coaching evaluation provided during Cohort 1 allowed respondents to select "undecided" from the available answer choices. This answer choice was omitted from all questions on the coaching evaluations for Cohorts 2 and 3. The final question in the table was not asked during Cohort 1, and so no reliable data exists.

Table 4: Summary of Coaching Evaluation for Cohorts 1, 2, and 3

Question	Respondent	Cohort 1	Cohort 2	Cohort 3
1. **Are you representing a clinic or PHD SHIP QI Staff?**	Clinic	72%	57%	84%
	PHD SHIP QI Staff	28%	43%	16%
2. **Do you trust the expertise and knowledge provided by your PCMH Coach?**	Yes	72%	100%	100%
	No	4%	0%	0%
	Undecided	9%	N/A	N/A
	No Response	15%	N/A	N/A

Question	Respondent	Cohort 1	Cohort 2	Cohort 3
3. **Do you feel your PCMH Coach understands the types of problems you encounter in your role daily?**	Yes	40%	96%	92%
	No	23%	4%	9%
	Undecided	22%	N/A	N/A
	No Response	15%	N/A	N/A
4. **Do you feel you know how to effectively utilize your PCMH Coach to get help with your PCMH transformation efforts?**	Yes	48%	92%	95%
	No	15%	8%	5%
	Undecided	22%	N/A	N/A
	No Response	15%	N/A	N/A
5. **Do you feel you have accomplished more in your transformation efforts because of your PCMH Coach?**	Yes	24%	73%	21%
	No	28%	4%	5%
	Undecided	33%	N/A	N/A
	No Response	15%	N/A	N/A
	Too early to tell	N/A	23%	74%
6. **Do you find value in the opportunity to participate in coaching sessions?**	Yes	45%	98%	67%
	No	7%	2%	4%
	No Response	48%	0%	29%
7. **Please indicate which type of coaching interaction was most valuable to you.**	Site Visits	N/A	50%	53%
	Coaching Calls	N/A	23%	26%
	Learning Collaboratives	N/A	23%	16%
	Webinars	N/A	4%	3%

Ensuring Clinic Participation and Retention

To help ensure that minimum criteria for clinic engagement and participation was met, the Team facilitated registration in Learning Collaboratives, educational or mentorship webinars, and other activities. If a clinic missed a scheduled event, Briljent not only sent an e-mail to the clinic leads, but also communicated this to the Coaches. The Coaches would then follow up with assigned sites to discuss make-up opportunities and schedule coaching calls at mutually agreeable times.

PCMH Transformation Roadmaps

At the end of each cohort year, the Department requested Coaches work with each site that had not yet achieved PCMH recognition or certification to develop a PCMH Transformation Roadmap. The Roadmap was a workplan that highlighted remaining gaps and activities for attaining the desired model of care and/or PMCH recognition or certification. The Roadmaps were developed to be specific with “who will do what by when” and any ongoing assistance desired from the PHD QI Staff in the subsequent year. The Roadmaps were uploaded to the portal for reference.

Technical Assistance to PHD QI Staff

At the local level, the PHD QI Staff hired by the PHDs were a diverse group. The Department's original intent was for the PHDs to hire registered nurses to fulfill the PHD QI Staff roles. While some of the PHD QI Staff had direct experience working in or with primary care clinics in a previous position, others were new to this work, though all the PHD QI Staff had relevant skills and experience. PHD QI Staff served as local partners to the Coaches to support clinic training, coaching, and TA efforts.

PHD QI Staff Interventions to Clinics

PHD QI Staff outreached to assigned clinics in the region between coaching calls. The PHD QI Staff helped with PCMH planning and implementation; reinforcing messages from SHIP, the Learning Collaboratives, educational or mentorship webinars, and coaching calls; and offering resource materials. Having local PHD QI Staff that knew the local context and had a local presence, particularly when the primary training and TA providers were remote, was important. Pairing these local staff with consultant experts to build regional capacity in Idaho was well-received, though sustainability was an issue as local budgets were limited.

Clinic Evaluation of PHD QI Staff Support

Per request from SHIP, Cohort 1 clinics were surveyed to assess clinic perspective of the value of the PHD QI Staff role in supporting clinic transformation. A total of 35 clinics completed the survey out of the 55 participating, and 80 percent of the clinics were either very satisfied or satisfied with the support received by the PHD QI Staff.

Representative comments from the survey results are listed as follows:

- "I think they did well with learning the NCQA requirements. They were unfamiliar with NCQA at the beginning and have come a long way this past year."
- "They [PHD QI Staff] attended nearly every PCMH clinic and whole-organization Team meeting so they were definitely present. I think they will be much better prepared to assist Cohort 2 and 3 participants than Cohort 1."

PHD QI Staff Retention and Training

The Team provided three Learning Sessions for PHD QI Staff with an emphasis on building the capacity of the PHD QI Staff. These Sessions were held in person, leveraging the momentum and interactivity of the Learning Collaboratives. Resources used in working with PHD QI Staff included the Clinic Facilitation Handbook: Training Modules for New Facilitators and their Trainers produced by Agency for Healthcare Research and Quality (AHRQ). PHD QI Staff development included both self-assessment and a skills assessment conducted by the Coaches.

These sessions were held in person, in the same location after the conclusion of a Learning Collaborative event. These targeted training and TA offerings were instrumental in preparing the PHD QI Staff to meet clinic needs statewide and represented a great effort by the PCMH Coaches. The first two Learning Sessions were conducted during Cohort 1 (one in February 2016 and one in June 2016), and the third Learning Session was conducted in Cohort 2 in June 2017.

Clinics appreciated the relationship with the PHD QI Staff.

"The PHD SHIP QI Staff that we had the pleasure of working with were positive, willing to step in and help any way they could and supported our clinic goals and vision. We LOVED working with them."

The first Learning Session in Cohort 1 for PHD QI Staff was two days in length and featured the following foundational elements:

- An Introduction to the Program
- The Anatomy of a Primary Care Clinic
- A presentation on High-Performing Primary Care
- A discussion on the Day in the Life of a PHD QI Staff
- Sessions on Building Support for Change, Facilitating High-Functioning Teams, the Model for Improvement and Accessing, and Using Data to Drive Change

The Transformation Plan Template and Tracking Tool was introduced and ended with a facilitated session for each PHD to develop a workplan for the next 90 days.

The second Learning Session in Cohort 1 for PHD QI Staff was one day in length and featured sessions on Managing Change and Resistance, Quality Data Collection and Improvement, staff discussion, and working sessions. PHD QI Staff reported a high level of satisfaction with the session with 55 percent reporting "very satisfied," 36 percent reporting "satisfied," and only 9 percent indicating "neutral," with none indicating dissatisfaction.

The third PHD QI Staff Learning Session in Cohort 2 was conducted in Award Year 3. Per the Department, a Learning Session was not conducted in Award Year 4.

The PHD QI Staff participated in all cohort Learning Collaboratives, coaching calls, and educational and mentorship webinars conducted or facilitated by the Coaches. Because of their local presence, the PHD QI Staff often met with their clinics in person and were able to assess engagement and barriers directly. Coaches and PHD QI Staff spoke regularly to discuss site progress, develop coaching call agendas, and debrief coaching calls. In Cohort 1, the PHD QI Staff began meeting regularly amongst themselves to share resources and learnings from experiences in their assigned clinics and from their Coach(es).

Overall, there was consistent stability in PHD QI Staff, with just a few exiting the program. This was helpful to the Coaches and to clinics, many of which experienced significant staff turnover.

Pre-Implementation Period Summary

Issues/Adjustments

The scope of the Pre-Implementation period necessitated an amendment to the execution dates from February 1, 2016 - March 1, 2016, to allow Briljent and the Department the necessary time to prepare for Award Year 2. Thereafter, Award Years 3 and 4 began on February 1, as originally planned.

Successes

Key successes of the Pre-Implementation period included the following:

- Planning three years of project work in just four months
- Developing close ties with SHIP and PHD QI Staff
- Developing and implementing Phase 1 of the SHIP PCMH Transformation Portal
- Enrolling 55 clinics to participate in Model Test Year 1
- Planning for the first Learning Collaborative to take place at the start of Cohort 1

MODEL TEST YEARS FOR COHORTS 1, 2, AND 3 (FEBRUARY 2016 – JANUARY 2019)

The first SHIP cohort of clinics, Cohort 1, started on February 1, 2016, with Briljent clinic agreements finalized in March 2016. Clinic agreements were completed for each clinic in Cohorts 2 and 3, as well as agreement amendments to extend the term and continue Training and TA with prior cohort clinics. Once agreements were executed, the Team was then able to begin training and TA activities to the clinics in each cohort. In addition to coaching and site visits, training and TA consisted of educational and mentorship webinars, and Learning Collaboratives.

Educational Webinars

Within each cohort year, a series of six PCMH educational webinars were conducted every other month. Coaches developed educational webinar topics based on clinic needs and solicited topics directly from clinics. Topics were prioritized based on clinic interest and experiences, resulting in a different or modified set of educational webinars each year. Having this variety worked well as many clinics participated in SHIP for more than one cohort year.

From Model Test Year 2 onward, clinics were required to attend five out six educational webinars (83.33 percent) to retain reimbursement payments.

To retain reimbursement payments, clinics were required to attend a minimum number of educational webinars to meet a benchmark established by SHIP.

All educational webinars were recorded. Discussion notes were transcribed, made Section 508-compliant, and uploaded to the portal's Resource Library. The educational webinars were made viewable to anyone with portal access so that clinic representatives unavailable at the time of the educational webinar could view them later. Coaches discussed and reinforced content as appropriate during coaching calls.

The Team was able to leverage the learning opportunities and experience in PCMH transformation to enhance training and TA deliverables. Educational webinars provided to all cohorts over the three Model Test Years are listed in Table 5 in order of occurrence.

Table 5: List of SHIP PCMH Educational Webinars for Cohorts 1, 2, and 3

Cohort 1 Educational Webinars
SHIP PCMH Transformation Group Coaching
Webinar # 1: SHIP PCMH Transformation
Webinar: SHIP PCMH Portal and Transformation Plan Demo – Walkthrough
Webinar # 2: Population Health Tools
Webinar # 3: Integrating Behavioral Health and Primary Care
Webinar # 4: Telehealth
Webinar # 5: Chronic Care Management
Webinar # 6: Value-Based Payments: A National Perspective
Cohort 2 Educational Webinars
SHIP Cohort 2 Kick-Off
Cohort 2 SHIP Budget Template
Webinar #1: 2017 NCQA PCMH Redesign – Mapping the Changes from 2014
PHD SHIP QI Staff Webinar #1
Webinar #2: Change Management
PHD SHIP QI Staff Webinar #2: 2017 NCQA PCMH Redesign
PHD SHIP QI Staff Webinar #3: Provider Engagement in PCMH Transformation
Webinar #3: Care Transitions and Coordination Follow-Up
Webinar #4: Oral Health Strategies
Webinar #5: Chronic Care Management
Webinar #6: The Relationship-Centered Medical Home Building Relationships to Build a Better Home
Cohort 3 Educational Webinars
SHIP Cohort 3 Kick-Off
Webinar #1: 2017 NCQA PCMH Standards
PHD SHIP QI Portal Walk-Through
Webinar #2: Change Management
Webinar #3: Care Coordination
Webinar #4: Moving to Sustainability – Patient and Provider Engagement
Webinar #5: Patient Centered Access, Continuity and Empanelment

Effectively Leading Change Workshop – Virtual Follow-Up Meeting
Webinar #6: Sustaining PCMH: Leveraging Knowledge, Quality Improvement, and Value-Based Payments
SHIP All Cohorts Closeout Webinar

Following each educational webinar, a list of confirmed attendees was entered into the portal's Event Attendance section by the Portal Team, allowing MSLC to produce an attendance report confirming each clinic's attendance or non-attendance at each educational webinar and post participation on the clinic's portal Dashboard.

Over 1,500 registered participants attended educational webinars throughout the project. The actual number of participants was higher as a registered participant could have been in a location in which multiple staff were viewing the session or viewed a recorded session following the educational webinar. Therefore, the impact of the cohort educational webinar training and TA was likely greater than attendance numbers reflected.

Through the Team's efforts, all clinics successfully met the educational webinar participation benchmarks and reimbursements were retained.

Mentorship Webinars

As part of the SHIP PCMH Mentorship Framework, the Team was awarded a CR in 2017 to develop and conduct a series of Mentorship webinars for all SHIP clinics, regardless of cohort year. This model allowed all clinics to further their transformation and sustainability efforts through peer engagement and learning.

The Mentorship webinar series conducted during Model Test Years 2 and 3 were a useful and effective accompaniment to the cohort training and TA for the clinics. It augmented both the sharing and networking between the clinics beyond the focused curriculum of the Learning Collaboratives. The mentorship activities, in general, led to collaborative sharing of PCMH transformation examples and tools from the PHD QI Staff, Medical Health Networks, and the Coaches. Mentoring was generally well-received based on over 30 clinics participating voluntarily for each event, the survey information, and anecdotal input provided to Coaches and PHD QI Staff. It was an opportunity to enhance networking and build relationships across clinics that went beyond regions and disseminated PCMH and mentoring best practices. It was also an opportunity to share the challenges and successes to transform to and implement the PCMH model.

Additionally, for some topics, this cross-regional sharing was expanded by the addition of experts in a topic paired with one or two clinic mentors. This occurred for the BHI topic with active participation by a representative of Idaho's behavioral health alliance. Cross-regional sharing also occurred during the educational webinar focused on oral health integration with the inclusion of both the state public health division's oral health lead and the executive director of Idaho's oral health coalition. A third example of blending mentors was a child wellness

initiative that involved a provider describing his efforts in his own clinic paired with the regional health district's Medical Health Neighborhood's efforts to spread information across their community. The initiative included promoting potential interventions for non-clinical partners in the community. This showed collaboration between mentors and illustrated how increased stakeholder awareness of and clinic transformation to PCMH could be effective using local and regional resources.

In-depth discussions of PCMH transition implementation by the clinics through experienced mentors and the Mentorship webinar series complemented the series of educational webinars which presented various aspects of the PCMH model to the clinics. Sharing practical tools as well as approaches, and having experienced peers who had faced similar challenges and were available to help a clinic in any cohort was often commented on in feedback from the post-Mentorship webinar surveys. This aspect of the mentoring was frequently noted as extremely valuable to the clinics. Over 500 registered participants attended the Mentorship webinar series.

At the time of this report, Idaho intended to continue evaluating their Mentorship framework and update recommendations as SHIP ends. The Mentorship webinar series delivered valuable content to support advancement and sustainability of the PCMH in Idaho's healthcare delivery system transformation.

Table 6 provides the list of mentorship topics presented to the clinics in support of their PCMH transformation journeys and sustainability of each transformation.

Table 6: List of All Mentorship Series Webinars

PCMH Mentorship Webinar Series
Mentorship Kick-off Webinar
PHD SHIP QI Staff Mentorship Call
Using CHWs in the PCMH Model
Behavioral Health Integration in a Community Health Center's PCMH Model
Behavioral Health Integration in a PCMH Model (Focus on Non-FQHC Clinics)
Strategies for PCMH Culture Change
Strategies for Care Management – Part 1
Strategies for Care Management – Part 2
Where to Begin: Getting Started on NCQA Standards – Tips and Approaches
Surviving the New NCQA 2017 Recognition Process: The Calls and Q-PASS
Oral Health Integration and the Patient Centered Medical Home
5210 Childhood Wellness Initiative
Patient Engagement and the PCMH

All Mentorship webinars were recorded and posted on the portal for reference and clinic review.

PCMH Learning Collaborative Events

PCMH Learning Collaboratives were popular and of high interest to clinics, as these in-person events enabled clinic representatives from all over the state to come together to engage in intensive and interactive learning opportunities (see Figure 6).

There were four Learning Collaborative events over the course of the project, with two events occurring during Cohort 1 and one each during Cohorts 2 and 3 respectively. Each Learning Collaborative was scheduled across two consecutive days and all clinics were required to attend to meet the participation benchmark. A maximum of four representatives per clinic was invited to register and participate. At the end of each day of each Learning Collaborative, the voluntary participant evaluation captured participants' perceptions of both the learning content and the quality of the event. This allowed the Team to analyze participant observations and data and, in turn, informed both immediate and long-range adjustments in Learning Collaborative development and management.

Figure 6: PCMH Learning Collaborative Event

Coordination

The Team was responsible for registration, hotel and event logistics, agenda development, presentations (including those led by guest speakers), and supporting materials. In addition, the Team conducted a review of all presentation materials and ensured they passed quality assurance and were appropriately branded for consistency. These additional activities helped ensure participants were provided a high-quality learning experience that would effectively support their PCMH transformation journeys and that they received value for the time spent traveling to and participating in the Learning Collaboratives.

Table 7 shows the aggregate attendance for all cohorts.

Table 7: Learning Collaborative Cohort Attendance

PCMH Learning Collaborative	Dates	Number of Attendees
Learning Collaborative 1	March 2 - 3, 2016	136
Learning Collaborative 2	October 24 - 25, 2016	135
Learning Collaborative 3	June 27 - 28, 2017	165
Learning Collaborative 4	June 27 - 28, 2018	149
Total Number of Attendees for All Learning Collaboratives		**585**

PCMH Learning Collaborative Detail

Each Learning Collaborative was unique and became a foundation for the next. In each instance, the Team reviewed and analyzed the planning and event execution, as well as development and delivery of learning content. Participant evaluations were carefully reviewed and assessed for improvement opportunities. The Team collaborated in detail with SHIP to ensure the events were well-planned and executed with great attention to detail in the content and presentations. Notably, the Learning Collaboratives grew in value of training and TA to the transformation efforts of the clinics.

PCMH Learning Collaborative 1 (March 2016, Cohort 1)

This first Learning Collaborative was held at the University of Phoenix in Meridian, Idaho. In Cohort 1, there were several clinics that had an advanced understanding of PCMH and those clinics that were less experienced. The different levels of experience made it difficult to target the presentations. Therefore, the Team developed two tracks for Day 1: one for clinics new to PCMH that addressed foundational elements and concepts, and a second track for those that had already attained some level of PCMH recognition or certification that addressed more advanced concepts.

PCMH Learning Collaborative 2 (October 2016, Cohort 1)

For the second PCMH Learning Collaborative in Cohort 1, and those thereafter, all participants were required to register via the Event feature of the portal. This option improved registration and tracking capabilities for the Team.

The second PCMH Learning Collaborative took place from October 24 - 25, 2016, and was held at Saint Alphonsus Regional Medical Center in Boise, Idaho. The PCMH Learning Collaborative was conducted over a period of two, half days; the sessions were targeted to the entire cohort. After the first PCMH Learning Collaborative provided foundational concepts to the less experienced clinics, the design for the second Learning Collaborative brought together the whole group for this learning and sharing opportunity.

The option of a recorded session was not available for the Cohort 2 Learning Collaborative due to budgeting constraints. Funding for audio-visual support for the Cohort 3 Learning Collaborative was secured by SHIP for the Award Year 4 contract with Briljent. This decision fortunately helped to support one clinic who, despite all efforts, needed the option to view recorded sessions. That clinic was able to review key recordings and completed an in-depth survey assessment after viewing the recordings as an alternative to meet the participation benchmark. In addition, the recorded sessions were posted on the SHIP website and further documented and supported the statewide adoption of PCMH transformation.

From the very beginning, the Department demonstrated the importance of aligning with payors because delivery system reform and payment reform are inextricably linked. The Department invited Idaho Medicaid Healthy Connections and commercial payors to sponsor and participate in every Learning Collaborative. The Team featured a provider panel at the Learning Collaboratives in Cohorts 1 and 3. Idaho Medicaid Healthy Connections led the group in payment reform and provided a Per Member Per Month (PMPM) payment structure to clinics that met milestones toward the achievement of PCMH recognition. Selected commercial payors presented and discussed limited value-based purchasing options and plans.

A Learning Collaborative panelist—a physician lead from a moderate-sized private practice—gave his "Top Ten" recommendations about PCMH transformation to peers along with an explanation for each. Recommendations included the following:

- ***"Don't do everything at once."***
- ***"Give all staff at least one small task related to the PCMH transformation."***
- ***"Engage patients and families in identifying and making improvements."***

Peer panel sessions were among the most highly rated; clinics wanted to hear from their peers.

Every Learning Collaborative featured a successful and well-received World Café concept, where participants chose two topic-specific round tables for a facilitated discussion among peers. Included were topics such as care management strategies and population health outreach. Participants were encouraged to exchange contact information and continue to support one another in implementation in these areas.

PCMH Learning Collaborative 3 (June 2017, Cohort 2)

The Cohort 2 Learning Collaborative was held on June 27 - 28, 2017, at BSU. Based on experience and learning from Cohort 1, the Learning Collaborative was designed to further engage the clinics to highlight peer successes and learnings and to facilitate relationships between clinics. Learning tracks were designed to facilitate sharing between more and less experienced clinics, which gave overall support to the theme of mentoring. Peer Mentors from Cohort 1 were featured in the Cohort 2 Learning Collaborative panel, PCMH Journey: Stories of Success from the Field, which presented key information from their experiences to newly enrolled clinics.

PCMH Learning Collaborative 4 (June 2018, Cohort 3)

The Cohort 3 Learning Collaborative was held on June 27 - 28, 2018, at BSU. HMA built on participant feedback from the previous two cohorts and continued with one learning track, which included a panel of PCMH leads from prior cohort clinics. Featured topics included technologies and a panel discussion with Idaho-based health plans about value-based payment. Breakout sessions were conducted, topic-specific networking was facilitated, and interest groups were formed around the most popular EHR systems used by clinics represented in the cohort.

By creating opportunities for clinics with the same EHR systems to network, an affinity group contact list of individuals/clinics associated with each EHR was developed. This list was disseminated to enable individuals and clinics to stay in contact with one another as they used new EHR functionality and refined work flows to meet competencies of the PCMH.

Table 8 provides a list of Learning Collaborative presentation topics offered to clinics in their respective years of participation.

Table 8: PCMH Learning Collaboratives Presentations and Training and TA Topic by Cohort Year

Cohort 1 (2016)
Overview of Performance Management and QI; Introduction of a Rapid Cycle Improvement Model (PDSA)
Team-Based Care and Communications
Population Health
Care Management, Care Coordination, and Transitions
Group Discussion – Setting the Stage for the Next Level of PCMH Recognition
PCMH Tools and Population Health; Review of Tools and Discussion on What Clinics Are Using and What Is Working and Not Working
Behavioral Health Integration; Overview of Principles and Levels of Integration, Gaps, and Common Barriers to Integration
Team-Based Care; Going to the Next Level and Integrating Care Management and Care Coordination
Patient-Centered Access
Care Transition Models
Leadership and Change
Review of Day 1 and Day 2 Components of PCMH
World Café and Time for Clinic Representatives to Work and With the Coaches
Idaho Clinical Quality Metrics, Idaho Health Data Exchange Update
Medical-Health Neighborhood and Virtual PCMH Designation
Practical Tips and Planning for the Submission of Successful Application for PCMH Recognition
Empanelment and Access Strategies
Risk Stratification and Vulnerable Populations

Strategies for Clinics to Prepare for Value-Based Payment Models
Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) Updates
Payers Panel: PCMH As a Driver of the Model of Care for Moving to Value-Based Payment
Cohort 2 (2017)
Vision and Progress for Idaho's PCMH Transformation
Setting the Stage – Cohort 2 PCMH Year of Activities and Collaborative Goals, Objectives for the Learning Collaborative
PCMH Journey: Stories of Success from the Field
Virtual PCMH
Patient Engagement Interviews
Getting Started on Becoming a Patient Centered Medical Home (PCMH)
Enhanced Systems
Care Management and Behavioral Health Integration – Structure and Reimbursement
Group Exercise and Facilitated Discussion (World Café)
Adaptive Leadership and Leading Change
Risk Stratification and Population Health Management
Steps to Team-Based Care
Patient Engagement
Embedding Quality Improvement
Cohort 3 (2018)
Vision and Progress for Idaho's PCMH Transformation
Welcome and Introductions: Cynthia York, Office of Healthcare Policy Initiatives
State Innovation Group at the Center for Medicare and Medicaid Innovation (CMMI)
Setting the Stage: Introduction to PCMH Cohort 3 and Learning Collaborative
PCMH Journey Discussion Panel
Stories of Success from the Field
State Evaluation Team – Patient Engagement and Data
The Idaho Health Data Exchange (IHDE)
Virtual PCMH Application
IDHW Bureau of Rural Health and Primary Care, Division of Public Health
NCQA and EHR Affinity Group Breakout Session
Debrief Take-Aways from EHR Groups
Introduction to the BlueCross of Idaho Foundation Rural Health Initiative – Supporting Practice Transformation
Idaho Multi-Payer Panel
Creating Sustainable Care Management Programs
Embedding Continuous Quality Improvement in the Medical Home: The Model for Improvement
Blending Cultures – Clinics and Hospitals Working Together
Group Activity – World Café

All Cohort Learning Collaborative Evaluations Summary

Learning Collaborative planning, organization, and learning opportunities evolved positively over the course of the project. During the first Learning Collaborative, cohort satisfaction with this live, in-person training and TA offering showed strong satisfaction rates, however, feedback pointed toward opportunities for continued planning and enrichment.

As the Team became more proficient at meeting the needs of the cohorts and employed greater precision in tailoring the learning options, the satisfaction rates steadily increased over time. There was an increase in the Very Satisfied and Satisfied response rate during all Cohort 2 and Cohort 3 years.

The overall level of satisfaction of all cohort Learning Collaboratives is presented in Table 9.

Table 9: Cohort Satisfaction of Learning Collaboratives

Learning Collaborative	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
Learning Collaborative 1: March 2, 2016	23%	60%	11%	6%	N/A
Learning Collaborative 1: March 3, 2016	32%	62%	5%	N/A	1%
Learning Collaborative 2: October 24, 2016	21%	52%	22%	5%	N/A
Learning Collaborative 2: October 25, 2016	27%	59%	12%	2%	N/A
Learning Collaborative 3: June 27, 2017	43%	57%	N/A	N/A	N/A
Learning Collaborative 3: June 28, 2017	39%	59%	N/A	2%	N/A
Learning Collaborative 4: June 27, 2018	25%	72%	N/A	3%	N/A
Learning Collaborative 4: June 28, 2018	41%	59%	N/A	N/A	N/A

Learning Collaboratives Feedback

Evaluations from the cohorts emphasized the desire of clinics to learn more from their peers and to hear success stories. Additionally, interest groups were formed and informal linkages between clinics were facilitated.

General feedback comments from the evaluations are listed below:

- **Breakout Sessions:** “The risk stratification breakout was extremely helpful. I'm looking forward to going back to my clinic and implementing suggested strategies.”
- **Collaboration and Conversation:** “Networking – hearing how others are moving through transitions. Good to hear we share common challenges and are able to collaborate and share solutions.”

- **Training:** “Seeing the progress being made. Virtual health; knowing everyone is challenged no matter where they are in the transformation.”
- **Detail:** “Redundant information. Measures were sent out months ago with details which align with CMS. Would have been nice to have more from IHDE payment for Cohort 1. Clinics who are NCQA level 1 or higher do not need to walk through submitting. Would have been nice as a breakout.”
- **Adaptive Leadership, MACRA, and PDSA:** “Great PDSA presentation. We use PDSA all the time. You started the fire and helped me realize I could be using them more.”
- **Mini Sessions:** “Patient engagement and motivational interviewing was very useful.”
- **FQHCs:** “FQHCs are a large group/presentation of SHIP but nothing was addressed in this talk that explained where we fall in MACRA.”
- **Usefulness:** “Generally, NCQA-recognized clinics like ours find these talks way too simple.”
- **General Content:** “So much review from last session. This is the end of the cohort year. We need tools not review of the same idea ...”

Project Management and Evaluation

Project Management Plan

Briljent was responsible for developing and utilizing a detailed PMP. This Plan included the planning and preparation period and the three-year test period for integration into the Master SHIP Model Test Operational Plan and the Master Project Plan and Schedule to ensure successful implementation of the contracted services. The expectation of Briljent was work closely with the Department and SHIP’s Project Manager.

The Team supported each clinic in multiple ways to meet PCMH transformation goals. The Team helped SHIP implement an innovative approach to PCMH transformation for each clinic using reimbursement payments to each clinic meeting PCMH transformation goals in each cohort year.

The first PMP was submitted by Briljent to SHIP in November 2015. It was finalized and approved by the Department at the start of Model Test Year 1.

The PMP included, but was not limited to, the following:

- Monitoring implementation of the contracted services
- Attending SHIP Model Test project management meetings
- Attending quarterly budget review meetings with the Department; the Department later added a requirement to estimate the upcoming quarter’s anticipated budget
- Providing other project management services, including the following:
    - **Issue Management** – verifying that issues, requests, and decisions were recognized, agreed upon, assigned to an owner, incorporated into an issue log, monitored, documented, and managed through resolution

- **Change Management** – identifying the impact of any change or correction that modified scope, deliverables, schedule, or resource allocations, and determining the disposition of the requested change or correction; and ensuring any change that may result in a significant or milestone date change is identified and approved by the Department prior to implementation
- **Quality Management** – verifying the quality of work products and deliverables
- **Reporting** – providing information to the Department for the quarterly, annual, and final Progress Reports, including, but not limited to, progress toward goals and response to challenges, performance on identified metrics, and an analysis and addressing of risks and mitigation strategies
- **Management** – utilizing the PMP and ongoing reporting on potential and actual issues and risks

Evaluations

Also stated previously, Briljent was required to evaluate coaching as identified in the PMP and specific scope sections, which included the following:

- Developing a methodology and facilitating the collection of quantitative and qualitative evaluation of Briljent subcontractor, HMA, performance in delivering TA services to clinics
- Compiling results of coaching evaluations in the ninth month of the cohort year and delivering them to the Department in a report

Transition Plan

One of the requirements in the PMP was the development of a Transition Plan. The Plan's objectives would be to minimize disruption of services provided to the Department and to provide for an orderly and controlled transition of the Team's responsibilities to a successor should Briljent be unable to complete the responsibilities of the contract.

Development of the Transition Plan began in June 2016 and the final version was approved by the Department on November 4 of that year. The PMP outlined the following key sections of the Transition Plan:

- **Goals** – Goals included ensuring the incoming vendor would be effective as soon as possible and minimize the risks to the quality or the continuity of the contract.
- **Assumptions** – All the necessary tasks of Briljent and its subcontractors were identified and ensured that each of these tasks had resources assigned to them.
- **Risks** –The Team would continuously monitor risks and put plans in place to mitigate those risks.
- **Transition Approach** – At the end of the transition, the incoming vendor would have a clear understanding of its role and responsibilities within the context of the contract, knowledge of how to perform the role, and awareness of the resources available.

- **Knowledge Transfer:** The portal would contain the foundation and source of all project-related documents to assist the new vendor in being able to quickly locate information and bring its team up to speed on all aspects of the project.

Portal Transition

As part of transition planning, the following actions were included in the transition plan for the portal's content:

- BSU received a copy of the educational Toolkits and the Resource Library documents and associated meta-data that are not private to specific clinics.
- The Department received flat files from the portal.
- The Department received Transformation Plan documents for each clinic that were generated from the portal's online transformation plans.
- The Department received PCMH Transformation Roadmap documents that were uploaded as a component of transformation plans.

Lessons Learned

During each of the three cohort years, the Team tracked issues and adjustments leading to positive resolutions. Each weekly update and monthly progress report tracked deliverables, issues, and risks. The Team engaged in constructive ongoing communication internally and with the Department to ensure mutual understanding and accountability. During times of challenge, such as near the end of the PCMH contract when a few PHD QI Staff were leaving their positions due to contract end, the Team committed to the Department to continue delivering support and coaching through the final days of the project.

The Team's structure allowed for the most effective and efficient methods to support SHIP and their PCMH transformation goals. As the prime contractor, Briljent led the project management and administrative tasks related to planning, scheduling, clinic contracts and reimbursement payments, portal, educational and mentorship webinar support, and planning and logistics for the PCMH Learning Collaboratives and all project reporting. This allowed HMA, as Coaches, to focus on coaching, which is at the heart of PCMH transformation support and delivered through training and TA. The Coaches also worked closely with the PHD QI Staff. MSLC supported the Department and the Team by providing the auditing and reporting tasks. Together, the Team formed a strong working relationship for the coordinated delivery of professional services.

As the cohort years progressed, more clinics engaged with the PCMH transformation efforts and the project gained momentum. The Team overcame any initial challenges and operated on a high level of expertise in meeting deadlines, providing a work product that satisfied the Department, and delivering the support and coaching to the clinics that increased PCMH transformation under the leadership of SHIP.

Healthy Connections

The Team believed that collaborating more closely and from the beginning with Medicaid Healthy Connections in their efforts to incentivize and support PCMH clinic development may have created additional synergies and further aligned clinic assessments and progress reporting.

Impact of Clinic Staffing and Turnover on PCMH Transformation

A fundamental feature of a PCMH is team-based care that requires active participation of all clinic staff. Unfilled positions and high turnover impact the ability to develop high-functioning teams, and noted across the participating clinics, particularly in Model Test Years 2 and 3 as clinics were unable to retain staff, and perhaps unable to compete with higher wages paid by other employers.

Achievement/Successes

The Team formed a well-diversified and experienced group who was able to overcome and succeed in challenges of assisting SHIP with their goal of PCMH transformation. There were many clinic success stories throughout the course of the three cohort years.

Both the achieved and continued progress by the clinics in PCMH transformation was rewarding for the Team. The following are a few highlights of the many clinic successes in SHIP PCMH transformation.

Cohort 1 Successes

Primary Health Medical Group received NCQA PCMH 2014 Level 2 Recognition for all 12 clinics in 2014. As of January 2019, all 17 Primary Health clinics are PCMH-recognized. A few of their notable highlights were as follows:

- The Primary Health clinics, spanning Cohorts 1, 2 and 3, appreciated the TA through SHIP, specifically both the Coach and on-the ground assistance of Region 3 and Region 4 PHD QI Staff to get all of their clinics ready to meet recognition requirements.
- Site visits to the clinics were invaluable for face-to-face discussions between Coaches and providers to facilitate understanding about the benefits of and sustainability in adopting the PCMH model.
- Discussions during coaching calls with the Population Health Director, the PCMH lead, and the clinics' managers on the PCMH Standards included, but were not limited to, providing resources for implementing depression and adolescent screenings, care plans, health literacy, and social determinants of health into the clinic's care model.

Cohort 2 Successes

- **Family Health Services – Twin Falls** received NCQA PCMH 2014 Recognition in 2014. Recognition was a major accomplishment, and the clinic credited the help of their Coach and the PHD QI Staff.

- **Seasons Medical** - received NCQA 2014 PCMH Level 2 Recognition for all three of their clinics in 2014. A few of their notable highlights are as follows:
  - The recognition was backdated to allow them to use the recognition for the Merit-Based Incentive Payment System (MIPS).
  - The clinic was grateful to their Coach and PHD QI Staff for their assistance in helping them to achieve this "monumental recognition."

Cohort 3 Successes

- **Two Rivers Medical Clinic – Weiser** attempted to participate in a PCMH pilot several years ago, but discontinued because they did not have an electronic medical record (EMR); the manual work was not feasible for them. However, they remained committed to transforming and migrated to an EMR and joined SHIP for Cohort 3. A few of their notable highlights were as follows:
  - The clinic undertook a painstaking process of assigning every patient in their practice to a provider team and improving continuity of care with the assigned provider.
  - A small team attended PCMH Learning Collaborative and indicated: "It's amazing what that little event has done." After the learning opportunity, the clinical champion began testing team huddles. The clinic also upgraded their EMR to enable them to produce data reports for preventive and chronic condition management and initiated a connection to IHDE to facilitate care coordination.

- Coaches helped **Sandpoint Family Medicine** to prepare their policies and procedures and aligning these with PCMH domains. Facilitated discussion of the design of their quality improvement plan and program ensued. The clinic set a goal to be ready to register with Quality Performance Assessment Support System (Q-PASS) and begin uploading their materials in February 2019.
- A Coach teamed with the SHIP Telehealth Coach to provide additional coaching to **Challis Area Health Center**. Challis made great progress in the original PCMH coaching phase, completed Q-PASS and obtained recognition. In this added phase of expanding PCMH into telehealth, Coaches provided them with tools for a telehealth Demand Analysis and Readiness Assessment. In addition, work flows related to telehealth psychiatric consultations and the collaborative care model were explored, and a background brief related to school-based telehealth programs was assembled.
- A Coach provided training to all prescribers at **RHS Family Medical Clinic**. The clinic had a clinician champion on the PCMH team; but, the other prescribers were less involved in the PCMH process and there was some turnover. Since they were having a training day that aligned with the end of the grant and the availability of extra coaching, the Coach delivered an hour-long training on PCMH via educational webinar and established an understanding of PCMH among the prescribers. (Note: RHS Family Medical Clinic is a reverse integration clinic and refers to their physicians and physician assistants [PAs] as "prescribers.") This training was very well-received, and the clinician champion said that it helped her to get a big-picture understanding of the process.

- **Community Family Clinic** became a residency training clinic on December 1, 2018. The Coach scheduled an educational webinar training on PCMH concepts for the residents on January 31, 2019. The residency director said he would be “delighted” to have the Coach talk to their residents.
- One Coach assisted in writing thorough job descriptions for **Southeast Idaho Family Practice** for Team Lead and Care Coordinator roles, and then discussed the job descriptions with the practice owner/lead physician. They will still have a quite a bit of work to do to become PCMH-recognized; but, the clinic benefitted from learning about what roles were needed to move forward.
- Another Coach wrote several Policies and Procedures for **Rindfleisch Family Practice**. This was a solo physician practice who had not had the time or office support to document his care processes. By streamlining administrative aspects of PCMH, he was able to focus more intensively on the clinical and transformational aspects. The Coach also addressed some of the overlap between PCMH and Healthy Connections which will help the physician achieve a higher payment tier and additional payment going forward.
- At the onset of coaching, **Saltzer Medical Clinic** was in the midst of a challenging buyout. They were short-staffed, leadership was not engaged, and they had very limited knowledge of PCMH or quality improvement. At the end of the cohort they had a dedicated population health person, as well as an IT person, and PCMH was a standing agenda item with leadership. They are hiring and training staff and hired one of the PHD QI Staff to be dedicated to PCMH. They will open Q-PASS at the end of the month with the goal of recognition for the Nampa clinic in 2020.
- Another Coach worked closely with **Kootenai Health** on creating a specific PCMH sustainability plan. The clinic was very excited about this plan and will be formalizing it with their leadership and throughout the organization.

Conclusion

The PCMH Transformation Training and TA project with the Department was successfully implemented and project deliverables completed. The Team, as part of the Department's solution in meeting SHIP Goals, worked directly on the front lines with clinics and clinic staff to systematically and consistently deliver training and TA to help both the Department and SHIP meet their goals.

Idaho clinics made remarkable strides toward PCMH transformation and recognition. Table 10 shows the results of the project in clinic PCMH recognition. Approximately a third of all clinics in Idaho participated in the PCMH transformation project, and the State developed a stronger healthcare delivery infrastructure to meet the needs of their Medicaid patients with a future and opportunity for better, high-quality, and lower-cost health care.

Table 10: National PCMH Accreditation Totals for All SHIP Clinics as of January 23, 2019

Clinic Recognition/Accreditation Status	Cohort 1	Cohort 2	Cohort 3
Accredited Prior to SHIP	31	17	6
Newly Accredited During SHIP	14	11	15
Renewed During SHIP	26	16	4

The following is a quote from a Cohort 3 clinic who received TA:

> *"Thank you for the tools you provided me with and the time that [you] spent answering our questions. We truly appreciate your patience with us as we explored a realm in which we are definitely neophytes. We can say without hesitation that we, as an organization, definitely benefitted from participating in the SHIP grant and all of the resources it brought to our practice."*

Patient Centered Medical Home (PCMH) Mentorship Webinar Series Summary

Development, Implementation, and Events

July 2017 - January 2019

PCMH TRANSFORMATION TEAM

The SHIP PCMH Transformation Team is supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

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Purpose

The Idaho Department of Health and Welfare's (IDHW) Statewide Healthcare Implementation Plan (SHIP) recognized the important role that mentoring plays in the PCMH transformation experience. A stakeholder group was convened by SHIP in May 2017 to discuss and develop a PCMH Mentorship Framework for the clinics across Idaho. Building on known national efforts and input from across the state, the stakeholder group identified multiple ideas and strategies to develop the Framework. The Framework was discussed at the Idaho Healthcare Coalition (IHC) in June 2017 and endorsed.

As an action item from the Framework, SHIP requested the SHIP PCMH Transformation Team (Team) to develop a mentorship webinar series to include clinic participation from across the cohorts of clinics, as well as take the first step in developing an ongoing mentorship program for Idaho and its primary care clinics in the future.

This document outlines the process, time lines, topics, templates, and evaluations of the series that started in July 2017 and extended through the end of January 2019. The first year of the series engaged the SHIP Cohort 1 and 2 clinics, and the second year of the series Cohort 3 clinics were added. The series was a collaborative effort with SHIP, the SHIP Public Health Department (PHD) Quality Improvement (QI) staff (QI Staff), the Team's Project Management (Briljent), and the Team's coaching team (Coach), with one of the Coaches (Jeanene Smith, MD, Health Management Associates [HMA]) serving as the PCMH Mentorship Lead (Lead). The series' success was dependent on assessing the needs of the clinics and having the flexibility to ensure adequate participation from mentor and mentee clinics. This document serves as a guide if the state considers further mentorship webinars following the completion of Idaho's SHIP grant.

Development Process and Time Line

Following the finalization of the Framework, in which PCMH coaches participated and contributed information on other states' approaches, the webinar series structure was developed. Led by the Lead, the first steps included the following:

Mentorship Webinar Series Development:

- A list of mentor and mentee roles and expectations was developed and reviewed with SHIP.
- A starter list of mentor topics was developed. This evolved from discussions in the Framework workgroup, experience of the Coaches from coaching the clinics, and review of the feedback from participants of the Cohort 1 Learning Collaboratives (LC) to identify topic areas the clinics felt important for more discussion and/or further training. The initial set of mentor topics developed are listed in Appendix A.
- A description and objectives, as well as a slide deck template for the mentorship webinars was developed to be used for both advertising the mentorship webinar series events and for outreach events to gain further input. The initial series was designed for two events: one with QI staff, and one with the Cohort 1 and 2 clinics.

- The webinar with the QI Staff included all the PHDs to discuss the expectations of clinic participants, the starter list of topics, the overall series approach and to brainstorm ideas on how to partner with the QI Staff for assistance to enlist both mentees and mentors across the districts' clinics.
- The Cohort 1 and 2 clinics were canvased for interested mentees on the proposed topic areas to identify specific areas/questions they wanted to discuss and receive guidance on. This was conducted via the Mentorship kickoff webinar that was held with these clinics.
- Using this additional input from clinics and QI Staff, a plan was created for recruitment of mentors and mentees, which included the initial Mentorship kickoff webinar. Part of the recruitment plan was the emphasis on these webinars being an optional activity for clinics and not part of their requirements for participation in SHIP; that clinics were free to join even if they had not yet identified themselves as in need of mentoring on a topic.
- A Mentorship tracker was developed to identify the responsibility of each role for outreach, mentor contact information and to track progress to recruit mentors (see Appendix B for this tracker).
- The recruitment plan was implemented by the end of July 2017, with the goal of creating an initial set of interested mentors and mentees, and recruitment continued into subsequent months as topics were finalized.
- Dates were identified with the first topic-focused Mentorship webinar on August 17, 2017.
- A standard PPT webinar template was created with potential discussion questions for mentors to later be adjusted for consistency with each webinar topic. These questions would be regularly reviewed with the mentors ahead of each mentorship webinar event to prepare mentors for framing their remarks (see Appendix D).
- An evaluation survey tool and process were developed and conducted after each mentorship webinar, that could be adjusted for consistency with each topic (see Appendix E for a copy of the survey tool).
- A process to record and store webinars for future use as a resource through the SHIP PCMH Transformation Portal (portal) was created.
- The Team understood that these sessions could be linked to an ongoing sustainable web resource for clinics as was proposed by the Framework subcommittee upon conclusion of the SHIP grant.

Mentor Expectations

In the development phase, a set of mentor expectations were developed and discussed with the SHIP team to make sure that the mentor would be open to assisting other clinics after the webinar on a topic they volunteer to present on. Originally, it was discussed to pair the mentors with an identified mentee. However, as the webinar series evolved, the clinics did not volunteer to be specifically identified as mentees. The mentors served as resources other clinics could voluntarily contact for more information or specific tools or documents without specific assignment. The expectations were always reviewed with the mentors during outreach to alert mentors that there may be additional requests for their time following the webinar.

The expectations reviewed included the following:

- Confirmation mentors were comfortable with mentoring on identified PCMH/practice transformation topics.
- Work with the Coach serving as facilitator to prepare for discussion webinars and frame their remarks around the discussion questions proposed for a topic.
- Commit to the time needed to prep and participate in webinars; leading discussions, sharing of stories and examples, and providing advice applicable to other clinics.
- Commit to be willing to receive e-mail and/or phone calls from mentees to answer questions, share expertise, stories, and tools on various identified topics following the webinar.

For each topic, it was an estimated 4 - 6 hours' time commitment for the mentor between preparation, presentation, and follow-up questions.

Mentee Expectations

As noted under the mentor expectations, in the development phase and during the first webinars, an effort was made to outreach to clinics who identified themselves as "mentees" to be more engaged in the sessions with the mentors. After several outreach efforts for the first two webinars in 2017, there was a reluctance of clinics to self-identify, even when directly asked by Coaches and QI Staff, or in subsequent surveys following the sessions. A set of expectations were developed for the mentees but were not fully utilized. They are the following:

- Request mentoring on various PCMH/practice transformation topics.
- Work with the Coaches serving as facilitators to clarify their specific questions through either a survey or preparatory discussion.
- Commit to attend and participate in a webinar with mentor, focused on requested topic(s).
- Reach out to mentors via e-mail or phone, if further questions arise.
- Implement ideas and lessons learned from mentors and complete an evaluation of effectiveness of process and outcome of the mentorship program.

After the initial attempt to recruit mentees for sessions and due to poor response, no further attempts were made.

The sessions were advertised across the cohorts and clinic participation was high. The evaluation of the webinar series was adjusted for not having designated mentees and included sending out a survey following each session to gain an assessment of the effectiveness of the webinar, ideas for future topics of interest, or willingness to participate as a mentor.

Pairing mentor and mentee could be further explored in the future where clinics with similar needs could be identified through a preliminary assessment process. Each cohort of clinics had varying levels of knowledge and progress on the PCMH model, so assignments pairing clinics with similar levels of expertise or offering incentives for more advanced clinics to assist less advanced clinics could be used as an approach to technical assistance.

Implementation and Recruitment Plan: Overall Approach

- **TOPIC SELECTION:**
  - Topics were finalized by the Lead from input received from SHIP, QI staff, feedback from the LCs, and the Framework document, plus from coaching calls and from surveys following each webinar to determine level of interest and potential mentor clinic options.
  - Appendix A includes the list of topics available from which the Team determined topics for the first year of the mentorship series. The plan was to select at least 1-3 topics before the beginning of the webinar series to allow for time to initiate recruitment of mentors as needed.
  - In the first year some flexibility was necessary in setting the webinar dates, to accommodate mentors' schedules and to ensure mentee participation (example: to avoid conflicting with other scheduled events).
  - Dates were pre-set in the second year at every other month alternating with the SHIP PCMH educational webinar series to allow for the clinics and the Team to have some regular advanced notice. Dates were occasionally adjusted to allow for mentor participation scheduling.
- **MATERIALS:**
  - A template webinar PPT slide deck was created and updated for each topic with reference to a PCMH Standard, if applicable – See Appendix D.
  - Post-mentorship webinar survey questions and an evaluation process was developed for each webinar and invited input on future topics and/or interest in being a mentor – See Appendix E.
- **MENTOR/MENTEE OUTREACH:**
  - The Lead outreached to gain input from QI Staff, other Coaches and clinics on suggested mentors by topic, as well as once a topic was determined.
  - Initial outreach to the mentors was conducted by either the Coaches or QI Staff, or contact information was shared with the Lead to contact the mentor directly.
  - The goal was to recruit at least 1 or 2 mentors per webinar.
  - Occasionally, an expert participated in the webinar to add additional experience and resources for clinics, which ultimately crossed various departments and organizations. This was valuable to the sessions regarding behavioral health integration (Idaho Behavioral Health Alliance) and oral health integration (Idaho Oral Health Alliance) with the IDHW.
  - The Lead would then work with the mentor, with assistance from the QI Staff, to prepare for the webinar and; discuss the discussion guiding questions to help shape the mentors' remarks, as well as confirm access to the Briljent webinar tool.
  - Webinars were advertised as voluntary events across all Cohorts.
- **DURING THE WEBINAR – FIELDING QUESTIONS FROM MENTEES/OTHER PARTICIPANTS**
  - Participants were able to write in questions during the webinar or have their phone line unmuted to ask questions directly to the mentors.

- The Lead served as facilitator and would ask questions from the participating clinics to the mentors. The Lead would probe with further questions on the mentors' initial remarks to highlight key aspects that might be helpful to clinics, based on the Lead's experience as a Coach to the clinics, from other input from surveys and from the LC discussions with clinics.

- **FOLLOWING THE WEBINAR – FOLLOWUP WITH MENTORS & PARTICIPANT SURVEY**
  - The Lead would routinely communicate with the mentors after the webinar to thank them for their time in participating in the webinar and share the level of participation of their event.
  - Participants were sent a survey following each mentorship webinar event. It would include an evaluation of the event and opportunities to suggest future topics and self-identify if willing to be a mentor for a specific topic.
  - The survey information was compiled and shared with the Lead to help to develop future webinar topics, as well as with SHIP.

Webinar Schedule and Topics Summary

The Mentorship Webinar Series consisted of the following topics:

Table 1: Mentorship Webinar Series – 2017-2018

#	Topic	Date
1	Using Community Health Workers in the Patient Centered Medical Home	August 17, 2017
2	Behavioral Health Integration in Federally Qualified Health Centers' (FQHC)/Community Health Center Setting	October 4, 2017
3	Behavioral Health Integration in non-FQHC/Community Health Center Setting	October 18, 2017
4	Strategies for PCMH Culture Change	November 7, 2017
5	Strategies for Care Management Part 1	December 12, 2017
6	Strategies for Care Management Part 2	January 25, 2018

Table 2: Mentorship Webinar Series – 2018-2019

#	Topic	Date
1	PCMH Transformation Toolkits and Portal Features Walkthrough	March 29, 2018
2	Where to Begin: Getting Started on National Committee for Quality Assurance (NCQA) Standards - Tips and Approaches	May 16, 2018
3	Surviving the New NCQA 2017 Recognition Process: The Calls and Q-PASS	August 15, 2018
4	Oral Health Integration and the Patient Centered Medical Home	October 17, 2018
5	"5-2-1-0" Child Wellness Initiative in the PCMH model and the Community	November 7, 2018
6	Patient Engagement	December 19, 2018

Impact/Evaluations

The mentorship webinar series was well received both years it was conducted.

- On average, the webinars were attended by over 30 participants who stayed on throughout the hour of the webinar, with over 500 participants over all webinars
- In most webinars, the audience did not ask many questions. This required the Lead to augment with additional questions to continue the conversation. This led to the mentors sharing additional experiences or observations related to the topic beyond their initial remarks. Frequently, the mentor clinics would ask questions of each other to share approaches or issues as part of the discussion.
- Tools were occasionally identified by the mentors that they had used or developed. As possible, these resources were made available following the webinar. If not, contact information was available at the end of the session to promote outreach to obtain the tool directly.
- It was reported many of the mentors were contacted following the sessions by both clinics and QI Staff working with clinics to gain more information and/or for tool sharing. No formal evaluation of the mentors was conducted but could be added.
- Surveys were provided to all participants following the webinar. Responses were received from around 5-10 respondents who provided generally positive reactions to the webinar, more limited willingness to be a mentor for future topics proposed, much less willingness to no willingness to participate as a mentee; and some topics were provided for future sessions.

Conclusion

The mentorship webinar series conducted during the second and third years of the SHIP PCMH project was a useful adjunct to the technical assistance provided to the SHIP clinics by the Team. It augmented the sharing and networking between the clinics beyond the focused curriculum of the LCs, the sharing of examples and tools conducted by the QI Staff, the Medical Health Networks, and the Coaches. The webinar series was generally well-received and provided an opportunity to enhance networking across clinics beyond the regions and spread best practices and sharing of the challenges and successes to implement key aspects of the PCMH model.

Idaho intends to continue to evaluate their Mentorship Framework and update their recommendations after the SHIP grant ends. The experience of the Mentorship webinar series is valuable to consider as the state aims to support the spread of the PCMH model as part of ongoing delivery system transformation.

Appendix A: Potential Webinar Topics Lists

Potential topics:

- CHW: use, timely as new enhanced payment options, coding/reimbursement for CHW, various licensure
- PCMH Culture change: adaptive vs. technical; provider/front office staff engagement, Team-based care
- Moving from NCQA 2011 to 2017 Standards – challenges and approaches
- Behavioral Health integration
- Team Huddles
- Risk Assessment and Stratification
- Chronic Care Management
- Collaboration with specialty care practice
- CHEMS involvement
- Preventing burnout
- How population health is organized between various agencies
- Case management
- Behavioral health integration, coding, and reimbursement models
- Emergency Department (ED) notices; importance of alerting other care providers from different clinics
- Training topics for staff
- Potential student internships and approach
- Motivational Interviewing
- Assisting clinics of larger healthcare systems on approaches for clinic-specific changes and PCMH implementation within corporate rules/policies
- Care plans and importance of top-level support
- Measuring success of Regional Collaboratives
- Virtual PCMH - stories of what worked and why
- Data analytics for dummies
- How to effectively use the Electronic Health Record (EHR) in the PCMH model
- More info on payment reform; sustainability after recognition
- Step by step of what happens with Q-PASS sign-up and other aspects of NCQA recognition process
- Integrating relationship between CHWs and care coordinators
- Social determinants of health in health care practice
- EHR data analyst help to get quality data
- How to get everyone to “buy in” to PCMH
- Share best practices
- Health literacy
- Chronic disease management
- Breakout for quality and risk stratification
- Medicare’s Quality Performance Program; deeper dive into Merit-based Incentive Payment System (MIPS); importance of MIPS “team”
- How to present care management to patients in a positive way – patients may refuse care management (CM) because they feel they are giving up control or are offended by being offered it

- Learn change management approaches
- Focus on specific NCQA - brainstorm solutions to more difficult items
- Plan-Do-Study-Act (PDSA) cycles
- Incorporate 5 BAR into conversations
- What value-based payment will look like for providers going forward and how to give them this data
- Involve insurance companies/payors
- Hands on training (role play)

Appendix B: Planning Template for Webinars and Outreach to Mentors

Time Line/Responsibilities for Topic #X: Title

For advertising the event/goals of the webinar:

Title of the Webinar: _____

This is part of a series of voluntary webinar events to allow clinics to share ideas and approaches, using mentors from clinics already implementing an approach or program with clinics desiring mentoring. All SHIP Cohort 1 & 2 clinics are invited to participate as they find the topics applicable to their efforts on PCMH.

This particular event is focused on _____ in the setting of a PCMH. It will provide an opportunity for sharing examples of how _____into their PCMH, including how clinics initiated and have supported their _____ programs. The format will be a conversation with the majority of the time available for clinics considering integrating a behavioral health program to ask questions and brainstorm with the mentors.

Tentative Date:

MENTORS

Mentor Name/Clinic	Who does initial outreach?	Who works with Mentor to prep?	Target Dates

MENTEES or Other Experts (If applicable)

Mentee Name/Clinics or Expert/Organization	Who does initial outreach?	Who works to get key questions from Mentee?	Target Dates

Webinar Slide Deck Completion	Ready for Review by _____
Evaluation Survey	• Ready for Review by__ • Send out electronically at completion of webinar on _____

Notes following webinar:
participants and location of attendees
Thoughts
responded to the survey and results

Appendix C: Listing of Mentors for Each Webinar in the Series

Table 3: Webinar Mentors – 2017-2018

#	Webinar Topic	Mentors/Contact Information
1	**Using Community Health Workers in the Patient Centered Medical Home**	**Genesis Clinic:** • Johnathan Farrell, johnny@geneisch.org / 208-854-3929 • Josh Campbell josh@genesisch.org **St. Mary's:** • Shari Kuther RN, Physician Practice Manager, Shari.kuther@smh-cvhc.org / 208-962-3267 **Additional Contributors:** • St. Luke's McCall - Don McKenzie, mckenzid@slhs.org / 208-630-2335
2	**Behavioral Health Integration in FQHC/Community Health Center Setting**	**Health West:** • Lyn McArthur, lmcarthur@healthwestinc.org / 208-232-6260 x 1013 • Doty Collins, dcollins@healthwestinc.org / 208-232-6260 x 1017 **Family Health Services:** • Tori Torgrimson, Behavioral Health, ttorgrimson@fhsid.org / 208-734-1281 **Additional Contributor: Idaho BH Network** • Jennifer Yturriondobeitia, yturrioj@slhs.org
3	**Behavioral Health Integration in Non-FQHC/ Community Health Center Setting**	**St. Luke's:** • Amy Walters, awalters@slhs.org, 208-331-1155 x 54062 **Shoshone Family Medical Center:** • Pam Lowder, manager@shoshone.net, 208-886-2703
4	**Strategies for PCMH Culture Change**	**Family Health Center:** • Dr. Scott Dunn – Physician Champion • Brandy Giese – Office Supervisor, bgiese@fhcsandpoint.com, 208-920-2536 **Kaniksu Health Services:** • Amber Villelli, Director of Performance Improvement, amberv@kaniksuhealthservices.org, 208-265-6262 x 2204
5	**Strategies for Care Management Part 1**	**St Mary's Hospital and Clinics:** • Shari Kuther RN, Physician Practice Manager, shari.Kuther@smh-cvhc.org, 208-962-3267 **Clearwater Valley Hospital and Clinics:** • Vicky Peterson RN, Clinic Manager, vicky.petersen@smh-cvhc.org, 208-476-4555
6	**Strategies for Care Management Part 2**	**St Mary's/Clearwater Valley Hospital & Clinics/Orofino Health Center:** • Shawna Altmiller, RN - Case Manager, shawna.altmiller@smh-cvhc.org, 208-476-8009 **Terry Reilly Health Services, Nampa:** • Ashley Freeman, LCSW - Behavioral Health Consultant, afreeman@trhs.org, 208-467-7654

Table 4: Webinar Mentors – 2018-2019

#	Webinar Topic	Mentors/Contact Information
1	**PCMH Transformation Toolkits and Portal Features Walkthrough**	**Briljent:** • Grace Chandler, Senior Project Manager, gchandler@briljent.com, 317-735-3497
2	**Where to Begin: Getting Started on NCQA Standards - Tips and Approaches**	**Portneuf Primary Care:** • Elisa Magagna, Physician Liaison/Marketing/Public Relations, Elisa.Magagna@portmed.org, 208-239-1059 • Brittany DeVore – Office Manager, Brittany.DeVore@portmed.org, 208-239-3818 **Primary Health Clinics:** • Jordyn Hale -Population Health Coordinator, Jordyn.Hale@primaryhealth.com, 208-955-6500
3	**Surviving the New NCQA 2017 Recognition Process: The Calls and Q-PASS**	**Driggs and Victor Health Clinics:** • Laurel Ricks, Clinic Manager, lricks@tvhcare.org, 208-354-6343 • Family Medicine Residency of Idaho (FMRI) – Boise • Mandy Bronco, Medical Staff Coordinator/PCMH Project Manager, mandy.brunkow@fmridaho.org, 208-514-2500 ext. 1827 **St. Mary's Hospital and Clinics – Cottonwood, ID:** • Shari Kuther RN, Physician Practice Manager, shari.Kuther@smh-cvhc.org, 208-962-3267
4	**Oral Health Integration and the Patient Centered Medical Home**	**Idaho Oral Health Alliance:** • Jennifer Wheeler, Executive Director, jwheeler@idahooralhealth.org, www.idahooralhealth.org, 208-994-9058 **Idaho Dept. of Health and Welfare:** • Angie Bailey, Health Manager, Oral Health, Angie.Bailey@dhw.Idaho.gov **From Region 3 (Southwest) Public Health District:** • Amber Aberasturi, SHIP Quality Improvement Specialist, Amber.Aberasturi@phd3.idaho.gov, 208-455-5422 **St. Alphonsus Pediatrics:** • Dr. Naya Antink, Naya.antink@saintalphonsus.org
5	**"5-2-1-0" Child Wellness Initiative in the PCMH model and the Community**	**Bingham Memorial Family Medicine, Blackfoot, Idaho:** • Dr. Chris Heatherton, cheatherton@binghammemorial.org, 208-785-4100 **Region 6 - Southeastern Idaho Public Health District:** • Rhonda D'Amico, PHD SHIP Manager, rdamico@siph.idaho.gov, 208-239-5227
6	**Patient Engagement**	**Kaniksu Health Services:** • Amber Villelli, Director of Performance Improvement, amberv@kaniksuhealthservices.org, 208-265-6262 x 2204

Appendix D: Mentorship Webinar PowerPoint Template

Statewide Healthcare Innovation Plan

PCMH Transformation Team – *Mentorship Webinar Series*
Date

Learning Objectives for the Webinar Series

- Sharing the implementation experiences and lessons learned of mentor clinic(s) with interested clinic participants around a particular topic; including key strategies and challenges
- Opportunity for the "mentee" participant clinics to ask questions in a facilitated discussion with the mentors
- Build relationships across Idaho to share lessons learned and increase knowledge of the on-the-ground steps needed to implement PCMH transformation
- Link to Statewide Healthcare Innovation Plan (SHIP) Mentorship Framework document (copy link and paste into your browser)

  http://ship.idaho.gov/Portals/93/Documents/PCMH/Idaho's%20PCMH%20Mentorship%20Framework%20DRAFT%20v7.0D_06052017.pdf?ver=2017-07-26-084527-037

PCMH TRANSFORMATION TEAM

PCMH TRANSFORMATION TEAM

Today's Topic: _____

(Brief background description of topic would go here)

(Plus a slide on any additional information/brief resource list if relevant - i.e. for CHWs, info on state's program)

PCMH TRANSFORMATION TEAM

Today's Mentors

1) Person(s), Clinic/System name, Region X
(with pic of either clinic or person if available)

2) Person(s) Clinic/System name, Region X
(with pic of either clinic or person if available)

4

PCMH TRANSFORMATION TEAM

Mentee(s)

A few of you have helped us identify key questions and will be contributing today based on the needs of their clinics

(if can be identified ahead of time each time)

1) Person(s), Clinic/System name, Region X

2) Person(s) Clinic/System name, Region X

5

PCMH TRANSFORMATION TEAM

Guiding Questions for Mentors

- Describe your clinical setting
- Why did your clinic decide to move forward with this effort?
- Where is your project/program today?
- What were your first steps? Key strategies?
- Who and how did you undertake this effort?
- How did you finance this effort, if needed?
- What were the top 2 challenges or barriers? How did you overcome them?
- What were the major lessons learned from this effort?

6

PCMH TRANSFORMATION TEAM

Specific Mentee Questions

(Identified Mentees would be asked to put out their questions or concerns)

(If identified early, will add their questions here as well)

7

PCMH TRANSFORMATION TEAM

Discussion and Sharing (Open up to broader audience here)

8

PCMH TRANSFORMATION TEAM

Mentors Contact information

For follow-up questions or further inquiries on this topic:

- Mentor 1 Contact email & phone
- Mentor 2 Contact email & phone

9

PCMH TRANSFORMATION TEAM

PCMH TRANSFORMATION TEAM

Wrap-UP: Next Topics in the series

Next Topic:

DATE and TIME:

Future topic/dates: (once known)

Recruiting is underway:

Reaching out in partnership with the (regional partners) for interested mentors on these topics

10

PCMH TRANSFORMATION TEAM

PCMH TRANSFORMATION TEAM

Mentorship Series- Contact information

If have ideas on future topics and/or if interested in being a mentor or need mentoring, please contact:

- **[Mentorship Series Lead name]**

  Email/phone contact information

- **[Any other partner/key contact name]**

  Email contact/phone contact information

11

PCMH TRANSFORMATION TEAM

Appendix E: Evaluation Survey following Mentorship Webinar

To be sent to all attendees, ideally immediately following the webinar as part of the "thanks for participating" e-mail to gather feedback on a particular webinar but also do outreach for future topics, mentors, and mentees.

E-Mail to the Attendees:

Please complete an evaluation of the mentorship webinar held on [DATE]. Please respond by [DATE].

Mentorship Webinar Evaluation Questions

1. How helpful was the topic to your clinic or health system?
    a. Extremely helpful
    b. Moderately helpful
    c. Somewhat helpful
    d. Not very helpful
2. Where is your clinic/health system currently on this topic?
    a. Actively pursuing or working with _____ program
    b. Developing our own or starting to discuss partnering _____
    c. Considering the development of a _____program
    d. Not there yet, but may consider in the future
    e. Never consider working with a _____program
3. Was there anything in the mentors' points that you will take back and implement/use?
    a. Yes
    b. No
    c. If so, what specifically? _____
4. Did the webinar approach to share lessons learned seem successful?
    a. Yes
    b. No

5. If not, how could it be improved?
   a. More time for questions
   b. More details about each mentor clinic presented
   c. Less details about each mentor clinic
   d. More details about the following aspects of this topic _____
   e. Other ideas/suggestions? _____
6. Will you be contacting the mentor(s) for more questions or assistance?
   a. Yes
   b. Maybe
   c. No
7. What additional types of assistance would be helpful for this topic?
   _____
8. What are other topics you would like to see covered in this type of format of sharing among clinics?
   a. _____
   b. _____
   c. _____
   d. _____
9. Is there a topic you would be willing to be a mentor for?
   a. Yes; Topic(s) _____

      If so, please provide your name, organization, and e-mail address:

      Name: _____

      Organization: _____

      E-Mail: _____
   b. No

10. Is there a topic you would like to help shape the questions for as a mentee?

a. Yes; Topic(s)_____

If so, please provide your name, organization, and e-mail address:

Name: _____

Organization: _____

E-Mail: _____

b. No

HOW PATIENT CENTERED MEDICAL HOME (PCMH) TRANSFORMATION TRANSLATES TO PATIENT CARE IN IDAHO

By Dawn R. Juker, LMSW, CCHt., CHW, PCMH CCE

Research Associate, University of Idaho

Public Health Districts 3, 4, & 5

January 29, 2019

"We want to understand the added value, especially from the patient perspective; need reminders on why we're doing it and why change…." (Clinic Portal Notes).

"I would really like more information to give to the team about describing/defining PCMH. I have a hard time explaining it in multiple ways so other staff are able to grasp the concept. Staff will ask time and time again even though I thought I had covered the defining mechanisms. One question is like 'why do we need all of these people' or 'what does that mean for me?' I'd almost like a script… (laughter)" (Clinic Staff Interview).

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.

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

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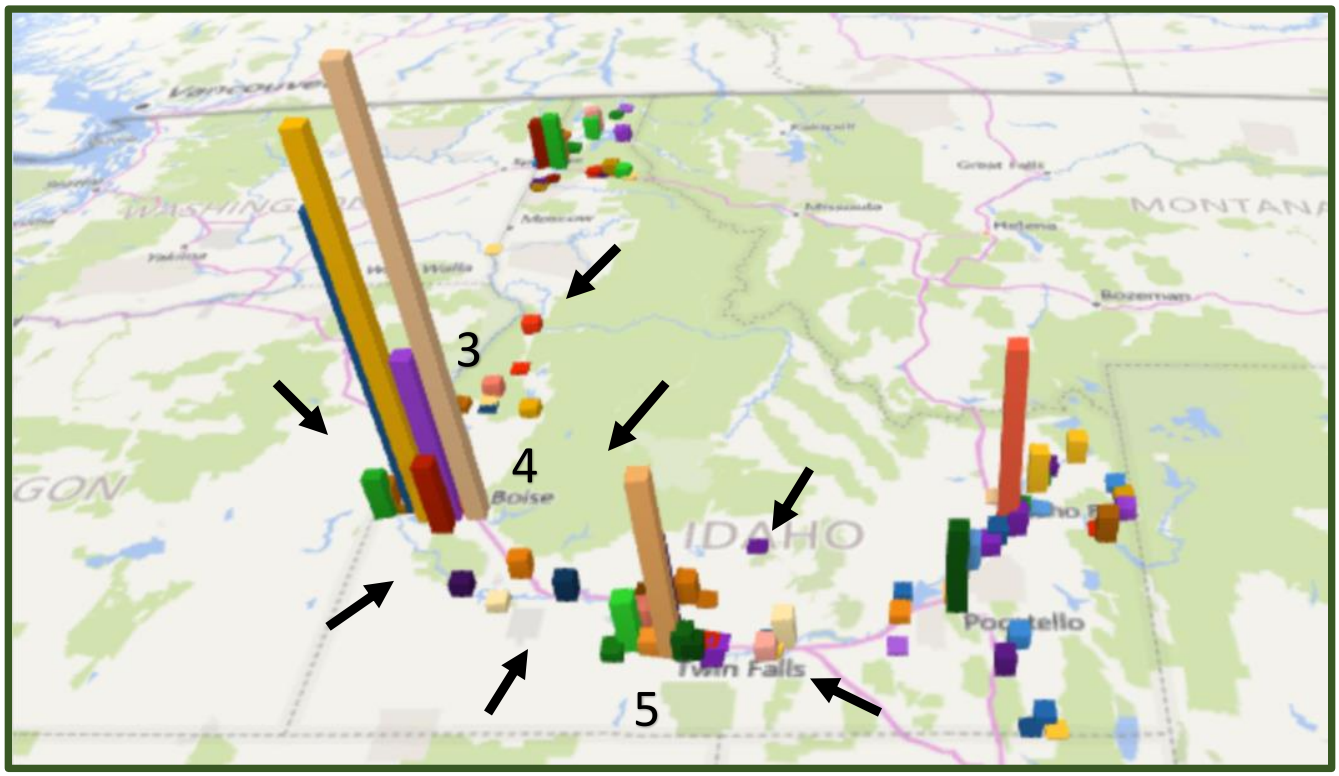
Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14- 001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

INTRODUCTION

In 2015, Idaho received a 39.6 million-dollar grant from the Centers for Medicare & Medicaid Innovation (CMMI) to expand Patient Centered Medical Home (PCMH) transformation in the primary care setting in Idaho, as well as addressing other aspects of healthcare and service delivery. The transformation was described in many instances as being more of a journey than a project. Clinics have made financial investments including technology, hiring personnel, or creating more space within the clinic(s) for care to be delivered. The support services provided by the Statewide Healthcare Innovation Plan (SHIP) grant, specifically under Goal 1 (Transform primary care practices across the state into Patient-Centered Medical Homes (PCMHs): Idaho is establishing PCMHs as the foundation of the state's healthcare system by making them the vehicle for delivery of primary care services. The PCMH focuses on preventive care, keeping patients healthy and stabilizing patients with chronic conditions. Grant funding is being used to provide training, technical assistance and coaching to assist practices in this transformation.), were instrumental in assisting primary care practices moving toward PCMH accreditation, as well as fostering improvements in the quality of patient care across the state. This report focuses on the activities of Goal 1.

Before diving into the data, the map below illustrates the approximate location of SHIP participating clinics, but more importantly represents where participating patients live. Details of patient interviews are discussed throughout this report. The State of Idaho is divided into seven (7) public health districts. Public Health Districts 1 and 2 are in Northern Idaho. Regions 6 and 7 are in Eastern Idaho around the Pocatello landmark shown on the map. This report is focused on regions 3, 4, & 5, which encompasses Western, Central and South-Central areas respectively. Three (3) distinct clinic cohorts received SHIP support for the duration of one year each.



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

HOW PCMH TRANSFORMATION TRANSLATES TO PATIENT CARE

The State Evaluator Team (SET) conducted a state level evaluation of SHIP activities and assigned three (3) research associates to the regions to collect patient and clinic staff interviews, windshield surveys, and review Goal 1 portal notes. Data collection occurred between 2016 and 2018. In total, 1143 patients and 110 clinic staff interviews were conducted across the state. In this report we discuss the data collected by the research associate assigned to regions 3, 4, and 5, and compare transformation activities against the PCMH 2017 Standards. Included in these districts were seventy-two (72) clinics in urban, rural and frontier counties. As illustrated in the map on the previous page, the greatest volume of interviews occurred in these three regions, which also provided a richness of diversity. Below are the demographics of patient interviews in regions 3, 4, and 5 in total. Individual cohort information is referred to throughout the remainder of the report.

REGION 3 - ALL COHORTS – PATIENT DEMOGRAPHICS									
# OF CLINICS ALLOWED PATIENT INTERVIEWS:			22 of 26 | 84.6%		# OF PATIENTS INTERVIEWED			349	
GENDER:	F	277	M	72	CONTACT METHOD:	IN PERSON -52 | PHONE - 57 | WORKSHEET - 240			
AVERAGE AGE:	44.3				CLINIC SETTING:	URBAN- 194 | FRONTIER- 10 | RURAL- 145			
WEIGHT ISSUES:	32	DIABETES:	53		ROUTINE WELLNESS	105		MENTAL HEALTH:	37
RACE:	WHITE:		235		HISPANIC:	111		OTHER:	3
TRANSPORTATION TYPE	RELATIVE/FRIEND:		27		PAYMENT TYPES:	SLIDING	7	MEDICARE/MEDICAID:	97
	TAXI/BUS:		5						
	OWN CAR:		316			PRIVATE	190	SELF/UN-INSURED:	49
	WALK/BIKE		1						

REGION 4 - ALL COHORTS – PATIENT DEMOGRAPHICS									
# OF CLINICS ALLOWED PT INTERVIEWS:			24 of 36 | 66.7%		# OF PTs INTERVIEWED			316	
GENDER:	F	232	M	84	CONTACT METHOD:	IN PERSON - 65 | PHONE - 98 | WORKSHEET - 153			
AVERAGE AGE:	45.8				CLINIC SETTING:	URBAN - 267 | FRONTIER - 20 | RURAL - 29			
WEIGHT ISSUES:	16	DIABETES:	35		ROUTINE WELLNESS	82		MENTAL HEALTH:	49
RACE:	WHITE:		266		HISPANIC:	34		OTHER:	16
TRANSPORTATION TYPE	RELATIVE/FRIEND:		20		PAYMENT TYPES:	SLIDING	5	MEDICARE/MEDICAID:	106
	TAXI/BUS:		7						
	OWN CAR:		287			PRIVATE	148	SELF/UN-INSURED:	46
	WALK/BIKE		1						

REGION 5 - ALL COHORTS – PATIENT DEMOGRAPHICS									
# OF CLINICS ALLOWED PT INTERVIEWS:			9 of 9 | 100%		# OF PTs INTERVIEWED			180	
GENDER:	F	157	M	23	CONTACT METHOD:	IN PERSON - 0 | PHONE - 13 | WORKSHEET - 167			
AVERAGE AGE:	37.7				CLINIC SETTING:	URBAN - 0 | FRONTIER - 180 | RURAL - 0			
WEIGHT ISSUES:	16	DIABETES:	16		ROUTINE WELLNESS	63		MENTAL HEALTH:	30
RACE:	WHITE:		92		HISPANIC:	85		OTHER:	3
TRANSPORTATION TYPE	RELATIVE/FRIEND:		5		PAYMENT TYPES:	PRIVATE	119	MEDICARE/MEDICAID:	31
	OWN CAR:		175					SELF/UN-INSURED:	30

DATA COLLECTION

There were a variety of ways in which the progression of PCMH transformation and subsequent results were recorded. Clinic staff and patients were interviewed, and clinic personnel recorded their journey in an electronic portal. Each of these methods had strengths and weaknesses as discussed below.

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

Clinic Staff Interviews

A total of 63 clinic staff interviews were conducted in regions 3, 4, and 5. One of the most important components of collecting information was that of flexibility. Flexibility allowed clinics to choose the way interviews would be conducted to minimize the potential impact on patient care resources. Interviews could be conducted in person, on the phone, or by completing a questionnaire and returning it to the research associate assigned to their clinic(s). Interview responses were dependent on the interviewee's familiarity with PCMH subject matter, clinic strategies, and their role in patient care. Not all 72 clinics were able to participate in the interviews due to scheduling conflicts for both clinic personnel and the assigned research associate. Some clinics allowed more than one interview to be conducted at each site, which not only improved staff engagement, but also provided rich insight as to various interactions regarding care delivery, patients, and transformation activities.

Questions asked of clinic staff were not all directly aligned with PCMH standards. For instance, several questions were asked about priorities of current transformation activities, the impact on patient care or outcomes, functions that promoted clinical quality measures, and future activities clinics planned to focus on. Other questions elicited definitions of patient engagement, definitions and experiences with the medical health neighborhood, and activities where additional assistance may be needed in the future. A master worksheet with the questions and all counted themes is attached as Appendix A.

Patient Interviews

There were 845 patient interviews conducted in the three regions in a variety of ways. Some clinics provided the assigned research associate a list of patient names with contact information. For these individuals, an introduction letter was sent to the address listed and patients were subsequently called and asked if they would be willing to participate in the interview. A few clinics chose to contact patients and obtain permission to be interviewed. In either instance, the assigned research associate would schedule the interview at the patient's convenience. Interviews were then recorded, transcribed and coded for themes relative to their healthcare experience. Telephone interviews had advantages, such as robust responses from participants. However, even with permission or receipt of an introductory letter, many still chose not to participate. Patients had a great deal of concern that the calls were a scam, or they simply did not have the time to participate. The method of calling patients required collection of several "no thank you's" or hang-ups to obtain one completed survey.

Other clinics chose to have patient interviews conducted on site. In this instance, patients were provided a paper worksheet and had time to complete the written interview as they waited in the waiting or exam rooms. Worksheets and consents were also translated into Spanish for patients who were unable to communicate in English. Upon completion of their medical exam, they were escorted to the interviewer to briefly discuss the questionnaire. A bilingual staff member was able to assist in the exchange of information. Patients who spoke a language other than English typically had their own translator. Although many of the answers were in a "bullet-point" list, the content did not differ from that collected through telephone interviews. Many participants were still quite verbose in their responses. In the event a patient was unable to read or write, they participated in a recorded interview. Connecting with patients on site was very successful in that 10-20 interviews could be completed in approximately 3-4 hours. Only one patient declined to participate under this method of data collection.

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Patient interview questions were not directly aligned with PCMH standards. Rather, questions elicited information such as what a patient believed to be his or her responsibility regarding their health versus what they believed to be the responsibility of the healthcare provider. Additionally, patients were asked to comment on barriers to health, whether they needed additional assistance from the healthcare team, new things they planned to do in the future, accessibility of various types of healthcare (i.e. dentistry, behavioral health, specialists or primary care), and whether they could afford healthcare costs.

Aggregated reports were provided to each clinic location as to the frequency of patient comments regarding each question, as well as disclosure of deidentified patient comments for the purpose of understanding the context of the themes that emerged. A master worksheet illustrating the questions and all counted themes is attached as Appendix B. It may provide a useful template for clinics looking to expand information they collect regarding patient experience(s) in the future.

Portal Notes

Seventy-two (72) SHIP clinics, located in districts 3, 4, & 5, were asked to record their transformation plans into a web-based portal. Each clinic participated in coaching calls with Health Management Associates (HMA), at least one clinic representative, and the SHIP Quality Improvement Specialist from the public health district assigned to their clinic. Summary information of the coaching calls were entered in the portal, along with operational activities each clinic was working on. Information contained in the portal was a window to the clinic's transformation process. Designated categories to collect information within the portal were directly aligned with PCMH standards.

When reviewing the portal notes, two areas of context are important to consider. First, some clinics were more experienced with PCMH, many having already become accredited under 2011 or 2014 standards. Some clinics were new to the PCMH model, and some clinics were seeking PCMH recertification, under the 2017 PCMH standards. There were regulatory differences depending on the certification year. Second, the design of the portal templates changed slightly from one cohort to the next, providing prompts for more detailed information, such as Plan-Do-Study-Act (PDSA) cycles. Less experienced clinics had more tasks to accomplish in their transformations, yet all clinics had similar guidelines to follow regardless of the accrediting organization or standard year.

Despite some data being lost due to technical difficulties, user error, &/or brevity, the portal information provided a layer of data regarding success, barriers, and areas of further interest or concern not otherwise gathered by the SET from clinic staff or patient interview data. All 72 clinics had entries in the portal. The data entered in the portal(s) is important because not all clinics were able to participate in clinic staff or patient interviews because of time or resource constraints. Portal notes offered a glimpse into <u>every</u> clinic's progress. The master worksheet illustrating all counted themes is attached as Appendix C.

PCMH STANDARDS TRANSCEND CLINIC AND PATIENT EXPERIENCES

Each of the individual PCMH concepts are listed below along with a summary of each concept's intent. Information gleaned from patient interviews, portal notes and clinic staff interviews are provided to illustrate PCMH activities at the clinic level and compare it with patient opinions regarding services or emerging themes of how activities had an impact on patient care.

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The frequency of similar activities implemented toward PCMH across the three regions and three cohorts is remarkable, as are the differences between them. Selected data for this report attempts to compare themes that were present in all three districts. An important consideration while reading the following material is that although some of the activities are not mentioned as frequently, it does not mean they are not being done at all. There are no right or wrong activities demonstrated in this report. The charts provided herein simply indicate how many times an activity is mentioned.

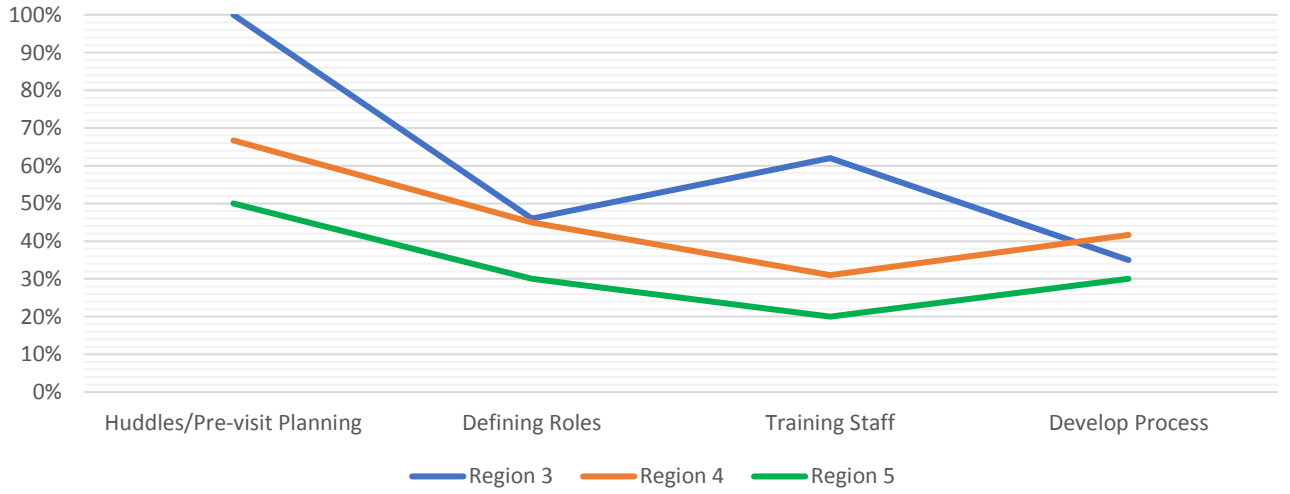
1. Team Based Care and Practice Organization (TC)–

The goal of team-based care is to enable clinics to function in an organized manner. It includes having an organizational chart, practice structure, staff training and communication with patients and staff about their respective roles within the medical home. A medical home is defined as the care facility that coordinates the patient's care throughout necessary treatment while providing access and continuity of care. Team-based care focuses on staff working at the top of their licensure and engaging the patient by providing information such as literature or education about the role of the medical home. Much like being on the playground as a child, people are selected to assume a specific role/function for the game being played, and decisions are being made about rules of the engagement. Sometimes coaching, or training, is needed to enhance the individual teammate's performance, and conversations occur about strategy. It is not really any different under this standard. Who is on the team and what are their strengths?

Through our morning huddles we have kept better track of our high-risk patients and can get them an appointment to meet with our CCM (coordinated care management) staff (Clinic Portal Notes).

Figure 1a illustrates the percentage of the most frequently mentioned clinic transformation activities under team-based care present in all three cohorts.

Figure 1a *- Comparison of Team-Based Care Elements from portal notes.*



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

How does Team Based Care translate to patient care?

Patients agree that clinicians need to understand the patient's medical condition and history when seen by providers. Perhaps patients do not experience the "huddle" in the same way the provider team does, but patients experience the outcome of huddle discussions. As one patient eloquently stated, *"Well, I think they're responsible to make themselves familiar with anything I have going on currently, medically, that concerns my health, and I think they also have an obligation to review my history and the information they have in front of them to the best of their ability, so that they are able to treat me in the moment, rather than me having to remind them that maybe I have some kind of a chronic condition that they haven't even bothered to ask me about. I think they're responsible to make sure that they know as much about me as they possibly can at that moment and time" (Patient interview).* Because providers may see the patient independently, huddles are a good way for all team members to obtain this knowledge and prepare for the patient's visit.

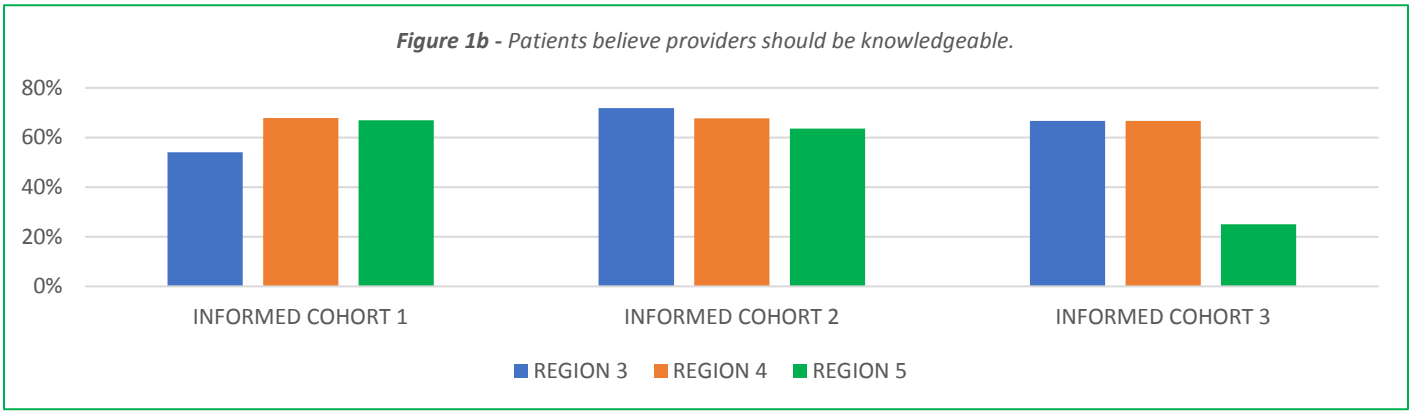


Figure 1b illustrates patient feedback on the importance of the care providers being educated. When asked what patients believe to be the responsibility of the healthcare team, one patient commented, *"Their knowledge base because that's their expertise. That's why we have patients go to the doctor to find out what's going on, what our symptoms are all about, how to get any treatment necessary, what we can do at home to better our health" (Patient interview).*

"I think they have the responsibility to use their knowledge, especially for things like health issues that I wouldn't be aware of as just an everyday person, & to use those – that knowledge and kind of help can prevent you from getting sick, and help you get better when you are sick" (Patient interview).

2. Knowing and Managing Your Patients (KM) –

The focus of this standard is to collect comprehensive data about the patient, and community, and then use the information to create a communication triad between the care team, patient, and community resources that may enhance health and well-being, often referred to as the Medical Health Neighborhood (MHN). Additionally, this standard incorporates a perspective of intervention safety by requiring providers to adhere to the use of evidence-based clinical decision support.

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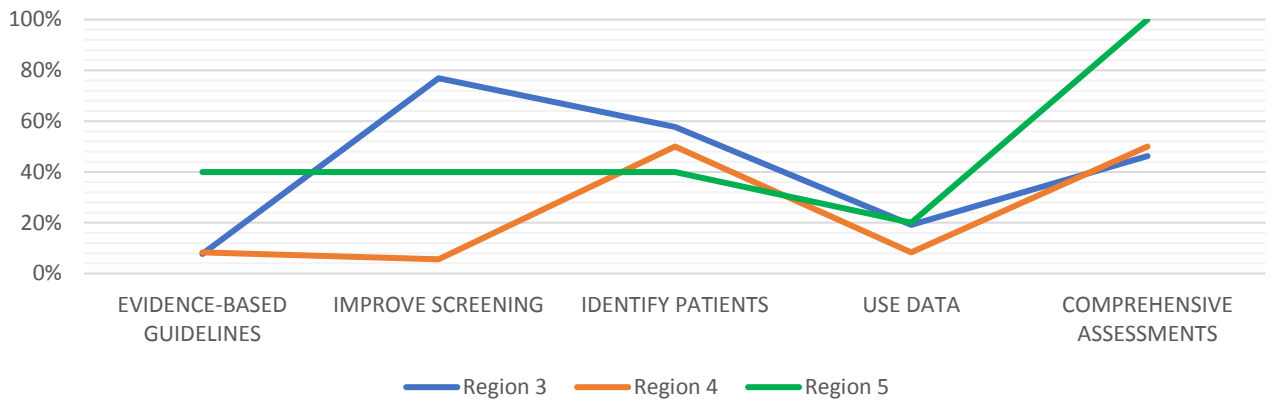
Understanding a patient's medical and medication history, family and cultural diversity, occupation, or other information commonly referred to social determinants of health (SDOH), and educating patients about resources in the community helps manage the population served by the clinic. Outreach activities such as contacting patients who have not completed routine or follow-up visits, reconciling medications, and screening processes all fall under this standard. Clinics can develop strategies to engage patients in taking care of themselves in ways they may not have previously understood. *"We would like the outcome of going through this process to be better team players, thus being a bigger help to our patient population…" (Clinic Portal Notes).*

Figure 2a demonstrates clinic activities that were common among all three regions.

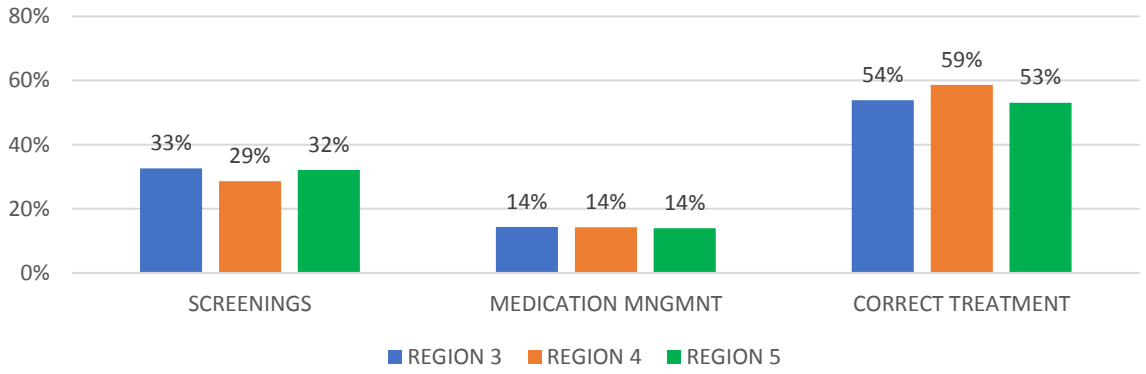
Figure 2a *- Knowing & Managing activities clinics focused on.*



How does Knowing and Managing Your Patients translate to patient care?

Services that patients believe to be the healthcare team's responsibility, as illustrated in Figure 2b, describe the connections to this PCMH concept of Knowing and Managing Your Patients. Patients from all three regions expressed themes such as routine screenings, medication management and providing treatments similarly. *"They are responsible for making sure that patients are up to date with physicals, immunizations, and chronic care visits. They should make sure that all physical and mental healthcare needs are addressed, and information is correct" (Patient interview).*

Figure 2b *- Patients mention providers should be responsible for certain services.*



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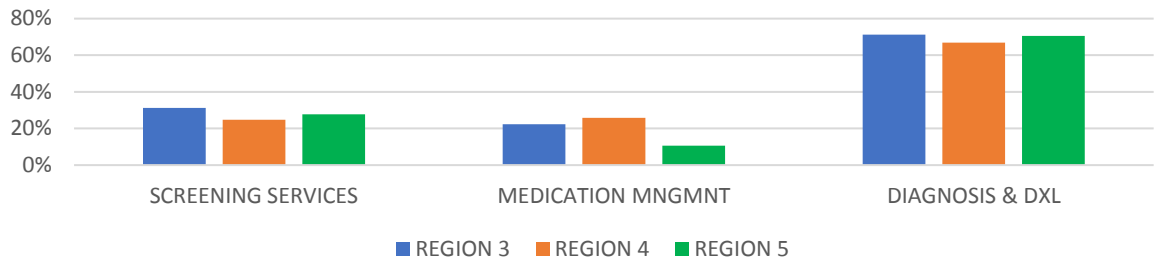
PATIENT STORY: *"… I decided by Tuesday that I should go have a checkup, and I found out that I do have some health issues that I didn't really know about. So, they gave me information, told me where to find information about things that, you know, might help me. They're always available if I call, to talk about things. I don't know, I'm 20 miles away from the clinic, so, I don't go very often. I must go after work usually and they're always very helpful about, you know, waiting for me and, you know, doing what I need to do, such as lab things. So, they helped with a routine procedure and found out that there might be some follow-up needed. I always call and let them know I'm on my way, because sometimes I don't get away from my work just when I want to, and being, 20 miles away, it does take a little while for me to get there. I've called in and they've waited. It's especially difficult in the lab, you know, if I need blood drawn or something, they waited for me and always been very helpful and cheerful and, you know, wanting to work with me" (Patient interview).*

Additionally, Figure 2c illustrates the types of services received during the last 12-month period mentioned in patient interviews. Approximately 70% of patients were seen for illness or injury that required the appropriate use of diagnostic testing. Roughly 25-30% of the patients reported being seen for routine exams or vaccinations.

***Figure 2c** - Types of services patients received.*

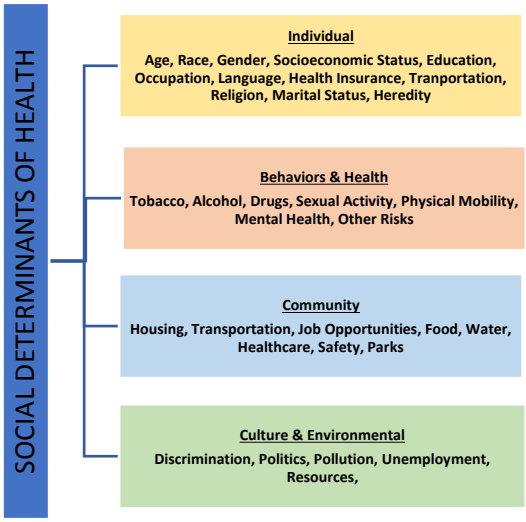


"My healthcare team has assisted me with ensuring my preventative screenings are completed pursuant to standards of care and evidence-based guidelines" (Patient interview).

2.1 Social Determinants of Health / Patient Barriers

Social Determinants of Health (SDOH) is a phrase used to describe items that impede or promote a patient's health and well-being – their quality of life. These things can be anything at the individual level such as race, religion, gender, etc. to cultural or environmental issues such as the political atmosphere or social inequities present at the community level. Figure 2.1a illustrates ways that SDOH can be categorized. The positive counter-part of SDOH includes available resources, abstaining from risky behaviors, and a patient's ability to overcome health obstacles. Under the traditional medical model of care, SDOH was not a widely considered piece of the puzzle when treating patient illnesses or injuries.

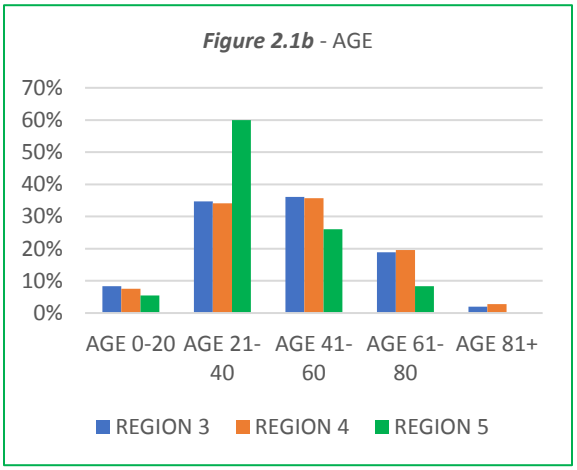
***Figure** 2.1a*

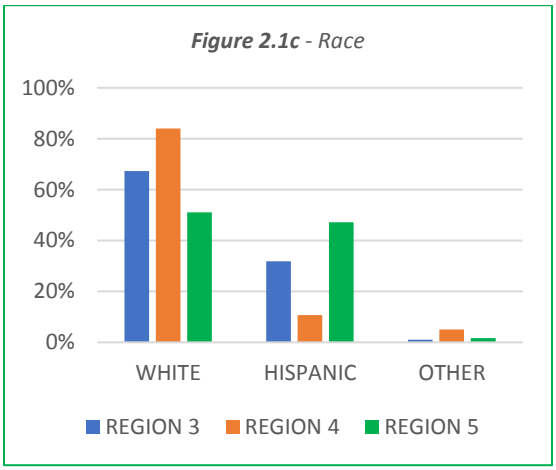


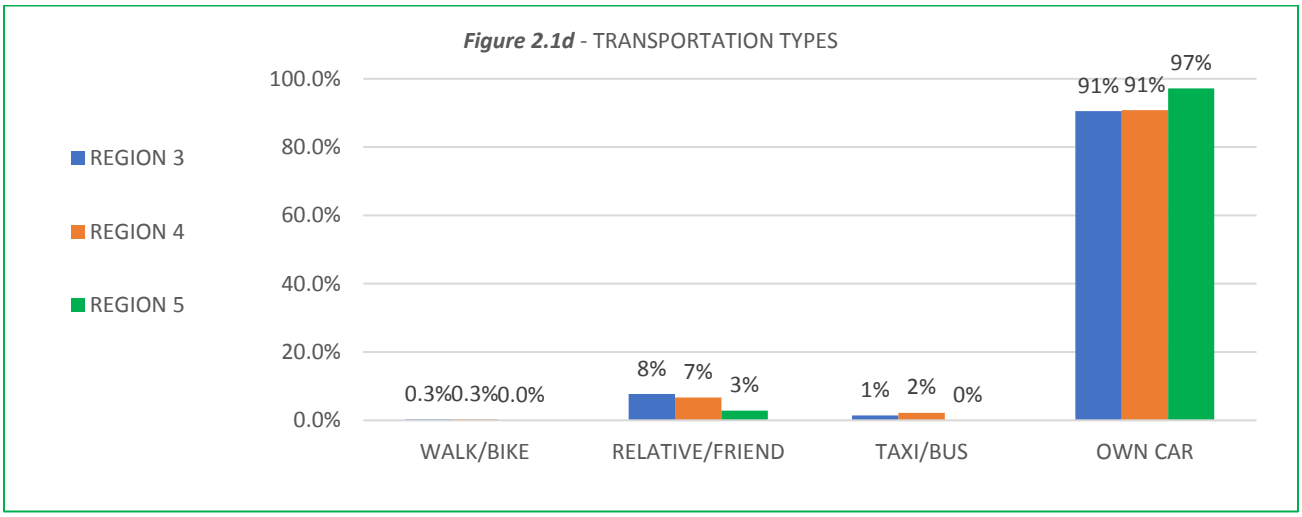
Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14- 001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

Elements of PCMH incorporate SDOH in medical care with the goal of improving patient outcomes and lowering costs. Many times, it is believed that everyone has the same opportunities or access to resources. However, this is not always the case. When considering SDOH, it is important to look for disparities, or inequities, that may negatively complicate patient health outcomes. Also, understanding SDOH and barriers to patient compliance (ie. following provider recommendations or taking prescribed medications correctly) with care plans or other health activities can foster a more trusting provider/patient relationship and may improve patient engagement (being involved in healthcare strategies and seeking more information if needed). For additional information about SDOH, please refer to the Tools and Resources Section of this report.

The SET did not ask patients directly about social determinants of health such as housing, income, occupation or how they perceived the community. However, indicators such as gender, race/ethnicity, age, health insurance type, and transportation are represented in the tables below in Figures 2.1b through 2.1g. Costs of care are addressed later under affordability.







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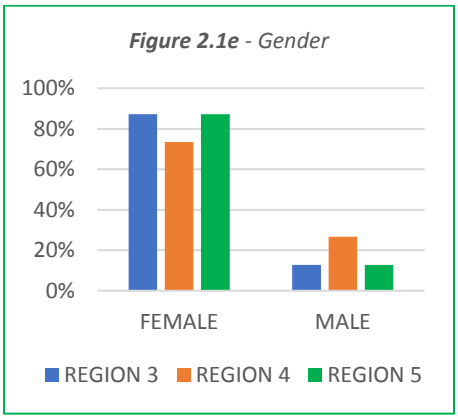

Figure 2.1e *- Gender*

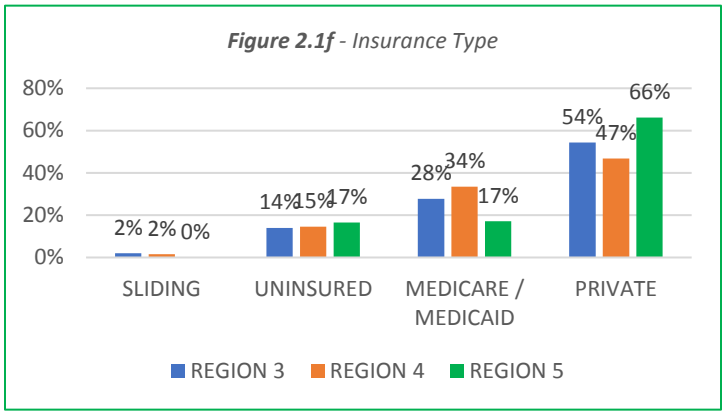

Figure 2.1f *- Insurance Type*

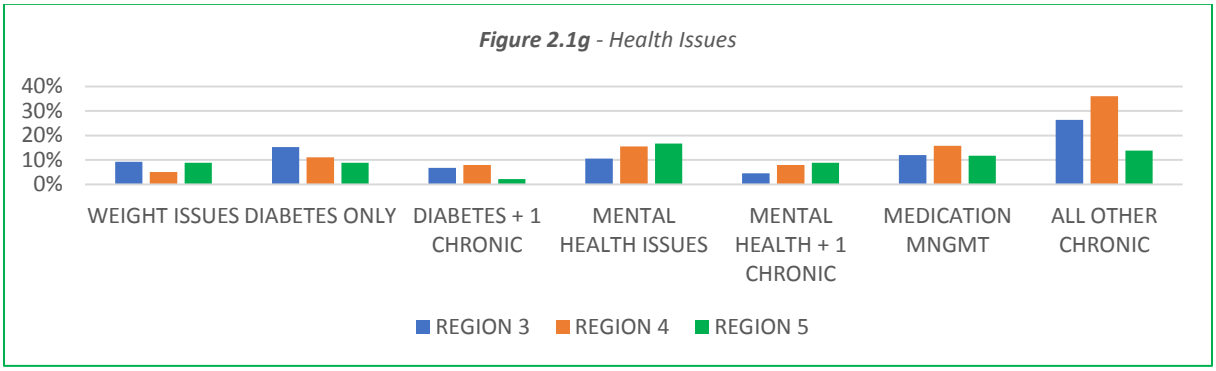

Figure 2.1g *- Health Issues*

Barriers to taking care of oneself are somewhat different than SDOH. Figure 2.1h illustrates themes from patient interviews when asked, "Are there things that prevent you from taking care of yourself as much as you would like to?" Pain is illustrated here because it could be caused by any of the above-referenced conditions. Nearly 70% of the patients in Region 3 reported pain as the most prominent barrier to taking care of themselves. The most consistent theme among all three regions is time management, with motivation being a close contender.

"…my work to life ratio is unbalanced. I have three young children that I care for" (Patient interview).

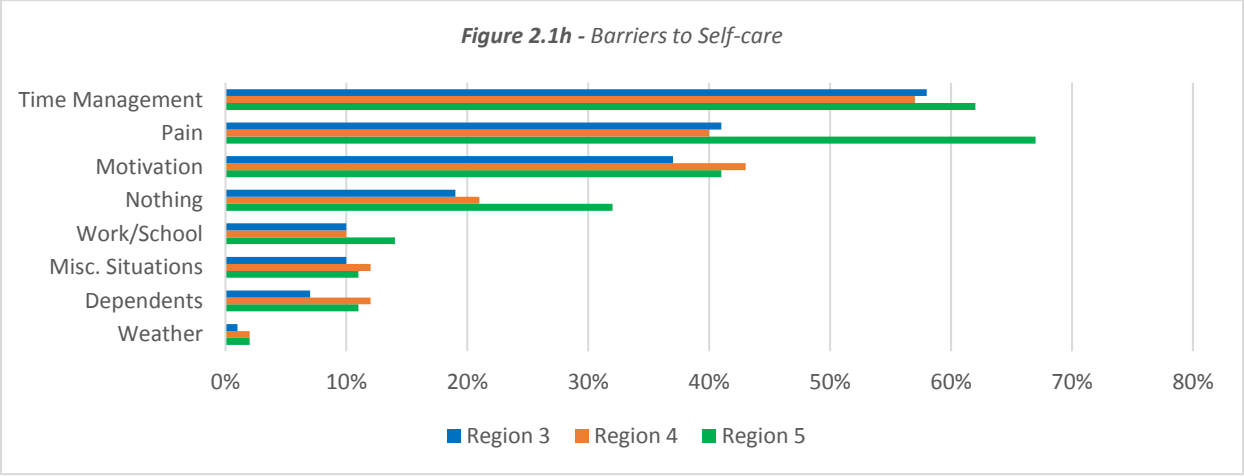

Figure 2.1h *- Barriers to Self-care*

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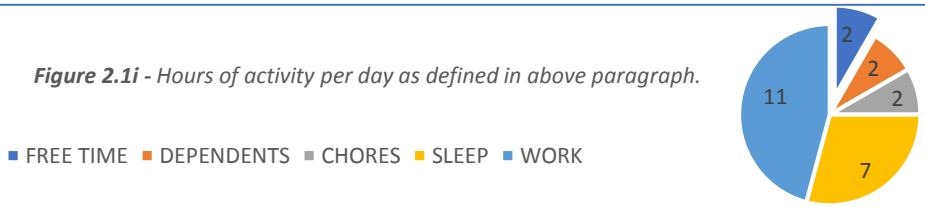
Considering the issue of time management for a moment, many people reported they lack motivation. Everyone has 24 hours in a day, but what happens during that day has a direct impact on how motivated a person might be to take better care of themselves. Most patients discussed how they are taking a very active role in caring for other things like work, family, and situations as illustrated in the Figure 2.1h above.

Figure 2.1i designates events in a typical day and how long it may take to complete the activities. The important caveat is that only sleep and work/school happens in blocks of time. The remaining six hours are chopped up across a day, fifteen minutes here, an hour there, it's very sporadic. Seven hours per day is imposed for sleeping. Work is calculated at eleven hours (eight hours of work, a one-hour lunch, one hour to get ready -shower, meal, dress, etc.- and thirty minutes driving each direction to/from home). Care of dependents require up to two (2) hours for meal prep, bathing, homework, getting dressed, other special needs, getting them to bed, transport to sports or appointments. Two (2) hours per day are allowed for household maintenance and chores such as laundry, mowing the lawn, vacuuming, paying bills, washing the car, taking care of pets, cleaning bathrooms, making beds, grocery shopping, picking up after yourself, children, pets, partner, etc. Even with these modest numbers, it leaves a balance of only two (2) hours in a day for things like miscellaneous emergencies to be handled, recreational activities, or taking care of one's own health issues.

Figure 2.1i *- Hours of activity per day as defined in above paragraph.*



When looking at this example of possible activities in a 24-hour period, and then overlapping obstacles as mentioned in patient interviews, such as costs of care, lack of insurance, mental health issues or pain, it is easier to understand how the patient's environment has the potential to impede health outcomes. Adding any potential systemic factors such as the work environment or discriminatory beliefs, or personal factors like risky behaviors or heredity, we see an environment that has the ingredients for a less than favorable health outcome.

"Well personally I'm supposed to be going to the Y to -- I don't know, their health facilities there and that was a suggestion from my doctor. That's pretty much all that I have as my own personal goal right now. Let's see as far as my kids go, one of my daughters is having trouble with anxiety as well and so I took her out of school, and now she's being homeschooled. So, we'll be continuing with that as well as her trips to doctor and her therapist whenever I get the health insurance thing, I ran out because that is going to take a little more work than I thought it was going to. That's about it that I can think of. Just in general, I don't know, maintenance, I guess, in between [laughter]; in between visits and stuff like that I guess" (Patient interview).

Despite busy days and other impediments to taking care of oneself, most patients indicate that there are some things they would like to accomplish in the future with respect to taking care of themselves better. Figure 2.1j on the following page illustrates ambitions patients have for new things they plan on doing in the next six months to maintain or improve their health.

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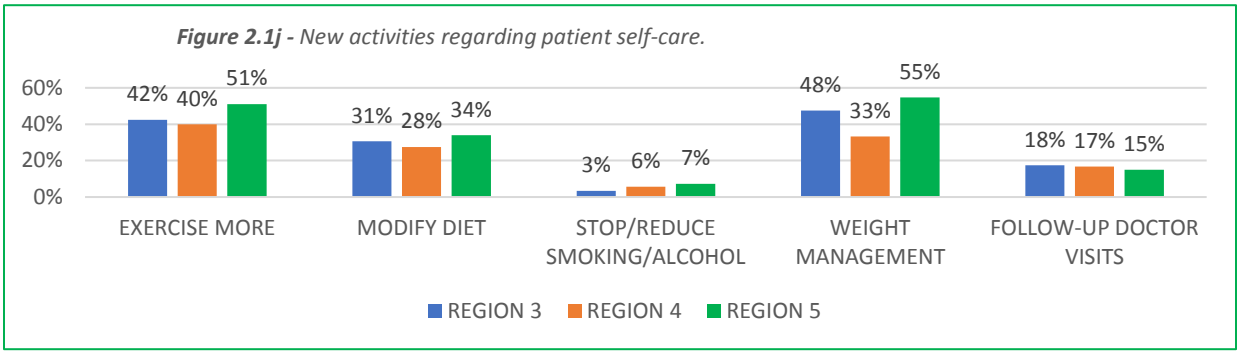

***Figure 2.1j** - New activities regarding patient self-care.*

2.2 Affordability

Socio-economic status is another element of SDOH. Patients were asked if they could afford healthcare services. Figure 2.2a illustrates yes or no patient responses totaled for each region. While most patients indicated an affirmative answer, there is possibly more to their story. For example, "yes" was entered when a patient responded in the affirmative - *"Yes, as long as it is covered by Medicaid" (Patient interview).*

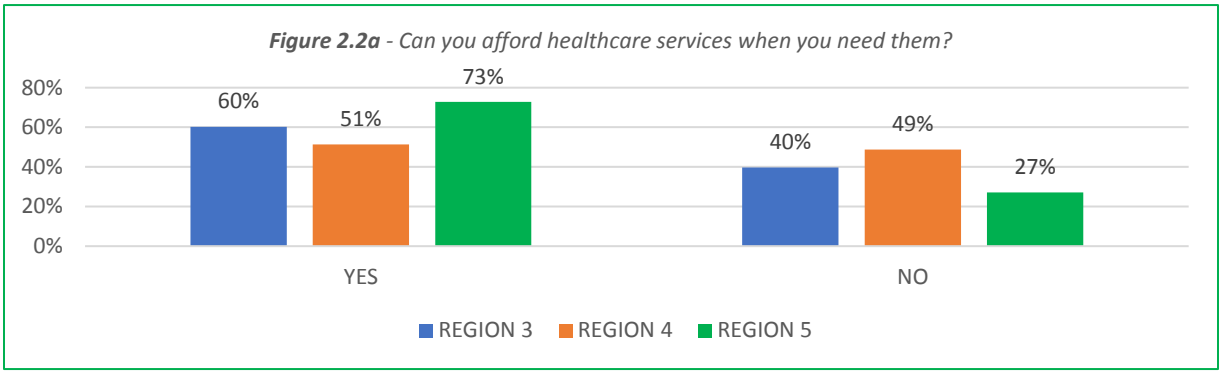

***Figure 2.2a** - Can you afford healthcare services when you need them?*

When taking a closer look at the data, and selecting only patients who answered "yes," a different picture of affordability begins to emerge. Only a few patients answering affirmatively were either uninsured or insured by Medicaid/Medicare. However, an important consideration is the number of patients who stated yes, they can afford services, but are seen in a Federally Qualified Healthcare Center (FQHC) or Community Health Center (CHC). These types of clinics have special funding mechanisms present, which affords the ability to have a sliding fee scale where patients can make payments based on their level of income. The most frequently mentioned barrier to patients taking care of themselves is the costs of care as shown in Figure 2.2b on the following page, which demonstrates that as many as 73% of the affirmative responses were by patients seen at an FQHC/CHC. Services outside of these types of clinics may quite possibly be unaffordable. Additional information should be gathered in this area in the future to provide a more concise understanding of how costs of care impact patient households.

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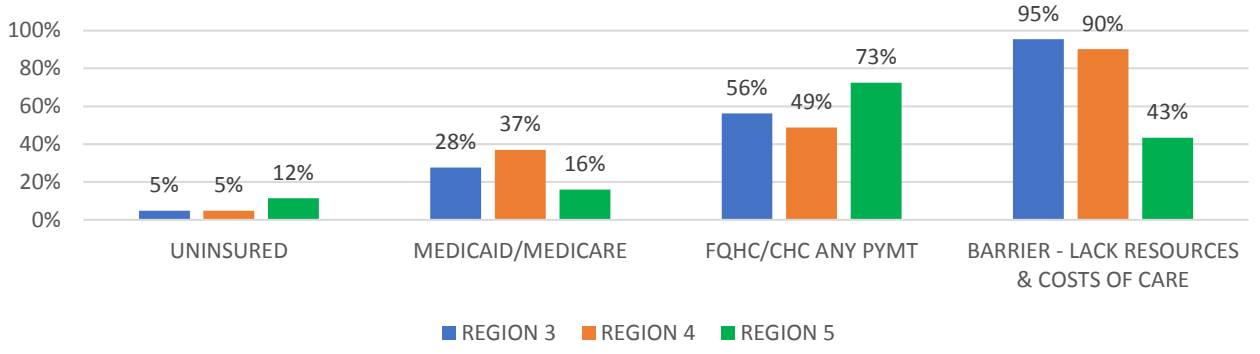
"You know I'm on a sliding fee program, so I can't really take any premiums or anything else into consideration. It's such a great program. It would be nice if there was Medicaid available in that gap, but you know, since I don't have it, I've been really fortunate to get onto this program that they have, so, I'm able to afford to go in. ***Sure, so it sounds like you're in pretty good health, can you tell me a little bit about what might happen if something were to happen to you, maybe an injury or an illness that the clinic wasn't able to address, would you be able to afford hospital care or something of that nature?*** *No, no I would not. We're stuck right in that spot where we just, we don't make enough for the insurance and we've been told we can't get subsidies. And you know, nothing else is available so if something happened, and I may be looking at more testing for some problems, that will be coming out of our pocket because it's not on a sliding scale - like an MRI and things like that - so that's the problem" (Patient interview).*

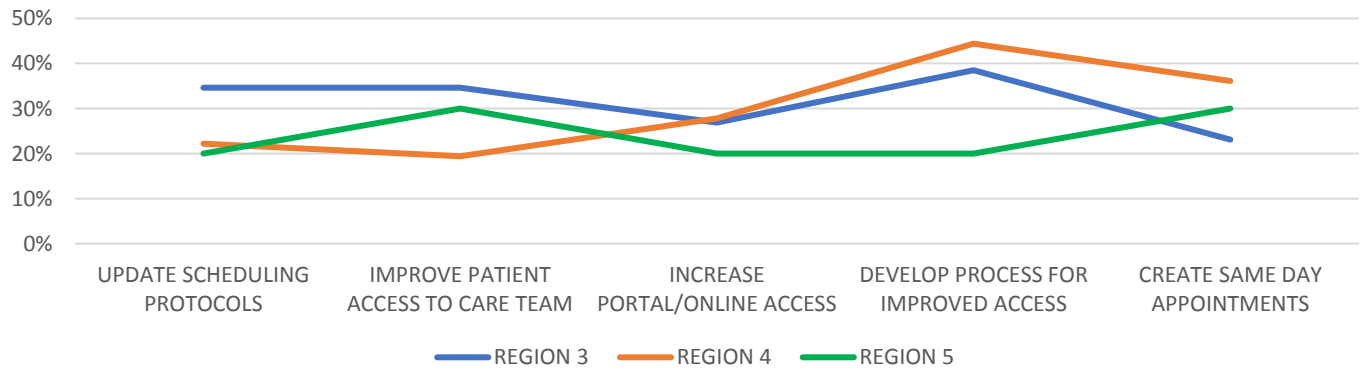
Figure 2.2b *- Of those patients who say they can afford healthcare services.*



3. Patient-Centered Access and Continuity (AC) –

This standard focuses on helping clinics organize their hours of operation and availability to provide continuous care for patients beyond traditional business hours. There are a variety of ways to operationalize patient access including same-day appointments, exchange of information through a web-based portal, expanding business hours before or after regular clinic hours, providing weekend services, providing alternative types of visits via telephone or other modes, empaneling patients with a primary care physician and monitoring the panel size, and using information to understand health disparities. Figure 3a illustrates the percentage of common clinic activities mentioned in the portal notes for all three regions.

Figure 3a *- Clinic focus activities regarding access.*

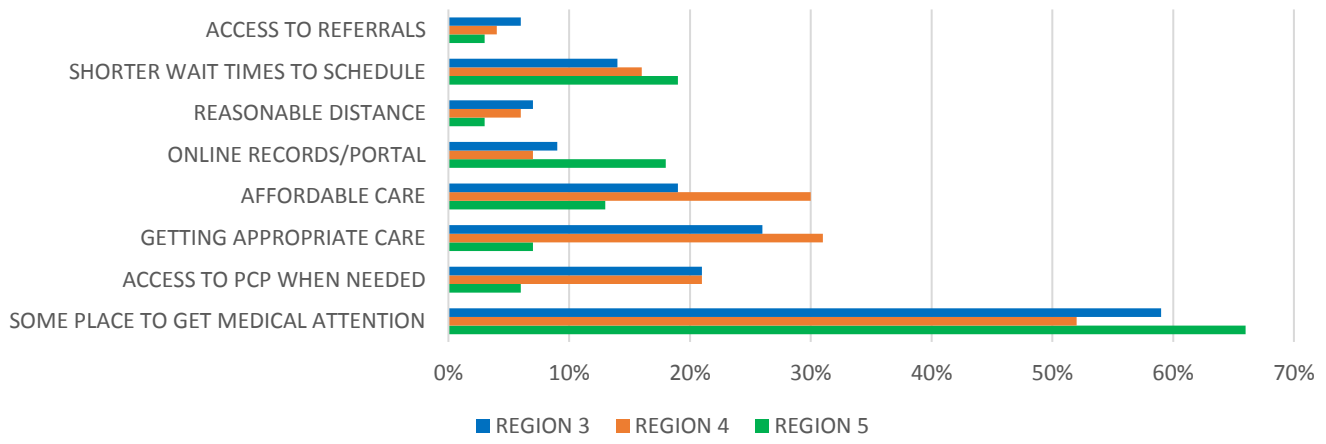


Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14- 001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

How does Patient Centered Access and Continuity translate to patient care?

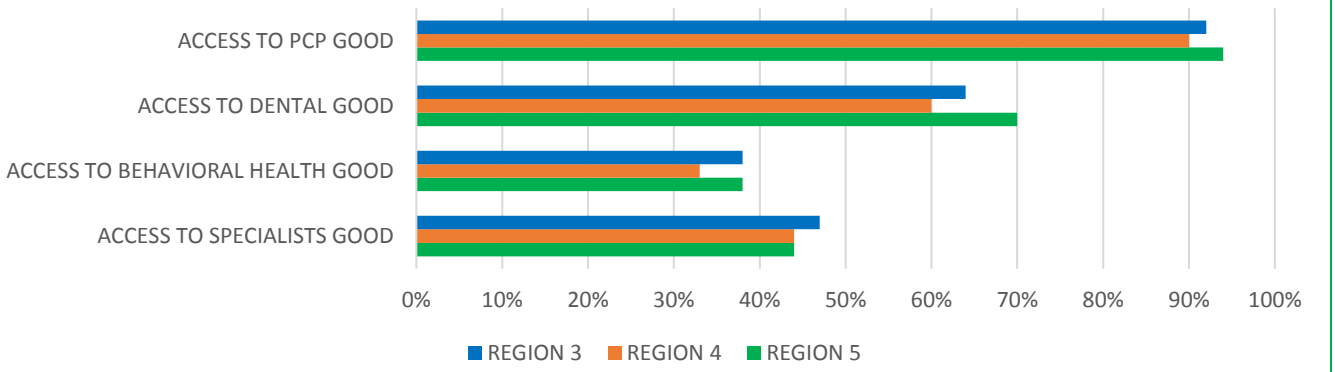
Patients defined access to healthcare in a variety of ways as illustrated in Figure 3b. The most common response was a place to obtain medical care. However, access was further clarified by the ability to obtain medical records, schedule online, have access to medical personnel within a reasonable distance and to have access to affordable care.

***Figure 3a** - How patients define "Access to Healthcare"*



Patients were further asked to provide feedback regarding their experiences with providers in primary care, specialty care, behavioral health and dentistry. Figure 3c illustrates that access was good 90% of the time for primary care and 60-70% of the time for dental care in most cases.

***Figure 3c** - Patient remarks on access to various healthcare entities.*



As illustrated above, access to care in behavioral health and specialty providers was good less than 50% of the time. More definitive information was captured regarding how long patients had to wait to have their visit scheduled. Access to dental care was challenging in all three regions, primarily because their insurance plans did not cover services. The sensitive nature of behavioral/mental health created a challenge in all three regions, where the common difficulty reported was finding a good match to meet patient needs.

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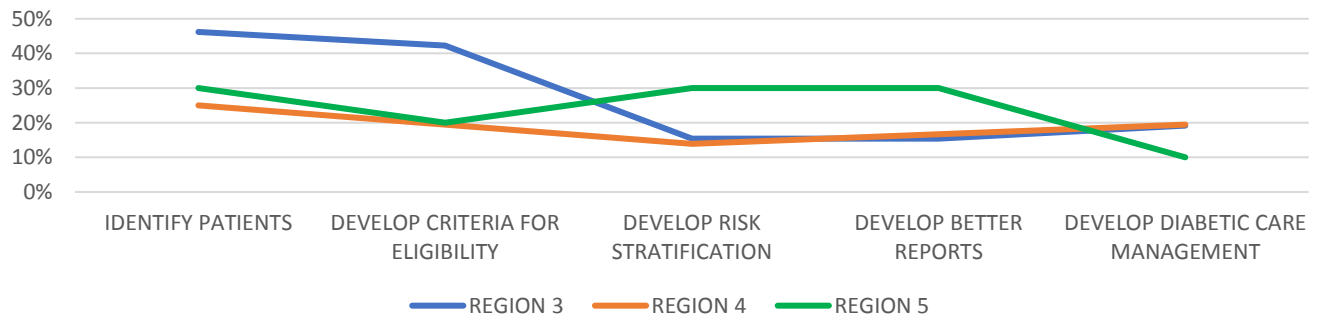
Challenges regarding access to specialty providers differed by region. In Region 3, the range of time to be seen was two weeks to two months. The most common theme in all three cohorts in Region 3 was the difficulty to afford the services due to a lack of insurance coverage. In Region 4, the most frequently reported wait time to be scheduled was one to six months. A common barrier in all three cohorts in Region 4 was the requirement to travel out of state, especially for pediatric care. Patients in Region 5 reported wait times of three to five months to be scheduled. Many patients in all three cohorts in Region 5 reported having to travel either to Boise (two hours away) or drive out of state to access needed services.

4. Care Management & Support (CM) –

The focus of Care Management & Support is for the teams to determine which patients are at the highest risk, and to manage their care effectively by engaging patients/families/caregivers and subsequent providers in the care plan. Identifying patients who might benefit from managed care is one of the first steps. Once identified, teams gather information about the patient such as goals, barriers to care, social determinants of health and other preferences. The process of collecting this information is commonly referred to as conducting a comprehensive assessment. A "care plan" is then created in collaboration with patients and other key persons involved in carrying out the activities (families, specialists, social supports, etc.). Figure 4a illustrates CM activities carried out by clinics in their respective regions.

"Diabetics with a follow-up appointment scheduled – was at 36% but now at 86%; Hypertension follow-up was 44% but now 71%. Still working on the management of those conditions, but at least scheduled follow-up appointments are being made prior to patient leaving the door" (Portal Notes).

***Figure 4a** - Care management activites reported by clinics.*



How does Care Management and Support translate to patient care?

When patients were asked what they thought the responsibility of the healthcare team was, many of their answers incorporated activities related to the management of their care. Helping patients make decisions that lead to outcomes, and follow-up phone calls or visits were most frequently reported. Many patients identified that understanding what they are responsible to do after they leave the visit was an important aspect toward achieving improvements in their health. For additional information about care plan templates for adult and pediatric patients, refer to the Tools & Resources section of this report.

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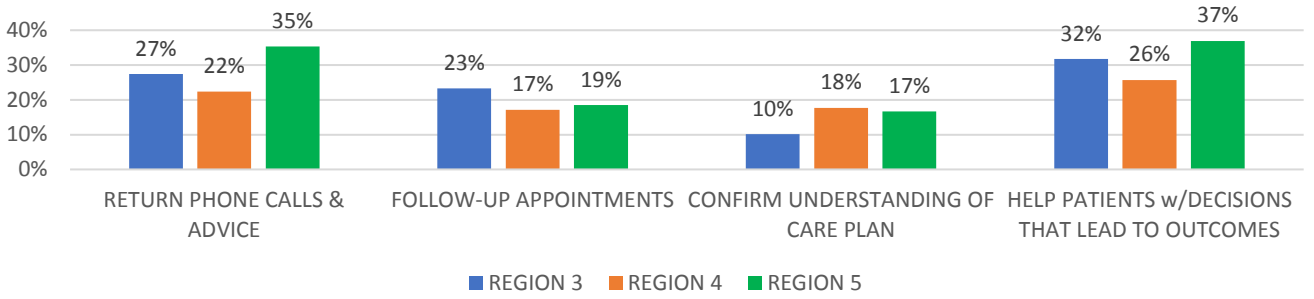
Figure 4b - How patients reported providers should be responsible for managing their care.



5. Care Coordination and Care Transitions (CC) –

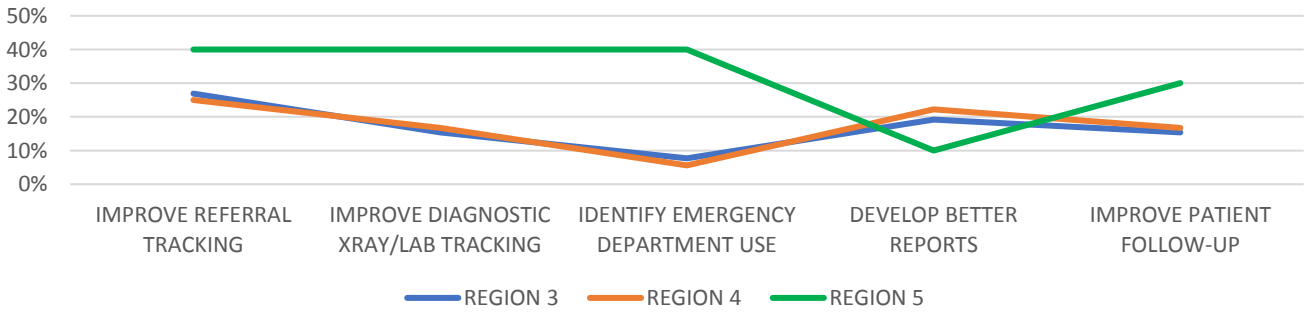
The focus of this concept is that of tracking diagnostic imaging and lab tests, as well as tracking patients as they navigate the path(s) of intervention appropriate for their condition(s). Care coordination is aimed at improving safety for the patient, reducing costs along the continuum of care, and providing detailed information between providers or support services in the Medical Health Neighborhood (MHN). Identifying patients with unplanned emergency department or hospital visits and exchanging information electronically with agencies outside the clinic are also important components. Figure 5a demonstrates clinic transformation activities by region under this standard. For more information about Care Coordination, please refer to the Tools & Resources section of this report.

"They're always giving me advice, they tell me what needs to be done, and if I don't do it, what the outcome is, so they're always encouraging. I'm real blunt with them about how I do things. I'm always surprised that they try to convince me that I need, to like keep going, you know what I mean, like push forward to take care of myself. They absolutely go out of their way. They actually try to explain to me a little bit more why it's not okay that I'm thinking a certain way" (Patient interview).

"I think they need to explain what they are doing so the patient understands it. Having a good conversation about the processes, and that communication is clear and understandable" (Patient interview).

"Healthcare providers should make sure the patient understands what is going on. They should help patients get the things they need for their healthcare, like appointments and medications. And most of all, providers should make sure that patients feel cared for" (Patient interview).

Figure 5a - Care Coordination activities identified by clinics.



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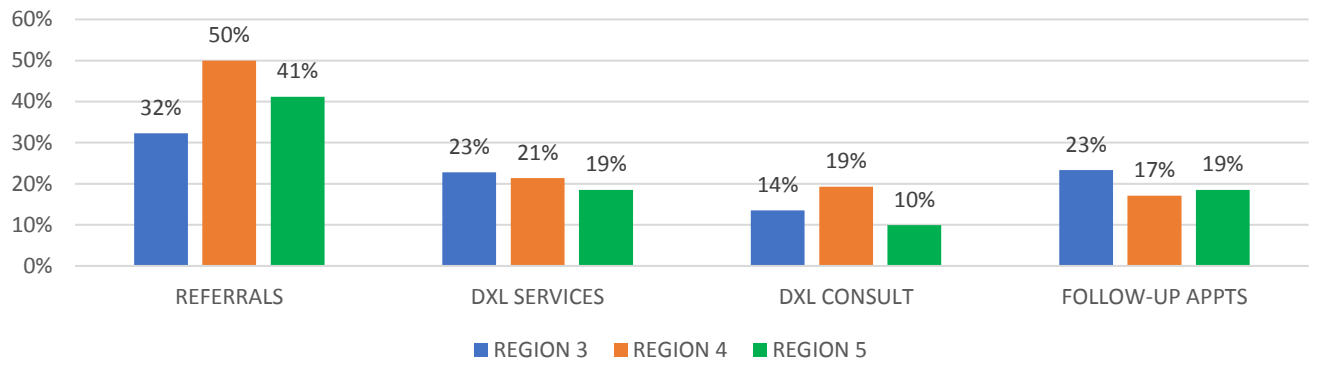
How does Care Coordination and Care Transitions translate to patient care?

Figure 5b illustrates the data collected in patient responses about their beliefs regarding the responsibilities of the healthcare team. Patients concur that referrals, diagnostic services, consultations, and follow-up appointments are important components to achieving health outcomes. The Patient Story illustrates a direct correlation of improved health and successful care coordination.

Patient story: *" I have been severely ill since 2015. I was in so much pain that I became bed bound. I was depressed and suffered with obesity. I pleaded with doctors and physician's assistants to advocate for me and to help me regain my health. I was sure that I was going to die. They advocated for me and set me up for several tests with a specialist. I was able to regain my health" (Patient interview).*

Figure 5b - *Patient beliefs on healthcare team's responsibilities.*



Defining the Medical Health Neighborhood:

"We are often the place where people land with multiple needs. We position ourselves with like-minded community partners. No single partner can meet all the needs of the community alone. We recognize clinic strengths and weaknesses as well as the strengths and weaknesses of our partners, so we work to promote each other's strengths to the benefit of patients and our community health partners. It requires a comprehensive overview and approach to meeting the needs of our patients" (Clinic Staff interview).

5.1 Medical Health Neighborhood

As discussed previously, one counter-part to adverse SDOH is the supply of resources available within the community. Clinic staff were asked to provide their own definition(s) of a Medical Health Neighborhood (MHN). Several responses included a broad scope of medical professionals, alternative therapies, and community resources such as food banks or housing, among others. However, most respondents indicated uncertainty of how to word or explain their understanding.

Idaho Department of Health and Welfare adopted the following definition of the MHN to guide medical personnel toward a broad vision of how the MHN could function within the state.

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

Definition: 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 health care 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. Adopted by the Idaho Healthcare Coalition 10/14/15 Population Health Workgroup VERSION 3.0 – FINAL – October 2015

"We have a good relationship with many of our community resources. We have community health workers that see our patients and assist with the social prescription. They assist our patients with resources such as food and help with insurance. We have a referral department that ensures patients get referred to the specialty providers as needed. The referral department also makes sure the records are in the chart when the patient returns to see their primary care provider" (Clinic Staff interview).

In addition to the benefits provided by the Medical Health Neighborhood, there can also be a few challenges. As noted above in section 2.1 Social Determinants of Health/Patient Barriers, time management can be a major hurdle for patients trying to get to and from multiple resources all at once. The comments below illustrate this point further:

"One of the greatest, unique strengths of the clinic is its deep relationships with a wide variety of community agencies to whom it refers patients. The clinic performs a very thorough assessment on each patient, including social determinants of health, and has a protocol for referring patients. A challenge is that multiple referrals are often given at one time and patients follow up on few of these and sometimes on none" (Portal Note).

5.2 Patient Engagement

Because care coordination and care management go hand in hand, it is important to consider patient needs, goals and elements they believe to be important to them. It is equally important to engage patients in their own health care during and between visits. Both clinic staff and patient interviews illuminate factors that may contribute to improved patient engagement. According to responses received through clinic staff interviews, the activities they believed helped with patient engagement fell primarily within the PCMH Standards of Knowing and Managing Your Patients and Care Management mentioned above, such as scheduling with patients that had not been seen within the last year, sending reminders for routine visits or following up with patients who had been referred out. Clinic staff in all three regions concur that patients are getting more information and are asking more questions, which in turn is creating the foundation for better patient compliance. Interviews also provided insight as to why patients may not be fully engaged with their care.

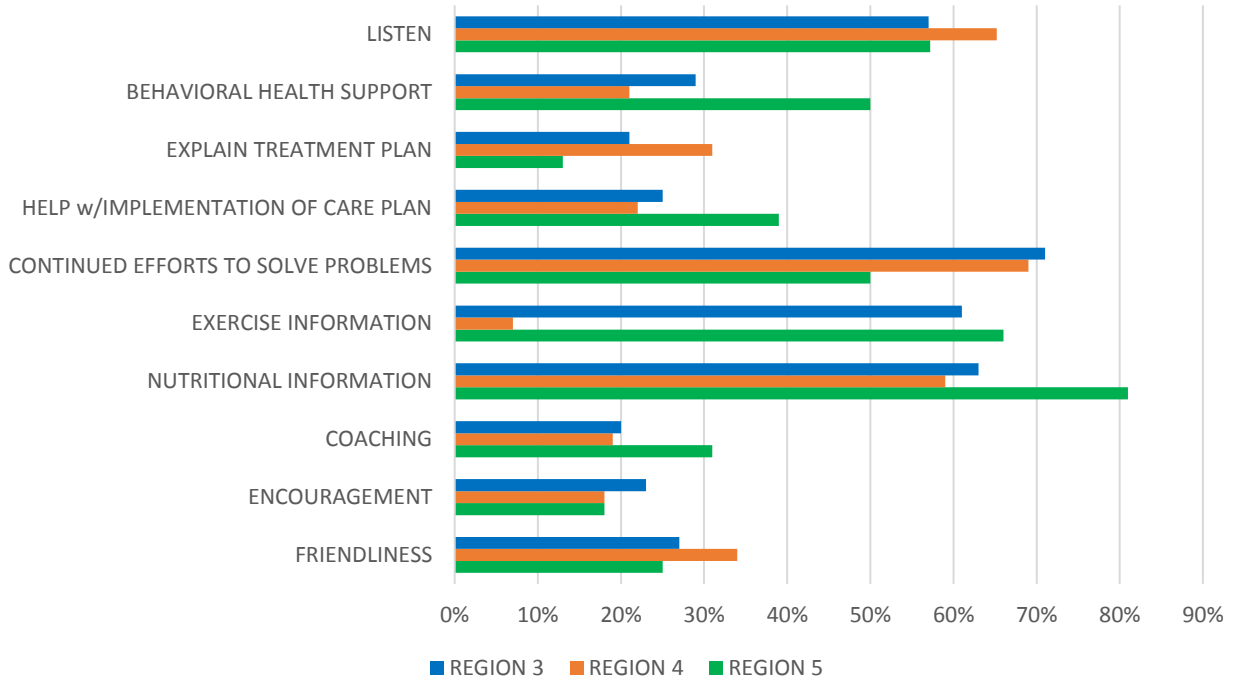
Statewide Healthcare Innovation Plan (SHIP) is supported by Funding Opportunity Number CMS-1G1-14- 001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services.

"Patients sometimes don't know they can be involved in the visit, or in the treatment of whatever their issues are. Sometimes they rely on everyone else to tell them every step they need to complete. Providers should educate patients to understand that the patient SHOULD participate in a visit. Patients should follow through with labs, specialists and return visits. Patients should discuss their values or define the goal that they want to move toward in that space and time of their lives, or they may not actually achieve the end result. We as providers need to discover if the patient needs are being met or what issues are most important to them along the way" (Clinic Staff interview).

Although patients were not asked directly how they might become more engaged in taking care of themselves, clues are evident in various responses to interview questions. Figure 5.2a below demonstrates insight to what patients need from their healthcare team to be more successful, and ultimately to become more engaged in taking care of themselves.

"Resources-wise, I would say it would be helpful to have like handouts given to patients like kind of explaining different ways to stay healthy, like different meal plans – well, not really meal plans, but just different options to eat healthy and stuff you can do to keep your body active and healthy" (Patient interview).

***Figure 5.2a** - Patient needs from healthcare team.*



Patients have hurdles to overcome in life. Whether they are currently in the workforce, raising the next generation, or retired, there are challenges in each phase of the lifecycle. The Patient Story on the following page is an excerpt from a patient interview describing their ambition to be engaged, along with the hurdles to overcome to get there. It has been noted in clinic staff interviews that clinics have taken heed to requests like this by implementing grocery shopping field trips with their patients.

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

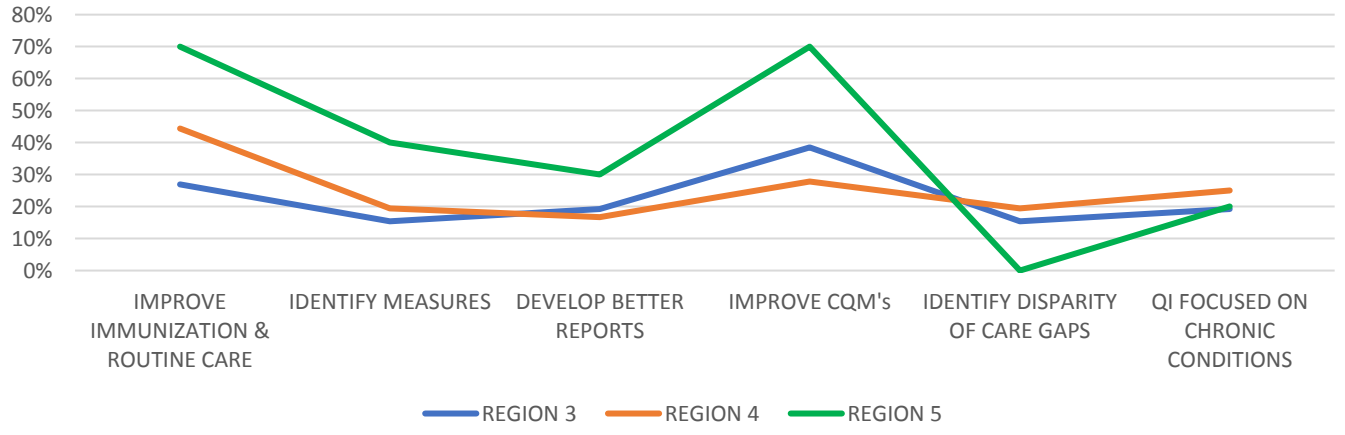
Patient Story: *"You know what I think would be really cool is somebody that would help grocery shop, to – like I've always – I worked at a grocery store for 20 years and I raised kids by myself. I've got grandkids now. It would be awesome if somebody could have gone to the grocery store with me and said don't get that, get this. You know, try fresh fruits instead of canned or, you know, if somebody could have actually gone with me with my $80 a week and helped me get what I needed to get, to get to where I needed to go, because that's been one of my hugest hurdles because it's so much easier to go get the dollar menu.* ***So, if I hear what you're saying, you would love to have an individual that could help you implement that doctor's directions?*** *Yes, exactly, because they tell you to eat healthy. Well, I have $80 a week to feed myself on a good week. I live by myself, so it's a pain in the butt to cook for yourself just for one. It's expensive to eat healthy. If I could have had somebody help me, I'm a smart person, it's not that I don't know how to grocery shop, I do, but I don't know how to make, you know, vegan spaghetti that was on my list, you know, they said don't eat meat one day a week. Okay, I'm going to be hungry that day. You know, I mean it would be great to have somebody help me implement what they were telling me to do, because just have some of these, you know, you eat – you don't eat healthy. Yeah, right, I don't, show me how"* (Patient interview).

6. Performance Measurement and Quality Improvement (QI) –

The goal of this standard is ongoing measurement and improvement clinic operations. Activities include clinical quality measures (CQM's) in categories such as immunization rates, chronic or acute care, behavioral health or prevention. Activities also incorporate patient experiences in both qualitative and quantitative methods, along with administrative level objectives, such as performing evaluations and sharing data with staff, patients and other agencies. Figure 6a demonstrates various quality improvement activities mentioned in portal notes for all three regions. A common theme in portal notes and clinic staff interviews that deserves honorable mention is the need for additional involvement from executive level clinic leadership.

"More support from Executive Leadership needed, i.e. resources, time commitment, IT support. Some progress has been made with leadership, but more improvements needed" (Portal note).

Figure 6a *- Quality improment activities.*



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

How does Performance Measurement and Quality Improvement translate to patient care?

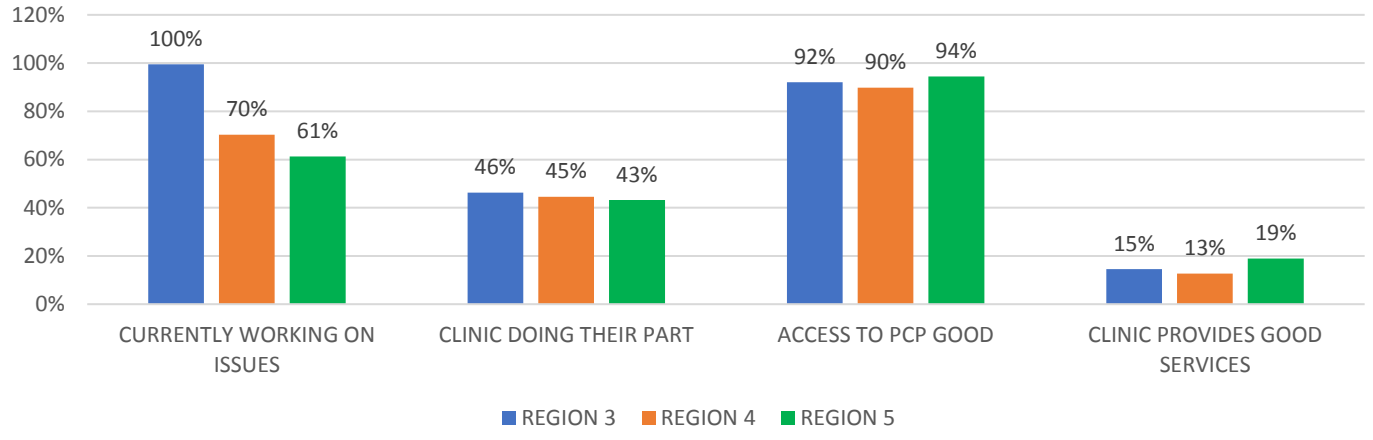
"The healthcare team has helped me immensely with financial services. I would not have been able to get the care and procedures without their help" (Patient interview).

Patients know when things are working right. Responses to interview questions provide a glimpse of feedback regarding patient satisfaction with operations and clinic personnel. The important issue to remember in the data below is that the data below only represents how many times a patient mentioned the activity. It is an amazing consideration that patients felt strongly enough to mention the great care they were receiving while also experiencing health challenges at the time of the interview. Figure 6b illustrates themes mentioned in patient interviews regarding the care patients have received in SHIP participating clinics.

"Oh my goodness. What haven't they helped with (laughter)! Okay and well, in particular we have been helped in that I have a daughter that has a special need and our doctor was able to pick up on the subtle symptoms and get the diagnosis that we needed which was a huge, huge blessing. And after that our doctor was very proactive in getting a, in getting the communication set up with who we needed whether it was the incident toddler program or whether it was financial, you know, they've helped about – help about financially. If we ever had questions about anything to do with a diagnosis, or just different people that we needed to help with my daughter's needs, they were always very willing to give information, get us in touch with somebody, and things like that. I mean they just, they are amazing. ***Yeah and it's excellent to hear that not only are they talking to you about the care but also the financial piece of it because you have to have that, right?*** *And a lot of times I didn't even know it existed. And I don't think a lot of people do. And so when that was just brought up to me, it was, it's been a huge blessing. Because, I think, if you look at, you know, if on paper you look at how much, you know, it's through the roof, but we wouldn't qualify for Medicaid, but if you look at how much we were spending on medication and all those behind the scenes that you can't put on paper, too significant now and it's been huge. It's been great" (Patient interview).*

"Diet, stress, living healthy, being honest forthcoming about issues. They don't sugarcoat things - if this is what you did, this is what it needs to be and if you don't get on track then there will be a lot of stress involved. ***Sure, so they're helping you with routine care, some illnesses, and just working through your things.*** *Yeah, the things that keep me going you know. Everyday above ground is a good one, my dad always said" (Patient interview).*

Figure 6b *- Themes mentioned in patient interviews regarding services received.*



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

7. Health Information Technology Capabilities (HIT)–

Although Health Information Technology (HIT) is interwoven in the various PCMH concepts, SHIP listed the category separately in the web-based portal, with the hopes of collecting specialized information. Little information was exhibited in portal notes or clinic interviews regarding this subject matter independently. Electronic Health Record (EHR) capabilities continue to be a challenge with all clinics as they develop new programs and reports to meet guidelines of internal and regulatory standards. Additionally, clinics have ongoing activities related to connectivity efforts with Idaho Health Data Exchange (IHDE). Refer to Figure 9a below to see challenges related to HIT.

8. Primary Care/Behavioral Health Integration (PC/BHI)–

Behavioral Health Integration (BHI) is interwoven in the various PCMH concepts, however SHIP listed the category separately in the web-based portal, with the hopes of collecting specialized information. Most clinics did not enter independent data into this category. What information did emerge is that ongoing activities continue to be developed with BHI, such as defining metrics or strategies to implement. Refer to Figure 10a on the following page to see success related to behavioral health integration.

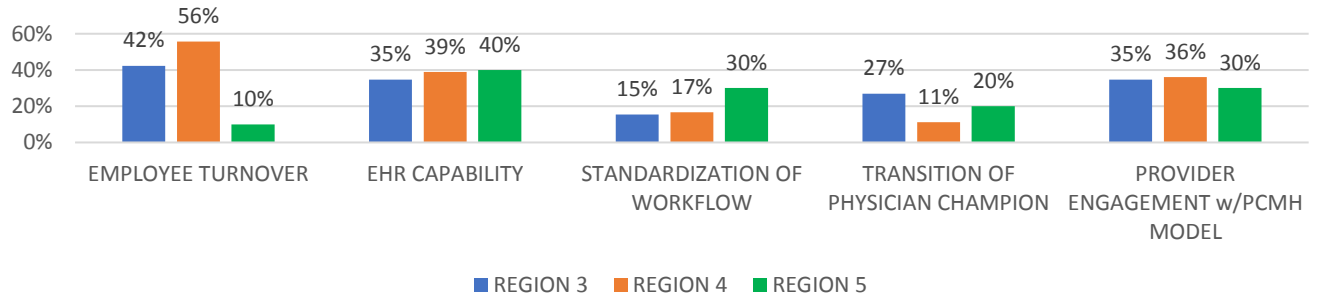
> *"The doctor has been more than helpful, helping me regulate my anxiety and making sure that I'm on the right medication and the right dose. He's helped me with my asthma, & my hypoglycemia. He's helped me through it all and kept me calm and informed through all of it" (Patient interview).*

CLINIC BARRIERS

PCMH transformation has created some challenges for all clinics, whether they are located in rural, urban or frontier areas. Employee turnover was mentioned more frequently in urban areas. Managing the difficulties with the EHR platforms and provider engagement with the PCMH model were mentioned with nearly identical frequency in all regions as well. Figure 9a below illustrates similarities and differences in the frequency of clinic challenges with the PCMH transformation process.

> *"We are unable to export this data with our current EHR package. We will have to purchase an add on package along with the care planning ability. This authorization is pending, as the update is the main focus at this time" (Portal note).*

Figure 9a *- Clinic Transformation Challenges*



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

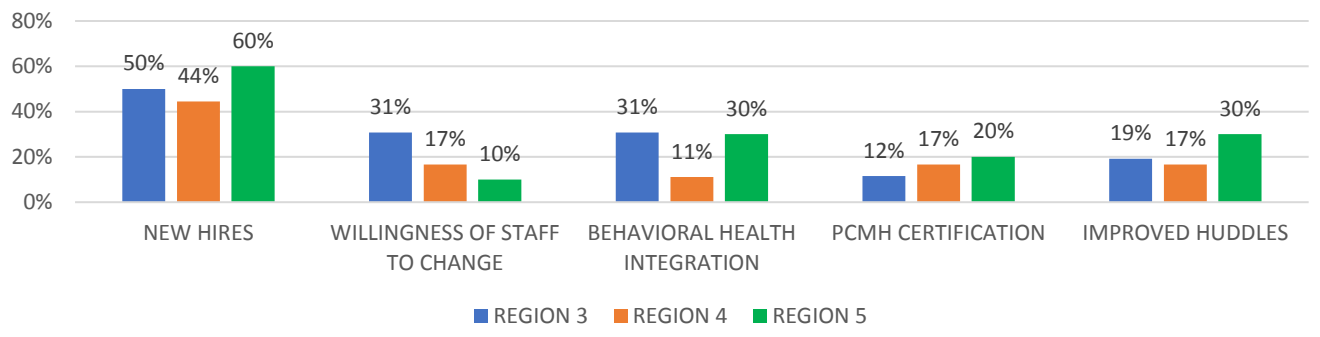
CLINIC SUCCESS

Despite challenges with PCMH transformation, there were a multitude of success stories mentioned as well. Although employee turnover was a challenge listed above, the most frequently mentioned success for clinics was hiring new people to fill the gaps. Many clinics achieved PCMH certification/recertification and implemented behavioral health services. Figure 10a demonstrates the frequency of success stories mentioned in the portal notes.

Success Story: *"Accomplished redistribution of tasks - centralization of referrals, prior authorizations, helping staff to understand the why support transformation, being able to change and mold a new mindset" (Portal note).*

Success Story: *...may have discovered a commonality in the majority of the no-shows. They seem to be acute issues that were given an appt anywhere from 3 days to 2 wks AFTER their call to the clinic. Either the condition clears up or the patient goes elsewhere to be seen and does not bother to cancel their existing appt." (Portal note).*

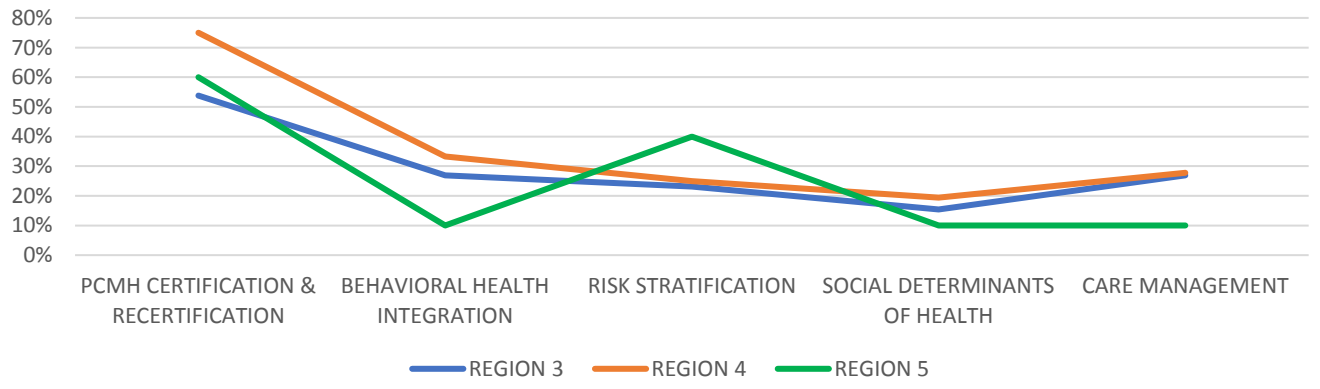
***Figure 10a** - Clinic Tranformation Success*



WHAT CLINICS NEED TO SUSTAIN PCMH

In all three regions there are important topics clinics want more information about. The activities listed are dynamic and are important considerations for PCMH sustainability. Figure 11a illustrates the most frequently mentioned topics clinics need to sustain the efforts toward PCMH transformation. These topics will likely require a need for funding, tools and ongoing training.

***Figure 11a** - Clinic needs for ongoing PCMH activities.*



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Clinic staff were asked if they had comments to share with leadership about their PCMH transformation and the experience with SHIP. Themes were not counted, but several statements are collected below so clinics can speak for themselves. Overall, clinics appreciate the structure PCMH provides their respective organizations and the efforts that have been implemented through the SHIP program.

Clinic Interviews:

"It's been exciting in spite of the changes we've grown through. We can see the benefits for the patients and how it makes us feel a lot happier with the things we do. The transition was very difficult, but we are seeing how integrated care and other strategies really are helping the patients be more involved."

"I look forward to assisting my patients and physician with PCMH transformation."

"We want to better understand our community resources and identify gaps that may exist such as transportation issues, we really need access to information to provide to our patients so they can be more successful in not just going through the motions but achieving their goals. Putting patients first! Making sure there are enough providers available so the patients can schedule appointments when they need to."

"It would be nice if State entities were on the same page; standardizing and using the same processes so clinics do not have to do multiple different assessments or forms. Submission times should all be aligned to prevent overlap."

"Being a part of a PCMH organization has been such a great experience. Our providers show the best interest for their patients in everything they do."

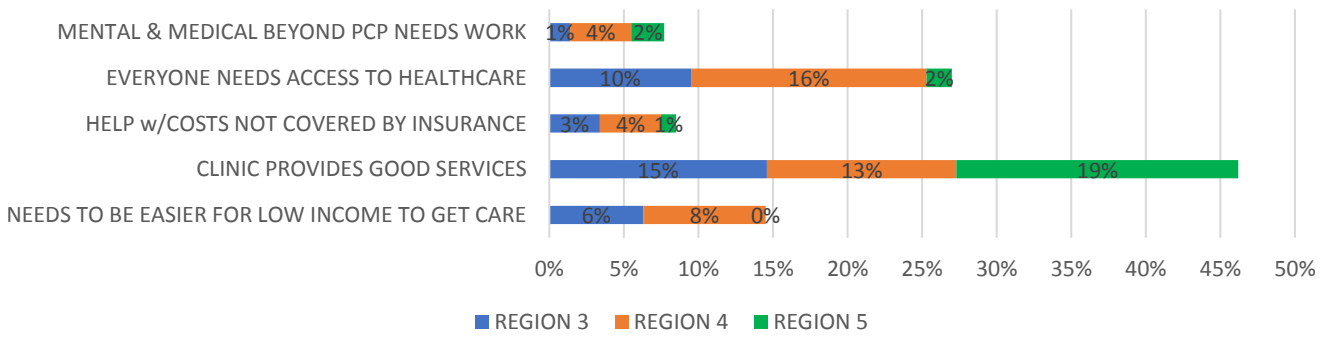
"It's been a really great experience. Awesome learning opportunities. It's great to see where other clinics are making improvements or developing new ideas. The growth is just great. We are recognizing issues, whether good or bad, and developing ways to respond to them."

Has been very positive and very informative. When we were feeling very stretched, the transformation team (HMA, QI Specialists, Kym Schreiber, SHIP Admin., etc.) has been very helpful to everyone and made it possible when we didn't think we had the ability or time to get the work done.

WHAT PATIENTS WOULD LIKE TO SHARE WITH CLINIC & HEALTHCARE LEADERSHIP

Patients were given the opportunity to provide feedback to leaders, payers, and/or clinic personnel. Common themes that emerged are illustrated in Figure 12a.

***Figure 12a** - Patient interview feedback to leadership.*



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

Several independent patients tell their story in the statements provided below:

Patient Interviews:

"I just don't like having my kids on Medicaid. It feels like they're not taken seriously because it's Medicaid. Like calling the dentist and they said, "Well if I have other patients, I'm going to take them in we have to wait on our Medicaid people. We have to schedule them until June," and that just feels like... You're not getting the same kind of care."

"The thing of it is, I think a situation like my husband and I we don't have any small children in our home. Which makes us not qualified for any sort of benefits from Idaho. Unless you are very aged or very sick is the only time they address these things. Father's been trying to get aid for several years since he retired and wasn't able to. Now that he's been in the hospital for a year all of sudden he qualifies for all of these things. I think it's really sad that our government doesn't help support us in the prevention. Instead of taking care of us when it's too late. Where it would be more efficient and less expensive to support the preventive care rather than waiting until somebody's at death's door before you start administering the care."

"Everyone needs affordable health care. Everyone needs to understand who can help and where they should go. Everyone needs to understand health problems and that their needs will be heard and met to the best of the healthcare team's ability."

"As far as healthcare reform is – I'm divorced but I still live with my ex-wife. She's has got big problems. They're basically going to tell her to go off and die, because her heart - she needs an operation, can't get it. Yeah, because it's horrible and the vast majority of people are in our situation, they can't access that healthcare."

"Well, I don't know if this is the place for it but I think leaders, insurance companies and medical personnel need to really think about what the target is. If the target is a smaller healthcare budget, then something else has to give in the social fabric. You have to put money into a pot that affords people things like food, shelter, preventative care like massages or stuff that says, "we want you to do those things so you will be healthy." It's ridiculous that I'm paying a fortune for insurance I currently don't need to use, but I also have to pay top dollar for all those other things as well. Why can't a health savings account pay for healthy behaviors or activities that help me manage my daily life? We need to think outside the metaphorical box if we are going to solve these problems and it's gotta start with the individual and the insurance companies. They need to work together. And it's the insurance company's fault because they set it up to pay on the wrong end of healthcare. They need to start paying at the beginning, or at least giving more generous savings to people who are taking their responsibility seriously."

FUTURE CONSIDERATIONS

Clinic staff were asked to indicate what PCMH functions or activities are priorities for the clinic in the months ahead. A variety of activities were listed under each of the PCMH standards in each of the regions. The information displayed in Figure 13a on the following page illustrates which standards clinics are hoping to see increased activity(ies) in moving forward.

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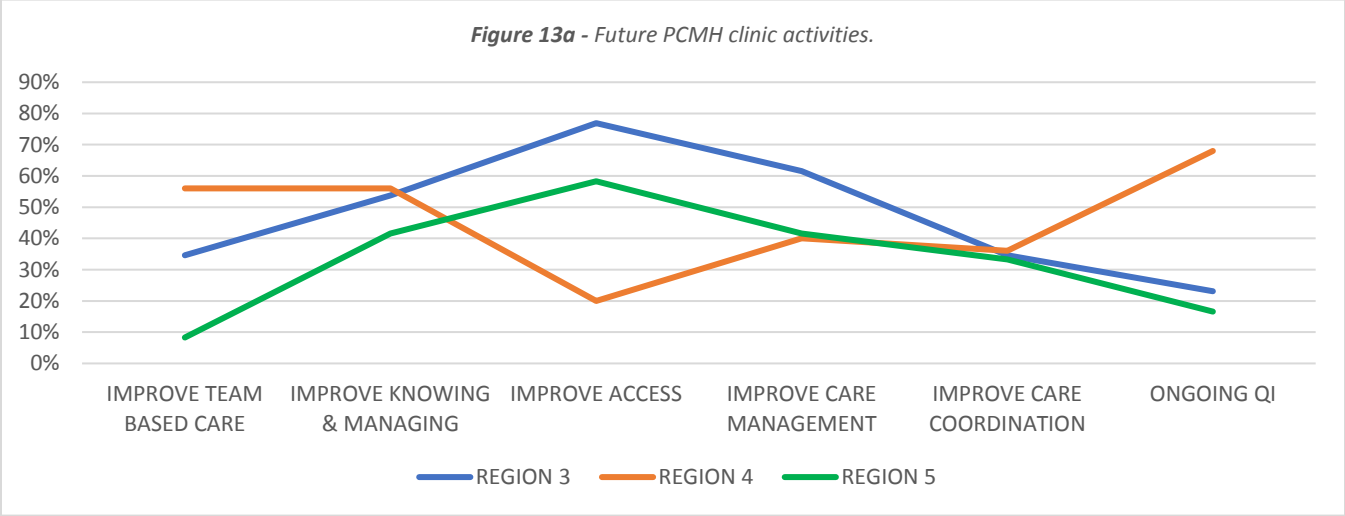

Figure 13a *- Future PCMH clinic activities.*

The data illustrated in this report is intended to tell the story of a moment in time, specifically during the implementation of the SHIP grant and PCMH transformation under Goal 1. To continue making informed decisions about healthcare delivery, healthcare reform and value-based payment models, additional information is needed.

ABOUT THE AUTHOR

Dawn Juker has a bachelor's degree in criminal justice and a master's degree in social work. She has worked as a PCMH Policy and Quality Improvement Program Manager in a clinic setting over 3 rural clinics and has managed multiple quality improvement programs such as Meaningful Use, UDS, PQRS, MIPS/MACRA, Idaho Healthy Connections, and PCMH 2011-2014. She is a 2017 PCMH Certified Content Expert. Ms. Juker began working with the SHIP State Evaluator's Team in 2016 as a research associate assigned to Public Health Districts 3, 4, & 5.

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TOOLS & RESOURCES

PCMH Transformation:

http://www.prohealthmd.com/pcmh/prohealthphysicians-pcmh.pdf

In search for joy in practice: http://www.annfammed.org/content/11/3/272.full.pdf+html

Care Coordination

http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf

Care Management

http://www.pcpci.org/sites/default/files/resources/Risk-Stratified%20Care%20Management%20and%20Coordination.pdf

http://www.oregon-pip.org/resources/SharedCarePlans_Brief.pdf

http://www.oregon-pip.org/resources/SharedCarePlan_Compendium.pdf

https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

Social Determinants of Health

https://healthleadsusa.org/resources/start-designing-your-program-with-the-action-plan-workbook/?tfa_next=%2Fresponses%2Flast_success%26sid%3Dkasmm7l6lip0h45n63t5o0ana5

http://www.rchnfoundation.org/wp-content/uploads/2015/12/PRAPARE-Patient-Risk-Data-and-the-Pathways-to-Transformation.pdf

Cultural/Customs/Beliefs: Discussion on approaches to evaluate Social/Cultural History - https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthlittoolkit2_tool10.pdf

Health Literacy Tool Kit: https://www.ahrq.gov/sites/default/files/publications/files/healthlittoolkit2_4.pdf

Health Literacy & Social Determinants of Health http://www.embed.chphealthmt.org/

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APPENDIX A - Clinic Staff Interview Worksheet

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

CLINIC STAFF INTERVIEW REGION COHORT

WHAT ARE TOP 3 PCMH FUNCTIONS OR ACTIVITIES YOU THINK WERE THE MOST SUCCESSFUL IN HELPING YOUR CLINIC ACHIEVE BETTER PATIENT CARE?

%	QTY	
		NOT ANSWERED

1 - TEAM BASED CARE

%	QTY	DESCRIPTION
		PCP EXPLAINING ROLE(s)
		CARE TEAM MEETINGS / HUDDLES
		HIRE CARE COORDINATOR(s)
		HIRE BEHAVIORAL/MENTAL HEALTH SPECIALIST
		ENGAGED LEADERSHIP
		HMA COACHING CALLS
		SHIP WEBINARS

2 – KNOWING & MANAGING

%	QTY	DESCRIPTION
		SCREENING – BEHAVIORAL HEALTH (ANXIETY, DEPRESSION, SUICIDE, etc.)
		IDENTIFY PTS NOT SEEN & SCHEDULE FOLLOW-UPS
		SCREENING – WELLNESS & ROUTINE CARE
		SCREENING CHRONIC CARE – (DIABETES, etc.)
		OUTREACH ACTIVITIES IN COMMUNITY
		ORAL HEALTH ASSESSMENT & SERVICES
		COMPREHENSIVE HEALTH ASSESSMENTS
		Rx LISTS

3 – ACCESS

%	QTY	DESCRIPTION
		PATIENT ACCESSIBILITY
		FOLLOW-UP APPOINTMENTS
		EXTENDED HOURS
		ACCESS TO CARE / TRIAGE PROCESS
		IMPLEMENT PORTAL TO SCHEDULE APPTS
		EMPANELMENT STRATEGIES
		SAME DAY APPOINTMENTS
		MULTIPLE LOCATIONS
		PHARMACY / Rx ACCESS

4 – CARE MANAGEMENT

%	QTY	DESCRIPTION
		CHRONIC CARE MANAGEMENT (DIABETES, HYPERTENSION, COPD, etc.)
		COSTS OF CARE
		CARE FOR CHRONIC MENTAL HEALTH ISSUES

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5 – CARE COORDINATION

%	QTY	DESCRIPTION
		DEVELOP CARE COORDINATION EFFORTS
		REFERRAL FOLLOW-UPS
		CLOSING LOOPS
		REDUCTION OF EMERGENCY VISITS
		COORDINATING WITH COMMUNITY RESOURCES
		DXL TRACKING

6 – QUALITY IMPROVEMENTS

%	QTY	DESCRIPTION
		REGULAR MEETINGS
		REVIEW ASSESSMENTS & IDENTIFY IMPROVEMENT MEASURES
		IMPROVE PATIENT EXPERIENCE WHEN CALLING CLINIC
		IMPROVE PATIENT SATISFACTION
		STRATEGIC PLANNING
		IMPROVEMENTS IN SAFETY
		IMPROVED DOCUMENTATION
		ASSISTANCE FROM QI SPECIALISTS

7 – HIT

%	QTY	DESCRIPTION
0		CONNECT WITH IHDE
		GAP REPORTS

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HOW DO YOU DEFINE PATIENT ENGAGEMENT?

RESPONSES

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HOW HAS PCMH TRANSFORMATION HELPED PATIENTS ENGAGE WITH THEIR HEALTH?

%	QTY	NOT ANSWERED
		NOT ANSWERED
		TOO EARLY TO MEASURE

1 TEAM BASED CARE

%	QTY	DESCRIPTION
		PRE-VISIT PLANNING / HUDDLES
		NUTRITIONIST
		PHARMACIST
		SOCIAL WORKER/BEHAVIORIST
		COMMUNITY HEALTH WORKERS
		TEAM BETTER EDUCATED ON PATIENT NEEDS / GAPS

2 – KNOWING & MANAGING

%	QTY	DESCRIPTION
		EVIDENCE BASED GUIDELINES
		IMPROVED ROUTINE SCREENINGS
		IMPROVED BEHAVIORAL / MENTAL HEALTH SCREENINGS
		IMPROVED OUTREACH
		UPDATED Rx LISTS

3 - ACCESS

%	QTY	DESCRIPTION
		SCHEDULING APPOINTMENTS
		EXPANDED/AFTER HOURS ACCESS
		TRIAGE PROCESS
		EXCHANGE OF INFORMATION THROUGH PORTAL

4 – CARE MANAGEMENT

%	QTY	DESCRIPTION
		IDENTIFYING PATIENTS THAT COULD BENEFIT FROM CM PROCESS
		FOLLOW-UP DIABETICS
		FOLLOW-UP BHI
		INCLUDING PATIENTS IN CARE PLAN DECISIONS
		CARE MANAGEMENT FOR OBESITY/BMI
		WRITTEN CARE PLANS FOR PATIENTS

5 – CARE COORDINATION

%	QTY	DESCRIPTION
		CARE COORDINATORS ASSIST IN NAVIGATING HEALTH SYSTEM(s)
		TRACKING DXL

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6 – QUALITY IMPROVEMENTS

%	QTY	DESCRIPTION
		PATIENT SATISFACTION SURVEYS

7 – HIT

%	QTY	DESCRIPTION
0	0	

8 – BEHAVIORAL HEALTH INTEGRATION

%	QTY	DESCRIPTION
		BEHAVIORAL HEALTH INTEGRATION ON SITE

9 – ORAL HEALTH

%	QTY	DESCRIPTION
		ORAL HEALTH ON SITE

10 – PATIENT ENGAGEMENT

%	QTY	DESCRIPTION
		BETTER COMPLIANCE
		LOWER NO-SHOW RATES
		INCREASED DXL FOLLOW-UP
		FEWER CANCELLATIONS
		ACCOUNTABILITY
		PATIENTS HAVE MORE INFORMATION & ARE ASKING MORE QUESTIONS
		PATIENT HAS VOICE AND CAN HELP MAKE DECISIONS
		REDUCE BEHAVIORAL/MENTAL HEALTH STIGMATISMS
		OFFERING EXERCISE GUIDANCE
		OFFERING COOKING CLASSES
		OFFERING GROCERY STORE FIELD TRIPS
		LOW COST GYM MEMBERSHIP RESOURCES
		NOT ALL PATIENTS FULLY UNDERSTAND CHANGES YET

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SHIP's STATE HEALTH PRIORITIES ARE DIABETES, SMOKING CESSATION, OVERWEIGHT/OBESITY & ACCESS TO PRIMARY CARE. ARE THERE SPECIFIC PCMH FUNCTIONS OR ACTIVITIES THAT YOU THINK HELPED YOUR PATIENTS DEAL WITH THESE HEALTH PRIORITIES?

%	QTY	
		NOT ANSWERED

1 TEAM BASED CARE

%	QTY	DESCRIPTION
		EDUCATING PATIENTS ABOUT SERVICES
		PRE-VISIT PLANNING / HUDDLES
		COMMUNITY HEALTH WORKERS
		STAFF TRAINING
		HIRED SOCIAL WORKER

2 – KNOWING & MANAGING

%	QTY	DESCRIPTION
		IMPROVED TOBACCO SCREENINGS
		IMPROVED SCREENINGS & COUNSELING FOR OBESITY
		COMPREHENSIVE ASSESSMENTS
		IMPROVED ROUTINE / WELLNESS CARE
		IMPROVED MENTAL HEALTH SCREENINGS

3 - ACCESS

%	QTY	DESCRIPTION
		EXTENDED HOURS
		PORTAL USE
		AVAILABILITY OF APPOINTMENTS
		IMPROVED ACCESS TO CARE TEAM
		PHARMACY ACCESS
		SAME DAY AVAILABILITY
		ALTERNATIVE APPOINTMENTS (PHONE, etc.)
		USE OF MOBILE BUS THAT INCLUDES DENTAL

4 – CARE MANAGEMENT

%	QTY	DESCRIPTION
		USE OF DATA TO IDENTIFY PATIENTS
		EDUCATING PATIENTS RE: IMPORTANCE OF CARE PLAN
		DIABETIC CARE MANAGEMENT PROGRAM(s)
		NUTRITION PROGRAM(s)
		FOLLOW-UP VISITS
		MANAGING MEDICATION COMPLIANCE ISSUES
		STRUGGLING WITH RESOURCES FOR OBESITY / OVERWEIGHT CARE
		HELPING PATIENTS WITH COSTS OF CARE

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5 – CARE COORDINATION

%	QTY	DESCRIPTION
		REDUCTION OF EMERGENCY ROOM VISITS
		CONNECTION TO COMMUNITY BASED RESOURCES
		CONNECTION/REFERRALS TO SPECIALISTS
		CHRONIC CARE COORDINATION EFFORTS

6 – QUALITY IMPROVEMENTS

%	QTY	DESCRIPTION
		IMPROVED A1c MEASURES

7 – HIT

%	QTY	DESCRIPTION

8 – BEHAVIORAL HEALTH INTEGRATION

%	QTY	DESCRIPTION
		IMPROVED ASSISTANCE / RESOURCES

9 – ORAL HEALTH

%	QTY	DESCRIPTION

10 – PATIENT ENGAGEMENT

%	QTY	DESCRIPTION
		PATIENTS COULD NOT GET OFF WORK / NEED MONEY
		PERSONAL/CULTURAL VALUE OF BODY SIZE
		HEALTHY FOOD TOO EXPENSIVE
		GYM MEMBERSHIPS TOO EXPENSIVE
		EXERCISE GUIDANCE
		IDENTIFYING PATIENT BARRIERS
		COOKING CLASSES AVAILABLE
		EXERCISE STRATEGIES AVAILABLE
		IMPROVED PATIENT COMPLIANCE

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WHAT ARE THE TOP 3 PCMH FUNCTIONS OR ACTIVITIES THAT ARE PRIORITIES FOR YOUR CLINIC IN THE COMING YEAR?

%	QTY	
		NOT ANSWERED

1 TEAM BASED CARE

%	QTY	DESCRIPTION
		APPOINTMENT MANAGEMENT WITH PCP
		HIRE CARE COORDINATOR(s)
		DEFINING ROLES OF CARE TEAM
		EDUCATING PATIENTS (POSTERS, BROCHURES, HEALTH FAIRS)
		PRE-VISIT PLANNING / HUDDLES
		IMPLEMENT CHW ROLE
		TRAIN STAFF
		HIRE BEHAVIORAL / MENTAL HEALTH SPECIALIST

2 – KNOWING & MANAGING

%	QTY	DESCRIPTION
		DIABETIC/CHRONIC POPULATION
		INCREASE A1c SCREENING
		INCREASE ROUTINE/WELLNESS SCREENINGS FOR ADULTS &/OR CHILDREN
		INCREASE MENTAL HEALTH SCREENINGS (DEPRESSION, ANXIETY, etc.)
		OUTREACH ACTIVITIES
		BMI / OBESITY SCREENINGS
		DIETARY HABITS
		PEDIATRIC CARE
		DEVELOP / IMPROVE POPULATION HEALTH MANAGEMENT
		IMPROVE SMOKING CESSATION SCREENING

3 - ACCESS

%	QTY	DESCRIPTION
		DECREASE NO-SHOW RATES
		OFFER SPECIFIC TYPES OF APPOINTMENTS WITH VARYING TIMES AVAILABLE WITH PCP
		MOVING TO NEW LOCATION / EXPAND CURRENT LOCATION
		AVAILABILITY OF PROVIDERS
		EMPANELMENT STRATEGIES
		IMPROVE PORTAL UTILIZATION
		EXTENDED HOURS
		MOBILE BUS AVAILABILITY

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4 – CARE MANAGEMENT

%	QTY	DESCRIPTION
		MANAGING PATIENTS WITH DIABETES
		MANAGING PATIENTS WITH OBESITY/WEIGHT ISSUES
		MANAGEMENT OF BEHAVIORAL/MENTAL HEALTH PATIENTS
		DEVELOP / IMPROVE CARE MANAGEMENT PROGRAM
		IMPROVE PATIENT COMPLIANCE
		IDENTIFY GAPS IN CARE
		RECONCILE Rx

5 – CARE COORDINATION

%	QTY	DESCRIPTION
		DENTAL INTEGRATION
		BEHAVIORAL HEALTH INTEGRATION
		PHARMACY
		REDUCTION OF EMERGENCY DEPARTMENT VISITS
		DEVELOPING CARE COORDINATION PROGRAM
		TRANSITIONS OF CARE
		CLOSE LOOP
		BETTER TRACKING OF DXL RESULTS

6 – QUALITY IMPROVEMENTS

%	QTY	DESCRIPTION
		LOWER A1c SCORES
		REDUCE/INTEGRATE FORMS FOR PATIENTS TO COMPLETE SO NOT SO MANY
		ONGOING QUALITY IMPROVEMENTS
		PATIENT SATISFACTION SURVEYS
		IMPROVED SAFETY
		IMPLEMENT PATIENT ADVISORY BOARD
		EXPAND SPACE WITHIN CLINIC TO ACCOMMODATE STAFFING NEEDS/ADJUSTMENTS

7 – HIT

%	QTY	DESCRIPTION
		IMPLEMENT NEW EHR
		CLEAN UP HER INFORMATION

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ARE THERE SPECIFIC PCMH FUNCTIONS OR ACTIVIES YOU WOULD LIKE MORE HELP WITH?

RESPONSES

HOW DO YOU DEFINE THE MEDICAL HEALTH NEIGHBORHOOD?

RESPONSES

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WHAT ARE YOUR EXPERIENCES COORDINATING CARE FOR YOUR PATIENTS WITHIN YOUR MEDICAL HEALTH NEIGHBORHOOD? (ie. HOME HEALTH, FOOD BANKS, SPECIALTY PHYSICIANS, etc.)

RESPONSES

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT REGARDING YOUR PCMH JOURNEY OR PROVIDE THOUGHTS TO IDAHO LEADERSHIP?

RESPONSES

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APPENDIX B - Patient Interview Worksheet

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COHORT -REGION PATIENT INTERVIEWS

WAYS PEOPLE TAKE CARE OF THEMSELVES:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		BEING INFORMED CONSUMER			
2		REGULAR EXERCISE			
3		WATCH DIET/NUTRITION			
4		BE MENTALLY ACTIVE/MENTAL HEALTH			
5		MEDICATION COMPLIANCE			
6		KEEP APPOINTMENTS AS SCHEDULED			
7		SELF-CARE	1. DRINKING WATER		
			2. COPING w/STRESS, ETC		
			3. LISTENING TO BODY		
			4. PRAY MEDITATE		
			5. ADEQUATE SLEEP		
			6. PERSONAL HYGIENE		
			7. BRUSH TEETH		
			8. VACCINATIONS		
			9. HOME SAFETY		
			10. CARE FOR PETS		
			11. JOURNALING		
			12. WEARING SEATBELTS		
8		STOP/ REDUCE SUBSTANCE	1. ETOH		
			2. TOBACCO		
			3. NARCOTICS		
			4. CAFFEINE		
			5. SODA		
9		WEIGHT CONTROL			
10		ROUTINE MAINTENANCE CHECK-UPS			
11		SEEING MD WHEN NECESSARY			
12		PAYING FOR INSURANCE			
13		BEING FINANCIALLY RESPONSIBLE FOR HEALTH AND HEALTH SERVICES			
14		ADVOCATE FOR YOURSELF			
15		USE OF NATURAL SUPPLEMENTS			
16		BEING ABLE TO COMMUNICATE WITH PROVIDER			
17		FOLLOW PROVIDER ORDERS	1. PHYSICAL THERAPY		
			2. WATCH BLOOD SUGAR		
			3. MANAGE DEPRESSION		
			4. WATCH BLOOD PRESSURE		
			5. WATCH BMI		
			6. BREATHING TREATMENT		
18		PROVIDE LIST OF MEDICATIONS TO PROVIDER(S)			
19		HAVING GOOD FAMILY SUPPORT SYSTEMS			
20		SOCIAL/ENVIRONMENTAL HEALTH			
21		BE RESPECTFUL TO PROVIDERS/STAFF			
22		SELECT PROVIDER w/IN INSURANCE NETWORK			
23		TRANSPORTATION TO/FROM APPOINTMENT			
24		CHECK EXPIRATION DATES			
25		SEE DENTIST			

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HOW HAS HEALTHCARE TEAM ASSISTED WITH ABOVE:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		RECIPROCAL LISTENING PT/PCP			
2		ADVICE ON DIET/NUTRITION			
3		SEMINARS &/OR SUPPORT GROUPS &/OR SHARED APPOINTMENTS			
4		VERBALLY ENCOURAGING			
5		REMINDER CALLS			
6		FOLLOW-UP CALLS			
7		COORDINATION OF CARE	1. PHYSICAL THERAPY		
			2. OPTHAMOLOGY		
			3. MANAGE CHRONIC CONDITIONS		
			4. PAIN MNGMNT		
			5. SUICIDE PREVENTION		
			6. SOCIAL WORKER/BHI		
			7. REFERRALS		
			8. EQUIPMENT ASSISTANCE		
			9. CONNECT w/RESOURCES		
8		AVAILABILITY TO SET APPOINTMENTS			
9		REGULAR CHECK-UPS / PREVENTATIVE CARE			
10		PRESCRIBE/ MONITOR/EXPLAIN Rx's			
11		DO NOT HAVE/NOT AWARE OF HEALTHCARE TEAM			
12		PROVIDERS SET A GOOD EXAMPLE BY WATCHING WEIGHT AND EXERCISING			
13		COMPLETE DIFFERENTIAL DIAGNOSIS & NEEDED DXL TESTS			
14		HELP WITH INSURANCE PROCESSING			
15		TRANSITION FROM HOSPITAL			
16		PROVIDE ACCURATE INFORMATION	1. DIABETES DIET/NUTRITION		
			2. RESPONSIVE TO EMAILS		
			3. CALL BACK TO ANSWER QUESTIONS		
			4. PROVIDE ALTERNATIVE TREATMENTS		
			5. NEWSLETTERS		
			6. HEALTH FAIRS		
			7. ELECTRONIC ACCESS TO RECORDS		
17		DENTAL WORK			
18		PAYMENT ARRANGEMENTS FOR CARE			

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WHAT DO YOU THINK ARE RESPONSIBILITIES OF THE CLINIC OR HEALTHCARE TEAM?

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
		NOT ANSWERED/NOT APPLICABLE			
1		SPECIFIC MEDICAL SVCS (DXL, Dx) &/OR CONSULTATION RE: SAME	1. DXL SERVICES		
			2. DXL CONSULT		
			3. ROUTINE PREVENTATIVE CHECK-UPS		
			4. FOLLOW-UP APPTS		
			5. CONTROL BLOOD SUGAR		
			6. PROVIDE CORRECT TREATMENT		
			7. TREAT WHOLE PERSON PHYSICAL/MENTAL		
2		CONFIRM PT UNDERSTANDS CARE/PLAN			
3		PROFESSIONALISM	1. FRIENDLY DEMEANOR		
			2. SHOW UP FOR WORK		
			3. BE INFORMED /KNOWLEDGEABLE		
			4. CLEANLINESS & ADHERANCE TO MEDICAL STANDARDS & PRECAUTIONS		
			5. HIPAA COMPLIANCE		
			6. BILLING MATTERS		
			7. DOCUMENT FILE		
			8. ANSWER THE PHONE		
			9. INTERPRETERS		
4		SPEND MORE TIME WITH PATIENTS DURING VISIT			
5		POSTING HEALTH INFO IN PT PORTAL			
6		FOLLOW-UP & CARE COORDINATION	1. REFERRALS TO OTHER PROVIDERS		
			2. 340B PHARM OR Rx ASSIST		
			3. SCHEDULING APPTS		
			4. TEAM BASED APPROACH		
			5. RETURN PHONE CALLS/ADVICE		
			6. DENTAL CARE		
7		PROVIDE DISEASE PREVENTION MATERIALS			
8		AVAILABILITY TO SET APPOINTMENTS			
9		MEET PATIENTS WHERE THEY ARE IN THEIR LIFE			
10		LISTEN TO PT ISSUES/CONCERNS & PROVIDE APPROPRIATE FEEDBACK/ INFORMATION	1. ENCOURAGEMENT		
			2. COACHING		
			3. TAKE EXTRA STEPS TO SOLVE PROBLEMS		
			4. EVIDENCE BASED		
			5. CURRENT/RELEVANT		
			6. ALTERNATIVE OPTIONS		
			7. TELL TRUTH RE: CONDITION		
			8. HELP PATIENTS W/ DECISIONS THAT LEAD TO OUTCOMES.		
			9. AGE APPROPRIATE INFO		
11		OFFER CORRECT Rx's			
12		CONNECT TO RESOURCES (NON-MEDICAL)	1. FOOD BANKS		
			2. TRANSPORTATION		
			3. HOUSING		
13		DON'T KNOW			
14		NEED TO TAKE CARE OF THEMSELVES			
15		REMINDERS			
16		PROVIDING LETTERS OR OTHER DOCUMENTS TO SCHOOLS			
17		PROVIDERS ARE NOT NECESSARILY RESPONSIBLE			
18		RESPECT THE PATIENT'S TIME			
19		PROVIDE AFFORDABLE MEDICAL CARE			
20		EDUCATE PUBLIC			
21		ORIENTING PATIENT RE: HEALTH			

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ARE THERE SPECIFIC THINGS NEEDED TO TAKE MORE RESPONSIBILITY FOR SELF:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		RESOURCES	1. FOOD		
			2. HOUSING		
			3. TRANSPORTATION		
			4. JOB OR SOURCE OF INCOME		
			5. HELP PAYING BILLS		
			6. INSURANCE OPTIONS		
			7. NUTRITION INFO		
			8. EXERCISE INFO		
			9. CAREGIVER		
			10. REFERRAL		
			11. SUPPORT GROUP(s)		
			12. STRESS RELIEF EDUCATION		
2		ADVOCATE FOR SELF			
3		KNOWLEDGE NAVIGATING SOCIAL SYSTEMS			
4		ACCESS TO MEDICATIONS			
5		INCREASED MOBILITY			
6		ACCESS TO 2ND OPINIONS COVERED BY INSURANCE			
7		IMPLEMENT HEALTH SAVINGS ACCOUNT (HSA)			
8		EQUIPMENT	1. HEARING AIDS		
			2. DENTURES		
			3. GLASSES		
			4. NEBULIZER/OXYGEN		
			5. BLOOD SUGAR TESTING SUPPLIES		
			6. SERVICE ANIMAL		
			7. MEDICATION		
			8. BODILY FUNCTION EQUIPMENT		
			9. COMPUTER		
			10. WALKER		
			11. Rx FORMULA FOR INFANT		
9		REWARD SYSTEM FOR FOLLOWING THROUGH ON CARE/TREATMENT PLAN(s)			
10		NEED MORE ACCESS TO SPECIALISTS			
11		WEIGHT LOSS SURGERY			
12		NEED CURRENT/INFORMED MEDICAL PERSONNEL			
13		NEED TO DO FOLLOW-UP VISITS WITH PROVIDERS			
14		MOTIVATION			
15		SEE DENTIST			
16		BETTER ACCESS TO CLINIC / SCHEDULING APPTS			
17		IMPROVE USE OF PORTAL			
18		HELP w/SHOPPING FOR HEALTHY ITEMS			
19		INSURANCE PAY FOR GYM MEMBERSHIP			
20		STOP SMOKING			
21		NEED EXPLANATION IN WAY THAT IS UNDERSTANDABLE AND TAILORED TO PATIENT			
22		FRIEND OR OTHER SOCIAL SUPPORT			
23		BETTER MEMORY/REMINDERS			
24		BETTER COMMUNICATION OR INFORMATION ABOUT HEALTH IN GENERAL			
25		INFO REGARDING ALTERNATIVES TO Rx's			
26		TAKE SUPPLEMENTS AND VITAMINS			
27		TAKING Rx's			
28		INCREASE FLOSSING			
29		KEEP BETTER TRACK OF APPTS.			
30		DECREASE USE OF ELECTRONICS			
31		PERSONAL HYGIENE			
32		MORE SLEEP			
33		ABILITY FOR VIDEO VISITS/TELEHEALTH			
34		MASSAGE, CHIROPRACTOR, ACCUPUNCTURE, OPTIONS			
35		USER FRIENDLY ENVIRONMENT			
36		KEEP MEDICAL JOURNAL			
37		RESEARCH HEALTH ISSUES			

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ARE THERE THINGS THAT PREVENT YOU FROM TAKING CARE OF YOURSELF AS WELL AS YOU WOULD LIKE TO?

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		SITUATIONAL STRESSORS THAT HAVE A START AND AN END BUT TAKE UP A LOT OF TIME IN BETWEEN	1. FAMILY EMERGENCIES		
			2. INJURY		
			3. ACCUTE ILLNESS (FLU, COLD, ETC.)		
			4. LOSS OF LOVED ONE		
			5. DIVORCE		
2		NO CHANGE:	1. DOING EVERYTHING		
			2. LEARNING SELF-CARE		
			3. HAVE LITTLE STRESS		
3		WEATHER	1. HEAT IS PROBLEM		
			2. COLD IS PROBLEM		
			3. SMOKE IS PROBLEM		
4		WORK ISSUES	1. LONG WORK DAY		
			2. LONG COMMUTES		
			3. SCHOOL SCHEDULE		
5		COST OF GYM FEES			
6		TOO MANY HOOPS TO JUMP THROUGH IN ORDER TO GET CARE			
7		FRUSTRATION w/MEDICAL PROVIDERS			
8		AGE IN GENERAL			
9		MEDICATION COMPLICATIONS			
10		RESPONSIBILITY FOR DEPENDENT(S)	1. AGING PARENT		
			2. INJURED/ILL SPOUSE		
			3. INJURED/ILL CHILD		
			4. SINGLE PARENT		
			5. GRAND CHILDREN		
			6. ADULT CHILDREN		
			7. AGING GRANDPARENTS		
11		HEALTH ISSUES	1. PAIN		
			2. NO DX NOT KNOWING WHAT'S WRONG		
			3. DEPRESSION/ANXIETY		
			4. LACK MOBILITY		
			5. NEED MORE OVERALL INFO		
			6. INSOMNIA		
12		LACK OF RESOURCES	1. TRANSPORTATION		
			2. COSTS OF CARE/MONEY		
			3. NO INSURANCE		
			4. NEED MORE LIVING SPACE		
			5. SSI		
			6. DISABILITY (SSD)		
			7. ACCESS TO SPECIALISTS		
			8. HOMELESSNESS		
			9. LACK OF FOOD		
13		SELF-CARE	1. LACK OF SLEEP		
			2. MOTIVATION		
			3. SELF-CONTROL		
			4. LACK OF FEAR OF CONDITION		
			5. TIME MANAGEMENT		
14		LACK OF FITNESS FACILITIES			
15		LACK OF ACCESS TO DR. VISITS			

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IS THERE ANYTHING NEW YOU PLAN ON DOING IN THE NEXT 6 MONTHS TO TAKE CARE OF YOUR HEALTH?:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		EXERCISE MORE	1. WALK		
			2. RUN		
			3. HIKE		
			4. FISH		
			5. GYM MEMBERSHIP		
			6. WALK w/DOG		
			7. BIKE		
			8. YARDWORK/GARDEN		
			9. MARTIAL ARTS		
			10. SWIM		
2		NOTHING NEW AS LONG AS HEALTH STAYS SAME			
3		MODIFY DIET	1. CUT OUT SWEETS		
			2. EATING HEALTHIER		
			3. DRINK MORE H20		
4		THERAPY (MEDICAL RELATED)			
5		STOP / REDUCE SUBSTANCE USE	1. TOBACCO		
			2. ETOH		
			3. NARCOTICS		
			4. CAFFEINE		
			5. SODA		
6		SCHEDULED SURGERY			
7		ADHERE TO MEDICATION SCHEDULE			
8		FOLLOW THROUGH ON PERSONAL RESPONSIBILITY	1. WEIGHT MNGMNT		
			2. ADEQUATE SLEEP		
			3. RETURN TO WORK		
			4. RETIREMENT		
			5. THINK ABOUT FUTURE		
			6. LOWER A1c		
			7. PROTECT SKIN		
			8. HYSTERECTOMY		
			9. RETURNING TO SCHOOL		
			10. INCREASE INCOME		
			11. MOVE IN w/FAMILY		
			12. FIND HOUSING		
			13. HOBBY		
			14. TAKE MEDICATIONS		
9		DOCTOR/PCP VISISTS			
10		RESEARCH INFO	1. SPECIFIC HEALTH CONDITION		
			2. DIET		
			3. SUPPLEMENTS / VITAMINS		
			4. GET INSURANCE		
11		MASSAGE THERAPY			
12		PREVENTATIVE HEALTH ACTIVITIES	1. VACCINATIONS		
			2. INFECTION CONTROL		
			3. HOME SAFETY		
			4. SEE DENTIST		
			5. REDUCE STRESS		
			6. VACATION		
			7. BIRTH CONTROL		
			8. USE SUNSCREEN		
			9. PRACTICE SAFE SEX		
			10. VISION EXAM(s)		
13		COUNSELING SERVICES			

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DESCRIBE ANYTHING YOUR CLINIC OR HEALTHCARE TEAM COULD DO TO HELP YOU:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		NO HELP NEEDED	1. CURRENTLY WORKING ON ISSUES		
			2. ALREADY ON TARGET		
			3. FOLLOWING PCP ORDERS		
			4. SELF-EDUCATION		
			5. PERSONAL RESPONSIBILITY		
			6. BEYOND SCOPE		
			7. CLINIC DOING THEIR PART		
			8. CLINIC KEEPS GOING AS IS		
			9. ABLE TO TAKE CARE OF SELF		
			10. PT RESPONSIBLE FOR OWN HEALTH		
			11. CLINIC SUPPORTIVE OF PT EFFORTS		
2		PROFESSIONAL	1. CONTINUED EFFORTS TO SOLVE MEDICAL CONDITION(S)		
			2. HELP PRIORITIZE HEALTH ISSUES		
			3. FOLLOW-UP HELPFUL		
			4. ADVICE WHEN ASKED FOR		
			5. RESPECT FORMER PROVIDERS' TREATMENTS		
			6. ABILITY TO GET THROUGH ON PHONE		
			7. CULTURAL & LINGUISTIC MATERIALS		
			8. ANSWER THE PHONE		
3		MORE PATIENT INFO REGARDING	1. EXERCISE		
			2. NUTRITION/ MANAGE DIET		
			3. SUPPLEMENTS		
			4. INSURANCE		
			5. SCHEDULING		
			6. SELF-CARE		
			7. COPD		
			8. DIABETES		
			9. TREATMENT PLAN		
			10. IMPLEMENTING DIRECTIVES		
			11. HELP FILLING OUT PAPERWORK		
			12. NUTRITION AS TREATMENT PLAN		
			13. KNOWING WHEN TO SEE PCP		
			14. MANAGE OR REDUCE Rx's		
			15. MOTIVATION/WILL POWER		
			16. HELP WITH PORTAL USAGE		
			17. MEDICATION/TREATMENTS BEING ADVERTISED IN MAINSTREAM MEDIA		
			18. HEALTH ORIENTATION		
4		SCHEDULING	1. NEED MORE TIME DURING THE VISIT		
			2. WOULD BE NICE TO SEE THE SAME DOCTOR EVERY TIME		
			3. PATIENTS NEED MORE LONGEVITY AND STABILITY FROM THEIR PROVIDER		
			4. SPEED UP APPOINTMENT TIME SO MY RIDE DOESN'T HAVE TO WAIT FOR ME FOR SO LONG.		
			5. MORE AVAILABILITY FOR APPTS		
			6. FLEXIBILITY WITH MISSED APPOINTMENTS		
			7. 24-HR WALK-IN CLINIC FOR EMERGENCIES		
5		CLINIC FAR AWAY			

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6		LISTEN TO CONCERNS OF PATIENT/CAREGIVER			
7		MORE COORD CARE / SPECIALTY REFERRALS	1. HEARING		
			2. PHYSICAL THERAPY		
			3. OPTHAMOLOGY		
			4. ACCUPUNCTURE		
			5. BEHAVIORAL/MENTAL HEALTH		
			6. ORTHOPEDIC		
			7. INTERNAL CLINIC COMMUNICATION		
			8. DENTAL		
			9. MASSAGE THERAPY		
			10. CHIROPRACTOR		
			11. OBGYN		
			12. COORDINATE w/INSURANCE re: PROVIDER ORDERS		
			13. NUTRITIONIST		
8		APPROPRIATE AGE-RELATED ACTIVITY(ies)	1. NEW-BORN – PEDS		
			2. TODDLER		
			3. PRE-TEEN		
			4. TEEN / ADOLESCENCE		
			5. ADULT		
			6. GERIATRIC		
			7. END LIFE		
9		ASSISTANCE w/RESOURCES	1. TRANSPORTATION		
			2. FOOD		
			3. LOW COST GYM / FITNESS		
			4. Rx SAMPLES		
			5. NEEDED TOOLS		
			6. “ALTERNATIVE” MEDICINE COVERED BY INSURANCE		
			7. HELP WITH COSTS		
			8. HELP NAVIGATING SYSTEMS		
			9. COMMUNITY HEALTH EVENTS		
			10. EXERCISE PROGRAMS		
			11. REDUCED FEE/FREE SVCS		
			12. PARKING		
			13. DAY OFF		
			14. SMOKING CESSATION		
			15. HOUSING		
			16. DESK RISER		
10		REMINDER &/OR FOLLOW-UP CALLS			
11		EXERCISE ROOM			

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WHAT DOES ACCESS TO HEALTHCARE MEAN TO YOU?:

QTY	%	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE
1		ACCESS TO PCP WHEN NEEDED
2		ACCESS TO REFERRAL(s)
3		ABILITY TO PAY (*)
4		FOLLOW-UP CARE
5		KNOWLEDGEABLE & COMMUNICATIVE PCP
6		ACCESS TO RECORDS ON-LINE/PORTAL
7		CALL BACK PROMPTLY
8		BEING ABLE TO GET APPROPRIATE CARE
9		SOMEPLACE I CAN GO TO GET MEDICAL ATTENTION/HELP
10		ACCESS TO MEDICATION(s) (*)
11		ACCESS TO INSURANCE (**)
12		DON'T REALLY KNOW HOW TO ANSWER
13		ACCESS TO NEEDED DXL TESTING
14		KNOWING ABOUT RESOURCES
15		AFFORDABLE CARE (*)
16		HAVING WAY TO PAY FOR CARE THAT'S NOT COVERED BY INSURANCE
17		HAVING ENOUGH EDUCATED PROVIDERS TO PROVIDE CARE IN COMMUNITY
18		BEING ABLE TO SEE SAME DOCTOR EVERY TIME
19		LIVE LONGER w/BETTER QUALITY OF LIFE
20		CARE IS WITHIN REASONABLE DISTANCE
21		SEEING DOCTOR OF CHOICE
22		LIFE OR DEATH
23		SHORTER WAIT TIMES TO SEE PROVIDER
24		ACCESS TO MENTAL HEALTH
25		BEING ABLE TO SEE DOCTORS AND HAVE INSURANCE COVERAGE WHETHER YOU'RE IN YOUR HOME STATE OR OUT OF STATE.
26		HAVING TRANSPORTATION TO GET TO PROVIDER(s)
27		MORE TIME SPENT WITH PROVIDER(s)
28		TRANSPARENCY OF PROVIDERS
29		EXTENDED HOURS
30		ACCESS TO DENTIST
31		WORD OF MOUTH TO CONNECT WITH PROVIDERS
32		UNDERSTANDING WHAT IS COVERED/WHAT'S NOT
33		ACCESS TO INTERPRETERS
34		ACCESS TO HEALTHY FOOD
35		ACCESS TO HOUSING
36		ACCESS TO INCOME OR JOB
37		ACCESS TO VISION CARE
38		ABILITY TO TAKE CARE OF SELF

DESCRIPTION	QTY	%
# RESPONSES RELATED TO COSTS OF SERVICES (*)		
# RESPONSES RELATED TO COST(s) OF INSURANCE (**)		

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ARE YOU ABLE TO SCHEDULE AN APPOINTMENT?

QTY	%		QTY	%	
		NO			YES

DO YOU HAVE ALL THE HEALTHCARE SERVICES YOU NEED IN YOUR AREA?

QTY	%		QTY	%	
		NO			YES

DO YOU HAVE RELIABLE TRANSPORTATION?

QTY	%		QTY	%	
		NO			YES

CAN YOU AFFORD HEALTHCARE SERVICES WHEN YOU NEED THEM?

QTY	%		QTY	%	
		NO			YES

OF THOSE WHO SAID YES THEY CAN AFFORD SERVICES:

DESCRIPTION	QTY	%
TIED TO FQHC ANY PAYMENT METHOD		
TIED TO FQHC UNINSURED		
TIED TO FQHC MEDICAID/MEDICARE		
UNINSURED ONLY		
MEDICAID/MEDICARE ONLY		

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THINKING ABOUT ACCESS TO HEALTHCARE AS MENTIONED ABOVE, HOW EASILY HAVE YOU BEEN ABLE TO ACCESS THE PRIMARY CARE SETTING OR YOUR CLINIC:

QTY	%	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE
1		ACCESS TO PCP GOOD
2		DIFFICULT BECAUSE OF TRANSPORTATION
3		LONG WAIT TIME TO SCHEDULE APPT
4		HARD TO FIND GOOD MATCH FOR NEEDS
5		SAME DAY TURNAROUND FOR EMERGENCY
6		NOT HARD TO SCHEDULE AN APPT, BUT WAIT TIME ONCE YOU GET THERE IS LONG
7		CARE TOO EXPENSIVE

THINKING ABOUT ACCESS TO HEALTHCARE AS MENTIONED ABOVE, HOW EASILY HAVE YOU BEEN ABLE TO ACCESS THE DENTISTRY:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		DON'T NEED BECAUSE OF DENTURES			
2		NEED BUT CAN'T USE BECAUSE OF EXPENSE			
3		DENTAL CARE IS ACCESSIBLE/ NO PROBLEMS			
4		ACCESS TO DENTISTRY NON-EXISTENT OR DIFFICULT	1. CAN'T GET IN FOR WEEKS		
			2. CAN'T GET IN FOR 1-2 MONTHS		
			3. CAN'T GET IN FOR 3-4 MONTHS		
			4. CAN'T GET IN FOR OVER 6 MONTHS		
5		TRAVEL DISTANCE IS TO FAR TO ACCESS DENTIST			
6		NOT HAPPY WITH DENTIST			
7		SPENT 6 WEEKS W/NO TEETH			
8		SKEPTICAL OF QUALITY OF DENTISTRY OFFERED			
9		WAITING TO HANDLE OTHER MEDICAL ISSUES			
10		HAD SOME TEETH PULLED – DIDN'T FEEL A THING			
11		THEY'VE OFFERED BUT I'M GOING TO KEEP THE FEW TEETH I HAVE FOR NOW.			
12		INSURANCE DOESN'T COVER DENTAL EXPENSE			
13		HOURS OF AVAILABILITY CONFLICT WITH SCHEDULE			

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THINKING ABOUT ACCESS TO HEALTHCARE AS MENTIONED ABOVE, HOW EASILY HAVE YOU BEEN ABLE TO ACCESS THE BEHAVIORAL HEALTH/COUNSELING:

QTY	%	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE
1		DON'T NEED BEHAVIORAL HEALTH
2		SEEING PAIN MANAGEMENT DOCTOR
3		BEHAVIORAL HEALTH USEFUL
4		ACCESS GOOD
5		AVOID DUE TO STIGMA
6		TOO EXPENSIVE/CAN'T AFFORD
7		ACCESS IS CHALLENGING
8		TRANSPORTATION ISSUES
9		HAVEN'T USED BUT PLANNING TO DO SO
10		VERY EASY TO GET IN IF YOU ASK FOR IT
11		EASY TO SET APPOINTMENT BUT WAIT TIME IN THE WAITING ROOM IS LONG
12		HAVEN'T USED BUT INTERESTED IN IT
13		DIFFICULT TO FIND A GOOD MATCH FOR SERVICES NEEDED THAT ALSO TAKE THE RIGHT KIND OF INSURANCE.

THINKING ABOUT ACCESS TO HEALTHCARE AS MENTIONED ABOVE, HOW EASILY HAVE YOU BEEN ABLE TO ACCESS THE SPECIALISTS/REFERRALS:

QTY	%	DESCRIPTION	SUB-THEME DESCRIPTION	QTY	%
0		NOT ANSWERED/NOT APPLICABLE			
1		REFERRALS TO SPECIALISTS HAVE BEEN GREAT.			
2		SCHEDULES CAN BE CHALLENGING	1. CAN'T GET IN FOR WEEKS		
			2. CAN'T GET IN FOR 1-2 MONTHS		
			3. CAN'T GET IN FOR 3-4 MONTHS		
			4. CAN'T GET IN FOR OVER 6 MONTHS		
3		NOT A LOT OF CHOICES AMONG SPECIALISTS AND THEY ARE BOOKED FAR INTO FUTURE			
4		NEED PHYSICAL THERAPY BUT HAVEN'T BEEN ABLE TO ACCESS.			
5		CAN MAKE APPOINTMENTS w/SOME, BUT IF NOT COVERED BY INSURANCE CAN'T AFFORD TO GO.			
6		PAPERWORK & PROCESSES CAN BE CONFUSING			
7		TRAVEL DISTANCE CREATES CHALLENGES			
8		SOME SPECIALISTS ARE A JOKE			
9		TRANSPORTATION CHALLENGES			

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IS THERE ANYTHING ELSE YOU'D LIKE TO TELL US THAT WE DIDN'T COVER?:

QTY	%	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE
1		FREE CLINICS ARE NECESSITY FOR PEOPLE WHO DON'T HAVE ANY OTHER OPTION. THEY NEED TO BE SUPPORTED SOMEHOW. (*)
2		NEEDS TO BE EASIER FOR LOW INCOME PEOPLE TO GET TO A DOCTOR. (*)
3		NEED MORE EMPHASIS ON PREVENTATIVE CARE RATHER THAN WAITING UNTIL IT'S TOO LATE.
4		PEOPLE NEED TO BE MORE EDUCATED ABOUT HEALTH INSURANCE COVERAGE
5		CLINIC PROVIDES GOOD SERVICES
6		CHOOSING PLAN vs DOCTOR MAKES GETTING INSURANCE A CHALLENGE
7		ELECTRONIC HEALTH RECORDS ARE GOOD BUSINESS
8		PROVIDERS NEED TO COACH PATIENTS ON HOW TO HELP THEMSELVES AND THE PROVIDERS BECOME BETTER PARTNERS
9		PATIENTS NEED TIME TO TALK & ASK QUESTIONS
10		EVERYONE NEEDS ACCESS TO HEALTHCARE (*)
11		ELDERLY PEOPLE CANNOT BE FORGOTTEN IN HEALTHCARE BENEFITS
12		INSURANCE NEEDS TO BE MORE REASONABLE IF PATIENT IS GOING TO TAKE BURDEN OF THE FINANCIAL RESPONSIBILITY. (HIGH DEDUCTIBLES) (**)
13		HELP w/COSTS NOT COVERED BY INSURANCE (*)
14		NEED TO BE ABLE TO SEE SAME PROVIDER
15		EXTENDED AGE LIMITS ON PROGRAMS
16		PROFESSIONALISM OF STAFF NEEDS IMPROVED
17		MORE COMMUNICATION & TRANSPARENCY AMONG PROVIDERS, INSURANCE AND RESPECTIVE STAFF MEMBERS
18		PROTECTION OF CONFIDENTIAL INFORMATION (HIPAA) SHOULD BE IMPROVED
19		PEOPLE NEED EDUCATION VENUES TO LEARN ABOUT HEALTH, ACCESSING SERVICES, AND OTHER RELATED TOPICS THROUGHOUT LIFE STAGES
20		NEED MORE ACCESS TO ALTERNATIVE/ PREVENTATIVE TYPES OF CARE
21		Rx REFILLS NEED TO BE MORETIMELY
22		STOP MAKING PATIENTS PAY FOR PROCEDURES THAT ARE UNNECESSARY
23		MENTAL & MEDICAL HEALTH DISPARITIES BEYOND PRIMARY CARE SETTING NEED TO BE ADDRESSED
24		INSURANCE NEEDS TO BE MORE ACCESSIBLE AND AFFORDABLE (**)
25		MEDICATION NEEDS TO BE MORE ACCESSIBLE (*)
26		MORE LISTENING TO WHAT PATIENT IS TELLING THE PROVIDER
27		IF A PERSON IS IN CRISIS, IT'S EXTREMELY HARD TO CONCENTRATE LONG ENOUGH TO FILL OUT COMPLEX PAPERWORK.
28		CLEANLINESS OF FACILITY NEEDS TO BE ADDRESSED.
29		IDAHO NEEDS TO MAKE SURE THERE ARE GOOD PROVIDERS AVAILABLE FOR PATIENTS.
30		TOO MANY HOOPS TO JUMP THROUGH TO GET TREATMENT FOR CHILDREN CAUSING DELAYS IN CARE AND SOMETIMES DEVELOPMENT – SPEND A LOT OF TIME PLAYING CATCH-UP
31		HELPING PATIENTS/FAMILIES CONNECT WITH FINANCIAL RESOURCES (*)
32		BEHAVIORAL INTERVENTIONIST AND COUNSELOR NOT SAME THING – IF CHILD HAVING SEVERE BEHAVIOR PROBLEMS THEN BEHAVIORAL INTERVENTIONIST NEEDS TO BE THE PRIORITY.
33		TRAINING FOR STAFF
34		NOT ENTIRELY GOVERNMENT'S RESPONSIBILITY TO TAKE CARE OF PEOPLE.
35		RURAL AREA CLINIC NEEDS FUNDING TO CONTINUE COMMUNITY WORK (*)
36		PAY ATTENTION TO PROVIDERS IN OTHER CLINICS – SOME SHOULDN'T HAVE PATIENTS REFERRED TO THEM
37		DRUG USE BECOMING A MORE SERIOUS ISSUE
38		STAFF CANNOT SMOKE WHEN CARING FOR PATIENTS
39		GET RID OF OBAMA CARE
40		IF IT AIN'T BROKE, DON'T FIX IT
41		WORRIED ABOUT FUTURE TRANSPORTATION ISSUES WHEN I CANNOT DRIVE OR DO NOT HAVE FAMILY

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42		NEED MORE SAME DAY APPOINTMENTS
43		IMPROVE BEING ABLE TO GET THROUGH TO CLINIC STAFF ON PHONE.
44		SHORTER WAIT TIMES
45		SPECIALISTS NEED LESS WAITING TIME AND IMPROVED FOLLOW-THROUGH WITH PATIENTS.
46		PATIENTS USING ER RATHER THAN PCP IS CONCERNING
47		ACCESS TO DENTISTS AND DENTAL SERVICES NEED TO BE IMPROVED. THERE ARE LONG WAIT TIMES AND NOT AVAILABLE AFTER TRADITIONAL WORK HOURS.
48		ONLINE PATIENT REFERENCE/INFORMATION MATERIALS THAT ARE SCHOLARLY AND RELEVANT BY SYMPTOMS OR CONDITION AND HOW TO TREAT UNTIL SEEN AT CLINIC.
49		FORTUNATE TO HAVE CLINICS THAT PROVIDE CARE TO PEOPLE WHO DON'T HAVE INSURANCE. (*)
50		MEDICARE SHOULD PASS SAVINGS ON TO PEOPLE WHO HAVE GOOD HEALTH BY LOWERING PREMIUMS.
51		PROVIDERS & STAFF NEED TO USE LANGUAGE THAT MAKES SENSE TO THE PATIENTS, NOT JUST INDUSTRY JARGON.
52		DXL RESULTS NEED TO BE COMMUNICATED TO PATIENTS IN A MORE TIMELY FASHION.
53		CHOOSING BETWEEN WORK & DR VISIT CREATES BARRIERS
54		ONLINE EDUCATIONAL INFORMATION ON CONDITIONS, PHYSICIANS, VACCINATIONS, ETC.
55		MEDICAID EXPANSION (*)
56		REMEMBER TO BE NICE TO HEALTHCARE WORKERS TOO
57		INFO RE: MEAL PLANNING TO IMPROVE CONDITION(s)
58		WHEN THINKING ABOUT HEALTHCARE REFORM LOOK AT WHOLE PICTURE, NOT JUST ONE PART OF PROCESS.
59		MORE CLINICS THAT PROVIDE CARE &/OR MEDICATION AT LITTLE TO NO COST (*)
60		PROVIDERS NEED TO EXTEND SAME CARE & COURTESY TO MEDICAID RECIPIENTS.
61		DISPARITIES IN VA COVERAGE NEEDS IMPROVEMENT
62		HELP SINGLE PARENTS BRIDGE COMMUNICATION GAPS ABOUT THEIR CHILDREN'S HEALTH/ISSUES
63		NEED MORE TRANSPORTATION OPTIONS/AVAILABILITY
64		VISION CARE NEEDS TO BE MORE ACCESSIBLE/AFFORDABLE (*)
65		NEED BEHAVIORAL HEALTH SERVICES IN THE CLINIC
66		SEND PROVIDERS TO NON-ENGLISH SPEAKING NEIGHBORHOODS TO CONNECT WITH PATIENTS TO LOWER "NO-SHOW" RATES AND IMPROVE TRUST.
67		PAY INTO HEALTH CARE ORGANIZATION RATHER THAN INSURANCE
68		MORE COMPETITION / NEGOTIATING HEALTH CARE SERVICES
69		NEED MORE INFO ON HEALTH ALTERNATIVES TO PRESCRIPTIONS
70		NEED HELP WITH DXL SERVICES AND RELATED COSTS (*)
71		NEED RESOURCE HANDBOOK
72		INSURANCE COMPANIES NEED TO LISTEN TO PROVIDERS WORKING WITH PATIENT

DESCRIPTION	QTY	%
# RESPONSES RELATED TO COSTS OF SERVICES (*)		
# RESPONSES RELATED TO COST(s) OF INSURANCE (**)		

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APPENDIX C - Portal Notes Worksheet

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PORTAL NOTES REGION 5 COHORT 1

IDAHO HEALTH HOME?	Y		N		# CLINICS:	

SETTING:	0-URBAN	1-FRONTIER	2 - RURAL	FAR SCORE:	0	1	2	3	4	5

CLINIC TYPES:	0-UNKN	1-PRIVATE	2-CHC	3-ACO	4-FQHC	5-HOSPITAL	6- RHC	7-IHS	8-FREE

ACCESS: AC STANDARD 1 GOALS IDENTIFIED BY THE CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NOT ANSWERED/NOT APPLICABLE	12		INCREASE PT PORTAL ENROLLMENT
1		DEVELOP BETTER REPORTS	13		INCREASE CLINIC UTILIZATION OF PT PORTAL
2		DEVELOP DOCUMENTED PROCESS	14		EMPANELMENT
3		TRACK SPECIALTY REFERRALS	15		DEVELOP ALTERNATE ENCOUNTERS
4		PROVIDE SAME DAY APPOINTMENTS	16		EXPAND HOURS OF OPERATION
5		UPDATE SCHEDULING PROTOCOLS	17		INCREASE # OF ENCOUNTERS
6		MONITOR NO-SHOW RATES	18		UPDATE/NEW EHR PROGRAM
7		TIMELY RETURN OF PATIENT PHONE CALLS	19		INFORM PT's RE: PATIENT PORTAL USAGE
8		IMPROVE PT ACCESS TO CARE TEAM	20		PRODUCE CLINICAL SUMMARIES FOR PT's
9		IMPROVE CARE TEAM ACCESS TO PT	21		INTEGRATE TEAM BASED CARE
10		DEPLOY ADVANCED ACCESS	22		ESTABLISH TRANSFER AGREEMENTS
11		DEVELOP POLICY	23		DEVELOP PATIENT EDUCATION/ORIENTATION PACKETS & MESSAGING MATERIALS

ACCESS: AC STANDARD 1 PLANS IDENTIFIED BY THE CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NO PLAN LISTED	18		TRAIN STAFF ON PT PORTAL
1		IMPROVE - INCREASE ACCESS	19		UPDATE TELEPHONE ADVICE POLICY
2		GENERATE ALTERNATE ENCOUNTERS	20		QI ACTIVITIES
3		INCREASE PORTAL/ONLINE ACCESS	21		INFORM PT's RE: PATIENT PORTAL USAGE
4		4-DAY OR LESS CHART ACCESS TO PT	22		PRINT CLINICAL SUMMARIES SAME DAY
5		TRAINING RE IMPROVED ACCESS	23		CHANGE EMPANELMENT STRATEGIES
6		DEVELOP STANDARDIZED REPORTS	24		TRACK NEXT AVAILABLE APPOINTMENTS
7		DEVELOP DOCUMENTED PROCESSES	25		MONITOR NO-SHOW RATES
8		REFINE ROLES OF PERSONNEL	26		DEVELOP & DISBURSE FLYER RE: PORTAL USAGE
9		CREATE SAME DAY APPOINTMENTS	27		COMMUNITY RESOURCE MANUAL AVAILABILITY
10		IMPLEMENT PDSA	28		SET UP FRONT OFFICE KIOSK FOR PATIENTS TO LOG INTO PORTAL TO ACCESS PROVIDERS
11		STANDARDIZE SCHEDULE TEMPLATES IN ALL SITES	29		OPEN 10 MIN EARLY SO PT STARTS VISIT ON TIME
12		GENERATE/ANALYZE REPORTS	30		EXPAND ACCESS TO BH SVCS VIA WALK IN APPTS
13		UPDATE HER	31		TELEHEALTH CAPABILITIES
14		EXTEND SCHEDULING CALENDAR (FROM AVAILABILITY OUT 8 TO OUT 12 WEEKS)	32		PCMH CERTIFICATION
15		VISIT/CASE MANAGEMENT	33		REVIEW/RECONCILE PANELS
16		CREATE WEEKEND AVAILABILITY	34		ADDRESS HEALTH DISPARITIES
17		CONTINUE WORKING WITH SHIP QI SPECIALISTS	35		DISTRIBUTE PATIENT EDUCATION/ORIENTATION PACKETS & MESSAGING MATERIALS

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TEAM BASED CARE: TC STANDARD 2 GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE	18		IMPLEMENT CULTURAL/LINGUISTIC CARE
1		DEVELOP DOCUMENTED PROCESS	19		EXPAND CARE TEAM (PAIR PCP w/APP)
2		INFORM PATIENTS (info related to services)	20		IMPROVE TEAM BASED CARE
3		EDUCATE PATIENTS (info related to treatment)	21		DEVELOP CARE PLANS
4		DEVELOP BETTER REPORTS	22		DEVELOP STANDING ORDERS
5		DEVELOP BROCHURE/FLYER	23		ASSESS CONTINUITY OF CARE
6		HUDDLES	24		OFFER MATERIALS IN ALTERNATE LANGUAGES
7		DEVELOP NEW PATIENT ORIENTATION	25		INTEGRATE BEHAVIORAL HEALTH
8		CREATE PRACTICE FUNCTION MTGS	26		IMPROVE UTILIZATION OF EHR
9		IMPLEMENT PATIENT ADVISORY COUNCIL	27		CLARIFY JOB DESCRIPTIONS
10		PRE-VISIT PLANNING	28		CLARIFY WORK FLOWS
11		MONITOR GAPS IN CARE	29		CREATE ORGANIZATIONAL CHART
12		DEVELOP/UPDATE POLICIES	30		DOCUMENT CARE TEAM MEETINGS IN PT CHART
13		TRAIN STAFF	31		UPDATE PATIENT HANDBOOK
14		DEVELOP PROCESS TO ALIGN PCP EXPERTISE WITH PT NEEDS	32		DEVELOP NEW EMPLOYEE ORIENTATION
15		ASSIGN TEAM MEMBERS TO CERTAIN PATIENT POPULATION	33		INTEGRATE DENTAL SERVICES
16		CLEARLY DEFINE TEAM MEMBER ROLES	34		IMPROVE SCREENINGS
17		CREATE PATIENT CARE TEAM MEETINGS			

TEAM BASED CARE: TC STANDARD 2 PLANS IDENTIFIED BY THE CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NO PLAN LISTED	24		REVIEW FEEDBACK FROM SHIP QI SPECIALIST
1		REVIEW EXISTING STANDING ORDERS	25		IMPLEMENT PDSA
2		SCOPE OF BH SERVICES OFFERED	26		GENERATE/ANALYZE REPORTS
3		DEVELOP BROCHURE/FLYER/ETC.	27		ADD WORKFLOWS TO JOB DESCRIPTIONS
4		SELF-CARE MANAGEMENT	28		CREATE FORM FOR CARE TEAM MEETINGS
5		CONNECT WITH MARKETING	29		DOCUMENT CARE TEAM MEETINGS
6		ENHANCE CARE MANAGEMENT	30		UPDATE PATIENT HANDBOOK
7		DEVELOP RISK STRATIFICATION METHODOLOGY	31		GATHER DATA ON HUDDLES
			32		DEVELOP/IMPLEMENT STANDING ORDERS
8		STANDARDIZE COMMUNICATION & DOCUMENTATION	33		EDUCATE PATIENTS (info related to treatment)
			34		IMPLEMENT SCHEDULED MTGS RE: PRACTICE FUNCTION
9		IDENTIFY/MEASURE OUTCOMES	35		DEVELOP ORGANIZATIONAL CHART
10		DEVELOP COMPREHENSIVE / INTERDISCIPLINARY CARE MGMT PROGRAM/MEETINGS	36		CREATE STANDARDIZED TEMPLATE FOR PRE-VISIT PLANNING
11		IDENTIFY POTENTIAL PFAC MEMBERS	37		DEVELOP CARE PLAN TO TRANSITION FROM PEDIATRIC TO ADULT CARE
12		IMPLEMENT CHW			
13		INTEGRATE BEHAVIORAL HEALTH PROVIDER	38		MONITOR GAPS OF CARE
14		CREATE "HOW TO" HUDDLES			
15		HIRE EMPANELMENT COORDINATOR	39		DEVELOP REFERRAL SCREEN TO SHOW PROVIDERS WHICH REFERRALS MAY BE AT A LOWER COST FOR CERTAIN PROCEDURES.
16		IMPROVE HUDDLE CULTURE			
17		DEVELOP POLICY	40		REORGANIZE PHYSICAL STRUCTURE TO PROVIDE INTEGRATED SERVICES
18		TRAINING RE: CHRONIC CONDITION MGMNT	41		CREATE AND UTILIZE AN INTEGRATED HUDDLE REPORT
19		DEVELOP BILINGUAL MESSAGING			
20		IMPROVE TRIAGE PROCESS	42		IMPLEMENT/IMPROVE SCREENING RATES
21		TRAIN STAFF			
22		DEVELOP NEW PT ORIENTATION	43		PARTICIPATION WITH EXTERNAL PCMH ACTIVITIES
23		IDENTIFY ROLES OF CARE TEAM			

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POPULATION MANAGEMENT: KM STANDARD 3 GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE	16		CREATE RECALL TICKET POLICY
1		DEVELOP REPORTS	17		USE DATA FOR POPULATION MANAGEMENT
2		DEVELOP DOCUMENTED PROCESSES	18		FOCUS ON MENTAL HEALTH/SUBSTANCE USE
3		EVIDENCE BASED GUIDELINES RESOURCES	19		IMPLEMENT/IMPROVE EHR MODULES
4		DEVELOP COMPREHENSIVE HEALTH ASSESSMENTS	20		CREATE/UPDATE POLICIES
5		IMPROVE PATIENT FOLLOW-UP	21		IDENTIFY SERVICES NEEDED BY PATIENTS
6		IMPROVE HEALTH LITERACY	22		REVIEW PT UNHEALTHY BEHAVIORS AT INTAKE
7		IMPROVE REPORTING/EHR CAPABILITIES	23		REVIEW PT ADVANCED DIRECTIVES AT INTAKE
8		INCREASE PT SCREENING RATES	24		IDENTIFY DEVELOPMENTAL DELAYS
9		INCREASE PT IMMUNIZATION RATES	25		DEVELOP CARE PLANS FOR DIABETES & ASTHMA
10		IDENTIFY POPULATIONS TO FOCUS ON	26		KEEP RECORDS OF OTHER PROVIDERS
11		IMPROVE/INCREASE ETOH SCREENINGS	27		DEVELOP PT Rx MONITORING
12		INCREASE DEPRESSION SCREENINGS	28		UPDATE INTAKE FORM RE: SOCIAL DETERMINANTS OF HEALTH
13		COLLABORATE WITH REGIONAL COLLABORATIVE & MEDICAL NEIGHBORHOOD			
14		ESTABLISH/ENHANCE CARE COORDINATION MANAGEMENT			
15		IMPLEMENT CHW PROGRAM			

POPULATION MANAGEMENT: KM STANDARD 3 PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NO PLAN LISTED	19		REVIEW STANDING ORDERS
1		DEVELOP BETTER REPORTS	20		REVIEW PATIENT ALLERGY LISTS
2		COLLECT DEMOGRAPHIC INFO	21		REVIEW PATIENT DIAGNOSIS LISTS
3		NOTIFY PATIENTS OF FOLLOW-UP/ROUTINE CARE	22		DEFINE PREVENTATIVE MEASURES
4		DEVELOP DOCUMENTED PROCESSES	23		DEFINE CHRONIC/ACUTE MEASURES
5		DEVELOP MENTAL/BEHAVIORAL HEALTH SCREENING PROCESSES	24		DEFINE IMMUNIZATION MEASURES
6		UPDATE PT INFO SHEET TO INCLUDE SOCIAL/CULTURAL INFO	25		CREATE CHECKLISTS
7		IMPROVE FOLLOW-UP ON ROUTINE MEDICAL SCREENINGS	26		REVIEW/IMPROVE EXISTING PROCESSES
8		USE DATA REPORTS WITH QI/QA COMMITTEE	27		IMPLEMENT ASQ SCREENING PROCESS
9		IDENTIFY PATIENTS	28		IMPLEMENT ASTHMA CARE PLAN
10		PURCHASE NEW SOFTWARE FOR EHR	29		IMPLEMENT DIABETIC CARE PLAN IN EHR
11		ASSESS HEALTH LITERACY	30		BUILD REGISTRY WITH EMERGENCY DEPT.
12		ASSESS BEHAVIORS AFFECTING HEALTH	31		DEFINE/DEVELOP/IMPLEMENT TEXT SEARCHABLE CAPABILITY IN EHR
13		DEVELOP POLICIES	32		IMPLEMENT COMPREHENSIVE HEALTH ASSESSMT
14		TRAIN STAFF RE: NEW WORKFLOWS	33		REVIEW ADVANCED DIRECTIVES PROCESS
15		INCREASE COMMUNITY OUTREACH	34		Rx RECONCILIATION
16		CREATE RECALL TICKET POLICY	35		INTEGRATE ORAL HEALTH EDUCATION
17		GENERATE/ANALYZE REPORTS			
18		DEVELOP/IMPLEMENT PDSA			

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CARE MANAGEMENT & SUPPORT: CM STANDARD 4 GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE	18		MONITOR PT POPULATION
1		DEVELOP REPORTS RE Rx	19		REDUCE ER UTILIZATION &/OR HOSP READMITS
2		ASSESS PT UNDERSTANDING OF Rx'S	20		IMPLEMENT/IMPROVE EHR
3		ASSESS PT FOR BARRIERS TO Rx ADHERANCE	21		REVIEW/RECONCILE Rx's
4		ASSESS PT RESPONSE TO Rx'S	22		REVIEW MED MANAGEMENT EFFECTIVENESS
5		IMPROVE REFERRAL TRACKING	23		REVIEW/REVISE CARE PLANNING PROCESS(es)
6		DEVELOP CARE PLAN PROCESS FOR DIABETIC PATIENTS	24		DEVELOP SELF-MANAGEMENT TOOL
7		DEVELOP CARE PLAN PROCESS FOR DEPRESSION PATIENTS	25		DEVELOP CARE MANAGEMENT MODEL
8		DEVELOP POLICY & PROCEDURES	26		ESTABLISH RELATIONSHIP w/UNIFIED HEALTHCARE OF IDAHO
9		DEFINE CRITERIA OF ELIGIBILITY OF CARE MGMT PATIENTS	27		DEVELOP REFERRAL PROCESS FOR BEHAVIORAL HEALTH
10		IDENTIFY PATIENTS	28		IMPLEMENT HIGH RISK REGISTRY
11		REFINE WORKFLOW	29		IDENTIFY ASTHMATIC PATIENTS
12		REPURPOSE CURRENT STAFF ROLES	30		ENGAGE ASTHMATIC PATIENTS IN SELF-MANAGEMENT
13		CONTINUE TO REFINE CURRENT PRACTICES	31		TRAINING
14		PT. NEEDS/BARRIERS IN EHR CARE PLAN NOTES	32		DEVELOP/IMPLEMENT CARE PLANS
15		IMPLEMENT CASE MANAGER POSITION	33		INCREASE USE & KNOWLEDGE OF COMPREHENSIVE SELF-CARE SUPPORT & COMMUNITY RESOURCES
16		IMPROVE PT PHONE CALL REMINDER SYSTEM	34		
17		EXPAND CASE MANAGEMENT & SUPPORT SVCS	35		

CARE MANAGEMENT & SUPPORT: CM STANDARD 4 PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NO PLAN LISTED	18		DEVELOP CARE COORDINATION MGMT PROCESS
1		DEVELOP BETTER REPORTS	19		STAFF TRAINING
2		INCLUDE PHARMACY SPECIALIST	20		CREATE STANDING ORDERS RE: WELLNESS
3		DEVELOP CARE PLAN PROCESS TRAININGS	21		IMPLEMENT BEHAVIORAL HEALTH SCREENINGS
4		IMPLEMENT DMAIC PROCESS (DEFINE, MEASURE, ANALYZE, IMPROVE, CONTROL)	22		REVIEW/RECONCILE Rx's
5		DEVELOP PROCESS FROM EHR MANUAL	23		DEVELOP PATIENT TOOL FOR RECORDING BLOOD SUGAR
6		DEVELOP CARE PLAN PROCESS TO INCLUDE PATIENT/FAMILY COLLABORATION	24		DEVELOP PATIENT TOOL FOR RECORDING BP
7		ENHANCE CARE COORDINATION TO INCLUDE ALL PAYER TYPES	25		IMPROVE UTILIZATION OF EHR
8		INCREASE # PT's W/ADVANCED CARE PLANS	26		UTILIZE CARE MANAGEMENT SOFTWARE
9		UNDERSTAND/TRAIN RE: REGISTRY USE	27		STANDARDIZE & DOCUMENT ACTION PLANS
10		IMPROVE EHR CAPABILITIES	28		DEVELOP PT FUNCTIONAL LIFESTYLE GOALS
11		DEVELOP RISK STRATIFICATION PROCESS	29		DEVELOP CARE PLANS FOR MENTAL HEALTH
12		FURTHER DEVELOP MENTAL HEALTH POP MGMT	30		DEVELOP CARE PLANS FOR DIABETIC PTs
13		HIRE CARE MGR/COORDINATORS	31		ASSESS Rx ADHERANCE BARRIERS
14		MONITOR HIGH Rx UTILIZATION PATIENTS	32		IDENTIFY PATIENTS THAT COULD BENEFIT FROM CARE COORDINATION EFFORTS
15		IMPLEMENT PDSA	33		DEVELOP NUTRITION EDUCATION
16		START CARE PLANNING & SELF-CARE SUPPORT	34		DEVELOP BEHAVIORAL EDUCATION STRATEGIES
17		IDENTIFY PATIENTS ADMITTED TO HOSPITAL			

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CARE COORDINATION & TRANSITION: CC STANDARD 5 GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NOT ANSWERED/NOT APPLICABLE	16		ASK PT's ABOUT SELF-REFERRALS
1		FORMAL &/OR INFORMAL MOU W/SPECIALISTS	17		COORDINATION OF CARE TRANSITIONS
2		DEVELOP REPORTS	18		IMPLEMENT DIRECT MESSAGING IN REFERRAL PROCESS
3		IMPROVE REFERRAL TRACKING PROCESSES	19		COMPLETE CHAIN OF ORDERS
4		IMPROVE INFO EXCHANGE WITH 3RD PARTY	20		DEVELOP TRANSITION PLAN TO ADULT CARE
5		IMPROVE PT FOLLOW-UP PROCESS	21		REDUCE COSTS
6		DEVELOP POLICY/PROCESS	22		HIRE CARE COORDINATORS
7		IMPROVE COMMUNICATION W/HOSP & ER	23		COORDINATE CARE BETWEEN MEDICAL AND DENTAL
8		INTEGRATE BEHAVIORAL HEALTH			
9		IMPROVE DOCUMENTATION			
10		ESTABLISH CARE COORDINATION MGMT PROCESS			
11		UPDATE CONSENT FOR RELEASE OF MEDICAL INFORMATION			
12		IMPLEMENT/IMPROVE EHR			
13		IMPROVE DXL TRACKING			
14		ASSESS EFFECTIVENESS OF CARE COORDINATION			
15		TRAIN STAFF			

CARE COORDINATION & TRANSITION: CC STANDARD 5 PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	%	QTY	DESCRIPTION
0		NO PLAN LISTED	18		DEVELOP/IMPROVE WORKFLOWS
1		DEVELOP BETTER REPORTS	19		DEVELOP DOCUMENTED PROCESS
2		ESTABLISH/MAINTAIN NEW SPECIALISTS	20		DEFINE JOB DESCRIPTIONS
3		IMPROVE REFERRAL TRACKING	21		IMPLEMENT PT CARE COORDINATOR
4		FOLLOW-UP WITH PATIENT & FAMILIES	22		WORK w/IHDE
5		CONDUCT PDSA TO TRACK PT FOLLOW-UP	23		NEWBORN SCREENING FOLLOW-UP
6		TRANSFER REFERRAL TRACKING TO CENTRAL LOCATION	24		DEVELOP DIRECT MESSAGING
7		DESIGNATE/TRAIN REFERRAL COORDINATOR	25		INTEGRATE BHI
8		IMPROVE DXL TRACKING	26		UTILIZE PERFORMANCE INFO ON OTHER PROVIDERS
9		IMPLEMENT MOU's W/EXTERNAL PROVIDERS	27		IDENTIFY GAPS IN CARE
10		DEFINE TRACKING PROCESS/POLICY	28		IMPROVE MULTI-LINGUAL SIGNAGE/LITERATURE
11		TRIAL BHI WORKFLOW PROCESS	29		IMPLEMENT CHW's IN WORKFLOW
12		CONNECT IHDE	30		REVIEW/IMPLEMENT TOC FROM PED TO ADULT CARE
13		CREATE REFERRAL FORMS	31		IDENTIFY PATIENTS w/UNEXPECTED ED OR HOSP VISITS
14		STANDARDIZE REFERRAL DOCUMENTATION WITH SPECIALISTS	32		ENGAGE w/PATIENTS RE: COSTS OF CARE &/OR COSTS OF RX's
15		DEVELOP CARE COORDINATION PROCESS			
16		UPGRADE EHR CAPABILITIES			
17		STAFF TRAINING			

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PERFORMANCE & QI: STANDARD 6 GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NOT ANSWERED/NOT APPLICABLE	16		IMPLEMENT/IMPROVE EHR
1		IMPROVE IMMUNIZATION MEASURES	17		QUALITY IMPROVEMENTS ARE CONTINUOUS
2		IMPROVE PREVENTATIVE CARE MEASURES	18		ESTABLISH QI COMMITTEE
3		IMPROVE DIABETIC EXAM FOLLOW-UPS	19		DEVELOP POLICY/PROCESS
4		IDENTIFY MEASURES TO IMPROVE	20		IDENTIFY ROLES & RESPONSIBILITIES
5		IMPROVE DEPRESSION SCREENINGS	21		INVOLVE PATIENTS & FAMILIES
6		DOCUMENT FOLLOW-UP PLAN	22		KEEP UP TO DATE QI RECORDS
7		DEVELOP BETTER REPORTS	23		IMPROVE FLUORIDE VARNISH RATES
8		IMPLEMENT PDSA CYCLE	24		IMPROVE PATIENT SATISFACTION SURVEY
9		ANALYSIS OF PT & FAMILY EXPERIENCE SATISFACTION SURVEY	25		EMPOWER FRONT LINE STAFF TO SOLVE PROBLEMS
10		DEVELOP QI PROJECT TO ADDRESS NCQA PCMH STANDARDS	26		
11		DEFINE HOW TO MEASURE IMPROVEMENTS			
12		IMPROVE CARE COORDINATION MEASURES			
13		IMPROVE COMMUNICATION w/PATIENTS			
14		STANDARDIZE ROOMING PROCESS			
15		IMPROVE UTILIZATION OF PT PORTAL			

PERFORMANCE & QI: STANDARD 6 PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NO PLAN LISTED	16		DEVELOP POLICIES
1		DEVELOP BETTER REPORTS	17		QI FOCUSED ON CHRONIC CONDITIONS
2		ADDRESS MEASURES AFFECTING HEALTH CARE COSTS	18		CONTRACT WITH HEALTH ANALYTICS VENDOR
3		REVIEW/ANALYZE SPECIALIST REFERRALS	19		BUILD CALENDAR OF ACTIVITIES
4		REVIEW/ANALYZE Rx GENERIC vs BRAND	20		BUILD QI STANDARDS LIST FOR ENTIRE ORGANIZATION
5		EVALUATE PT SATISFACTION SURVEYS	21		IMPROVE PT. SATISFACTION SURVEY
6		IMPROVE CQM's	22		START USING CAHPS SURVEY
7		IDENTIFY DISPARITY OF CARE GAPS	23		ANALYSIS OF PT & FAMILY EXPERIENCE SATISFACTION SURVEY
8		INCREASE INTERNAL TRANSPARENCY	24		ASSESS PERFORMANCE CHANGES IN CLINIC STAFF AND CARE COORDINATION MGMNT
9		CREATE A FORMAL PLAN	25		SCRUB CHARTS FOR ACCURACY OF INFO
10		DESIGNATE STAFF TO BE RESPONSIBLE FOR QI PLAN	26		DEVELOP HEALTH LITERACY ACTION PLAN
11		HOLD REGULAR CQI MEETINGS	27		"CALL US FIRST" CAMPAIGN
12		IMPROVE PATIENT COMMUNICATION PROCESS			
13		IMPLEMENT PDSA TO INCREASE SCREENING RATES			
14		CREATE STANDARDIZED PROCESS(ES)			
15		STAFF EDUCATION/TRAINING			

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HIT GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NOT ANSWERED/NOT APPLICABLE	5		IMPLEMENT NEW EHR
1		IMPROVE COMMUNICATION WITH ER	6		CONNECT BIDIRECTIONALLY WITH IHDE
2		IMPROVE COMMUNICATION WITH HOSPITALS	7		CONNECT WITH IRIS
3		IMPLEMENT NEW EHR FEATURES	8		UTILIZE EHR TO FULL POTENTIAL
4		IDENTIFY NEW HIT PROCESS IMPRVMNTS	9		

HIT PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION	10		
0		NO PLAN LISTED			
1		DEVELOP BETTER REPORTS	11		
2		WORK WITH VENDOR	12		
3		ALIGN CQM's TO MEET REPORTING SPEC's IN NEW EHR.	13		
4		CONNECT TO IHDE	14		
5		STAFF TRAINING	15		
6		SELECT NEW/IMPROVED EHR			
7		VENDOR PROVIDED AUDIT			
8		IMPLEMENT EHR IMPROVEMENTS			
9					

BH INTEGRATION GOALS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NOT ANSWERED/NOT APPLICABLE	10		DIABETES EDUCATION
1		DEVELOP INTERDISCIPLINARY WORK GRP	11		INTEGRATE UNIFIED HEALTHCARE OF IDAHO
2		OUTLINE STRATEGIC BHI MODEL	12		DEVELOP SUSTAINABILITY
3		OUTLINE BHI METRICS	13		STREAMLINE BEHAVIORAL HEALTH BILLING
4		IMPLEMENT F-T BHI PROFESSIONAL	14		DEVELOP MENTAL HEALTH REGISTRY
5		EXPAND BHI TO PT w/CHRONIC DISEASE	15		MAINTAIN WEEKLY CONTRACT BETWEEN PT & CARE MANAGERS
6		BHI AT ALL WELLNESS EXAMS	16		IMPLEMENT AIMS MODEL (Adv Integ MH Svcs)
7		INCREASE PT. OPTIONS FOR B-HEALTH	17		
8		DEVELOP PLAN FOR BHI	18		
9		IMPLEMENT GATE (GIVING ACCESS TO EVERYONE) ESTABLISHED BY Univ of UTAH	19		

BH INTEGRATION PLANS IDENTIFIED BY CLINIC: (check all that apply)

%	QTY	DESCRIPTION			
0		NO PLAN LISTED	10		EDUCATE PATIENTS (info related to treatment)
1		DEVELOP BETTER REPORTS	11		CONDUCT REGULAR MEETINGS w/STAFF
2		ASSESS BASELINE PROCESS OF BHI IN AMBULATORY CARE	12		COORDINATE w/OTHER PRACTICES
3		REVIEW BHI WORKFLOW	13		IDENTIFY TOP 3 DX's
4		HIRE BHI PROFESSIONAL	14		COLLABORATE FOR MEDICATION MANAGEMENT
5		IMPLEMENT PDSA CYCLE	15		MAINTAIN CONSULT CONTRACT w/PSYCHIATRIST
6		TRAINING	16		
7		DEVELOP BHI PLAN	17		
8		BHI EXPANSION OPTIONS	18		
9		INCREASE PT ACCESS TO BH SPECIALISTS	19		

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PCMH SUCCESSES MENTIONED IN PORTAL NOTES BY CLINIC OR OTHER PARTICIPANTS: (check all that apply)

%	QTY	DESCRIPTION			
0		NO SUCCESSES LISTED	31		UPDATED & DISBURSED PATIENT HANDOUT
1		TRAINING	32		COMPILED QI ACTIVITIES CALENDAR
2		POP HEALTH MNGMNT STRATEGY	33		ASQ IMPROVEMENT PROJECT
3		DIABETIC DAY	34		IMPROVED FLUORIDE VARNISH RATES
4		END OF LIFE CARE IMPROVEMENTS	35		MEDICAL HEALTH NEIGHBORHOOD
5		NEW CLINIC SITES	36		IMPLEMENTED i2i
6		NEW HIRES	37		SECURED PARTNERSHIP w/ST. LUKES TO GET NOTIFICATION OF DISCHARGES
7		GRANT FUNDING RE: COLORECTAL SCREENING	38		SUPERVISITS FOR MEDICARE PT's w/CCM & HCC WRAP (45 min G-CODE)
8		PCMH ORIENTATION W/NEW EMPLOYEES	39		TELEHEALTH EQUIPMENT IN PLACE
9		COMPLETE POLICY & PROCEDURES	40		IMPROVED HUDDLE PROCESS/CULTURE
10		EHR CONVERSION COMPLETED	41		STANDARDIZED PROCESSES
11		WILLINGNESS OF STAFF TO MAKE CHANGES	42		IMPROVED INFORMATION LOADED INTO PORTAL
12		"CLOSE THE LOOP" IMPLEMENTED	43		MINI-RETREATS SUCCESSFUL & HELPFUL
13		REDISTRIBUTION OF TASKS	44		PCMH COMMITTEE
14		INTEGRATION OF PHARM-D ON CARE TEAM	45		STRONG MEDICAL HEALTH NEIGHBORHOOD RELATIONSHIPS
15		IMPROVEMENTS TO EHR	46		PEER TO PEER CONNECTIONS
16		BEHAVIORAL HEALTH INTEGRATION	47		INCREASED PT EDUCATION AND USE OF PT PORTAL
17		INCREASED SCREENING FOCUS IN EHR	48		IMPROVED UTILIZATION OF SHIP PORTAL DOCUMENTATION OF PROCESSES
18		LONG-TERM PCMH EXPERIENCE	49		CLINIC RENOVATION
19		POSITIVE PATIENT SATISFACTION FEEDBACK	50		DENTAL INTEGRATION
20		PCMH CERTIFICATION	51		IMPROVED COMMUNICATION ACROSS PROVIDERS
21		STANDARDIZED PROCESS/POLICY ACROSS SITES	52		DEVELOPED HIV RISK ASSESSMENT TOOL
22		QUALITY IMPROVEMENTS	53		DIETICIAN
23		DEVELOPED RISK STRATIFICATION PROCESS FOR EHR	54		DISCOVERY OF NO-SHOW RATES & REASONS
24		UPDATED SOFTWARE FOR CASE MGMNT	55		EMPLOYEE SATISFACTION SURVEYS
25		SATURDAY WALK-IN CLINIC ACCESS	56		PCMH CONTENT EXPERTS ON STAFF
26		IMPLEMENT CHRONIC CARE MNGMNT PROGRAM	57		SUICIDE PREVENTION TOOLKIT BOOKS
27		IDENTIFIED PT's FOR CCM PROGRAM	58		DOMESTIC VIOLENCE MATERIALS
28		ROBUST DIABETES EDUCATION PROGRAM	59		IDENTIFY/IMPLEMENT PDSA/PROGRAM TO DECREASE PAIN MGMNT/OPIATE USERS
29		DIRECT MESSAGING FROM EHR (w/IN ORG & w/HOSP)	60		CONNECTED WITH IHDE
30		ELECTRONIC SUMMARIES OF CARE	61		GRANT FUNDING: DIABETIC CARE

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PCMH BARRIERS MENTIONED IN PORTAL NOTES BY CLINIC OR OTHER PARTICIPANTS: (check all that apply)

%	QTY	DESCRIPTION			
0		NO BARRIERS LISTED	33		PARENT BUY IN
1		EMPLOYEE TURNOVER	34		STAFF PROFICIENCY WITH EHR
2		RURAL AREA	35		TRANSITION FROM ONE EHR TO ANOTHER
3		BEING PULLED IN MANY DIRECTIONS	36		NEED FOR POPULATION HEALTH TOOLS
4		EHR CAPABILITY	37		LARGER EMPANELED POPULATION
5		IMPLEMENT/MAINTAIN COORD CARE	38		WORK CENTRALLY/UNCLEAR OF SITE KNOWLEDGE
6		SCOPE OF LICENSURE	39		BEHAVIORAL HEALTH BILLING
7		REFERRAL PROCESSES	40		LIMITED ACCESS TO BEHAVIORAL HEALTH
8		STANDARDIZATION OF WORKFLOW ACROSS MULTIPLE SITES	41		NEED SPANISH SPEAKING CARE MANAGER
9		TRANSITION OF PHYSICIAN CHAMPION(S)	42		TRANSIENT POPULATION
10		PROVIDER ENGAGEMENT WITH PCMH MODEL	43		GETTING PATIENTS TO CALL PCP BEFORE GOING TO EMERGENCY ROOM
11		IMPLEMENTING DEPRESSION SCREENINGS	44		NOT MANY AREA RESOURCES FOR ASTHMA
12		DEMONSTRATE VALUE OF USING SCREENING TOOLS	45		PAYMENT
13		TRAINING NEW EMPLOYEES	46		CORPORATE MERGER
14		DEVELOP FIELD FOR OCCUPATION IN EHR	47		PORTAL TRAFFIC/USAGE
15		CONNECTING WITH IRIS (IMMUNIZATIONS)	48		CARE PLANS w/OUT ADEQUATE TOOLS
16		REPURPOSE CURRENT STAFF ROLES	49		LOCAL CLINIC CLOSURE CREATING INCREASED PATIENTS TO MANAGE CARE FOR
17		STRATEGY TO WORK WTH LARGER SYSTEM	50		EMPANELMENT
18		IMPLEMENTING NEW POSITIONS	51		AFTER HOURS ACCESS WHEN ONLY OPEN 4 HALF DAYS PER WEEK
19		BEHAVIORAL HEALTH INTEGRATION	52		PROVIDERS ROTATE A LOT DUE TO NATURE OF CLINIC.
20		TRANSITION FROM 2011 TO 2014 PCMH STANDARDS	53		CARE COORDINATION PERFORMED OUTSIDE CLINIC
21		CHALLENGES WITH HUDDLES	54		ORGANIZATIONAL RESTRUCTURE
22		QUALITY OF DOCUMENTATION	55		TRANSITION FROM HEALTHY CONNECTIONS TO VALUE CONNECTIONS SHARING SAVINGS WITH STATE.
23		BREAKDOWN OF COMMUNICATION INTERNALLY	56		UPDATING SHIP TRANSFORMATION PORTAL.
24		STAFF PAY FOR ADDED RESPONSIBILITY	57		INSURANCE COVERAGE FOR SERVICES
25		CLOSE REFERRAL LOOPS.	58		PTS TRAVEL LONG DISTANCE FOR SPECIALTY SVCS
26		SPACE FOR STAFF/PROVIDERS	59		NOT ENOUGH FUNDING
27		BILLING FOR SERVICES WHEN NOT FQHC	60		PATIENT EDUCATION RE: PCMH
28		FRONT OFFICE ADVANCED APPT SCHEDULING PROCESS	61		CARE MANAGERS “TAPPED OUT”
29		HYSTERECTOMY DOCUMENTATION PROCESS	62		LANGUAGE BARRIER
30		OVERALL WORKFLOW PROCESSES			
31		PATIENTS NOT RETURNING DOCUMENTS			
32		INACCURATE REPORTS/DATA IN EHR			

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OTHER AREAS OF INTEREST OR CONCERN MENTIONED IN PORTAL NOTES BY CLINIC OR OTHER PARTICIPANTS: (check all that apply)

%	QTY	DESCRIPTION			
0		NO OTHER AREAS OF INTEREST OR CONCERN LISTED	49		DVLPMNT/BILLING CARE MNGMNT PRGRM
1		CHW SCOPE OF PRACTICE	50		COMMUNICATION GAPS W/UPPER LEVEL LEADERSHIP
2		CHW CHART NOTES IN EHR	51		STAFF/PROVIDER ENGAGEMENT
3		BILLING FOR CHW WORK	52		EHR TRAINING
4		TRAINING	53		BILLING GROUP VISITS
5		NCQA CERTIFICATION	54		LACK OF STAFF TO APPROPRIATELY OVERSEE QI ACTIVITIES
6		NCQA RE-CERTIFICATION	55		HOW TO IMPLEMENT CHW PROGRAM
7		TOO MANY TARGETS TO HIT	56		SATISFY SHIP REQUIREMENTS
8		MARKETING &/OR MESSAGING TO PATIENTS	57		TRANSLATING DOCUMENTS TO OTHER LANGUAGE
9		DOUBLE DOCUMENTATION IN EHRS	58		IMPLEMENTATION SOCIAL DETERMINANTS IN EXAM
10		HRSA GRANT ELIGIBILITY	59		ASKING PT's TOUGH ??'s ABOUT JOB, ABUSE, HOMELESSNESS, SUBSTANCE, ETC.
11		HANDLING GRIEVANCES	60		TRANSFORMATION PLANS FOR MULTIPLE SHIP COHORT SITES
12		SCOPE OF VOLUNTEERS WITH CLINIC INFO	61		CHRONIC PAIN MGMNT TOOLS
13		IMPLEMENTING COMMUNITY NEEDS ASSESSMENT REPORT FINDINGS TO IMPROVE CARE	62		DOMESTIC VIOLENCE/SEX ASSAULT SCREENING TOOLS
14		POPULATION HEALTH MNGMNT	63		VALUE BASED PYMNT MODELS
15		SHARE TRANSFORMATION PLAN WITH EMPLOYEES	64		CARE MANAGEMENT
16		DOCUMENTATION OF REFERRAL PROCESSES	65		CLOSING REFERRAL LOOP PROCESS(ES)
17		PFAC (PATIENT & FAMILY ADVISORY COUNCIL) INFORMATION	66		STAFF BURNOUT / CHANGE FATIGUE
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OTHER NOTES:

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Portal Use Statistics

- 166 clinics from 74 clinic organizations (53-56 clinics per cohort), within 7 PHDs
- 69 events with 2,663 participants
- 10,075 Transformation Plan entries were created throughout all sections of the transformation plans, averaging 61 per clinic, and 5 per clinic per month
    - 1,079 Goals with 1,195 Plans for Change
    - 1,137 Progress entries
    - 1,412 Coaching Calls and Sessions with 2,547 attendees
    - 2,705 Notes
- 375 resources organized into one or more of 46 categories

PCMH Webinar Title	Attendees
SHIP Cohort 1	
Webinar: SHIP PCMH Transformation Group Coaching	72
Cohort Webinar # 1 - SHIP PCMH Transformation	102
Cohort Webinar: SHIP PCMH Portal and Transformation Plan Demo - Walkthrough	54
Cohort Webinar # 2: Population Health Tools	67
Cohort Webinar # 3: Integrating Behavioral Health and Primary Care	51
Cohort Webinar # 4 - Telehealth	67
Cohort Webinar # 5: Chronic Care Management	61
SHIP Cohort 2	
SHIP Cohort 2 Kick-Off	99
Cohort 2 SHIP Budget Template	47
Cohort Webinar #1 - 2017 NCQA PCMH Redesign - Mapping the Changes from 2014	59
PHD SHIP QI staff Webinar #1	11
Cohort Webinar #2 - Change Management	66
PHD SHIP QI staff Webinar #2 - 2017 NCQA PCMH Redesign	12
PHD SHIP QI staff Webinar #3 - Provider Engagement in PCMH Transformation	10
PHD SHIP QI Staff Mentorship Call	14
Cohort Webinar #3 - Care Transitions and Coordination Follow-up	58
Mentorship Kick-off Webinar	54

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PCMH Webinar Title	Attendees
Mentorship Webinar - Using Community Health Workers (CHWs) in the Patient Centered Medical Home Model	47
Cohort Webinar #4 - Oral Health Strategies	46
Behavioral Health Integration in a Community Health Center's Patient Centered Medical Home Model	38
Behavioral Health Integration in a Patient Centered Medical Home Model (Focus on Non-FQHC Clinics)	38
PCMH Mentorship Webinar Series: Strategies for PCMH Culture Change	37
Cohort Webinar #5 - Chronic Care Management	51
PCMH Mentorship Webinar Series: Strategies for Care Management	43
Cohort Webinar #6 - The Relationship-Centered Medical Home_ Building Relationships to Build a Better Home	39
PCMH Mentorship Webinar Series: Strategies for Care Management - Part 2	31
SHIP Cohort 3	
SHIP Cohort 3 Kickoff	77
Cohort Webinar #1 – 2017 National Committee on Quality Assurance (NCQA) PCMH Standards	49
PHD SHIP QI Portal Walk Through	14
PCMH Mentorship Webinar Series - An In-depth Look at the Enhanced SHIP PCMH Transformation Portal Features	58
Cohort Webinar #2 - Change Management	65
PCMH Mentorship Webinar Series - Where to Begin - Getting Started on NCQA Standards - Tips and Approaches	47
Cohort Webinar #3 - Care Coordination	59
PCMH Mentorship Webinar Series - Surviving the New NCQA 2017 Recognition Process - The Calls and Q-Pass	39
Cohort Webinar #4 - Moving to Sustainability - Patient and Provider Engagement	71
PCMH Mentorship Webinar Series - Oral Health Integration and the Patient Centered Medical Home	44
PCMH Mentorship Webinar Series - 5210 Childhood Wellness Initiative	38
Cohort Webinar #5 - Patient Centered Access, Continuity and Empanelment	61
Effectively Leading Change Workshop - Virtual Follow-Up Meeting	7
Effectively Leading Change Workshop - Virtual Follow-Up Meeting	8
PCMH Mentorship Webinar Series - Patient Engagement and the PCMH	35
Cohort Webinar #6 - Sustaining PCMH: Leveraging Knowledge, Quality Improvement, and Value-Based Payments	73
SHIP All Cohort Close Out Webinar	41

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As the cohort years progressed and more clinics engaged with the PCMH transformation efforts and the project gained momentum, the support and coaching to the clinics helped increased PCMH transformation.

As part of the SHIP Mentorship Framework, the PCMH Team developed and conducted a series of Mentorship Webinars for all SHIP clinics, regardless of cohort year. This model allowed clinics to learn from their peers.

A keystone event of the final year of the contract was the PCMH Learning Collaborative in which the Team successfully coordinated and provided robust speakers and content, which included engagement by clinics with their PCMH transformation experts, a multi-payer panel, discussions on electronic health records (EHR), healthcare quality improvement, a presentation from NCQA, and targeted breakout sessions with clinics. Each year the PCMH Learning Collaboratives were better received and evaluated by clinics, showing the Team's value and acuity to deliver useful materials in an engaging manner to the clinics.

The topic of Mentorship also gained significant traction during Cohort 2 and Cohort 3 with a dedicated learning tract for a series of Mentorship webinars. This venue allowed specific competencies in PCMH transformation to be shared with clinics in a way that allowed the clinics to meaningfully gain from and use that real-world experience to advance their clinic's PCMH transformation.

Portal Transition

Looking forward to continuing use of the project information for ongoing support of PCMH transformation, the following actions are included in the transition plan for the portal's content:

- BSU will receive a copy of the educational Toolkits and the Resource Library documents and associated meta-data that are not private to specific clinics.
- The Department will receive flat files from the portal.
- The Department will receive Transformation Plan documents for each clinic that are generated from the portal's online transformation plans.
- The Department will receive Transformation Roadmap documents that have been uploaded as a component of transformation plans.

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PCMH Sustainability Best Practices Toolkit link

http://pcmhsustainability.oso-sandbox.com/index.html

NCQA PCMH Webinar Series for SHIP Clinic Teams		
Webinar Title	Date conducted	No. Attendees
Using the PCMH Model to Overcome Idaho's Rural Health Challenges (Part I)	1/4/2019	25
Using the PCMH Model to Overcome Idaho's Rural Health Challenges (Part II)	1/9/2019	32
An Inside Look at PCMH Annual Reporting Requirements	1/15/2019	43
Live Q-Pass Demonstration	1/22/2019	28
Preparing for NCQA's Virtual Review	1/29/2019	18
"Ask the Expert" Q&A Session	1/30/2019	18
	Average No. attendees	27.333

Final Progress Report

Goals 2 & 5

Prepared for
CMMI

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

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GOAL 2 & GOAL 5 SUMMARY:

Goals 2 and 5 of the Statewide Healthcare Innovation Plan (SHIP) grant focused on the health information technology (HIT) and health information exchange (HIE) aspects of Idaho's healthcare delivery system transformation. The major objectives in this area were to build bi-directional clinic connections to the Idaho Health Data Exchange (IHDE) and produce statewide data analytic reporting on select clinical quality measures (CQMs).

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

Idaho's SIM project included establishing Primary Care Medical Homes (PCMH) through practice transformation and coaching. The clinics' progress and performance was proposed to be measured for continuous rapid cycle feedback, performance measurement, and transformation plan evaluation. To do this, it was critical to use a data analytics vendor who could use the state's data sources, make clear and reliable measurements, and then transparently report the measurements to the state and stakeholders.

HealthTech Solutions (HTS) was the data analytics vendor hired to handle the initial quality measurement assessment for providers and clinics. This was one piece of a much larger effort to transform rural health in Idaho. HTS was narrowly focused on a three-year project to take data from providers and measure the quality of care that was provided.

Idaho's SHIP initiative relied heavily on health IT in several ways. First, in order to extract clinical measurements, provider practices and clinics should have an electronic medical record (EMR). Furthermore, the state required data ingestion, cleansing, analysis, and reporting in order to inform and change performance. It was critical to electronically connect the clinics to the HIE in order to exchange data for improved care coordination, benchmark and compare measurement results, and provider performance improvement.

TECHNICAL ASSISTANCE ACCESSED DURING SHIP

History of SHIP Center for Medicare and Medicaid Innovation Cases – Goals 2 & 5					
Case Number	**Type**	**Description**	**Priority**	**Date**	**Resolution**
00483005	HIT Resource Center	HIT workgroup was between project and was seeking to increase member awareness and knowledge of the ONC guidelines on data connectivity nationally. The Office of the National Coordinator (ONC) has a 10-year infographic and presentation that was provided to the SIM state participants. The Goal of this request was to increase understanding by the HIT workgroup member of the national practice and plans for health information technology and connectivity. A webinar or in-person ONC presentation of the roadmap was requested.	High	8/19/2015	In-person presentation by ONC completed. Case closed
00483054	HIT Resource Center	The HIT workgroup requested to link up to Oklahoma's health data exchange for an in-person consultation session. At the time, OK was the only state that had a public/private hybrid that appeared to align with the product Idaho wanted to produce. The workgroup additionally requested to consult with the ONC to see a case example to engage with and discuss operationalization issues.	High	8/24/2015	Presentation by OK completed 10/5/15
00485744	HIT Resource Center	Idaho state requested a consult with ONC and other participants to learn more about resources to assist data exchanges in organizational reviews. Specifically, companies and individual that had direct experience in the state-based exchange world and the satisfaction the customers received from their services.	Medium	2/17/2016	Information was provided to the state. Case closed
00494818	HIT Resource Center	Idaho requested assistance with developing a data quality and	High	9/29/2016	Site visit completed.

		governance group to advise the project and provide feedback on project milestones. The assistance included a site visit by ONC staff to work with Idaho stakeholder team to advance implementation of the SIM and state HIT plan. Included in the assistance requested was a site visit by at least one ONC staff members to work with HIT stakeholders in an information sharing and facilitation capacity.			Case closed
00510627	Metrics & Reporting	Idaho requested assistance with NQF 0421 operationalization. Idaho had several CCD non-billable encounters creating data gaps and it was not clear from the guidance how to adjust the algorithm.	High	8/15/2017	Case closed
00513971	HIT Resource Center	SHIP and Medicaid were in need of strategic planning support as the state continued to struggle to operational clinic eCQMs. IHDE elected to change to a new SaS platform to provide an opportunity to re-evaluate deadlines and strategies for success. Goals were outlined as an opportunity to meet with Craig Jones and David Kendrick to provide both SHIP and Medicaid the opportunity to openly discuss the specific activities taking place and how to reconcile those with the state HIT plan.	Medium	10/31/2017	Case closed
00516433	HIT Resource Center	ONC on-site Technical Assistance (TA) request	High	12/26/2017	Case closed with SME interview
00518437	HIT Resource Center	SHIP was in need of assistance to support their data quality improvement effort. The State Innovation Model (SIM) team patterned its data quality improvement efforts off the Vermont and Colorado models, which were highlighted in an ONC webinar in 2017. The Idaho data quality effort primarily focused at ensuring data accuracy at the state aggregated level, as opposed to the data quality at a clinic's EMR report level. The Idaho team encountered several EMR barriers that were significantly skewed the state eCM analytic reports and prevented Idaho from producing	Medium	2/8/2018	Case closed

		meaningful and actionable reports for clinics, regional collaboratives, or state employees. In addition, they experienced a few other nuanced issues related to how HTS extracted data from the patient CCD files.			
0051993	HIT Resource Center	TA request in collaboration with IDHW and IHDE team members to engaged in reviewing and revising the platform transition plan to strategically guide and accelerate the IHDE transformation, thus supporting the state' interoperability and health IT objectives. Objectives were to establish a more defined IHDE platform transition plan for the intent of accelerating the speed of transition and leveraging lessons learned. Establish a more defined plan for data completeness and data quality.	Medium	3/13/2018	ONC participated in HIE immersion visit in preparation for CMMI site visit
00530099	HIT Resource Center	The Idaho SHIP team requested continued expertise and assistance from the ONC resource center related to a sustainable, on-going HIT strategy, particularly as it relates to the IHDE. In addition, the SHIP team requested to learn more from the ONC team about its coordinated effort with the National Committee for Quality Assurance (NCQA), particularly as it relates to our future efforts to engage with rural clinics. Idaho requested to have the availability to the ONC resource center team for these discussions, and the availability for an on-site visit.	High	12/17/2018	?

IDAHO HEALTH DATA EXCHANGE EVALUATION AND ASSESSMENT (GOAL 2)

A. IHDE Customer Satisfaction and Use Report – 2017

In the Fall of 2017, IHDE authorized a mixed-methodology study to assess the attitudes, use, and needs of Idaho residents utilizing the IHDE for sharing of patient medical records across a tri-state area of Idaho, Eastern Washing, and Eastern Oregon. This assessment was conducted by DMS Marketing Inc.

As a mixed-method study, the quantitative sample was broad in nature and was not scoped to gain a specific census of any type of user; just users in general. In addition, only small sample of users participated in the quantitative portion of the study with the aim of understanding general user sentiment, use, and feedback.

Therefore, the summary of findings, as well as the general report, should be viewed in light of this approach. Results provided a good overview of a general Idaho user's perspective of general functionality and opinions of the IHDE but didn't reflect specific or calculable results that could be applied to specific user types or census. In addition, through the quantitative study of 12 self-selected individuals, it was shown that individual user types and uses were more varied than anticipated. Thus, feedback analysis was elevated to a higher level of commonality.

Over 4,000 individuals across all seven health districts, providers, clinics, and hospitals were invited to participate. Based on a user population, 264 individuals completed the online survey. In addition, 12 individuals were then interviewed by telephone to provide greater insight.

A mixed method quantitative and qualitative study was conducted by DMS Marketing, Inc. to assess the attitudes, use and needs of a cross section of individual user types utilizing the system that included clinicians, nurses, nurse practitioners, doctors, medical directors, hospitals and clinics across the state of Idaho.

The quantitative portion of this study was conducted utilizing an online survey platform. A total of three emails were distributed by the IHDE to its user base, inviting them to partake in this survey. The quantitative study was fielded on November 13, 2017 and made available for response until closing on Sunday November 26, 2017.

The quantitative study consisted of 24 closed and open-ended questions focusing on user satisfaction, familiarity of system features, use, value and improvement recommendations. Additionally, responders were asked if they would be interested in participating in a post-survey in-depth interview. The qualitative portion of this study was conducted from November 27th to December 21st, 2017 through individual, telephonic interviews.

> **Finding #1** –Users of the system were more than satisfied with the performance and features of the system and would recommend the system to a co-worker or colleague and found the system useful and beneficial.

Finding #2 – Data availability and printing functionality were top concerns. The biggest complaints about the IHDE centered around the need for more availability of patient data from additional organizations or entities in the system. Specifically, several responders wanted the ability to "select all" and deselect items not needed when printing instead of having to select each item. Additionally, responders desired the ability to have results printed together instead of different pages.

Finding #3 – Though the system seems to be easy to learn, responders seemed to desire more information about features, wanted to be informed when system features were updated and needed more training. Responders found IHDE customer service to be informative, responsive and available.

Finding #4 – As for secondary system functionality improvements, responders echoed a need for increased speed with EMRs. 90% of respondents said that they felt the IHDE provided results in a timely manner.

Finding #5 – Most of the respondents trust the IHDE, found that the value the system provided to the organization was worth the cost, helped the organization improve the safety of patient data, improved patient outcomes, improved the quality and speed of patient care, and improved workflow efficiency and processes. Most of the respondents provided productivity improvement of greater than 20%.

Finding #6 – There is a significant use mix of the system by responders and, therefore, the need for features and functionalities within the system are varied. Within the Clinical Portal, the key essential and preferred functionalities were the same – access, results, and search/look up. The most unessential feature was Direct Messaging. In the interview process, it was found that certain items were not used or perceived to be essential because they were not essential to the individual's workflow or process. The most unused functions in order were Direct Messaging, Sending to EMR and Imagery Retrieval.

Finding #7 – As for specific functionalities and the top features responders were unfamiliar with, more than 60%, responding "Not familiar at all", included setting up notifications to receive information about important patient events, including where and when, adding or removing patients from worklists, creating continuity of care documents, and all functionalities around message, lab, and document sending.

Finding #8 – IHDE, compared to other software tools and applications, has a very favorable recommendation factor. Based on the use of a Net Promoter Score® (NPS®), where users were asked on a scale of 0 to 10 how likely they would be to recommend the system to a colleague or friend, almost 60% responded with a 9 or 10 and are deemed promoters and evangelists of the system. When the responder's responses who answered this question are rolled up into Workgroups, 51% of these responded with an average that was 9 or above. Although relationship building should be increased to any Workgroup whose average NPS® is less than 9 – most critical are those whose average is less than 7.

B. State Evaluator Clinic Interviews

SHIP state evaluator conducted clinic interviews in Regions 1, 2, 6, and 7 interested in clinics experience with IHDE. Cohort 1 interviews were conducted in Regions 1, 2, 6, and 7 during the fall of 2017. Cohort 2 clinic interviews were conducted in Regions 1, 6, and 7 in the spring of 2018. Cohort 2 clinic interviews in Region 2 will be conducted in the coming weeks. Included below is a synthesis of clinics responses

Cohort 1 Clinic Interviews (Fall 2017) – Clinic Responses

- The clinic recently accomplished a bi-directional connection with IHDE. This was the best part of SHIP and one of their best accomplishments over the last year. They are looking forward to utilizing it.
- The whole region has trouble with hospital follow-up after discharge.
- IHDE has helped them coordinate better with the medical health neighborhood. The provider can have the patient's information reviewed and pulled up before/during their clinic visit so the patient feels like the provider knows them.
- Clinic Admin expressed frustrations with IHDE. She said it was talked about in the beginning of SHIP, then everything got quiet. They didn't hear anything for a long time then all of a sudden it "pounced" back on them. Bi-directional connection happened in August. The entire system takes a lot of work. Still much fine-tuning to do.
- They were very frustrated with IHDE. Bi-directional connection was supposed to happen last year but they only became connected recently. IHDE took forever to prepare/communicate, then once they were ready on their end they became really pushy with the clinic and rushed them. This was frustrating for the Clinic Admin because she was ready for IHDE in the beginning of the year, when they were supposed to connect, but after a year had passed she became very busy with other priorities. Clinic Admin expressed that IHDE was harassing the clinic and the clinic had to hire a subcontractor just to deal with IHDE.
- The MHN includes everyone in the region: Public health districts (PHD), primary care physicians (PCPs), and specialists. They have a good relationship with the food bank, Agency on Aging, etc. They have a grant to collaborate with these groups and are having good experiences. Bi-directional connection with IHDE will help.

Cohort 2 Clinic Interviews (Spring 2018) – Clinic Responses

- They have connected with IHDE and LightBeam[1]. It has been exhausting but worth it. When everything works, it is amazing.
- The clinic currently has "viewing privileges" with IHDE. They are in the middle of building an interface with IHDE. The Clinic Manager expressed that the project is unpleasant. She explained that her interactions with the people on the project have been very pleasant, but it is just a very complicated project. They work with many different vendors and she describes their clinic's data interaction as "archaic." She said she has enough experience with health IT to "get in trouble" meaning she knows enough to fall

[1] A product used by the local health system in the area, not affiliated with IHDE

into holes and ask questions, but she does not know enough to be much help building an interface. She thinks that IHDE staff have been very patient with her.

- The clinic listed IHDE connection as a goal for the coming year. They explained that the
- information exchange will play a big part in doing a better job. This has not materialized yet for this clinic, but the physician champion thinks it will be a very useful tool.
- The clinic identified IHDE connection as a goal for the coming year. They just switched to Athena and are hoping this makes getting connected an easier process IHDE process has been really long and they are not connected yet. They do participate in weekly
- calls with their EMR vendor and IHDE; they have some IT support for this process, but their IT staff are based in the hospital, not at the clinic site.
- They feel IHDE is not really applicable to what they do because there are not many users in this part of the state. If all urgent cares and such were on it in Eastern Idaho, it would be more valuable. Not many of their patients get anything done in Boise, so they cannot pull useful information from it.
- Still working on IHDE connection.
- IHDE has been difficult and frustrating.

C. IHDE Project Close Out Report

As part of the IHDE contract, a final report was request from IHDE to provide a high-level summary of the various successes, opportunities and lessons learned throughout the course of the SHIP project. This report was compiled and transmitted in January 2019 at the end of the project and final month of the contract period.

Integration Connections – SHIP Cohort 1, 2 & 3 Interface Builds

In mid-2016, IHDE began interface build connections based on SHIP identified cohort participants. The goal was to connect clinics and provide care coordination amongst across the state. A total of three cohorts were provided to IHDE between 2016 to 2018, representing SHIP's 166 clinics. At the completion of the SHIP contract with IHDE, connections increased by 182% from 86 to 240 interface connections. In addition, view access to the IHDE portal increased by 14% from 811 to 922 organizations by December 31st, 2018.

Weekly Reporting

In order to keep SHIP/Medicaid apprised of the IHDE's progress with respect to components of the contract, a weekly status was requested and generated:

- SHIP/Medicaid Project Status – Provided the deliverables associated with the build process, project management, clinic/hospital visits, etc.
- Behavioral Health (BH) Project – Designed to interface with WITS that will share BH data with IHDE (excluding Psychotherapy notes) to provide care coordination with other connected participants for BH patients. This project was added with Amendment 8 of the contract and provided the status of the BH project as IHDE progressed with connecting WITS with IHDE.
- Raw Historical Data Project – Designed to leverage raw data currently maintained by Orion and transfer to an interim datastore within IHDE. This project was added with Amendment 8 of the contract and provided the status based on deliverables of the extraction of historical raw data from Orion to be maintained in a separate IHDE location

that would be instrumental in the advancement forward for various projects (i.e.: CSL, DSL, Payers, etc.).

- Verinovum Migration Project – This project was designed for the IHDE migration from the current platform to the Verinovum SaaS HIT platform, thus providing IHDE to provide Data Analytics and more effectively intake both Payer and Clinical data, in support of State objectives to transform primary care landscape to PCMH model. This portion of the weekly status provided the status associated deliverables associated with the contract.
- Briljent Project - The objective of this project was to identify activities and a timeline necessary to provide IHDE with consultative services to support the migration of the HIE platform and steps necessary to support the long-term sustainability of IHDE. This portion of the weekly status provided the status of the deliverables associated to the Briljent contract.
- Communication Service Layer (CSL) – This project was designed to develop a layer between the participants and the IHDE health information exchange (HIE) platform to more effectively intake and deliver all manner of health care data. This portion of the weekly status provided the status associated deliverables added during Amendment 7.
- Data Services Layer (DSL) – This project was designed to allow for the extract of data from the HIE platform, maintain a data warehouses, and allow for particularized data delivery. This portion of the weekly status provided the status associated deliverables added during Amendment 7.

Monthly Reporting

In conjunction with contractual reporting, IHDE was required to provide various monthly reports, expected no later than the 10th of the month. Monthly reports included:

- 30-Day Tickets – Provided a status on support tickets associated with a variety of system issues, new user set-up, password resets, etc. opened with in the past 30 days.
- Additional Services – Provided a status on other non-contract related topics in which IHDE was investigating/pursuing.
- Data Quality Report – Initially provided a status on the data quality, however with Amendment 7 was modified to provide a status on patient attribution files for participants.
- Organizational Chart – Provided the current IHDE organizational status of employees and positions.
- Project Interface Reporting – Provided reporting on Clinic Site Adds (CSA), Interfaces Connections related to Cohorts, View only Participants, and Hospital connections. Information provided was cumulative and provided historical information beginning in January 2017.
- Project Management Status - Specific to contractual deliverables - provided in a PowerPoint presentation and included pages specific to the various major deliverables within the contract (same as weekly report, however encompassed the month):
- SHIP Build Report – Specific to deliverables associated with the build process, project management, clinic/hospital visits, etc. (same as weekly report, however encompassed the whole month).
- Training Report – Provided a status on trainings that occurred for participants that had either view only or connections to IHDE. Information contained in this report included:

participant, affiliated with SHIP/Medicaid, number of users, duration of training, and areas of training (various).

- IHDE Work Breakdown Structure (WBS) – Provided an overall project plan status of the projects associated with the contract.
- Verinovum Work Breakdown Structure (WBS) - Provided an overall status of the Verinovum project in a project plan structure.

Level of Participation

During the three (3) cohorts, IHDE experienced a variety of levels of participant participation – these were categorized as three (3) types:

I. Type One – Fully engaged, eager to see to completion, provided input and available to participant in most, if not all meetings, no delays.
II. Type Two – Semi engaged, attended some meetings, took a little nudging to get feedback/approvals, minimal delays.
III. Type Three – Non-existent, rarely attended meetings, had to call for feedback and in some cases escalate to SHIP/Medicaid to get assistance to obtain participant participation, extensive delays.

While IHDE made every effort to ensure that participants were invited to all meetings, provided meeting minutes, included in email communications, we found interface builds for participants under Type 1 and Type 2, went relatively smoothly and adhered to project timelines for successful implementation, whereas participants under Type 3, resulted in timeline slippage and overall frustration to get project(s) moving forward.

To learn from these types of participants and improve the overall IHDE process, the Implementation Team constantly looks for process improvements that might ease the frustration and improve the overall project connection process. This process began following the completion of Cohort 1 in preparation for Cohort 2. The Implementation Team evaluated the Cohort 1 projects and identified a variety of items that would improve the participant's expectation of the builds, these included: Interface Information document, reduction of meeting expectations, PowerPoint presentation, streamlined participant questionnaire, and running project plan task concurrent to other tasks to ensure the best utilization of resources. This method of identifying "lessons learned' proved to be valuable and was applied again following the completion of Cohort 2, prior to Cohort 3, once again improving processes, forms, and information based on experience and is being applied to Cohort 3 in preparation for the next interface builds.

Readiness Assessment

Prior to connections being built for SHIP's clinics, a Readiness Assessment (RA) had to completed by IHDE and submitted to SHIP and/or Medicaid for approval. RA's contained cost components related to EMR costs, IHDE Clinical Portal licensing for 1 year, IHDE vendor costs, IHDE projected project hours, and projected timeline. During Cohort 2, the CSA was introduced and provided the ability to incorporate additional Medicaid Health Connections clinics into the interface feeds, analytics, and provided IHDE Clinic Portal licensing for 2 years to them as well as SHIP clinics. CSA's required Medicaid approval and were considered complete once the participant was fully live/bi-directional and clinic staff received application Clinic Portal user training. In the event a new clinic for an existing connected Health Connections participant was

identified, a CSA was generated that provided for approval and IHDE Clinical Portal license were provided to the new clinic.

Patient Attribution Files

In the later part of 2016, under Cohort 1, IHDE was tasked by IDHW to create a method by which to obtain participant patient attribution files that would be used by HTS to connect with patient CCD message. Data received in the patient attribution file, provided critical information that linked patients to specific clinic sites and providers. The intent was to link the patient attribution files to the CCD's for use in CQM analytics. Patient Attribution files were requested to be received on a quarterly calendar basis, following an initial 2-year file load. Successful files would trigger a transmission to HTS to link data with the CCD's for the participant. File failures would require intervention by IHDE to analyze the file errors and provide details to the participant for a revised file to be submitted.

During the SHIP, IHDE documented the gaps in clinic knowledge and experience including:

1. Participant inexperience with SFTP process
2. Participant inability to create pipe delimited files
3. Participant lacking IT resource to create files
4. Participant cost to generate and maintain file creation; some resulting in outside IT support
5. EMR intervention, at additional cost, required to generate file(s)
6. IHDE increased work effort to education participant on file creation
7. IHDE increased work effort to monitor, analyze failed files, maintain specifications, and notification to participant(s)
8. IHDE increased reporting to SHIP to include participant patient attribution file
9. HTS constant "reprocessing" of old patient attribution files, resulting in confusion/duplication, requiring IHDE intervention to assist with analysis

Clinic Post-Connection Follow-Up Visits

The SHIP goals of the Clinic Post-Connection Follow-up visits were to verify all connections are functioning properly within 12 weeks of completion, to include:

- Troubleshoot and repair any connections not functioning as anticipated.
- Document all issues discovered during post-connection site visits, the resolution, and how the resolution will be implemented.
- Confirm that users knew how to successfully access outbound results.
- Solicit and document user feedback regarding IHDE services and training to use in future improvements.
- Provided the Department with a summary document of the site visit that meets all minimum acceptance criteria listed.

Key Lessons Learned:

- The biggest piece of feedback from clinic visit surveys was that they desired more connections to clinics, specialists, and hospitals in their area.
- The next three most frequent survey responses from clinics were regarding a desire for enhanced communication and/or training from IHDE.

D. Hospital Engagement Visits

The purpose of 2018 hospital visits were to engage hospitals that were not currently fully connected to IHDE within the regions and states served by the IHDE. IHDE is the designated HIE for the state of Idaho. Increased participation by all IHDE partners is a vital part of improved patient care, increased provider productivity, decreased risk and lower overall healthcare costs. Increased participation is also critical to the long-term sustainability of IHDE.

The scope was focused on hospitals not currently customers of or not currently connected bi-directionally with IHDE. A hospital connected bi-directionally not only sends patient records to IHDE, but the participating hospital also receives records back that can be integrated into their EMR systems.

The time frame of this plan began approximately November 1, 2017 and carried on through on through October 31, 2018. Goals included:

- Identify and document the barriers to connecting with IHDE and create a plan to remove those barriers.
    - Cost of creating connections between the hospital and IHDE.
    - Cost of IHDE access licensing.
    - Lack of hospital IT hospital staff to assist in implementation and build interfaces with EMR vendors.
    - The hospital uses a system that does not connect to the IHDE database.
- Drive increased participation by hospitals in IHDE by visiting at least 10 prospective hospital new customers or current customers not connected bidirectionally, by January 31, 2019.
- Capture and define the customer value proposition for hospitals to be fully connected to IHDE and integrate those findings into IHDE sales and marketing, customer service and technology planning activities.
- Enroll and connect 10 or more prospective hospitals into IHDE (view only services access at a minimum) by December 31, 2019.
- Contact all remaining unconnected hospitals during 2018 with the goal of connecting all as soon as their budgets allow.

Key Lessons Learned:

- A lack of funding is the key reason hospitals are not connecting to IHDE. The cost of building the interface connection to the EMR by especially the Critical Access Hospitals, is the main reason hospital are not connected or connecting. Funding issues include:
    - Funding to cover the cost of the hospitals' portion of building the interface to the hospital EMR.
    - Ongoing maintenance fees charged by the EMR to the hospital for the interface connection.
    - The license fees charged by IHDE to allow access to the Clinical Portal.
- Many of the SHIP clinics that are located near many of the State's Critical Access Hospitals employ the same Providers that are a part of the SHIP clinic. The question arose more than once about allowing the same Provider at the clinic to have clinical portal access from the hospital. After discussions late in 2018 it was decided to treat the

CAH like a clinic and charge for only those Providers that do not already have User log ins.

- Beyond those hospitals that were visited personally by IHDE staff a mail campaign was created and mailed to all hospitals in the State of Idaho sharing with them information on IHDE and the benefits of connecting with IHDE.

E. EMR Vendor Engagement

During the IHDE / SHIP interface build engagement; IHDE coordinated interface builds with a variety of EMR's, each bringing their own challenges and obstacles to the project, these challenges included:

EMR Challenges	Challenges Description
EMR Agreements	Prior to assignment of a resource and beginning connections, EMR's required signed agreements between participant and EMR, this added to the overall project timeline due to many participants needing their board approval to obtain signatures.
Excessive EMR one-time interface costs	Inability to reduce, resulting in prevention of interface builds or resulting in IHDE absorbing the different not covered by SHIP.
High EMR Maintenance Costs	Several EMR's have excessive maintenance fees preventing participants from connecting as they are unable to absorb the ongoing cost.
Inability to connect to an HIE	Some EMR's were not equipped to connect to an HIE, preventing participant connection(s) with IHDE, thus reducing the care coordination goal within the State of Idaho.
HL7 Messaging	A few EMR's were unable to generate Inbound (participant to IHDE) HL7 messages; as a result, interface connections were
Resource Availability	It was quite a frequent occurrence that EMR's had a backing of project and ultimately delayed the assignment of the resource for the IHDE connection project(s), which had an immediate impact to the project timeline.
Inexperience in connection builds	A variety of EMR's, while they had the ability to connect with an HIE, they lacked the knowledge resulting in a huge learning curve, increased costs, and timeline delays to the projects.
Initial Deposit	In most situations EMR's required a deposit of 50% of the total expected costs. IHDE would request the payment of the deposit, only after the RA was approved, however this also added time to the project, as IHDE would need Board of Directors (BOD) approval/signature on the check.

It should be noted that in a few cases, IHDE absorbed the costs in which SHIP was unable to reimburse if an interface was completed, but due to EMR constraints were unable to go live. Below is a high-level recap of the EMR's encountered during the Cohorts.

EMR Vendor	Comments
eCW	• EUA (End User Agreement) required to be signed by clinic before tech resource will be assigned and work can begin. • No IB HL7 availability unless v.11 or greater • HUB Connection - quicker timeline (if resource provided)
EPIC	• Tech Resource Timeframe (avg. time: 8-12 weeks to obtain resource)
GW-Intergy **GW-PrimeSuite**	• Uses Change Healthcare – additional cost per interface • Unable to build HL7 inbound interfaces • Resource coordination between Intergy and CHC is time consuming • Tech Resource Timeframe (avg. time: 8-12 weeks to obtain resource)
NextGen	• Clinic site survey required by NextGen PRIOR to assignment of technical resource • IB HL7 in PDF format ONLY • Tech Resource Timeframe (avg. time: 4-8 weeks to obtain resource)
Office Ally	• EMR Vendor is unable to filter BH • Tech Resource Timeframe (avg. time: 3-6 months to obtain resource) • HUB Connection - quicker timeline (if resource provided)
Office Practicum	• EMR Vendor inexperienced in HIE integration. • Unable to build HL7 inbound interfaces • OB HL7 - Pending middleware - unable to integrate. • Workaround for both IB CCDA and OB LAB/RAD/TRN to be accommodated via SFTP as a Phase 1 approach pending development/middleware by OP. • EMR Vendor slow to complete action items and move forward resulting in project delays. • Tech Resource Timeframe (avg. time: 8-12 weeks to obtain resource)
Practice Fusion	• Practice Fusion cannot support/accommodate direct integration with HIE as a result – UNABLE TO INTEGRATE IHDE WITH PARTICIPANTS
Practice Velocity	• Tech Resource Timeframe (avg. time: 4-8 weeks to obtain resource)
Raintree	• Uses 3rd Party (Kno2) developer for interface connections; resulting in additional costs • Lack of HIE connections experience - results in timeline delays • Tech Resource Timeframe (avg. time: 4-8 weeks to obtain resource
Stanford	• Reasonable EMR costs

	• Tech Resource Timeframe (avg. time: 1-2 weeks to obtain resource) • Aggressive EMR; easy to work with to get interfaces connected
Visual Healthnet	• Reasonable EMR costs • Tech Resource Timeframe (avg. time: 6-8 weeks to obtain resource)

Raw Historical Data Extraction

Included with Amendment 8 (later part of 2018), SHIP/Medicaid requested the extraction of Raw Historical Data (RHD) from Orion to be maintained in an IHDE interim datastore for future use. Data was to be extracted from Binary Large Objects (BLOBs) and the raw data stored within IHDE in a useable format. The extraction process was broken down into five (5) deliverables:

1. Demonstration of script extraction
2. Demonstrate one (1) full calendar year of raw data
3. Demonstration of raw historical data from year 1 to 12/31/17
4. Demonstration of raw historical data from 1/31/18 – 9/30/18
5. Demonstration of raw historical data from 10/1/18 – 3 days prior to current date

IHDE utilized on-site architect to develop/optimize script, monitor extraction of data and perform data extraction analysis in order to accommodate the extraction of the data. It was noted that during the extraction process for data in 2017, an increase in time to extract data was identified due to the increase in longitudinal CCD's and increase in new connections.

The raw historical data extraction will be utilized by IHDE to develop and hydrate their data analysis system for their future applications in house and with potential future vendors. Additionally, this data source will be used in test environments for future development initiatives to ensure that a full testing production regiment is utilized to enrich the development of the end product.

F. IHDE Immersion Visit to Tulsa

The Office of the National Coordinator (ONC) Health IT Resource Center attended an immersion visit with Idaho, Idaho SIM, Medicaid, and IHDE in Tulsa, Oklahoma. The immersion visit had three main components:

1. Intensive contract review for the IHDE with the new state HIE vendor, Verinovum, in support of HIE implementation planning.
2. Observe how a regional Oklahoma HIE, MyHealth Access, implemented Verinovum as their HIE vendor.
3. Discuss Idaho SIM HIT next-steps for HIE planning and implementation.

The anticipated outcome goals of the HIE Immersion visit were as follows:

- Leverage lessons learned by MyHealth and establish a more defined IHDE platform implementation plan for accelerating the speed of transition.
- Establish a more defined plan for data completeness and data quality for the IHDE, SHIP, and Medicaid value-based payment models, specifically defining how PCMHs will be

accessing and using care coordination data in support of patient and care giver health decisions.
- Learn from MyHealth, a more mature state HIE, in order to accelerate IHDE business mo del development and HIE platform implementation

IHDE Meeting with HIE Vender

IHDE and their contractor Briljent, arrived early in the week May 1415, 2018 and reported havin g two intensive days with the new state HIE vendor, Verinovum. The contract with Verinovum was executed in the fall of 2017 but IHDE staff reported having difficulty getting adequate time and attention from Verinovum; hence, a decision was made to visit the vendor on their home territory.

The IHDE team met to discuss contractor expectations, such as understanding timing for develop ment and receipt of a project plan, a data migration plan from the existing Idaho HIE vendor Orion to Verinovum, and an implementation plan. To further compound IHDE's financial outlook the HIE is paying both vendors as this migration happens.

The two major concerns identified by the Idaho team were:
- Vendor inability to produce or agree to a workplan detailing timelines with deliverable Contract negotiated outcomes, such as; implementation, data migration, and training and other associated materials, etc.
- The meeting with Verinovum also served to address lingering technical issues as part of the migration. "Show stoppers", defined as discrete HIE functionality that without vendor delivery completely halts further implementation of the Verinovum HIE platform based on Idaho usability, required HIE functionality, and explicit contact requirements.

Experience and observe implemented Verinovum

The Idaho SHIP, Medicaid, IHDE, and ONC Resource Center team convened with MyHealth Access leadership for a two-intensive day exploration of MyHealth best practices, operations and experiences with Verinovum, which also currently serves as MyHealth's HIE vendor.

MyHealth and IHDE were able to substantively speak to "show stoppers" HIE functionality essentials for deployment and activation. This discussion entailed line-by-line review of requirements and functionality between MyHealth and IHDE's team of developers, programmers, and leadership. Below is a list of sample show stopper:
- EMPI loading / tuning
- Connectivity and onboarding
- Message process
- Data optimization for eCQM measurement
- Map Building
- Analytics environment
- Portal
- Roll-out planning
- Patient attribution

Comments/Considerations/Recommendations

1. Contract terms with its new vendor, Verinovum, while continuing to pay for HIE services with the existing HIE vendor, Orion.
2. Need to manage state perceptions of HIE across stakeholders; i.e. maintaining a seamless level of HIE functionality and health data exchange throughout the move to Verinovum from Orion.
3. Need to identify funds to support IHDE operations post January 31, 2019 when SHIP funds are the conclude.
4. Need of IDHW to determine ability and willingness to continue IHDE financial post January 31, 2019.

It was apparent across the immersion visit that conversations were occurring in silos at the state, as they did during the immersion visit. It was suggested that increased coordination across state partners could:

- Better align funding opportunities;
- Improve business operational needs;
- Align organizational resources (both financial and non-financial) supporting Medicaid SHIP and IHDE HIE planning and implementation, concluding but not limited to inclusion of key partners in SIM, CMMI, and TA Partner calls and meeting planning.
- Though Medicaid and SHIP are under the same agency, it was apparent from both formal and informal conversations that the two IDHW project divisions are at odds ad presumably either purposefully exclude or engage in planning and activities without the other project's knowledge.

HEALTHTECH SOLUTIONS - DATA ANALYTICS VENDOR (GOAL 5)

A. HealthTech Solutions

Award Year 1 Summary

In February 2016, HTS and Idaho executed a scope of work (SOW) for data analytics aspects of the SIM grant. The key tasks for HTS included the following highlights:

- Provide analytics services for evaluating outcomes for SHIP's performance measurement, including visual and analytic outputs in a variety of display formats.
    - In the first year, this included at least four measures, moving to ten in the second year and 16 in the third year. The system was to provide output at the clinic level, as well as the county, regional, and state level.
    - 55 clinics in year 1, 110 clinics in year 2, and a maximum of 165 clinics in year 3.
- Provide technical services for hosting, data transfer, data design, testing, analytics output display.
- Expertise in using statewide healthcare analytics to track, analyze, and report feedback to individual providers on selected performance and outcome measures to improve their practice.
- Maintain expertise in data warehouses, data analytics, healthcare data, health outcomes, and user accessibility. Project management and operations management experience was also critical.
- Provide a hosted solution for clinical and claims-based analytics that supports the retrieval of data from a variety of data sources and file formats.
- Maintain a data dictionary and systems controls for data integrity.
- Provide business intelligence output such as reports and a dashboard.

Award Year 2 Milestones: Feb 2016 – Jan 2017

- Executed an initial Statement of Work between Idaho and HTS
- Completed software and system design and implementation
- Implemented four measures in 55 clinics

Challenges

- The first major challenge was that the state did not have the clinical data or data exchanges in place to support the measurement calculations required under the SOW. The (RFP) response proposed a solution using business objects to produce reports, but this was not possible with the state's data. Since there was no front-end consensus for how to consistently collect, attribute, and validate the clinical data from all clinics, there were many months of discussion, which disrupted the project plan for the analytics work.
- There were varying levels of technology capabilities and the connections in place were new. Providers participated in a variety of CMS programs, which meant that there was no singular format or extraction that worked for all providers. While the stakeholders eventually agreed to use CCDs, Quality Reporting Document Architectures (QRDAs) were also proposed.

- The delays in obtaining clinical data for the data analytics solution created an unearned frustration for most of the stakeholders with the data analytics vendor, HTS. Obtaining clinical data was clearly not within the scope of the data analytics.
- Once the initial measures were implemented, HTS worked with the state to arrange for ten providers to send in CCDs and beta test any issues. There were major issues, such as:
    - The CCDs were not fully populated and therefore measure rates looked poor
    - The data was trickling in at a very slow pace

Successes

- While CCDs were not the perfect alternative to a database backup of normalized and attributed clinical data, after a consensus-driven process, the stakeholders seemed satisfied with being able to populate CCDs and that they would successfully be able to meet the measure specifications.
- Since there were still challenges with how patient data was not attributed to providers in a CCD, HTS worked with SHIP staff and IHDE to design a flat file process – the files produced by the clinics were initially for two years, then subsequent quarterly updates -- for primary and specialty care providers.
- HTS developed a proprietary CCD parser in order to extract the necessary data from the CCD to calculate the quality metrics.
- All fixes identified to nuances in parsing CCDs, were applied historically to all the CCDs sent previously. That involved sometimes reparsing 400,000 CCDs to enhance the quality of the data. Despite this challenge, HTS was able to reprocess without affecting business hours.
- HTS developed an automated gap analysis report to assist in time spent on manual reviews.

Although certain clinics were unable to restrict duplicate longitudinal information being sent on every CCD, the vendor initiated run time improvements and always kept the daily processing of longitudinal CCDs up to date.

Award Year 3 Milestones: Feb 2017 – Jan 2018

- Refining measures
- Implementing new measures
- Expanding the number of clinics submitting measures
- Creating a training protocol and training clinics on the system

Challenges

- One of the biggest challenges in the second contract year was the state's concern for drawing providers' attention to the system while the rates were poor, which would decrease providers' confidence in the process, but the rates could only improve with provider attention. This was an unfortunate conundrum for the state.
- HTS hosted several trainings and prepared web-based modules, but there was insufficient participation and then very little follow through after the trainings. HTS monitored the provider log-ins after trainings and did not see an increase.
- Ongoing troubleshooting between providers, the analytics vendor, and the state's Data Quality Improvement Specialist Contractor was often slow and bottlenecked with the Specialist, as this was a one-person operation, working between the analytics vendor and the multitude of clinics and providers.

Successes

- HTS produced high quality live, video, and manual-based training materials.
- Ongoing data validation and resolutions, such as:
    - Some of the measures required medication and not all the medications were captured in the initial tool because the vendor was using CMS' list on their website, which included only brand names. In the second year, the vendor bought a file for mapping brand to generic, which increased the rates for several measures.
    - Working with the state's Data Quality Improvement Specialist Contractor in order to capture the issues, discern the source of the problem (e.g., developer or provider/clinic), and then propose solutions.
- Clinics were added at a faster pace, albeit not at the pace or quantity the contract planned.
- HTS not only met the measure requirement for the grant year but exceeded by implementing additional enhancements requested by the state such as the "merge" and "unmerge" process to eliminate duplicate counting of patients in the rates, based on a proprietary feed from the HIE. We also implemented enhancements to allow for reporting by rolling cohort as well as filtering by cohort on reports, Data Quality Indicator added to reports for filtering by clinics that had been through data quality and those who were not and added another security role level and reports for Measures to be reported by Health Systems.

Award Year 4 Milestones: Feb 2018 – Jan 2019

- Refining measures
- Implementing new measures
- Expanding the number of clinics submitting measures
- Completed the issues identified in the gap analysis

Challenges

- The reports were never fully rolled out for provider use the way the state intended at the beginning of the project.
- The data submitted by providers had issues that needed to be corrected by their vendors and/or the data for whatever reason was not populating on the CCD.
- The measures while calculating correctly were not true to what the provider may have performed due to gaps in the data submitted on a CCD. The vendor and SHIP staff had discussed adding in claims to fill the gaps but since this was a contract based on a grant, time and money ran out.

Successes

- The vendor closed all issues identified in the data validation process that could be completed by the vendor and continued refining solutions implemented in previous years. For example, they added new references to better identify more drugs used in the measure by implementing a crosswalk for translation of RXNorms in the current SHIP measures to RxTerms, which is custom coding for GE Centricity's proprietary CCD sections.
- The vendor also enhanced reports such as the Patient Measure Rules. This report clarified how a patient was determined as a participant for a measure.

- To attribute patients faster we implemented a feedback loop where every other week we sent IHDE all the patients that did not have an EMPI for each historic file broken into a file size that Orion could support, and they would then check to see if the patient had an EMPI assigned and return the file to us.

OHPI Health IT/Data Analytics Comments and Observations

Idaho's SHIP initiative was a very innovative effort to deliver health care services to the state's unique populations. The state worked carefully to strategically plan for the public health needs, leveraging the best available resources, while undergirding this with federal resources for technology support and planning.

A procurement that reflects a more agile development approach may give the state an opportunity to iteratively plan the next IT or data analytics project. For example, on this project, an agile development approach would have set out goals and let a vendor approach the process for helping the state figure out the strategy for gathering the data a little differently. It also would have helped the state set expectations accordingly. It would also afford an opportunity to closer align with Medicaid in terms of program goals as well as consideration of IT infrastructure.

The state could have also allowed an agile development approach to include user-centered design where there was more preliminary work done by the vendor. A vendor would have been able to determine what data sources were available, what data would be problematic or disruptive to which providers, and then incorporate that into the architecture as part of the work, not as part of the RFP response. To the extent the development team works directly with the end-users, there is usually a higher rate of success for the product or system.

Finally, although the vendor faced many challenges with the project there were just as many successes. The Idaho SHIP team, IHDE, the Data Validation specialist, and the vendor, HTS were able to come together as partners and overcome many of the challenges. Although the outcome may not have been what was initially expected, there was still a win in the lessons learned about the data expectations, provider and provider vendor involvement and the dedication it takes to pull together quality measure outcomes.

Contract Close-Out Activities

A. Prior to January 31, 2019, HTS destroyed all protected health information (PHI) data from their databases and ensured their servers were wiped clean.
B. The Contractor developed a Case Study of the SHIP data analytics project and the final version was approved by IDHW January 15, 2019. The Case Study shall be derived from interviews from within HTS and shall explain the goals, key activities, successes and challenges and outcomes and results from the data analytics project. The following proposed Case Study outline will be used as a basis to plan and write a narrative report presenting details about the project. Please note the proposed report outline may be further tailored as needed:
    1. Executive summary.
    2. Introduction
        i. Data analytic project goals overview

ii. Idaho's Health IT landscape at start of the project.

B. SHIP Goal 5 Pivot – 2018

A challenging, but critical, aspect of these efforts was the data quality improvement process. In Award Year (AY) 2 of the SHIP grant, the data quality effort was identified as a barrier to success, and the OHPI adjusted focus and resources in an attempt to improve this process and remove it as an obstacle to success. This included developing a process and IHDE adding a data quality specialist to be co-located with the SHIP team. Additionally, at the end of AY3 OHPI engaged their federal partners, the ONC, by submitting a technical assistance request to provide guidance on improving the data quality improvement process.

Simultaneous to receiving the technical assistance, stakeholders began to share additional information regarding their interest in CQMs and statewide data analytics. Previously, it was thought that the clinics and payers were interested in the selected SHIP analytic reports, but further discussion revealed that payers found the SHIP analytic reports in their current state offer little value to their organizations' quality management program. The information from the technical assistance and the stakeholders resulted in OHPI re-evaluating their current approach to both the connection builds and the data analytic reporting.

Idaho recognized that the current state of the analytics system was not meeting our long-term goals due to changes in the Idaho health IT environment. Therefore, it became critical to identify alternative options to best use SHIP resources and grant funds. OHPI worked to identify possible options for data analytics reporting and determine each option's feasibility, including whether the option would have value to stakeholders. The process included numerous conversations with ONC, IHDE, and Idaho's analytics vendor, HTS, Medicaid and other stakeholders to consider all possible options in order to establish the most value for our stakeholders by the end of the grant.

OHPI's analysis identified several options and evaluated each one utilizing a set of decision factors, as well as a set of assumptions and constraints. The decision factors addressed critical factors such as funding, schedule, resources, technical feasibility, and sustainability after the SHIP grant ends.

Along with the decision factors, some of the most critical assumptions and constraints included:

1. There are no plans or funds for HTS data analytics reporting to extend beyond the SHIP grant, which ended January 31, 2019.
2. IHDE was not planning to provide a statewide analytics system once it switches to its new Verinovum platform. It will provide an analytic solution for an unidentified group of independent clinics and/or rural hospitals that potentially request those services.
3. Idaho payers do not intend to use the current SHIP measures and data analytics. Many SHIP clinics are part of larger health systems that conduct their own data analytics, and therefore, do not have a need for SHIP measures and data analytics.
4. Medicaid was working with Truven to develop a quality measurement/analytics solution for its Shared Savings program.

OHPI considered six general options, with some of the options having a few variations:

1. Continue to build the proposed analytics system with no changes.
2. Add the recommended new data feeds.

3. Change the clinical quality measures being reported to eliminate the data quality improvement process.
4. Leverage Medicaid's quality measures program.
5. Add HTS functionality to build connections to Medicaid's quality measures program.
6. End the current statewide data analytics development by ending the HTS contract.

OHPI Recommendations

As part of the evaluation process, OHPI considered the constraints, assumptions, and decision factors as well as identifying pros, cons, and the value propositions for each option. Additionally, they continued to seek input and guidance from ONC, and it was ONC's most recent recommendation to add HTS functionality to build connections to Medicaid's quality measures program that showed the most potential. Initially, the benefits identified for this option outweighed all the other options and it appeared to be the best choice. However, when obtaining the Medicaid team's input during the evaluation process, the team identified significant risks to several of the Medicaid/Truven projects. Based on these risks, this option was not considered feasible.

OHPI used the following decision factors to evaluate the alternative options developed for Goal 5:

- **Value:** Did the end product provide enough value for the stakeholders?
- **Funding:** Extent to which the option could impact AY 4 SHIP funding.
- **Technical Feasibility:** Feasibility of implementing the technical option.
- **Time/Schedule:** Likelihood that the option can be fully implemented in the remainder of AY 4.
- **Sustainability after SHIP grant:** Is there a likely path for sustaining the option after SHIP?
- **Contribution towards long-term goals:** How well does the option support Idaho's long-term goals?
- **Staffing resources:** Does implementing the option require additional staff?
- **Impact on Stakeholders:** Any additional impact the option might have on stakeholders
-

At the conclusion of this thoughtful and deliberate evaluation process OHPI recommended that SHIP make the following changes to Goal 5:

- Explore how SHIP clinics might leverage Medicaid's quality measures program.

- End the HTS contract early but redirect funds that were used for data quality and data analytics to another component of SHIP that provides greater long-term value.

Medicaid's analytics partner, Truven, launched its quality measure reports for Idaho during the summer of 2018. OHPI recommended reviewing what was already planned within the Medicaid program and determine whether these quality measure reports could be provided to the SHIP clinics. Some of the selected Medicaid measures overlap with SHIP measures, while others do not.

In addition, OHPI recommended that SHIP end the HTS contract early. While ending the HTS contract could impact future partnerships (particularly with HTS), it demonstrated fiscal responsibility, and most stakeholders would support this decision.

Finally, OHPI recommended that funds directed to data quality and data analytics be redirected to another component of SHIP that provided long-term value.

Appendix A: Acronyms

AY	Award Year
BH	Behavioral Health
BLOBs	Binary Large Objects
BOD	Board of Directors
CCD	Continuity of Care Document
CMMI	Center for Medicare & Medicaid Innovation
CQM	Clinical Quality Measures
CSA	Clinic Site Add
CSL	Communication Service Layer
DSL	Data Service Layer
EMPI	Enterprise Master Patient Index
EMR	Electronic Medical Record
EUA	End User Agreement
HIE	Heath Information Exchange
HIT	Health Information Technology
HTS	HealthTech Solutions
IDHW	Idaho Department of Health and Welfare
IHDE	Idaho Health Data Exchange
IT	Information Technology
NCQA	National Committee for Quality Assurance
NPS®	Net Promoter Score
NQF	National Quality Forum
OHPI	Office of Healthcare Policy Initiatives
ONC	Office of the National Coordinator
ONC	Office of the National Coordinator
PCMH	Patient Centered Medical Home
PCP	Primary Care Physicians
PHD	Public Health District
PHI	Protected Health Information
QRDA	Quality Reporting Document Architecture
RA	Readiness Assessment
RHD	Raw Historical Data
SHIP	Statewide Healthcare Innovation Plan
SIM	State Innovation Model
SOW	Scope of Work
TA	Technical Assistance
WBS	Work Breakdown Structure
WITS	Web Infrastructure for Treatment Services

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

Final Progress Report

Goal 3

Prepared for
CMMI

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

At the local level, Idaho's seven Public Health Districts have convened Regional Collaboratives that are supporting provider practices as they transform to PCMHs.

1. Major activities

RC Summit 2016
RC Summit 2017

Development of 7 different models to support the integration of PCMH clinics in the medical health neighborhood
Regions 1-7 Ongoing member meeting
Regions 1-7 Executive Mtgs.

Region 1 Initiatives:

- Community Health EMS, Fluoride Varnish Policy and Procedure, Diabetes QI Project, Community Health Assessment Plan,

Region 2 Initiatives:

- Behavioral Health & Regional Crisis Response Project, Linkage of CHW w/ Free Clinic,

Region 3 Initiatives:

- Idaho Integrated Behavioral Health Network, Let's Talk Series, Healthy Minds Partnership, Dental Care Coordinator Project, EMS Social Services and Communication Project, Brief Intervention for Behavioral Health Providers ED Utilization Pilot, IDCareNetwork, Care Coordination, School-Partnered Behavioral Health and Trauma-Related Issues

Region 4 Initiatives:

- Caregiver Integration Project, alignment of programs administered through Central District Health Department, Idaho Integrated Behavioral Health Network, Let's Talk Series, Quality Improvement Calls, Dental Care Coordinator Project, Medicaid Transformation Alignment

Region 5 Initiative:

- Resource Directory

Region 6 Initiatives:

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- Suicide Prevention Initiative including a Suicide Prevention Symposium, PCMH Workforce Development with Idaho State University

Region 7 Initiative

- EHC Resource Guide,

Omissions or changes to project activities

No **changes in key personnel** affected performance of the Regional Collaboratives

- Turnover in SHIP Goal 3 Project Manager
- Changes to some Region Co-chairs
- Staff turnover at the clinic level

SHIP public health managers used a computer reporting portal, and there were no **changes that were made in computer applications**.

2. Efforts to publicize results

- Presented activities and results statewide at the RC Summits and Learning Collaboratives
- Reported activities and results to Idaho Healthcare Coalition
- Results shared with researchers from the State-level Evaluation Team
- Discussions with Medicaid

3. Goals Not Achieved

Population-level data was not available to Regional Collaboratives
- Post-grant plans to complete
- Post-grant funding
- Post-grant completion

4. Audiences

165 SHIP PCMH clinics from cohorts 1, 2, 3

- Clinics in urban, rural, and frontier communities, many of whom indicated they were not previously familiar with community-based organizations in the region that play a role in addressing social determinants of health. As a result of participating in the Regional Collaboratives, many clinic staff reported greater awareness of community resources, and greater ability to work in partnerships with public health agencies and community agencies to address critical health needs in the region.

Public health agency within each of the seven regions

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- State-level recognized public health department within the region. As a result of facilitating the Regional Collaboratives, many public health staff reported greater ability to work in partnerships with clinics and community agencies to address critical health needs in the region.

Community agencies within each of the seven regions

- The full scope of non-medical organizations in the community whose work involves aspects of social determinants of health. Includes: schools, transportation, caregiving, behavior health, food banks, and more. As a result of participating in the Regional Collaboratives, many agency staff reported greater ability to work in partnership with medical clinics and public health agencies to address critical health needs in the region.

Local communities

- Idaho communities vary greatly in nearly all aspects. Communities range from urban, to rural, to frontier and in geographic reach. The majority of residents identify as white among a growing Hispanic population. Many Idahoans live with limited resources and food insecurity. Chronic diseases, accidents and suicide rank high in the most common causes of death. Some communities have significantly less grocery stores per capita than the state average, and many experience transportation concerns. Communities report community health benefit from nature paths, pools, and recreation centers. Many Idahoans lack health insurance; lack of coverage as well as high deductible plans are a significant concern. Furthermore, many communities face a shortage of physicians, behavioral health providers, and oral health professionals. RC's have impacted communities by introducing initiatives (discussed above) which address local health needs and social determinants of health.

5. Evaluation

RC Member Survey

- In July 2018 researchers from the State-level Evaluation Team contacted members of the 7 RCs by email to request their participation in a 15-minute, one-on-one, confidential interview. A total of 25 members participated in the interviews. Participants included health care providers, public health administrators, community organization leaders, and professional association representatives.
- In summary, interview participants valued the role and their experience with the Regional Collaborative in their communities. They hope the RCs or a group like this continues, and they have suggestions for the group and group members going forward. Additional comments highlighted the need for a statewide vision, leadership, and continued partnership with public health. Based on their experience, some individuals felt very strongly about the need for community level data, and greater financial support as well as visibility in order for any group like the Regional Collaboratives to be successful in their communities.

RC Success Snapshots

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- In November 2018 members from the State-Level Evaluation Team spoke with select leaders of 3 RCs to learn more about the need, development, and future outlook of RC initiatives that especially captured the spirit and objectives of SHIP. What emerged were snapshots of success which demonstrate what can happen when individuals from the medical community come together with members of community-based organizations in an open forum to share thoughts and ideas about how to identify and address the most pressing health needs in the community. This leads to partnerships that, leveraged with local resources, build capacity. The capacity to improve the health of communities throughout Idaho.

RC Physician Co-Chair Interviews

- In May 2018 a Research Associate (RA) with the State-Level Evaluation Team (SET) contacted three RC Physician Co-Chairs to request an interview. Two of the co-chairs provided responses to questions which sought to explore the views of the RCs toward value-based care.

6. Continuation of the Project

With few exceptions, members of the RCs who participated in the RC Member Survey described their experience as positive, and nearly all would recommend that others in their community become members of the Regional Collaborative. Looking beyond the SHIP grant, most interview participants want a group like this to continue to serve as the convener in their communities. They identified additional roles, likely to address some of the concerns that emerged through the initial experience. They want individual members who are willing to offer their unique perspectives to meetings, share resources and information. They want members who are willing to own the group goals and be held accountable for working together to meet the needs of their communities. If a group like this does continue, it will be important to acknowledge that some individuals do not think it is needed.

Leaders and members of the RCs identified post-SHIP focus areas that consider impact, align with current activities, and appear to be scalable. Focus areas mentioned include care coordination, behavioral health integration, and PCMH support

All seven of the RCs submitted a Regional Transition Plan which detail region-specific focus areas and modified approaches to continuing the work.

7. Long-Term Impact

The project activities that were funded through the SHIP RC sub-grants resulted in tangible short-term outputs and outcomes, and laid a foundation for continued support of PCMH, collaboration in the medical health neighborhoods, and growth and expansion of activities within each community.

In some of the regions the work that began with the Regional Collaboratives will continue post-SHIP. In some cases, the partnerships that developed led to the identification of additional funding sources and opportunities for collaboration within the neighborhood.

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Furthermore, Medicaid's plans to advance value-based payment strategies post-SHIP have led to the development of Value Care Organizations to be pursued.

8. Grant Products with URLS

RC Strategic Plans
RC Summits

- RC Summit 2016 –
- RC Summit 2017 http://ship.idaho.gov/Portals/93/Users/152/00/2200/2017%20RC%20Summit%20Agenda.pdf?ver=2018-01-23-104644-163

RC Updates

- Region 1 http://ship.idaho.gov/Portals/93/Users/152/00/2200/1%20Panhandle%20RC%20Update%202017.pdf?ver=2018-01-23-104644-210
- Region 2 http://ship.idaho.gov/Portals/93/Users/152/00/2200/2%20North%20Central%20RC%20Update%202017.pdf?ver=2018-01-23-104644-257
- Region 3 http://ship.idaho.gov/Portals/93/Users/152/00/2200/3%20Southwest%20RC%20update%202017.pdf?ver=2018-01-23-104644-320
- Region 4 http://ship.idaho.gov/Portals/93/Users/152/00/2200/4%20Central%20Regional%20Collaborative%20Update%202017.pdf?ver=2018-01-23-104644-367
- Region 5 http://ship.idaho.gov/Portals/93/Users/152/00/2200/5%20South%20Central%20RC%20Updates%202017.pdf?ver=2018-01-23-104644-430
- Region 6 http://ship.idaho.gov/Portals/93/Users/152/00/2200/6%20Southeastern%20RC%20update%202017.pdf?ver=2018-01-23-104644-490
- Region 7 http://ship.idaho.gov/Portals/93/Users/152/00/2200/7%20Eastern%20RC%20update%202017.pdf?ver=2018-01-23-104644-553

RC Transition Plans

- Region 1 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC1%20Transition%20Plan%20FINAL.pdf?ver=2018-12-06-114411-217
- Region 2 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC2%20Transition%20Plan_final.pdf?ver=2018-12-06-153851-550

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- Region 3 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC3%20Transition%20Plan%20FINAL.pdf?ver=2018-12-06-153935-793
- Region 4 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC4%20Transition%20Plan_final.pdf?ver=2018-12-06-154023-897
- Region 5 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC5%20Transition%20Plan_final.pdf?ver=2018-11-16-151748-757
- Region 6 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC6%20Transition%20Plan_final.pdf?ver=2018-12-10-090111-273
- Region 7 http://ship.idaho.gov/Portals/93/Documents/RC%20Transition%20Plan/RC7%20Transition%20Plan_Final.pdf?ver=2018-12-11-163801-103

9. Supporting Materials

Regions 1 – 7 Transition Reports in the pages that follow

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 1: Panhandle

A. Regional Collaborative (RC) Mission and Goals for Healthcare System Transformation

Mission: "The mission of the Panhandle Regional Collaborative is to support Primary Care Medical Practices in their transition to the Patient Centered Medical Home (PCMH) model of care and to support the integration of each PCMH with the Medical Health Neighborhood. This will be accomplished by providing a forum for sharing valuable knowledge and resources through PCMH meetings. We will invite and encourage clinics to be a part of Regional Quality Improvement projects. The Regional Collaborative will promote the PCMH model of care.

The goals of the Panhandle Regional Collaborative: 1. To sustain a Regional Collaborative with representation on the Medicaid CHOICe Board structure when formed. 2. Support legislation to fund a Quality Improvement Specialist through Panhandle Health District. 3. Support the PCMH model of care and clinics transforming to this model in the region through the coaching efforts of a QI Specialist. 4. Support regional quality improvement by giving input to a QI Specialist on possible project areas and measures. 5. Support the sharing of best practices through the facilitation of regional PCMH meetings and regional IIBHN meetings by the QI Specialist.

B. Accomplishments to Date

B.1. Patient-Centered Medical Home (PCMH) Support

Early Barriers/Successes

The Regional Collaborative (RC) has relied heavily upon the Health District SHIP team to provide support for clinics transforming to the patient centered medical home (PCMH) model of care. This team consists of the QI Specialist, the Administrative Assistant and the SHIP Manager. The Health District SHIP team regularly gives the RC updates on the progress of the clinics and any barriers or needed support. One barrier we found was clinic line staff didn't know what SHIP was about. We also found that many programs and organizations work with the clinics in various capacities and line staff didn't know how SHIP was different. To differentiate the SHIP program from the others and to give more information about the PCMH model of care, we met with each clinic during an all staff meeting. These meetings were typically at lunch time when the office was closed so all staff could attend. The majority of the meeting time was dedicated to SHIP and PCMH. The meetings included the background on the SHIP grant and an overview of each PCMH standard. We found that by having these meetings the staff were much more receptive to us being in the clinic and helping them. This really helped with our ability to work with the clinics more effectively throughout the year.

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Some clinics didn't know where to start in transforming to the PCMH model of care. This was a barrier for clinics new to change and the PCMH model. To help remedy this barrier, we started having group PCMH meetings with the clinics about every other Month. This practice was started early in cohort one and the PCMH meetings were scheduled through cohort three. These meetings were typically two hours long and included discussions among clinics and sharing of best practices. The willingness and enthusiasm of the clinics to collaborate was an unexpected success. We found clinics to be very open to sharing their efforts and best practices. In our first cohort year we had two large FQHCs represented and a couple of smaller clinics at these PCMH meetings. The PCMH meetings were initially intended for each clinic's PCMH key contacts. But we found in the first year the clinics sent more providers and nurses than we expected. This helped the PCMH leads in the clinics gain the support they needed with implementation. In the second cohort year, we had more clinics from each of those large FQHCs. We found the number of providers and nurses lessened, so we asked the PCMH "mature" clinics to present to the group on key topics.

One of the challenges all clinics encounter is staff turnover. This challenge affected a few of Region One's SHIP clinics. Some of the turnover issues involved Office Managers, Care Managers, and other key PCMH positions. Newly hired clinic PCMH leadership used the SHIP QI Specialist to quickly learn their PCMH role as it relates to SHIP. This relationship helped speed up the process of getting these key clinic team members up to speed and helped the clinics get back on track with their PCMH goals.

Another challenge that was faced throughout this grant was the lack of an involved Physician Champion in some organizations. Other organizations faced push back from other providers against the champion and the PCMH efforts. These issues lessened as it was realized the changes were leading towards better patient health outcomes.

The biggest challenge was time and financial resources to fund personnel and technology to help with the transformation process. Different clinics used different ways to help overcome those challenges. Two clinics used the spouses of their physician champion to help organize the clinic's PCMH efforts. It just happened that these two individuals were Nurses and were very familiar with their clinic's providers and staff.

Other ways clinics overcame challenges with PCMH transformation involved the contributions of the Health District SHIP staff. Specifically, the role of the Quality Improvement Specialist cannot be overstated. This key team member's role has resulted in the cultivation of close relationships with 24 clinics in working with them in their PCMH transformation goals. Acquired training and experience enabled the QI Specialist to provide direct PCMH technical assistance and help clinics with understanding NCQA standards. Much of the QI Specialist's training and experience came from working with HMA coaches.

The QI Specialist also provided a vital role to the success of the RC by providing the RC with updates on clinic progress in PCMH transformation. Other updates to the RC include progress updates on the regional quality improvement project, PCMH meeting updates, and IIBHN meeting updates.

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RC Grant

After the opportunity was announced for RCs across the State to apply for a mini grant, the Panhandle RC was eager to participate in this opportunity. The Panhandle RC met and discussed possible projects that would be beneficial to the population in the Region. Several ideas were presented from the RC membership. A workgroup of RC members met to develop each of the ideas further. The SHIP Manager then vetted each of the ideas with State SHIP Grant Managers to determine if each of the proposed ideas would meet the CMS standards.

After going through this process, the three viable ideas were presented to the full RC membership. The RC members were given the opportunity to ask questions about each idea. After the question and answer session a survey was sent to each RC member to get a vote on which idea would be pursued. The CHEMS project idea received the most votes from the RC members. The RC CHEMS grant focused on high level program development of two types of home visits. The first type of home visit involved those patients referred by a physician or PCMH. The second type of home visit was for patients going home from a Hospital stay and referred by hospital discharge staff. With input from the State of Idaho SHIP staff, the Panhandle Health District SHIP Manager prepared the RC CHEMS grant request paperwork. The grant was awarded through Panhandle Health District. The first CHEMS agency to be part of the RC CHEMS grant was Bonner County EMS. They were the pilot organization for the grant. The grant was later amended to include two other agencies. Those agencies were Boundary Ambulance Service and Shoshone County EMS. The pilot organization had very good results. During the grant period, they saw nine patients post cardiac surgeries. Through the home visits, the agency noted blood pressure checks that were out of the parameters and communicated this information to the physician. This resulted in 15 total medication changes to bring blood pressure results within parameters. Zero patients on case load with this pilot CHEMS agency were re-hospitalized or visited the emergency department.

QI Projects

The Chair and Co-Chair were very clear from the formation of the RC that they would like to do a regional quality improvement project. The cohort one SHIP clinics didn't know how they would get data from the electronic health records system. We decided to start small. It was suggested by the RC Chair that we ask our Oral Health representative on the RC to prepare a fluoride varnish policy and procedure. Dr. Ukich (RC Member) prepared a one-page document (front and back) that was used to educate the clinics on fluoride varnish application to children. The document included why fluoride varnish is needed and how to determine the need. The document also explains what causes the problems requiring fluoride varnish and what happens if it goes untreated. A thorough description is given on how to apply the fluoride varnish. The document also discussed how to order the product (vendor and product ordering information) and how to bill for the procedure – billing codes. He gave the presentation at a PCMH meeting and answered questions. He also offered to go to any clinic that wanted more information and give a short presentation or demonstration on the topic. We did not track any data for this project. The second project involved reducing opioid use. We asked a Pain Management Physician to attend a PCMH

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meeting and give a presentation on the subject. He also furnished a white paper on the topic. One clinic shared their opioid reduction program with policies and procedures. Several SHIP clinics in this region have adopted that program.

For the second cohort year, the RC wanted to do a larger project and collect data. The goal of a larger project was to help more people in the region and help the clinics learn care management by creating directories and monitoring a chronic disease. After discussing project ideas with the clinics and RC, it was decided to do a Diabetes QI project. The project would strive to reduce the number of type 2 diabetics with uncontrolled diabetes. This was defined as an A1C greater than 9%. We partnered with a Certified Diabetic Educator. The QI project was presented at a PCMH meeting with much more support and interest than we anticipated. Clinics interested in participating were invited to attend large group meetings intended for providers, nurses, and key stakeholder at each clinic. The meeting was very well attended. We set up training sessions for each of the clinics interested in joining the Regional QI project. These training sessions went into the clinical pathway and best practices to treat patients with uncontrolled type 2 diabetes.

The training sessions were successful and the support for the QI project grew. The clinics then started to make appointments to see their patients with uncontrolled type 2 diabetes using their new clinic pathway to approach the issues. One of the difficulties has been to get patient compliance with following through with an appointment to meet with the physician. The help overcome this obstacle, a large FQHC organization shared their script used when calling patients to set up an office visit. This script proved to be a good tool for care managers and other office staff in setting up the appointment. The SHIP QI Specialist collected data over the course of the year. Nine SHIP clinics participated in the Regional QI project. Seven of those clinics were able to pull data and share their results. These results showed that 192 patients that had uncontrolled type 2 diabetes (greater than 9%) had reductions in their A1C levels to less that 9%. During cohort three, the clinics and Regional Collaborative agreed to continue the uncontrolled type 2 diabetes QI project.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

The Medical-Health Neighborhood (MHN) in our region is unique. Region One consists of the five Northern Counties in Idaho. The regional hub of the MHN is in Coeur d'Alene – Kootenai County. Each of the other four counties have their own MHN. Those MHNs include the critical access hospital as the county medical hub. Each of those county hubs interact with the regional hospital and regional hub for complex and specialized medical situations.

Typically, the citizens of the four counties outside the regional hub use community and medical services in their county hub first and the regional hub as needed. Some people in our region also use an even larger MHN spanning into eastern Washington and even to Seattle for very specialized and complex medical situations.

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Early in the grant we did a survey with cohort one clinics to see what entities in the MHN they work with in the regional hub. Clinics outside the regional hub mentioned urology, oncology, and the crisis center as the top areas of care they referred their patients to the most in the Coeur d'Alene area. To focus on integration of all SHIP clinics into the regional MHN, we focused on bringing entities to our meetings that serve all five counties. These resources shared what services they provide, who they provide services to, where these services are located, how to get access to those services. Also shared was information about any health insurances they accept, if they have a sliding scale or if they offer any free services. The clinics found the presentations by the different entities informative and helpful. This gave all SHIP clinics help in integrating and helping their patients with the services available regionally.

The RC found the Regional Hub has several resource services directories in place. One directory seems to be more complete than the others. That directory was highlighted at our PCMH and RC meetings. Sandpoint also has a very good resource services directory, but it is limited to Bonner County. These directories were shared with all SHIP cohort clinics on several occasions. The RC decided that we didn't need to make our own directory. One reason not to do this is because of sustainability issues after the SHIP grant. Another reason is because the directories out there are good resources and we didn't need to recreate the wheel.

The RC found we have the services needed in our region. Our region does need more behavioral health providers, but many of the behavioral health entities that presented at our meetings were previously unknown to the clinics. The SHIP clinics have always had Behavioral Health partners they work with and refer their patients, but the wait times are long. Having members of the MHN present their services to SHIP clinics has allowed the clinics to learn about other services available and how to work with them. The clinics can give their patients options for services that are more timely.

It was mentioned several times in our PCMH meetings that Medicaid dental services need to be expanded. To help with this situation, the FQHCs in the region have expanded their services by adding providers and staff. Also Panhandle Health District has added limited dental services one day a Month at the Hayden office. These services are on a sliding scale.

B.3. RC Development and Implementation

The Regional Collaborative was established over the Summer and early Fall of 2015. A couple of key Providers in our region were involved in the Idaho Medical Home Collaborative. They were involved in the PCMH pilots and were asked to serve as our Regional Collaborative Chair and Co-Chair. Panhandle Health District's Director also serves on the Executive Committee of the RC. We also have representation from Family Medicine, Oral Health, Behavioral Health, Emergency Management Services, the Regional Hospital, Specialty Care, Medicaid, and SHIP staff. As the second cohort started, the RC recruited representation from each of the clinics. Near the end of the first cohort, we lost our Co-Chair due to retirement and the desire to travel. Dr. Bell was recruited to be the new Co-Chair. He is a Family Medicine Physician and is very established in the medical community. His clinic was also a cohort two clinic.

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The Regional Collaborative is supportive of PCMH development. The RC membership were involved in both the recruiting of clinics to be part of SHIP and in sharing of their best practices to clinics in all cohorts. Our RC Chair has personally talked to many clinics interested in the PCMH model and SHIP participation. He is also very willing to share best practices and his insight both regionally and statewide. He has participated in learning collaboratives, webinars, teleconferences and live meetings. Our RC Chair is also the Chair of the Medical Home Workgroup. Our Regional Hospital representative on the RC is also a member of the IHC. Meg Hall with the Medicaid Healthy Connections program has also been a key member of the RC and has contributed greatly to the PCMH efforts.

The RC started its interaction with the first cohort clinics at the kickoff meeting. The kickoff meetings became an annual event and gave the RC and clinics a chance to meet each other and learn. Another meeting that was key to the early success in our region was the PCMH meetings. These meeting were held roughly six times each year. Later in the grant we also started facilitating IIBHN meetings. These meetings continue to develop in scope and in attendance. We hope in future meetings we can establish a regular meeting structure with set times for this group.

The Regional Collaborative has been effective in supporting clinics in their PCMH transformations and integration into the Medical Health Neighborhood. The biggest challenges facing the RC has been time constraints and scheduling meetings to meet everyone's needs. As busy professionals, time is very limited. To save time, some members have participated in the meetings by phone. This approach has worked well in Region One. I feel the RC has been flexible and this has aided in the success of the RC. One area that required the RC to do something different was the RC mini grant. Because of time constraints, the RC formed a work group to work on the RC grant. Using the work group allowed many possible ideas to be vetted and in turn narrowed the choices down to three.

B.4. Other Focus Areas, please refer to strategic plan objectives

One area of focus in the Regional Collaborative's strategic plan is the review of the Community Health Assessment (CHA). In this last year of the SHIP grant, the Health District was due to complete a Community Health Assessment. Panhandle Health District assembled a team to engage community leaders in all five counties to give input on the various parts of the assessment. To obtain information from the citizens from each community, the Health District implemented an electronic health survey. The public was encouraged to complete the survey during public events in their community. A booth was set up at events with electronic devices available to take the survey at that time. The link to the survey was also published in the regional paper, on web sites and in various literature handed out. To help entice participation, a drawing for a kindle was advertised. The winner of the kindle was chosen from citizens of the region who participated in the community health survey.

Through a series of meetings over the last year, a review of health indicators and survey information gathered from a good segment of the population in all five counties, a Community Health Assessment (CHA) was completed. The RC Membership were briefed on the process from the beginning and were given updates throughout the process during regularly scheduled RC meetings. Some RC members

participated by taking the surveys and attending community meetings. The RC Membership's knowledge and experience of the region's health issues contributed greatly in this process.

After the CHA was completed, the Panhandle Health District team also worked with community leaders on developing a Community Health Improvement Plan (CHIP). The RC has been kept informed on this process and invited to be involved. The work on the CHIP has also been completed and presented to the community leaders in the Region. Work groups have been formed to implement the CHIP. An update on this process was also given to the Regional Collaborative Membership during at the scheduled meeting. The RC in the future could be a big asset in future CHA development and helping implement the CHIP throughout the region. The RC could help determine where shared savings should be used to benefit population health. This could be done with RC members serving on the Medicaid CHOICe board.

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

In late March 2018 a survey was sent out to RC membership. The survey's purpose was to find out what areas the RC Membership would like to see sustained after the SHIP grant ends. From that survey three areas were identified for sustainability. Those areas were holding regional PCMH meetings, continuing regional QI project(s), and promoting PCMH model to clinics in the region. All three of these areas revolve around the PCMH model of care which has been shown to improve quality of care, improve population health, and reduce the rate of health care cost growth.

Organizing and holding PCMH meetings is the first activity that the RC plans to continue. We would like to facilitate three PCMH meetings in 2019 at Panhandle Health District. We would like to also facilitate three IIBHN meetings in 2019 in the region. We plan to invite clinics that have an integrated behavioral health model and clinics that would like to learn more about this model. Behavioral Health Integration has been a focus for the RC as a mechanism for PCMH support, MHN engagement, and communication/advocacy. The IIBHN at the State level has five main goals include 1) provide education on different integration models regarding value, implementation, best practices, and resources; 2) facilitate opportunities for statewide and local professional network development among BHCs and administrators on a regular basis; 3) identify a common readiness tool and promote utilization of the NCQA guidelines for integrated behavioral health; 4) position the IIBHN as a key policy, advocacy, and technical assistance resource in the state of Idaho; 5) educate specialty behavioral health providers on integrated care and provide resources to improve co-management environment.

The second area the RC wants to sustain is having a regional quality improvement project. With clinic input, a new quality improvement project could be selected or the QI project from the previous two years could be continued. Many clinics have voiced their support for this project in the past. As stated earlier, this project was the reduction of the number of type 2 diabetics with uncontrolled diabetes as defined as A1C levels greater than 9%. We had nine clinics voluntarily participate in the education and implementation part of the QI project with seven of those nine clinics also provide base line and outcomes

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data. All SHIP clinics were encouraged to participate in the QI projects in the past. Following the SHIP grant, we would also like to reach out to other primary care clinics in the region to participate as well. This is a task that could be facilitated by the QI Specialist if funding is available.

The Third activity the RC would like to see continued after the SHIP grant is promoting the PCMH model of care. This task requires someone to actively promote the PCMH model of care to clinics not already in the PCMH transformation process. The person that makes the most sense to do this is the QI Specialist. There is a plan; supported by the Health District Directors, to propose legislative action that would fund five full-time QI Specialist positions statewide. The duties of this position would also include providing PCMH coaching to clinics in the region. This service would include both former SHIP clinics not receiving recognition and clinics just beginning or wanting to start PCMH activities. The QI Specialist in our region is a certified content expert for NCQA 2017 standards. Based on her training and experience over the last three years, the RC feels she could effectively coach clinics.

The QI Specialist provides support for new and established clinics, they also provide an avenue for clinical and community linkages, facilitating partnerships within the larger Medical Health Neighborhood. To continue this crucial support, backbone funding is needed. Types of technical assistance activities proposed to continue through QI support include advancing PCMH principles and practices through integrated behavioral health, group visits, team-based care, health literacy, motivational interviewing, health coaching and chronic disease self-management. The SHIP Health District teams from across the State recently developed a written justification for additional funding to be provided to the legislature for the continuation of the PHD SHIP QI Specialist role after the SHIP grant is complete.

Through our work with three cohorts of clinics, the RC and SHIP staff have put into place a network of clinics. The RC and the clinics are now able to provide peer to peer facilitation to help each other. Also, theses 24 clinics and the RC are willing and able to help mentor clinics new to PCMH concepts. This will also help grow the number of PCMH recognized clinics in our region in the years ahead.

RC Post SHIP The RC post SHIP will most likely transition to a smaller group. In the short term this group can support PCMH development. In the long term a core of the RC membership will most likely be tapped to serve on a regional Medicaid Advisory Board. This new RC will be structured to be aligned more with the Medicaid RCO to provide enhanced continuity of service and support to providers and systems. This includes independent provider perspectives and strategic planning as it relates to the RCO and CHOICe structures. Perhaps in the future this board will be tasked with deciding where a portion of the shared savings should be used to help population health. It is understood these potential shared savings will not be available for a few years.

Some of the areas identified in the CHIP will require a shift in financial resources to help meet the needs identified. When the Medicaid shared savings program is developed in Region 1 & 2, potentially some of the savings funds could be used to help fund CHIP plans in the future. As proposed in the Medicaid shared savings program, an advisory group would be formed to help with advising the program and choosing community health projects to be funded with a small portion of the shared savings. Some

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possible areas that could be funded to help CHIP implementation and result in better population health in the future could include CHW, CHEMS, telehealth, behavioral health integration and other initiatives.

Areas RC Not Able to Develop Further in Near Future

The RC Membership felt one of the activities that would not be focused on by the RC is the development of Community Health Workers (CHW). While the RC Membership sees the value in Community Health Workers, without funding there would be little resources for training or support for their activities after SHIP. The RC does not have the financial resources to move this effort forward. If funding incentives and other resources are obtained by other organizations; such as, FQHC Organizations, Tribal Organizations, and/or Hospital Networks CHWs could enhance population health efforts in the region. Large and small organizations are looking for a way to bill for the services prior to starting programs.

After the SHIP grant, the RC will not able to support the development of new CHEMS agencies. Also, most of the developed CHEMS agencies will need a revenue source to sustain their efforts. The ability for established CHEMS agencies to bill payors for services would help them sustain and grow their programs. This was a deciding factor for the largest EMS agency in our region not to become a CHEMS agency.

Telehealth is regularly utilized by two clinics in our region. These two clinics are willing to share best practices with other clinics. This has spurred other clinics' interest in telehealth. The limiting factor is the lack of most payors to allow for billing. Medicaid currently allows for billing of some codes. As payors accept billing codes for telehealth more clinics will be inclined to explore the options. The RC feels when the billing codes for telehealth are allowed, telehealth with grow naturally. The RC after SHIP does not plan to further facilitate telehealth.

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 2: North Central

A. Regional Collaborative (RC) Vision and Goals for Healthcare System Transformation

The mission of the North Central Health Collaborative (RC2) is to act as a forum where SHIP clinics share information about transformation into Patient Centered Medical Homes. Through incorporation of non-SHIP clinics in the Regional Collaborative, information about successful practice transformations can be used by new clinics to complete their own transformation. The RC identifies resources to achieve improved health outcomes, improved quality and patient experience of care, and lower costs for all Idahoans.

RC2's goals are:

To ensure the PCMH model is promoted in local healthcare practices; to ensure information on local resources for the Medical health neighborhood is readily available to local healthcare practices; and to identify resources on PCMH transformation that will be available to future clinics seeking transformation.

B. Accomplishments to Date

B.1. Patient-Centered Medical Home (PCMH) Support

The PMCH Support has been our primary focus through all cohorts. Building upon a mentor framework, assisting PCMH clinics to develop relationships with each other in a safe atmosphere that public health as fostered. Our QI Specialist has supported each cohort clinic as they work through the NCQA application process. She has advised them on NCQA criteria and assisted with quality improvement efforts to advance their NCQA efforts.

Our approach to bringing along the cohort clinics in a coaching and mentoring model around the RC table has not changed because of its success and value among RC members. Data has been the primary and ongoing challenge. A lack of access to real-time clinical data has left the group frustrated with not being able to show regional clinical or community outcomes. The initial wanting of the group to be able to show that through their PCMH efforts the regional community health data has improved, has been a dream not-yet realized.

Our PCMH clinics were able to develop a regional data workgroup in an effort to collate our own regional data but found this task to be beyond the available resources to accomplish due to differences in data collection methods and EMR challenges. The RC should continue to convene clinics and support the ongoing mentoring between clinics as they maintain their PCMH journey. This will maintain the triple aim because they will continue to share their best practices with each other. This will also reduce health care costs by reducing staff efforts to reinvent wheels that already exist.

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B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

The initial ideas surrounding the MHN suggested producing a resource guide for clinics to utilize for their referrals; this has proven a waste of resources. The paper version of a resource guide was let go because clinics already have their own internal referral sources and if they encounter situations in which they don't know where to refer they call each other or public health to suggest referral options in the community.

Facilitated collaboration efforts with several MHN groups including, behavioral health, chronic disease, tobacco, and oral health. These MHN efforts are ongoing based upon a collaborative of clinical and community health needs. Some of the ongoing MHN efforts include:

- Behavioral Health Integration at the clinical level as well as working in our communities around BH access has strengthened PCMH and community partnerships. As integration becomes more commonplace the community referrals and resources have been shared with all providers for safety planning in the home. With the ongoing increased emphasis on BH integration we are hoping to see an overall improvement in our suicide rates.

- Chronic Disease - Tobacco - Oral Health

B.3. RC Development and Implementation

Through regular meetings and joint participation of cohort clinics and public health, our Regional Collaborative 2 has focused its efforts on the development of relationships and best practice sharing among clinics. Beginning with cohort one, the relationships between clinics and PH were established. As additional cohorts were added in our Region, the RC was passionate about including all of the PMCH clinics from each cohort to be invited into the RC. Using the early cohort clinics as mentors to the new clinics quickly established a comradery between clinics and a natural safe space for all clinics to share best practices. The RC safe space allowed an enthusiastic exchange of dialogue and sharing of clinical expertise. Some of these joint efforts and sharing have included: transitional care management, chronic care management, community health workers, data sharing, behavioral health integration, HIT, oral health integration, billing and coding, and the implementation of group visits. The flexibility of the RC in meeting the needs of the clinics is evidence in letting the clinics set the agendas and, in their desire, to focus on these topics and share with others during these meetings.

B.4. Other Focus Areas, please refer to strategic plan objectives

A secondary accomplishment by community partners in the behavioral health neighborhood showed success in funding for a Regional Crisis Response Project. Although the RC was not the primary driving force in these efforts the RC was an active participant in the initial discussions and framework for crisis services. During our initial year with cohort one, it was determined that BH integration was a key focus for all clinics. With the intent of the medical home, BH was critical for inclusion in patient care. R2 has been lacking in community resources for client BH needs. The RC invited the behavioral health

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neighborhood partners to a joint meeting to discuss needs and gaps in our region. It was this gathering that nudged the community partners to focus on a strategy to bring crisis response services to each of our five rural counties. The neighborhood partners worked to design a regional model which would establish crisis response in each county rather than just one center for all five counties. This model was then proposed to H&W and ultimately the Legislature for funding.

Another secondary accomplishment was the linkage of CHW with the Snake River Community Clinic (the only free clinic in Region 2). The CHWs in our rural areas engaged with the rural clientele that did not have a PCMH and sought out the clinical services of SRCC. Many of our low income rural patients were unable to find transportation to town, which lead to them being unable to pick up their medications as the free clinic. Through our community partners and the CHW's a process was developed to have CHWs make a home visit to check on these patients and track their history and vital signs. This data was then related back to the SRCC who now mails some medications directly to patients unable to travel to town. The RC with the PCMH cohort clinics discussed this option using CHWs as the eyes and ears of the medical provider and then worked with the free clinic to implement this medication option.

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

The activity that needs to continue is the convening of the clinics, in order to offer support for the mentoring between clinics in our area. There are still a few clinics in our region that were not ready to work through PCMH and someone needs to stand ready to support them, when the time comes that they are ready to make the transition to become a PCMH.

There needs to be a mandate from funders that clinics will used their shared savings to fund public health in their community efforts to improve population health outcomes. It would be nice to know if the funders have had any discussion about shared savings and the role of public health and population health outcomes in those discussions. The IHC should lead the discussion that encourages funders (Medicaid) to continue these efforts.

If there is no additional state funding or funding provided through shared savings, then the RC as it currently exists will no longer be able to function. Our RC will either die or carry-on depending on the shared savings. But because of the lack of understanding of where clinics and payers stand in this process, as well as a lack of knowledge on how long this process will take we have a gap in our ability to say that it will continue to be funded any time in the near future.

Without the addition of funding, our RC has determined that clinic staff could join pre-existing coalitions within the region. Many of our PCMH clinic staff have, over time, participated in community coalitions, based on the topic of interest. Diabetes, Chronic Disease (High Blood Pressure, Heart Disease), Tobacco and Oral health coalitions have been ongoing community coalitions with Public Health involvement. RC members can or do attend as they are available. The RC members have expressed their support and

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appreciation for the RC format as it is a smaller group of like-minded clinics working toward collective outcomes. Coalitions also work toward improvements in community health outcomes however are very broad and diverse and often don't meet the needs of the clinics. Public Health will continue to partner with and support our regions clinics to the best of our abilities. We have a long standing, mutually respectful relationship with our clinics and we value each other in addressing community needs. Public Health will continue in our role of supporting our clinic partners because that is what we have always done.

We are fortunate to exist in a region where our rural nature has required us to work together as organizations in everything that we do in order to accomplish most goals. We are small, we are strong, we are partners, we will continue to foster and maintain those partnerships because there is no other way.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

Focus Area: Continue to convene clinics and support ongoing mentoring between clinics.

Objective(s): Before the end of the SHIP project, PHD program coordinators will include all SHIP cohort clinics in their outreach and planning of existing health coalitions to encourage the maintenance of clinic to clinic mentoring. Steps to achieve objectives: Be specific and include important subsets. Anyone should be able to pick up this document and understand what needs to happen. Who will do the work? For every task, there needs to be a responsible party or parties. Who will "own" these activities after SHIP concludes? What resources are needed for this step? Where will they come from? Consider staffing, financial resources, infrastructure, technical assistance, etc. Are there other supports needed to support the activity, (e.g., legislation, multi-payer alignment, etc.)? If funding is needed for this step, what funding strategies could be considered? Target date Enter a target date by which the activity must be completed. Q1 Q2 Q3 Q4 1. Invite clinics to participate in other coalition efforts occurring in the district. Existing program coordinators who convene coalitions in the health district. No additional resources are required.

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RC 3: Southwest

The Southwest Health Collaborative's mission is to support healthcare communities to improve health outcomes, delivery of care, quality of life and the environment for wellness and care while lowering the cost of care in Adams, Canyon, Gem, Owyhee, Payette, and Washington counties by providing a structured forum for sharing valuable knowledge, finding common solutions and identifying shared resources to the patient and the provider.

The Southwest Health Collaborative's goals include:

1. The facilitation of continuous PCMH support for all primary care practices in the Southwest Region. 2. Care coordination 3. Behavioral health 4. The maintenance of the SWHC as the leading advocacy voice for healthcare providers, organizations, and partners in the Southwest Region.

B. Accomplishments to Date

B.1. Patient-Centered Medical Home (PCMH) Support

The SWHC relied heavily upon the expertise and skills of the region's Quality Improvement Specialist to continually assess clinic needs. Early in the SWHC development, it was noted that there were an immense number of outreach programs targeted at primary care and that managing the extensive technical assistance could be more of a hindrance than help to clinics. Bandwidth for PCMHs and staff was becoming increasingly tight in the face of accelerating transformation activities. As a result, the SWHC decided to focus more on building system level solutions to support the PCMHs instead of developing new interventions or resources targeted exclusively at the primary care practices. This created a community team approach to supporting the PCMH as opposed to one that was solely directed at building capacity in primary care clinics. As a result, work highlighted in section B2 captures PCMH support but is more broadly applied to multiple stakeholders in the medical health neighborhood as partners in the work (ie IIBHN, care coordination, oral health workgroup, EMS partnerships).

The value of the Quality Improvement (QI) Specialist cannot be overstated. This key team member's role has been to cultivate close relationships with clinics, provide direct TA, and elevate significant challenges or observations to the SWHC. The QI Specialist's rapport, trust, and understanding with the clinic was integral to creating a positive transformation environment. This direct, personal relationship also helped the SWHC to avoid overburdening clinics with perceived "support" as the QI Specialist acted as a gatekeeper. We have consistently received positive feedback on the value of this position. Issues that have been elevated to the SWHC include challenges around coordinating with and integrating behavioral health, challenges in defining care coordination programs and connecting coordinator staff across care setting, and leveraging EHRs and the IHDE to engage population health management strategies. As a

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result of this feedback from the PCMHs, we have targeted workgroup solutions in integrated behavioral health, pursued grant funding in care coordination, and elevated the data issues to Idaho Department of Health and Welfare and the Idaho Healthcare Coalition.

Early in the SWHC development, a PCMH workgroup was formed to help practices across the region connect on key topics. However, with the role of the QI Specialist in place, we have found that these connections are occurring through an informal TA network that has formed. In addition, it is often a burden for clinic leads to take on another meeting in a busy clinic day. It may be beneficial to consider reconvening this group if QI support is no longer available.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

The SWHC has focused on five action areas as identified by membership in 2016 through a community health assessment and community health improvement plan including • Behavioral health • Oral health • Senior health • ED utilization • Care coordination

Originally, wellness exams and Latino health were included in these focus areas. However, these groups did not continue to convene after the first six months due to lack of momentum. They remain in "the parking lot" for the opportunity to potentially revisit. A lesson learned from this experience is to start with fewer focus areas and build momentum and capacity from there. For each of these focus areas, a workgroup was convened and tasked with developing and implementing one clinically focused solution and one community focused solution. Overall, this approach has been successful, generating a strong variety of projects with diverse stakeholders. Highlights include:

Idaho Integrated Behavioral Health Network (IIBHN):

The IIBHN represents behavioral health consultants and primary care practices across the state of Idaho. The group is dedicated to advancing the practice environment for integrated behavioral health throughout the state. The SHIP Managers from the SWHC and CHC are the lead facilitators for the state leadership group. The SWHC's BHI workgroup coordinates local activities and primarily pursues comanagement strategies. The IIBHN five main goals include 1) provide education on different integration models regarding value, implementation, best practices, and resources; 2) facilitate opportunities for statewide and local professional network development among BHCs and administrators on a regular basis; 3) identify a common readiness tool and promote utilization of the NCQA guidelines for integrated behavioral health; 4) position the IIBHN as a key policy, advocacy, and technical assistance resource in the state of Idaho; 5) educate specialty behavioral health providers on integrated care and provide resources to improve co-management environment (see Appendix 3 for the full strategic plan). In 2018, the IIBHN hosted its first annual conference, selling out in one week and bringing in national and local experts in integration with funding from ten different agencies totally approximately $19,000.

Let's Talk Series:

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The SWHC's BHI Workgroup decided to target communication between primary care providers and specialty behavioral health providers after receiving feedback from clinicians in both care settings indicating that there was room to improve co-management practices. This started with the development of a one-page guide (see Appendix 4) that was distributed in primary care clinics and behavioral health offices. The group received positive feedback from providers in both settings as well as requests to receive more training on integration and co-management. As a result of this work, the SWHC BHI workgroup, in partnership with the CHC, secured funding to bring in experts from the Farley Policy Center to train over 40 providers on best practices in working together. Not only was the training effective, but it also provided an opportunity to link the Farley Policy Center to the Division of Behavioral Health and Idaho Medicaid. This introduction resulted in a partnership that yielded TA from a Robert Wood Johnson grant. Finally, the BHI Workgroup has provided facilitation sessions between local behavioral health agencies and primary care practices to discuss information sharing. As a result, one of the largest primary care groups in the area now has a standard referral management process with behavioral health agencies.

Healthy Minds Partnership:

The SWHC's BHI Workgroup has also pursued a more community-based strategy to support the practice environment for providers and more importantly the health of the population through a partnership with schools. The group has worked closely with two local foundations, a local school district, and a wide variety of TA partners through the workgroup to develop a partnership between external behavioral health agencies and school districts. The group brought together public health, Optum, and local providers to determine a process for embedding services on-site in schools. This process has not only served seven schools in the district but has also been documented to share with school districts across the state who may be interested in implementing (see Appendix 5). It is worth noting that several local PCMHs have requested referral information for these providers in the schools as it greatly reduces barriers to access to care for children. A major success and lesson learned from this work is that multisector partnerships at the local level can have profound impacts on practice environments and access issues.

Dental Care Coordinator Project:

In partnership with the CHC, the SWHC Oral Health Workgroup collected pilot data on four dental practices including private practices and FQHCs. Out of 375 patients assessed, 145 or 39% did not have a primary care provider (PCP). In fact, 12% of all patients had high blood pressure and were unmanaged. This data was used to develop a dental care coordination program to connect dental patients without a PCP to a clinical organization to manage their medical needs. Dental hygienists from Delta Dental were placed in a pilot clinic over the summer of 2018 to trial the coordination program.

EMS Social Services and Communication Partnership:

The Senior Workgroup has targeted working with EMS agencies to enhance communication with both patients and primary care providers. As a result of this work, the largest paramedic agency in the region

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was trained on social services resources and distributed over 500 referral cards for non-medical assistance to community members in their homes. In addition, the group developed a process for EMS to notify primary care providers when a patient was repeatedly using EMS.

Brief Intervention for Behavioral Health Providers ED Utilization Pilot:

The ED Utilization Workgroup and BHI Workgroup have partnered to target the behavioral health component of repeat utilization patterns. A local primary care group will flag high utilizers and use excess utilization (as determined by a primary care provider) as referral criteria for behavioral health. The behavioral health agency will then work with the patient to address underlying mental health, substance use, or health behavior patterns. Utilization will be tracked over time and reported out.

IDCareNetwork:

As described in section B1, the SWHC received feedback from PCMHs and other medical health neighborhood partners regarding the challenges of coordinating within the care coordinator community. As a result, the group created the IDCareNetwork with RC Grant funding from CMMI via the IDHW Office of Healthcare Policy as the granting agency. This funding allowed the SWHC to host several trainings on key elements of care coordination (including registry management, billing and coding, and motivational interviewing), create a directory of care coordinators across settings including primary care, inpatient care, behavioral health, payer groups, and specialists, and create a local peer network. As a result of this work, over 100 care coordinators are now linked via the directory and there is now an established network group that meets quarterly to connect and share best practices.

In addition to these efforts, the SWHC has experienced success in the medical health neighborhood through relationship develop across care settings and sectors. For example, through the meetings health systems have been able to connect with vision care providers to help close gaps in care for diabetic eye exams. Primary care providers have begun working with local elected officials on mental health and community wellbeing policies. Schools have started working with the health sector to partner on services. These accomplishments, while not driven by the SWHC, were cultivated through relationships originating within the SWHC. As a result, the collateral benefits of convening have been immense.

Lastly, it is important to note that the SWHC very intentionally positioned primary care clinics as partners (instead of drivers) in MHN development work. As primary care is asked to do more and more, it is crucial that their care partners and community partners help create a supportive context for the work of the PCMH. Often, bandwidth is taxed at the primary care setting and they simply need to ground truth supportive interventions instead of doing the legwork to implement.

These strategies have allowed us to be very active and for the most part successful in our MHN work.

B.3. RC Development and Implementation

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As previously described, the SWHC was formed in late 2015 and met for the first time in January of 2016. Membership was selected by the executive committee to represent a broad range of healthcare providers and MHN partners. Initially, membership very formal and only the defined SWHC members participated in decision-making. It was this group that supported a more defined priority selection process through the CHA. As previously described, primary care organizations and hospitals emphasized that the focus of the collaborative should be on MHN activities that supported the PCMH and advocacy/communication to reduce the burden on systems that were already strained. As a result, the selected focus areas were organized into workgroups with both a clinical activity and a prevention activity. This structure remains in place. Aspects of this model are detailed below.

Democratic Selection Process The process for selecting key priorities was intentional and was designed to give membership a voice in the activities for the next three years. We believe that the process, based on quantitative and qualitative community data was crucial to promoting buy-in and participation.

Focus of Activities Outside of PCMH As healthcare transformation accelerates, primary care providers and hospital systems are at the nexus of this change. The SWHC strongly believes that these organizations should help drive change but that it should not be the exclusive responsibility of primary care and hospitals to develop and implement systems improvements. Early in the process, we heard from stakeholders from these care settings that there was a high level of change fatigue from providers and administrators. As a result, we aimed to design projects and processes that were supportive of enhanced care environments for primary care and hospitals but did not put the primary responsibility for implementation on them.

Workgroups The workgroups were a key element for the work of the SWHC. Based on the Central Oregon CCO, the workgroups allowed the SWHC to manage multiple improvement projects simultaneously without overwhelming the leaders on the SWHC. The workgroups could rapidly iterate designs between the SWHC meetings, report out, and allow the SWHC to function in more of an advisory capacity.

Data Initially, the SWHC focused on obtaining data from the IHDE data analytics output. However, implementation of interventions would have been much more rapid had the group simply used local data for baseline and evaluation analysis. Reliance on high level reporting inhibited the initiation of projects when a constellation of hospital and self-report data would have been sufficient.

B.4. Other Focus Areas, please refer to strategic plan objectives

Another key function of the SWHC has been a focus on advocacy, communication, and coordination. The group has attempted to be intentional about addressing truly local issues and elevating more systemic, high level challenges. For example, reimbursement for virtual PCMH services has been a consistent challenge for practices in the region. However, the SWHC lacks the influence to change this at the state level. As a result, it was elevated to the IHC as the SWHC assumed more of an advocacy/communication role. Coordination has been an outgrowth of communication goals. This includes activities such as

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hosting “Regional QI” calls to bring together multiple QI agencies (IPCA, Pfizer, St. Luke’s Health Partners, Central District Health, the Saint Alphonsus Health Alliance. Even more significantly, the Executive Committee (EC) of the SWHC has played a key role in elevating provider voices in design of Medicaid Transformation in Idaho. The EC has conducted several meetings, in partnership with the EC for the CHC, with Medicaid leadership. Through the summer of 2018, the EC will be inviting provider partners to participate in development sessions with the Medicaid team to help inform design. This demonstrates the power of the SWHC in elevating the voices of local providers to shape statewide policy.

The SWHC has also been responsible for several population health activities. As previously reported, the group conducted a region-wide CHA and improvement plan. Participants have also been invited to participate in the CHA work of local hospital systems and the United Way of Treasure Valley.

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

The SWHC will work with the CHC to merge leadership and activities. This is a result of overlapping health systems, service areas, and projected ACO coverage. The RC Leadership for both groups believe that it is more efficient and ultimately advantageous to align resources and representation as Canyon and Ada Counties continue to blend with regards to health system efforts.

Three key areas of focus have been identified for post-SHIP transition in alignment with the CHC as the RCs are combined: 1) Care coordination 2) Behavioral health integration 3) PCMH Support

These focus areas were selected by key members of each of the RCs and the ECs as being high impact, in alignment with current activities, and scalable. Each focus area is highlighted in more detail below:

Care Coordination

Care coordination is a natural fit for the RCs as they engage key stakeholders and leadership across various health and health-related care settings. By providing enhanced connections among providers to support communication along the same lines that patients travel, care coordination helps improve patients experience through information and navigation, outcomes through medical decisions that are made by teams of providers with the right information, cost by reducing complications and duplication, and finally provider satisfaction by supporting the provision of the most information possible to make care decisions. Two key current activities will be maintained and expanded by the combined RCs in the future.

Pathways Community Hub Model: For the past year, the CHC has focused its efforts on discussing and developing a proposal to implement the Pathways Community Hub model. The Pathways Community Hub model is an evidence-based model that focuses on prevention and early treatment by connecting at-risk individuals to social services that support patient care plans and produce positive health outcomes. The HUB is a shared database that tracks referrals and connects children and their families to services they need to live healthy lives. Specifically, the CHC has spent time building partnerships with local

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SHIP clinics, elementary schools, nonprofits and payers to focus on connecting local elementary school aged children and their families to resources for basic needs, like food, clothing, housing and transportation. The CHC and the SWHC plan to work together to implement the Pathways Community HUB model to effectively address the priorities and challenges that face low-income children and families in the Treasure Valley. We aim to demonstrate that the Pathways Community HUB model is an effective approach to reach at-risk individuals in the community and reducing disparities by connecting medical care and social services through community-based care coordination.

IDCareNetwork: The IDCareNetwork was created through a grant to the SWHC by CMMI via the IDHW Office of Healthcare Policy to establish a web-based tool to help care coordinators find contact information for other care coordinators across the valley and create a network for these professionals. The web-based tool now has over 90 users and 30 organizations represented. The professional group is meeting quarterly and has reported that the networking and learning opportunity is crucial to their connections to other care settings with which they share patients. The tool and the group is easily scalable. The only funding required is some staff time for maintenance and webpage hosting.

Behavioral Health Integration While not explicitly described as one of the goals of the SWHC or the CHC, behavioral health integration has been a central focus for the RCs as a mechanism for PCMH support, MHN engagement, and communication/advocacy. We anticipate that the RC will continue to support activities in this area as described below.

Idaho Integrated Behavioral Health Network (IIBHN): As mentioned above, the IIBHN represents behavioral health consultants and primary care practices across the state of Idaho. The group is dedicated to advancing the practice environment for integrated behavioral health throughout the state. The SHIP Managers from the CHC and SWHC are the lead facilitators for the state leadership group. The IIBHN five main goals include 1) provide education on different integration models regarding value, implementation, best practices, and resources; 2) facilitate opportunities for statewide and local professional network development among BHCs and administrators on a regular basis; 3) identify a common readiness tool and promote utilization of the NCQA guidelines for integrated behavioral health; 4) position the IIBHN as a key policy, advocacy, and technical assistance resource in the state of Idaho; 5) educate specialty behavioral health providers on integrated care and provide resources to improve comanagement environment. In 2018, the IIBHN hosted its first annual conference, selling out in one week and bringing in national and local experts in integration with funding from ten different sponsorship agencies including St. Luke's Health Partners, Saint Alphonsus, Optum, the Blue Cross of Idaho Foundation for Health, St. Mary's Clearwater, the Region 3 Behavioral Health Board, IDHW Division of Behavioral Health and others, totaling approximately $19,000. This funding was used to secure speakers for the event and support event costs.

Healthy Minds Partnership: As previously described, the Healthy Minds Partnership is focused on enhancing access to behavioral health services for children and adolescents through the cultivation of partnerships between behavioral health agencies and schools. We anticipate that the RC will continue to

serve as a TA and network development lead for this work. The Blue Cross of Idaho Foundation for Health and Optum of Idaho have committed to financially supporting continued programming. In addition, the Federal Reserve Bank of San Francisco has committed to hosting convenings across the state through September 2018 to help scale.

RIBHHN-In order to support ongoing development in behavioral health integration, SWDH applied for HRSA funding to enhance local integration resources and plan to scale to the rest of the state through IIBHN hubs.

PCMH Support

Quality Improvement Staffing: The SHIP Quality Improvement (QI) Specialists work with independent and group primary care clinics in each region in Idaho to support adoption of the PCMH model. Not only do the QI Specialists provide support for new and established clinics, they also provide an avenue for clinical and community linkages, facilitating partnerships within the larger Medical Health Neighborhood. In order to continue this crucial support, backbone funding is needed. Types of technical assistance activities proposed to continue through QI support include advancing PCMH principles and practices through integrated behavioral health, group visits, team-based care, health literacy, motivational interviewing, health coaching and chronic disease self-management. The CHC and the SWHC groups recently developed a justification for additional funding to be provided to the legislature for the continuation of the PHD SHIP QI Specialist role after the SHIP grant is complete. This role is critical for the success of practices, especially those that are independent and/or rural, as they work to transform. The QI Specialist allowed the SWHC to function at a broader level of healthcare transformation and prevent local clinics from being overwhelmed by support activities.

Medicaid RCC and System ACO Alignment-The new combined RC will structure itself to be aligned more with the health systems and the Medicaid ACO region to provide enhanced continuity of service and support to providers and systems. Historically, the SWHC and CHC have coordinated activities but by combining, it will allow the RC to better serve the needs of health systems as a whole and leverage potential funding through these structures. While no funding is required to support this alignment directly, it is important that capable staff remain in place to continue the convening of the RC. This will promote sustainability for the group. This work is scalable to other regions but may or may not be appropriate based on service area coverage of health systems. Currently the SWHC and the CHC are participating in conversations with Medicaid to discuss RCC planning and alignment of efforts and goals. This includes independent provider perspectives and strategic planning as it relates to the RCC and CHOICe structures. Specifically, this group has been working with Medicaid to form a provider workgroup to help advise Medicaid on transitions. This group is also meeting with private payers as well as the Saint Alphonsus Health Alliance and St. Luke's Health Partners (SLHP) to determine alignment with their delivery models. In addition, the SWHC and CHC are working together to develop strategy with St. Luke's Health Partners, PacificSource, and SelectHealth.

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Activities that should be let go include dedicating meeting time to update sharing, working on reimbursement issues, data management at the local level until appropriate infrastructure is in place, and direct clinic representation to deemphasize an exclusive healthcare focus.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 4: Central

A. Regional Collaborative (RC) Vision and Goals for Healthcare System Transformation

Review your RC's original vision and/or mission and goals. Does the vision and/or mission and goals still accurately describe what your RC is working towards? Adjust as needed so that your vision and/or mission and goals reflect your next priorities beyond the SHIP funding period. (It might be helpful to first complete Sections B and C, which describe your RC's accomplishments to date and focus areas moving forward, before completing this section. Your RC's vision and/or mission and long-term goals should build on your successes to date and provide a unifying direction for your identified focus areas moving forward.)

Briefly describe your RC's post-SHIP vision and/or mission and long-term goals.

The mission of the Central Health Collaborative (CHC) is to organize healthcare stakeholders by providing a structured forum for sharing valuable knowledge, making connections, finding common solutions and identifying resources to improve health outcomes, improve quality and patient experience of care, lower costs of care and improve joy of practice in Region 4.

The Central Health Collaborative's goals are:

1. Develop a sustainable combined Regional Collaborative (RC) structure with Region 3's Southwest Health Collaborative group. 2. Strengthen partnerships within the Medical Health Neighborhood (MHN) throughout the Southwest Region of Idaho, to include the 10-county service area of Regions 3 and 4. 3. Support shared population and community health goals of Idaho's healthcare system transformation from a fee-for-service model to a sustainable value-based model. 4. Communicate regional efforts, successes and challenges to all stakeholders and partners.

B. Accomplishments to Date

B.1. Patient-Centered Medical Home (PCMH) Support

The Central Health Collaborative (CHC) is an engaged group of diverse and passionate stakeholders that includes primary care providers, representatives from community and social service organizations, local elementary schools, and various other Medical Health Neighborhood (MHN) professionals and leaders. The CHC came together in January of 2016 to focus on building partnerships across the fields of medical and community health, in addition to encouraging participation from Patient-Centered Medical Home (PCMH) SHIP clinic physician champions and staff. Knowledge and expertise among members is shared freely and meetings provide a forum for discussion and professional guidance for the Public Health District (PHD)4 SHIP Team as well as one another. CHC meetings are an open platform to make

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connections and to share resources, knowledge and ideas to identify duplications, examine available data and ultimately improve the current healthcare landscape throughout Region 4.

The CHC relies upon the knowledge and expertise of the PHD Quality Improvement (QI) Specialists to provide PCMH transformation support to clinics and practices in Region 4, with CHC members playing an advisory role. The QI Specialists have the skills to assess and monitor clinic progress and needs, resulting in extremely successful partnerships to assist clinics in the transformation process. The QI Specialists have successfully worked within a wide variety of clinic structures and cultures, adapting training needs as necessary and connecting clinics to much needed resources for their patients. These individuals have also had the opportunity to assist in evaluating clinic policies, procedures and workflows, that have an impact on both staff workload and patient care. All of the work implemented by the QI Specialists is presented to the CHC, resulting in opportunities for discussion and feedback on the clinic transformation process as well as potential areas of alignment across clinic practices.

As a result of this work and guidance from the CHC, the PHD4 SHIP Team have been able to successfully engage all Cohort 1, 2 and 3 SHIP clinics in the PCMH transformation process. Specifically, the QI Specialists take in-clinic opportunities to implement QI activities that educate staff on the importance of role delineation in care teams by promoting the roles of the Nurse Practitioner (NP), Physician's Assistant (PA) and Clinical Pharmacist (PharmD), in order to improve access to care. They have also worked collaboratively with clinic staff to train care team members on various concepts and methodologies, including advanced access scheduling, empanelment, health literacy and after hours' accessibility. QI Specialist(s) have also encouraged the implementation of shared medical appointments or group visits for various chronic conditions including diabetes and asthma.

Outside of the clinic setting, the QI Specialists have been able to provide technical assistance and support through educational webinars, electronic health record (EHR) utilization learning sessions, resource sharing and relationship building as well as training opportunities provided at local MHN meetings and networking events. Examples such as these, have led to positive outcomes for SHIP clinics. As a whole, the majority of the SHIP clinics in Region 4 have made several notable improvements to their practice through PCMH and QI efforts, becoming successfully engaged in the process. As a result, twenty-eight (28) SHIP clinics are applying or have applied for NCQA recognition in Region 4.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

As noted in Section A of this document, the CHC is focused on strengthening partnerships within the Medical Health Neighborhood (MHN). The CHC attempts to meet this goal in a variety of ways. Specifically, by identifying and sharing promising practices for successful care coordination, including improving strategies for communication between medical providers and community service organizations in the MHN, including specialty care, behavioral health, caregiver services, and social service organizations.

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CHC members and stakeholders have identified a variety of key focus areas to assist clinics in PCMH transformation. Specifically, focus areas include care coordination and management across various care settings, behavioral health integration, resource sharing and strategies to develop meaningful relationships and partnerships. Available data sources are also shared with members, as meetings are utilized to present community data, including data sets from Pfizer, Medicaid, local hospital Community Health Needs Assessments (CHNA) and the Asset Limited, Income Constrained, Employed (ALICE) report from United Way, to ultimately spark conversation around the collective impact concept and various avenues for increasing access to care.

Early on, the CHC determined a need to identify clinical and community linkages throughout the MHN. Through a voting process, the group decided to support family caregivers in their unique role as an extended member of the health care team. By taking advantage of the available Regional Collaborative (RC) subgrant opportunity, the PHD4 SHIP Team and the CHC implemented a highly successful Caregiver Integration Project to educate and train clinic staff and Community Health Emergency Medical Service (CHEMS) agencies on identifying and assessing caregivers for their needs, improving knowledge and referring to local community care coordination agencies for resource assistance and navigation.

In addition, the CHC has spent time identifying opportunities to align efforts with the various programs administered by Central District Health Department (CDHD), including the Idaho Physical Activity and Nutrition, Tobacco Cessation and Heart Disease, Diabetes and Stroke programs. The PHD4 Policy Analyst, SHIP Manager and QI Specialists work closely with one another to connect clinics to subject matter experts and resources for tobacco cessation, obesity prevention and diabetes and hypertension.

Specifically, Tobacco Quit line flyers have been implemented in SHIP clinics and patient education brochures have been translated into Spanish at the request of our SHIP Cohort 1 clinic staff. The PHD4 SHIP Team also developed a MHN survey to assess clinic knowledge and understanding of local diabetes resources in the community. The survey was sent to all cohort 1 clinics. Based on responses received, a MHN meeting for Diabetes was coordinated and scheduled. Local diabetes service providers and organizations were invited to attend, to share resources and make lasting connections with SHIP clinic staff for referral and patient financial assistance.

The area of Behavioral Health Integration (BHI) is also a priority and focus for the CHC, informed by demonstrated clinic need and interest. Specific examples of how the PHD4 SHIP Team and the CHC support BHI and the connecting between primary care and specialty mental health, are listed below:

Idaho Integrated Behavioral Health Network (IIBHN):

The IIBHN represents behavioral health consultants and primary care practices across the state of Idaho, who are dedicated to advancing the practice environment for integrated behavioral health. The SHIP Managers from the CHC and Southwest Health Collaborative (SWHC) are the lead facilitators for the state leadership group. The IIBHN has five overarching goals. These include: 1) to provide education on different types of integration models regarding value, implementation, best practices, and resources; 2) to

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facilitate opportunities for statewide and local professional network development among BHCs and administrators on a regular basis; 3) to identify a common readiness tool and promote utilization of the NCQA guidelines for integrated behavioral health; 4) to position the IIBHN as a key policy, advocacy, and technical assistance resource in the state of Idaho; 5) to educate specialty behavioral health providers on integrated care and provide resources to improve co-management environment. In 2018, the IIBHN hosted its first annual conference, selling out in one week and bringing in national and local experts in integration with funding from ten (10) different agencies, totaling approximately $19,000 in support.

Let's Talk Series:

In partnership with the SWHC Behavioral Health Integration (BHI) Workgroup, the CHC decided to target communication between primary care providers and specialty behavioral health providers after receiving feedback from clinicians in both care settings that there was room to improve co-management practices. The group received positive feedback from providers in both settings as well as requests to receive additional training on integration and co-management. As a result of this work, the SWHC BHI workgroup, in partnership with the CHC, secured funding to bring in experts from the Farley Policy Center to train over 40 providers on best practices in working together. Not only was the training effective, but it also provided an opportunity to link the Farley Policy Center to the Division of Behavioral Health and Idaho Medicaid. This introduction resulted in a partnership that yielded technical assistance from a Robert Wood Johnson grant.

B.3. RC Development and Implementation

In January of 2016, the PHD4 SHIP Team and the CHC Executive Leadership team began the strategic planning process by developing a charter that aligned with the statewide SHIP Operational Plan. The charter was approved and adopted by the CHC Leadership team in February of 2016 and provided a foundation from which the strategic plan was built and subsequently updated each year.

The CHC identified five overarching goals and objectives to help develop foundational and enhanced infrastructure for PCMH transformation and improved coordination in the broader MHN. These goals have been expanded upon and can be found in Section A of this document. Each objective was coupled with strategies, time frames, target measures, status indicators, and responsible parties to ensure the CHC remained on track for goal completion throughout the SHIP grant and to ultimately strive for the quadruple aim – lower cost, better health, better health outcomes and greater provider satisfaction, throughout the region.

In regards to implementation of strategic plan activities, the PHD4 SHIP Team along with the CHC identified a need amongst Cohort 1 and Cohort 2 clinics that use AthenaClinicals (Athena) as their electronic health record (EHR). Staff from various clinics wanted to learn more about the complexities of Athena and how to utilize the system to help improve patient care. Several clinics who recently implemented this EHR or were considering purchasing Athena, were looking for tips to become a more efficient utilizer. A physician volunteered to share his knowledge, expertise and workflow processes of

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Athena with other SHIP clinic care teams, including the use of encounter notes, patient portal access and practice management reporting. This physician champion worked alongside the PHD4 SHIP QI Specialists, to lead an hour-long utilization webinar where he guided an educational walkthrough of Athena, based on questions gathered from other Cohort 1 and 2 SHIP clinics throughout the state. Hosting this webinar led to an in-person mentorship opportunity and relationship building session between various SHIP clinics and the Idaho Primary Care Association (IPCA).

As a multi-sector stakeholder group, the CHC has learned that PCMH transformation is an ongoing process. Transformation works best with buy-in and engagement from all levels of the clinic rather than having only leadership engaged in conversations related to transformation. This has been a great start to the transformation process for many clinics in Region 4. Through the work of the QI Specialists and continued engagement from CHC members, the group has identified a variety of opportunities that could be considered for project continuation post-SHIP. Those opportunities include advancing care coordination, progressing behavioral health integration and continued Medical Health Neighborhood development and PCMH transformation support.

B.4. Other Focus Areas, please refer to strategic plan objectives

Regional Quality Improvement (QI) Calls

In partnership with SWHC, the CHC works to build cross-agency partnerships connect on the QI work that is occurring our communities at the regional level. This includes activities such as hosting Regional QI calls to bring together multiple QI agencies, including IPCA, Pfizer, St. Luke's Health Partners and the Saint Alphonsus Health Alliance, to discuss what each organization is working on and how we may partner together to reduce duplication of efforts.

Dental Care Coordinator Project

In partnership with the CHC, the SWHC Oral Health Workgroup collected pilot data on four dental practices including private practices and FQHCs. Out of 375 patients assessed, 145 (39%) did not have a primary care provider (PCP). In fact, 12% of all patients had high blood pressure and were unmanaged. This data was used to develop a dental care coordination program to connect dental patients without a PCP to a clinical organization to manage their medical needs. Dental hygienists from Delta Dental will be utilized over the summer of 2018 to trial the coordination program.

Medicaid Transformation Alignment

The Executive Leadership Teams from the CHC, and the SWHC, have played a key role in elevating provider voices in the design of Medicaid Transformation in Idaho. These teams have conducted several meetings with Medicaid leadership, representing the independent and system level provider voice. Through the summer of 2018, these teams will be inviting provider partners to participate in development sessions with the Medicaid team to help inform design. This demonstrates the power of the RCs in elevating the voices of local providers to shape statewide policy.

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C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

The CHC, along with SWHC, have identified three key areas of focus for post-SHIP transition as the two RCs are combined. See section below regarding Regional Collaborative Alignment for more detailed information. These focus areas include:

1. Care Coordination 2. Behavioral Health Integration 3. Patient Centered Medical Home (PCMH) Support

These focus areas were selected by key members of each of the RCs and the Executive Leadership teams as having potential for high impact, in alignment with current activities, and scalable. Each focus area is highlighted in more detail below:

1. Care Coordination

Care coordination is a natural fit for the RCs as they engage key stakeholders and leadership across various health-related care settings. By providing enhanced connections among providers to support communication along the same path that patients travel, care coordination helps to improve the patient experience through information and navigation, outcomes through medical decisions that are made by teams of providers with the right information, cost by reducing complications and duplication, and provider satisfaction by supporting the delivery of the most information possible to make care decisions. Two key current activities will be maintained and expanded by the combined RCs in the future.

Regional Collaborative Alignment

Over the course of the past year, the CHC has focused its efforts on discussing and developing a proposal to implement the Pathways Community Hub model. The Pathways Community Hub model is an evidence-based model that focuses on prevention and early treatment by connecting at-risk individuals to social services that support patient care plans and produce positive health outcomes. Specifically, the CHC has spent time building partnerships with local SHIP clinics, elementary schools, non-profits and payers to focus on connecting local elementary school-aged children and their families to resources for basic needs, like food, clothing, housing and transportation.

However, the CHC participated in various discussions regarding the feasibility of the Pathways Community Hub model in the Treasure Valley and whether or not the state of Idaho currently has the value-based payment structures in place to truly support the implementation of this model. Various questions and concerns have been raised regarding the feasibility of implementation, specifically given the current timeline of the SHIP grant.

As a result, the CHC and the SWHC plan to work together to build a combined Regional Collaborative structure, loosely based on the HUB model concept, to effectively address the priorities and challenges

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that face our shared communities. With the help of a local consultant, we aim to develop a shared charter for this group, resulting in equal representation from both Regions 3 and 4. In addition, the Healthy Connections Value Care Program (HCVCP), within the Division of Medicaid, is in the process of pursuing movement towards a health care system for Medicaid patients that transitions providers and other stakeholders away from focusing on volume to a system that delivers better care, better health for communities and achieves lower costs.

The HCVCP seeks to transform the Medicaid system by establishing three to five Regional Care Collaboratives (RCCs) advised by Community Health Outcome Improvement Coalitions (CHOICe). Currently the CHC and the SWHC are participating in conversations with Medicaid to discuss RCC planning and alignment of efforts and goals with local Regional Collaboratives. This includes independent and system level provider perspectives and strategic planning.

IDCareNetwork

The IDCareNetwork was created through a grant opportunity awarded to the SWHC by the IDHW Office of Healthcare Policy Initiatives, to establish a web-based tool to help care coordinators find contact information for other care coordinators across the valley and create a network for these professionals. The web-based tool now has over 90 users and 30 organizations represented. The professional group is meeting quarterly and has reported that the networking and learning opportunity is crucial to their connections to other care settings with which they share patients. The tool and the group is easily scalable. The only funding required is some staff time for maintenance and webpage hosting.

2. Behavioral Health Integration

While not explicitly described as one of the goals of the CHC or the SWHC, behavioral health integration has been a central focus for the RCs as a mechanism for PCMH support, MHN engagement, and communication/advocacy. We anticipate that the RC will continue to support activities in this area, as described through the mechanisms below.

Idaho Integrated Behavioral Health Network (IIBHN)

As mentioned above, the IIBHN represents behavioral health consultants and primary care practices across the state of Idaho. The group is dedicated to advancing the practice environment for integrated behavioral health throughout the state. The SHIP Managers from the CHC and SWHC are the lead facilitators for the statewide leadership group. IIBHN meetings serve as an opportunity to collaborate on provider outreach and education opportunities, capacity building and status assessment of the strategic plan. The overarching goals of the IIBHN are listed in Section B.2 of this document. In 2018, the IIBHN hosted its first annual conference, receiving funding from over ten (10) different agencies interested in advancing integrated behavioral health, totaling approximately $19,000 in funds.

Healthy Minds Partnership

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The Healthy Minds Partnership is focused on enhancing access to behavioral health services for children and adolescents through the cultivation of partnerships between behavioral health agencies and schools. We anticipate that the RC will continue to serve as a technical assistance and development lead for this work. The Blue Cross of Idaho Foundation for Health and Optum of Idaho have committed to financially supporting continued programming. In addition, the Federal Reserve Bank of San Francisco has committed to hosting convenings across the state through September 2018.

Rural Integrated Behavioral Health Hub Network (RIBHHN)

In order to support ongoing development in behavioral health integration, Southwest District Health (SWDH) applied for HRSA funding to enhance local integration resources and plan to scale to the rest of the state through the local IIBHN hubs. There is a small budget to support SHIP staff management of the grant and the team will hire a dedicated project coordinator who will work closely with the Region 3 Behavioral Health Integration Workgroup and the IIBHN.

3. PCMH Support

Quality Improvement Staffing

Since 2015, the PHDs have been convening healthcare leaders and stakeholders across the state to localize healthcare transformation and cultivate regional expertise in practice transformation. This support is critical to advancing the practice and payment environment across Idaho. To continue the momentum, two key activities should be maintained beyond the SHIP grant: 1) convening the Regional Collaboratives and 2) providing patient-centered medical home support through PHD based Quality Improvement Specialists.

Each PHD provides administrative and operational support to facilitate and host meetings, providing a home-base for partners to come together to make connections and find common solutions to local issues. The SHIP QI Specialists provide support for new and established clinics and provide an avenue for clinical and community linkages, facilitating partnerships within the broader MHN. In order to continue this crucial support, backbone funding is needed. Types of technical assistance activities proposed to continue through QI support include advancing PCMH principles and practices through integrated behavioral health, group visits, team-based care, health literacy, motivational interviewing, health coaching and chronic disease self-management. The CHC and the SWHC recently developed a position justification for additional funding to be provided to the legislature for the continuation of the SHIP QI Specialist role after the SHIP grant is complete.

Regional Care Collaborative (RCC) Alignment

As mentioned above, as part of the Healthy Connections Value Care Program (HCVCP), within the Division of Medicaid, the state of Idaho is pursuing movement towards a health care system for Medicaid patients that transitions providers and other stakeholders away from focusing on volume to a system that delivers better care, better health for communities and achieves lower costs.

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The HCVCP seeks to transform the Medicaid system by establishing three to five Regional Care Collaboratives (RCCs) advised by Community Health Outcome Improvement Coalitions (CHOICe). The role of the RCC is to be accountable for community engagement to improve cost, quality and utilization across the region.

Currently the SWHC and the CHC are participating in conversations with Medicaid to discuss RCC planning and alignment of efforts and goals. This includes independent and system level provider perspectives and strategic planning, as it relates to the RCC and CHOICe structures. Specifically, this group has been working with Medicaid to form a provider workgroup to help advise Medicaid on transitions. This group is also meeting with private payers as well as the Saint Alphonsus Health Alliance and St. Luke's Health Partners (SLHP) to determine alignment with their delivery models.

Beyond that, there are various activities that should be phased out of the RC structure, due to lack of available resources and time, as the SHIP grant comes to a close. Activities that should be phased out, include dedicating meeting time to update sharing, working on reimbursement issues and data management at the local level, until the appropriate infrastructure is in place across the state.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 5: South Central

A. Regional Collaborative (RC) Vision and Goals for Healthcare System Transformation

Briefly describe your RC's post-SHIP vision and/or mission and long-term goals.

The mission of the South Central Regional Collaborative is to act as a forum where SHIP clinics share information about transformation into Patient Centered Medical Homes. Through incorporation of non-SHIP clinics in the Regional Collaborative, information about successful practice transformations can be used by new clinics to complete their own transformation. The RC identifies resources to achieve improved health outcomes, improved quality and patient experience of care, and lower costs for all Idahoans.

SHC's goals are:

To ensure the PCMH model is promoted in local healthcare practices; to ensure information on local resources for the Medical health neighborhood is readily available to local healthcare practices; and to identify resources on PCMH transformation that will be available to future clinics seeking transformation

B. Accomplishments to Date

Describe what your RC has accomplished across each of your focus areas, as outlined in the RC Strategic Plan and Subgrant Scope of Work, and what has made your RC successful.

B.1. Patient-Centered Medical Home (PCMH) Support

In November 2015, the RC co-chair, Dr. Kohtz, spoke at the SCPHD Legislative Update. Several legislators voiced their approval of the PCMH model and the SHIP agenda. Several even asked where they could go to be seen by a PCMH provider. The RC chair, Dr. Keith Davis, took time to visit each cohort clinic, each of the 3 years. He was a great champion for promoting PCMH as he had achieved the highest level of recognition prior to the first cohort year. A provider, only in practice less than 1 year, joined SHIP and became recognized at level 3 during the year with SHIP. Cohort 1-3 clinics were able to meet at the Regional Collaborative meetings and discuss issues and develop possible solutions. SHIP staff acted as a liaison between Briljent and IDHW to address questions or difficulties with transformation. SHIP staff were constantly looking for areas where work in one cohort clinic could benefit another. Having a QI specialist attend all of the PCMH meetings has been valuable for the majority of our clinics. The QI was seen as an active participant in the weekly meetings. Staff knew they could raise questions in the meeting and had ready access to the QI to have her research and provide feedback. According to the requirements of the subgrant, the QI could attend as few as 6 times during the cohort year. Our district felt this would make the QI a visitor, rather than an active participant in the transformation.

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1. What challenges or obstacles have we encountered?

a. During the first year, the SHIP staff had not been trained in the PCMH model. They gained more knowledge and have become a valued asset for the clinics during their transformation.

b. Clinics had difficulty connecting with the IHDE due to many different EMRs. Clinics were also surprised by the cost of connecting and maintaining the IHDE connection. Clinics had not anticipated this added cost.

c. Interest in the SHIP program was not as widespread as envisioned. Some areas of the district had no participation by local clinics. Some clinics expressed the idea that their local hospital system was not supportive of the PCMH/SHIP model at this time. One hospital system did include 2 clinics in the SHIP model for year 2, but declined to participate in another year. Though not a problem with the SHIP program, this agency preferred to complete PCMH transformation on their own. Having another hospital, with affiliated physicians, which was part of an out of state hospital system was also a challenge. This hospital system was not interested in participating with the SHIP program.

2. Are there any new opportunities that the RC discovered over the past three years?

a. The RC identified a need for someone, maybe the IHC, to develop a library of resources for new providers to be able to find assistance with PCMH transformation post SHIP.

b. During the first cohort, two clinics utilized the same EMR. This allowed these clinics to share reports and best practices. If other resources were available, a state user group for each EMR might have been helpful to the practices. 3. What lessons have we learned? Should this type of project be started again, training for the support staff should be fully completed prior to the start of the project.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

1. What have we accomplished in this area? SCPHD staff discussed the potential for a lasting legacy post SHIP. One of the District board members was a county commissioner. His county had started a resource guide. It was felt the District could take advantage of the resources available with the SHIP project and expand this resource directory. It was the goal of the District to have a resource directory that reflected resources from the 8 counties by the end of the SHIP funding. All of the SHIP clinics could utilize the directory, and it could be utilized by numerous public and private agencies as well. SCPHD worked with many local agencies to develop the resource database. This resource list is available on the PHD 5 website. This document is widely used and valued in the District. The Regional Collaborative meetings were used as a time when local resources, such as Medicaid representatives or the Office on Aging, could increase knowledge of local providers for their programs. Providers were able to incorporate these agencies into their own Medical Neighborhoods. One cohort clinic was able to start working toward incorporation of Community Health Workers in their clinic. The success of this program can be attributed to the vision of the physician champion and a dedicated staff. Assistance was also provided by a community member that had been involved in a similar program in another state.

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2. What challenges or obstacles have we encountered? One Health System started working on incorporating Community Health Workers. They discontinued this process due to lack of funding for this activity. A local EMS showed interest in the CHEMS program. The agency declined to continue with CHEMS due to lack of funding from third party sources for services provided.

B.3. RC Development and Implementation

1. What have we accomplished in this area? The RC brought in members from areas of our Health District that did not have cohort clinics. Even though clinics did not join from these areas, the information on PCMH was shared and these clinics are more aware of the transformation process and available resources. Without the SHIP funded QI specialist and SHIP manager to coordinate meetings and speakers, the RC would not have become a reality. The RC showed initial interest in the resource directory and was quick to promote this to other clinics and agencies. This was seen as the most important accomplishment to come from the SHIP project besides the PCMH transformation of clinics. The RC had initial success with input from the cohort 1 clinics because the PCMH idea was new. During cohort 2, a new health system was added which brought an infusion of new members. This enthusiasm waned midway during year 2 and a quorum could not be reached to conduct business. Members left due to retirement, no longer providing healthcare services or redirection of their duties. Although interest in the topics for meetings was expressed, this did not translate into attendance at meetings.

B.4. Other Focus Areas, please refer to strategic plan objectives

1. What have we accomplished in this area? The RC members commented that aggregate patient data from the clinics or IHDE would have been useful to make recommendations about local health issues. The RC, through the SHIP staff, was able to spread information about the PCMH model to various community groups and healthcare providers

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

Identify and describe your RC's focus areas after the SHIP funding period ends. [Questions embedded in this section can be used as a "discussion guide" to help identify your post-SHIP focus areas.]

One cohort 1 clinic took advantage of SHIP funding to implement telehealth. The clinic owner/current SHIP RC chair has offered to be a resource to other clinics that wish to investigate the possibility of utilizing telehealth in their clinics. Telehealth should be investigated to address resources and best practices for other local providers. Telehealth could make healthcare more accessible and affordable to the residents of our rural counties. Funding for telehealth is a problem that will need to be addressed by future projects, if funded.

The resource directory was identified as needing to be continued in the future. Funding for this activity is not available, but SCPHD will continue to update this as they are able. It was determined that IDHW has

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a website, Living Better Idaho that could also be utilized as a source of on-going information for clinics. Currently, few resources are listed on this website. By inviting IDHW to the local service providers meetings, it is hoped that these service providers would become listed on the Living Better Idaho website and provide another source for identification of resources in the area.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 6: Southeastern

A. Regional Collaborative (RC) Vision and Goals for Healthcare System Transformation

Review your RC's original vision and/or mission and goals. Does the vision and/or mission and goals still accurately describe what your RC is working towards? Adjust as needed so that your vision and/or mission and goals reflect your next priorities beyond the SHIP funding period. (It might be helpful to first complete Sections B and C, which describe your RC's accomplishments to date and focus areas moving forward, before completing this section. Your RC's vision and/or mission and long-term goals should build on your successes to date and provide a unifying direction for your identified focus areas moving forward.)

Briefly describe your RC's post-SHIP vision and/or mission and long-term goals.

The post-SHIP vision for the Southeastern Healthcare Collaborative is that PHD6 SHIP Clinics have the knowledge, skills, and resources needed to move toward PCMH recognition, advancement, and the achievement of developing a true Patient-Centered practice culture. Our vision for the Medical Health Neighborhood is that the connections made between healthcare and community service agencies will be maintained and developed and that Medical Health Neighbors will seek opportunities to collaborate on goals and projects that result in improved health outcomes. We also envision the region working together towards Zero Suicide.

• Goal 1: By January 31, 2019, assure that PCMH Clinics are aware of and have access to tools and resources important to maintenance and advancement of PCMH recognition and cultural change.

• Goal 2: After February 1, 2019, the PHD6 SHIP Manager and Quality Improvement Specialist will continue to support PCMH workforce development by providing educational presentations to students enrolled in health professions at Idaho State University when such opportunities arise.

• Goal 3: By February 1, 2019 Southeastern Idaho Public Health will recruit and hire a Suicide Prevention Program Manager who will continue and build upon work started via the RC Subgrant Opportunity.

B. Accomplishments to Date

Describe what your RC has accomplished across each of your focus areas, as outlined in the RC Strategic Plan and Subgrant Scope of Work, and what has made your RC successful.

B.1. Patient-Centered Medical Home (PCMH) Support

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1. What have we accomplished in this area? In Region 6, the Quality Improvement Specialist has provided PCMH transformation support to 26 primary care clinics that applied and were selected for participation in the Statewide Healthcare Innovation Plan. Eight participating clinics had NCQA recognition before enrolling in SHIP and all those clinics have maintained or enhanced their recognition status. Two additional clinics have achieved new NCQA recognition, three are in the QPass system (indicating significant progress toward recognition), and 13 clinics continue to progress toward recognition. All SHIP PCMH clinics in Region 6 are seeking NCQA recognition, though timelines for recognition vary among unrecognized clinics.

a. Have we been able to accomplish what we planned to do? Overall, we have been able to achieve our goal of providing strong transformation assistance and resources to the PCMH clinics in our region.

b. Were we able to implement our work plan in this area as we envisioned? If yes, what has contributed to our success? If not, why not? We have been able to adhere to our plans but understood from the beginning that we would have to be flexible and adaptive to the needs of the clinics we are supporting.

c. Are we having positive outcomes? If yes, what has contributed to our success? If not, why not? Recognition status is the ultimate measure of success for the PCMH clinics and we are pleased with the progress made by the clinics we support. However, positive changes in clinic processes, team cohesion, quality improvement efforts, etc. occur throughout the transformation process that that growth should be acknowledged along with recognition status. One of our greatest assets in PHD6 was our Quality Improvement Specialist's knowledge and expertise in PCMH transformation. She is an NCQA Certified Content Expert (CCE) and this designation was very important to gaining trust and buy-in from clinic staff unfamiliar with this model of care. Her ability to promote PCMH, provide high-quality coaching, and find solutions for clinics has been noted by several clinic staff as the most valuable benefit to SHIP participation.

2. What challenges or obstacles have we encountered? The constantly changing nature of the healthcare environment has been a significant challenge. Organizational buy-outs, changing leadership and staff, evolving EMR systems, politics, and regulatory/payor requirements, etc. place additional demands on staff and participation in SHIP adds another layer of responsibility to all staff members. PCMH transformation and improved patient outcomes are worth those efforts but come at a time when clinic staff may already be overwhelmed. Improved alignment of clinical quality measure goals, data analytics and reporting requirements could reduce this burden. Clarity and uniformity in reimbursement processes for clinical and behavioral health services is needed.

3. Are there any new opportunities that the RC discovered over the past three years? The Southeastern Healthcare Collaborative recognized an opportunity to engage in PCMH workforce development by working with Idaho State University health professions programs. In each of the cohort years, the PHD6 SHIP team sought out opportunities to introduce future health care professionals to the PCMH model of care. The SHIP Manager and Quality Improvement Specialist provided multiple guest lectures to students in Health Care Administration, Health Education and Promotion, undergrad and graduate level

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nursing programs, medical assisting, and pharmacy. Lecture topics included from Health Care Reform in Idaho, Population Health Management, Using Data to Drive Improved Patient Outcomes, Introduction to Patient-Centered Medical Home, Quality Improvement in Healthcare, and others. Learning activities included work-flow processes improvement, role delineation in team-based care, and mapping work-flows. The nursing faculty invite the PHD6 SHIP team to provide a 4-8 hour "PCMH Nursing Day" to approximately 70 nursing students each year. Guest lectures delivered to students in the Medical Assisting program have resulted in invitations to speak at local- and state-level professional conferences, broadening our educational reach beyond students to reach practicing health care professionals. Providing an entry-level introduction to patient-centered care and the philosophy and activities that drive the model not only prepares students to practice in PCMH settings but also elevates the Quadruple Aim and the Medical Health Neighborhood concept. Following a presentation, one student commented on the evaluation that he/she would like to practice in a PCMH setting. By generating interest in and building skills for PCMH practice, workforce development efforts support PCMH sustainability for transitioning SHIP clinics and for new PCMH practices in the future.

4. What lessons have we learned? We have learned the value of having a well-trained, trusted, competent Quality Improvement Specialist acting as a PCMH change agent in clinics within a region. We believe it is an asset to have the QI Specialist positioned in the Public Health Department to act as an independent, objective, but non-regulatory support for PCMH transformation. The PHDs have established trusting relationships within the communities they serve, and our work is familiar to medical providers and their staff, creating a foundation of trust important to the PCMH transformation process. Quality Improvement Specialists working out of health districts also have extensive knowledge of PHD services offered and current health initiative opportunities available through grants and contracts that can help practices with their practice improvement goals. An independent PCMH QI Specialist (vs. one hired by a health system) would be less influenced by the politics and personalities that can hinder change within an organization and better able to focus on next steps toward transformation. Another key lesson we have learned is the level of performance pressure and reporting requirements our primary care providers experience in daily operations. Improved alignment of clinical quality measures, reporting requirements, and payor reimbursement processes could help reduce the administrative burden on practitioners and staff.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

1. What have we accomplished in this area? At the beginning of this effort the Medical Health Neighborhood (MHN) concept was brand new to our region and much thought was put into defining it and understanding roles therein. (Who are the neighbors and what are their responsibilities to the MNH?) We also wanted to establish goals for our neighborhood. (What can and should be done given our regional needs and resources?) The goals for our Medical Health Neighborhood centered on regional health priorities identified through annual review of available data. Heart disease, diabetes, and suicide prevention have been identified as health priorities in our region.

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a. Have we been able to accomplish what we planned to do? Overall, yes. We dedicated time and effort during each cohort year to providing education and networking opportunities surrounding our region's identified health priorities. We have provided best-practice tools that address risk factors for heart disease, diabetes, and suicide prevention and clinics utilized resources best-suited to their practice quality improvement goals. The highlight of the Medical Health Neighborhood work was the Regional Suicide Prevention Symposium, where over 200 people (healthcare and non-healthcare) were trained to use the Columbia Suicide Severity Rating Scale and the Western Interstate Commission for Higher Education (WICHE) Suicide Prevention Toolkit for Primary Care via the SHIP RC Grant opportunity. A full report was submitted to the SHIP IDHW team, so details are not included here.

b. Were we able to implement our work plan in this area as we envisioned? If yes, what has contributed to our success? If not, why not? We were able to implement our strategies as planned. We were able to find subject matter experts to provide education and technical support for transitions of care, diabetes and heart disease best-practice standards, suicide prevention resources, and patient-centered care delivery. Each meeting provided the opportunity to promote understanding of the medical health neighborhood concept and the critical partnership between healthcare providers and organizations that address social determinants of health. Contributors to the success of the Regional Suicide Prevention Symposium included:

• High public interest/support due to the growth in suicide rates

• Desire for knowledge and skills to prevent suicide

• No cost for initial training and continued access to cost-free training

• Funding through the SHIP RC grant opportunity supported targeted marketing in rural newspapers expanding our reach

• Partnerships with ISU, SPAN Idaho, Region 6 Behavioral Health Board, and other key stakeholders

• Low cost of WICHE toolkits created opportunity for statewide distribution to SHIP clinics

c. Are we having positive outcomes? If yes, what has contributed to our success? If not, why not? Yes. There is a growing understanding of the need for collaboration between clinical and non-clinical human service providers. Meeting participants are beginning to use "Medical Health Neighborhood" in their vocabulary, indicating greater familiarity/comfort with the concept. Time has been an important factor in the development of the Medical Health Neighborhood and relationships are what hold the work together. The meetings and activities have helped create an evolving vision for what can be accomplished in the MHN.

2. What challenges or obstacles have we encountered? A significant challenge is bringing the right people to the table at the right time. The Medical Health Neighborhood meetings are each dedicated to a specific health priority and the invitees differ from meeting to meeting. (For instance, we invited hospital

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discharge planners, care coordinators, care managers, and clinical social workers to our meeting that focused on transitions of care but invited a different group to our diabetes-focused meeting.) The idea is to get the people most closely involved in the work of the topic under discussion to the meetings and to keep the meetings a manageable size. The challenge for practices is balancing community involvement with the demands of delivering quality patient care.

3. Are there any new opportunities that the RC discovered over the past three years? Each connection made and relationship built through the convening of the Medical Health Neighborhood offers the potential for further collaboration and knowledge sharing. The Medical Health Neighborhood provides a forum for sharing opportunities to participate in health initiatives like the Idaho Integrated Behavioral Health Network, Project ECHO, Pneumococcal Vaccine Campaign, etc. The Medical Health Neighborhood meetings help non-clinical community service providers better understand their role in building healthy communities.

4. What lessons have we learned? We have learned that the Medical Health Neighborhood concept is new to many but that community members quickly see the value and necessity of breaking down silos and working collaboratively. We have learned that community service organizations and health systems have interest and willingness to work together toward improved wellness but need an organizer/facilitator and framework to direct efforts.

B.3. RC Development and Implementation

1. What have we accomplished in this area? The Southeastern Healthcare Collaborative established a three-tiered Regional Collaborative structure to organize the work in PHD6. The first tier is composed of the Executive Leadership team and functions to provide overall guidance and direction to the larger RC. The second tier is the Clinic Committee, which is made up of staff members of the SHIP-selected primary care clinics. The Clinic Committee focuses on PCMH transformation and helps direct the work of the Medical Health Neighborhood. The third tier is the Medical Health Neighborhood and includes a large and varied membership. The Medical Health Neighborhood functions to support health priorities identified through SHIP and the annual community needs assessment review.

a. Have we been able to accomplish what we planned to do? Yes. The RC structure operated as we had hoped and the tiers each had a specific area of focus. The Executive Leadership Committee established and maintained awareness of the goals of the SHIP and the IHC. They responded to questions from the IHC and directed the work in PHD6. The Clinic Committee was made up of participating SHIP clinics and functioned to support PCMH transition and recognition efforts. This group came together to share successes, challenges, and practical experience in becoming recognized Medical Homes. It also offered clinics the opportunity to compare their efforts with those of other area clinics as a way to assess progress. Clinics with more transformation experience are able to assist practices who are newer to change processes. The larger Medical Health Neighborhood meetings have been useful for networking, sharing of best practices and clinical toolkits, and for educating community members about health problems prevalent in our region.

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b. Were we able to implement our work plan in this area as we envisioned? If yes, what has contributed to our success? If not, why not? For the most part, yes. Each tier is functioning as planned, though clinic staff participation remains a challenge in the Clinic Committee and Medical Health Neighborhood meetings. The PCMH teams in each clinic system operate a little differently. Some clinics will send an entire team (provider, nurse, administrator, care coordinator, social worker) to RC meetings while others will have a single representative representing several clinic locations. It is difficult to know if the level of detail we are providing is appropriate to the needs of the clinic representative and if information gets disseminated to the correct clinic personnel after the meeting. Having a more consistent clinic committee membership would likely make the meetings more focused. The changing Medical Health Neighborhood invitation list has advantages and disadvantages. The advantage of having a fluctuating MHN membership is that invitations are targeted to those for whom the information is most relevant, thereby reducing the number of meetings a person needs to attend. It also keeps the meetings small enough to be manageable. The disadvantage is that when people are invited to occasional meetings they may never develop a sense of connection with other attendees. Opportunities to follow up on discussions and participate in long-term projects may be lost when attendees are not invited to every meeting.

c. Are we having positive outcomes? If yes, what has contributed to our success? If not, why not? The three tiered RC structure has been useful in organizing and implementing the activities of the subgrant. Participants in the Medical Health Neighborhood meetings are building relationships with one another and discovering/accessing services for their patients that they were not aware of prior to the SHIP effort. Practices have demonstrated a willingness to share processes, knowledge, and successes with one another even though some are in direct "competition" as businesses.

2. What challenges or obstacles have we encountered? PCMH and RC sustainability have been the biggest challenge. The IHC and SHIP have provided a framework, leadership, funding that has driven the work to this point. Without a strong continued infrastructure, sustaining the growth and development of regional PCMH practices will fall primarily upon the practices themselves.

3. Are there any new opportunities that the RC discovered over the past three years? Region 6 developed a strong relationship with the local Medicaid Healthy Connections representative who has detailed knowledge about the goals, culture, and change readiness of many regional primary care clinics. The QI Specialist and Healthy Connection representative spent significant time together discussing area clinics, learning the requirements of each other's work so they could see where their work intersected, and identifying which clinics could be a good match for quality improvement initiatives and SHIP recruitment. Together, they were better able to organize their work to accomplish their contract deliverables because of the unique knowledge they possess about the clinics in our region. The Healthy Connection representative also attended the 2017 NCQA PCMH training which helps her better understand how to assist clinics in their multiple quality improvement efforts.

4. What lessons have we learned? We have had the opportunity through the SHIP subgrant to learn about the complexity of healthcare delivery and the strong commitment by providers and their staff to deliver

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high quality care in an ever-changing healthcare environment. We have learned that healthcare organizations and non-medical community service organizations are interested in learning how to better work together for the good of the community. We have learned that opportunities for collaboration exist that are yet to be discovered. We have learned the complexity of data mining and analysis and have been confounded by the functionality and lack of interoperability of EMR systems in clinics and have a new appreciation of the IT challenges primary care practices face. We have learned to identify personnel in clinics who drive change and that the champions of change are not necessarily those with leadership titles. We have learned that data is important for driving the processes of change but that stories drive motivation for change.

B.4. Other Focus Areas, please refer to strategic plan objectives

1. What have we accomplished in this area?

a. Have we been able to accomplish what we planned to do?

b. Were we able to implement our work plan in this area as we envisioned? If yes, what has contributed to our success? If not, why not?

c. Are we having positive outcomes? If yes, what has contributed to our success? If not, why not?

2. What challenges or obstacles have we encountered? 3. Are there any new opportunities that the RC discovered over the past three years? 4. What lessons have we learned?

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

Identify and describe your RC's focus areas after the SHIP funding period ends. [Questions embedded in this section can be used as a "discussion guide" to help identify your post-SHIP focus areas.]

1. Which activities has your RC invested in that should be continued post-SHIP?

a. SHIP Clinics have continued access to resources important for PCMH transition, recognition, maintenance, and advancement.

b. Workforce Development with Idaho State University health professions

c. Suicide prevention

2. How will those activities contribute to Idaho's Triple Aim of improving health outcomes, improving quality and patient experience of care, and/or reducing healthcare costs in Idaho?

a. Availability and access to PCMH resources are needed to continue the work begun on the SHIP subgrant. Continued access to local, state, and national resources are critical to advance PCMH adoption,

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maintenance, and advancement continue movement toward achievement of the Triple Aim. This will support overall PCMH growth and sustainability in our region. Reminding or making clinics aware of available PCMH resources and providing resource lists and the directory assures that clinics have multiple avenues of support for PCMH advancement.

b. Idaho is a medically underserved state and it is important that providers and their support staff are ready to serve the 165 SHIP clinics that have transitioned to Patient Centered care. Nurses, health educators, medical assistants, healthcare administrators, and other staff members have expanded roles in a PCMH practice as compared to a traditional care delivery system, and the provision of PCMH training while students are preparing for a career in healthcare benefits both the student and PCMH clinics seeking to hire qualified staff. Training elements related to population health, quality improvement in healthcare, healthcare data management, work-flow processes, and team-based care can benefit students working in any healthcare setting. c. Idaho's suicide rate is increasing and ranks 5th highest in the nation but funding for suicide prevention continues to be scarce. Primary care providers and their staff are able to screen for, identify, and treat suicidal behavior, depression, and other associated conditions. In rural areas, primary care providers deliver behavioral health treatment in the absence of available behavioral health practitioners. The provision of suicide prevention training and resources for primary care is an important part of delivering comprehensive care. According to Shepard, Gurewich, Lwin, Reed, and Silverman, "The national cost of suicides and suicide attempts in the United States in 2013 was $58.4 billion based on reported numbers alone. Lost productivity (termed indirect costs) represents most (97.1%) of this cost. Adjustment for under-reporting increased the total cost to $93.5 billion or $298 per capita, 2.1–2.8 times that of previous studies. Previous research suggests that improved continuity of care would likely reduce the number of subsequent suicidal attempts following a previous nonfatal attempt. We estimate a highly favorable benefit–cost ratio of 6 to 1 for investments in additional medical, counseling, and linkage services for such patients" (2016).The Regional Suicide Prevention Symposium that was funded through the SHIP RC subgrant not only provided training to those who attended, but also played a role in the reestablishment of a Suicide Prevention Action Network (SPAN) chapter in our region. The work that began with the Symposium is being continued through SPAN. The funds from the RC grant purchased a hard copy of the WICHE Toolkit for each of the SHIP clinics across the state via the SHIP QI Specialists. The QI Specialists will provide implementation assistance for clinics who have identified suicide prevention as a practice goal.

Suicide and Suicidal Attempts in the United States: Costs and Policy Implications Donald S. Shepard PhD Deborah Gurewich PhD Aung K. Lwin MBBS, MS Gerald A. Reed PhD, MSW Jr Morton M. Silverman MD First published: 29 October 2015 https://doi.org/10.1111/sltb.12225

3. Are there activities that should be "let go" because they did not yield the most value or for some other reason? Some of the RC activities could be merged into the work of existing public health programs. The convening of the Medical Health Neighborhood could be wrapped into existing coalitions that exist within the health district. Three examples of existing coalitions are: Chronic Disease Coalition, Cancer Coalition, and the Healthcare Preparedness Coalition. Some healthcare systems have representatives

serving on multiple coalitions, so merging the RC into existing coalitions may eliminate the need for additional meetings. The Clinic Committee tier may be less necessary post-SHIP if a QI Specialist continues to be available to assist clinics with transformation. The value of the Clinic Committee was that it provided a venue for information sharing between clinics but a highly qualified PCMH Quality Improvement Specialist would be able to fulfil that role through coaching and technical assistance, eliminating the need for the convening of the Clinic Committee. This approach would not have worked at the beginning of the SHIP subgrant because the healthcare community lacked basic knowledge of the PCMH model of care and it was important for practices to hear from PCMH-experienced healthcare leaders.

4. Has the RC identified any new activities not originally planned but that would contribute to the RC's goals moving forward? We did not originally focus on workforce development but presentations to Idaho State University students were so well received by students and faculty that we recognized the value and importance of workforce development and put more effort there.

5. How will the RC's activities moving forward contribute to Idaho's triple aim of improving health outcomes, improving quality and patient experience of care, and reducing healthcare costs in Idaho? If funding becomes available through the Idaho Legislature to place a PCMH Quality Improvement Specialist in each district, a highly trained, experienced QI Specialist could carry out much of the RC work including PCMH transformation support and delivering educational presentations to ISU health professions students. The suicide prevention work can (and has been) adopted by the local SPAN chapter. The SHIP Program Manager is a member of the SPAN group and will continue to be involved post-SHIP.

6. How will those activities contribute to your vision and/or mission and long-term goals? They are the same activities as those we implemented during the SHIP subgrant that have been most valuable in our region, but the activities will have to be delivered differently without the SHIP structure in place.

7. Can these Identified Post-SHIP Focus Areas be replicated in other regions? If so, please explain how? In regions that have a university or college that trains health professionals, QI Specialists with health education experience could provide workforce training valuable to the continuation of this work. The ability to merge the Medical Health Neighborhood into existing PHD healthcare coalitions will vary by how those programs are operated in each district.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

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Statewide Healthcare Innovation Plan
Regional Collaborative Post Implementation SHIP Transition Plan

RC 7: Eastern

A. Regional Collaborative (RC) Vision and Goals for Healthcare System Transformation

Mission: The Eastern Health Collaborative (EHC) is established to improve the community's understanding of the Patient-Centered Medical Home (PCMH) model and to assist clinics in the transformation to that model of care.

Vision: The Eastern Health Collaborative (EHC) will support Patient-Centered Medical Home practice transformation through collaboration, resource sharing, and the fostering of relationships within the Medical-Health Neighborhood. This transformation will assist in establishing a thriving and healthy community and achieving the quadruple aim of healthcare.

Lower Cost of Care

Improved Health Outcomes

Increased Provider Satisfaction

Better Patient Experience

B. Accomplishments to Date

B.1. Patient-Centered Medical Home (PCMH) Support

The priority and mission of the Eastern Health Collaborative (EHC), as decided by the State appointed executive team for region 7, was to help establish PCMH concepts and assist clinics in transforming to recognized PCMH status. To help accomplish this mission EHC centered meetings and activities on this goal. Further, EHC's strategic plan was to recruit at least 25 clinics to participate in SHIP and PCMH transformation efforts. EHC, through PHD staff, was able to contact nearly all of the approximately 40 primary care clinics in the region and recruited over 30. EHC has a unique region where many clinics are not part of a larger organization. These 28 clinics actually belong to 22 different organizations. This clinic and organization structure provide both benefits and challenges. Individual clinics are able to potentially transform at a rapid pace and not have to wait for a larger organization for approval. Challenges center on limited resources and time that clinics, their providers and staff have to dedicate to the transformation while still keeping their doors open. Previous PCMH recognition or status of the clinics follows:

• Two of 28 clinics were NCQA recognized before starting SHIP program • 15 of 28 clinics received/renewed NCQA recognition • An additional 10 clinics are enrolled in NCQA recognition program with anticipated recognition by end of 2019 • One clinic had change in ownership • Remaining

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two clinics are in process of culture change and implementing PCMH principles and have plans to enroll at a future date

We feel that many clinics, while not fully aware of PCMH, trusted the individuals in the Eastern Health Collaborative (EHC) and decided to apply for SHIP and transform into a PCMH. Further, clinics were able to share best practices, successes and challenges at both EHC meetings through dedicated networking time and during quarterly care-coordinator calls. This helped to develop relationships between clinic staff that helped them to feel comfortable reaching out to each other between meetings. They continue to collaborate, network, and support each other. For example, an EHR affinity group developed between clinics after our last PCMH training event and with help from quality improvement (QI) specialist. Pediatric Care-coordinator call was a challenge to start and continue as limited number of care coordinators that focused solely on pediatric patient population. However, there is an opportunity to reorganize and potentially sustain this effort across the region and other public health districts. The support from PHD staff facilitated identification of concerns that clinics face and facilitated resource identification, teaching opportunities, and collaboration to address common gaps among clinics. This encouraged utilization of community resources or other medical-health neighborhood members.

B.2. Medical-Health Neighborhood Development, Implementation, and Expansion

After the mission and vision of the EHC were finalized, the next step was to identify Medical-Health Neighborhood partners to help with PCMH requirements for community resource utilization. EHC recommended community resources currently being utilized. PHD staff also utilized existing connections with other community resource guides and a central aggregated community resource guide was created. Resource guide encompasses all known resources in medical-health neighborhood that may be utilized by patients within EHC region. Resources identified included behavioral health, support groups, as well as many other topics. A complete list: https://eiph.idaho.gov/Home/Resources/communityresources.html.

Particular information collected and made available in resource guide was payment options and language services available from each resource. This information was made available on the EIPH website so both clinics and the public could utilize the resource guide. EHC meetings highlighted an online resource, community partners, public health resources, or other health entities the clinics were interested in obtaining more information or a gap was identified through clinical quality measures. Quality Improvement (QI) specialists identified community resources through their work in individual clinics. Some examples of resources highlighted at EHC meetings include:

• FreeMed: resource that helps patients receive their meds at free or reduced cost • Child Protection Services (CPS): focused on communication between clinics and CPS • Medicaid Transportation services: services available to help meet transportation barrier of Medicaid individuals • Medicaid Healthy Connections: presented on how PCMH transformation aligns with Tier system for increased clinic reimbursements and resources they provide • Eastern Idaho Public Health Resources: Smoking Cessation, Prescription Drug Monitoring Program, Fit and Fall Proof, Community Diabetes classes, Immunization reminder recall services and Immunization services for adults, including reduced fee for uninsured adults

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• Idaho Parents Unlimited: parent ran organization that helps parents and children with special health care needs navigate the school and healthcare system • Rocky Mountain Diabetes: local clinic that specializes in diabetes care and has many clinical trials • Behavioral health services: Tueller Counseling Services and local Behavioral Health Center, Eastern Idaho Crisis center and other inpatient/outpatient mental health services available and child Mental Health Resource guide

Through these meetings, clinics were able to identify partners and develop both informal and formal agreements with those partners. This aided clinics to develop their own personal resource list that they utilize on a regular basis.

A challenge faced by clinics undergoing transformation and medical-health neighborhood participation was geographic distance between clinic and resource. For example, certain resources that were only available in certain locations, i.e. FreeMed is based in Idaho Falls and individuals located in Custer County (approx. 3-4 hours away) have a hard time accessing this service. Further, a similar challenge is communicating between resources and clinics. A common referral networking pathway, possibly through a HIE could alleviate this concern and potentially help to address geographic distance. EHC members had discussions during meetings on how to overcome some of these barriers, temporary solutions, and best practices amongst each other. Continued resource/information collection from a central source would benefit all clinics and medical-health neighborhood partners.

B.3. RC Development and Implementation

Eastern Health Collaborative was instrumental in providing a non-competitive/safe location for clinics and community partners to come together, identify opportunities for common ground and to enhance ability to improve individual's lives. A great example of EHC member's collaboration was the choice to collect and share individual clinic data to use in identification of regional gaps in care. Clinical quality measures (CQM) were determined after careful discussion with EHC members. These CQM were agreed to by vote of EHC members with clinic, provider, and patient's perspective considered. CQMs were aggregated from all clinics and proved beneficial in identifying community resources. QI's were crucial in collecting, aggregating data and presenting updates to EHC. See appendix A for Eastern Health Collaborative's clinical quality measures. These measures assisted clinic's ability to improve health outcomes and population health in our community. Through data collection effort by clinics, QI's involvement, assistance from other clinics, individual's confidence increase to capture and validate EHR data within their clinic. The skills gained from this initiative transferred to other value-based driven activities in which clinics are engaged.

As clinics progressed on their PCMH transformation efforts, clinics were invited to share best practices and lessons learned during EHC meetings. Clinic presentations included successful quality improvement cycles, clinic engagement in transformation, and individuals PCMH standards. These clinic presentations were well-received from other clinics and useful information/action items were gathered. This provided a platform to open the lines of communication and collaboration between clinics outside of regular scheduled meetings.

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One potential challenge of regional collaborative was that individual members of EHC have different priorities and patient population/needs. Clinics in EHC comprised of specialty clinics, reverse integration clinics, pediatric clinics, rural vs urban, single provider vs multiple provider, as well as standard family practice clinics. This difficulty led to potential decreased participation, as members need to see the application for them at every RC meeting. QI's information and interaction with clinics helped to identify common themes that would benefit the majority of EHC clinics during meetings. Another challenge was lack of real-time regional data to help EHC focus on highest priority needs of community. This was also a problem in collecting data to evaluate if initiative or program EHC/clinics implemented was successful. EHC faced an additional trial in overcoming limited resources in community even when a gap was identified. For example, long wait times or lack of mental health providers that treated adolescents was not something EHC could influence. A problem faced by EHC's decision to have clinics at the forefront of the regional collaborative was the unforeseen decision by some clinics to not engage in the EHC if they were completed in the PCMH recognition. However, many clinics did help mentor other clinics who were early on in the transformation process. This was a great benefit to all clinics involved.

B.4. Other Focus Areas, please refer to strategic plan objectives

A hallmark of PCMH transformation is increased communication between all parties involved in the delivery of healthcare, including the patient. Similar to this, communication was identified as a potential challenge to successful implementation of the SHIP project. To this end, PHD staff were instrumental in helping to overcome these challenges with different strategies. A few of these are detailed below.

Quality Improvement Specialists call: to maximize the learning and collaboration QIs from around the state joined in an every other month conference call. During these calls QIs shared lessons learned and shared updates. Topics discussed during these called include: suicide prevention resources, engaging clinics/ clinic recruitment, EHR shared resources, Chronic Care Management, additional funding opportunities (pacific source and diabetes funds), other state initiatives and Project Echo, community health workers and CHEMS, as well as and PCMH transformation.

Care coordinator call: In an effort to improve the quality of care coordination, provide training opportunities and detailed information about community resources in our region, a quarterly care coordination call was facilitated. This allowed care coordinators to development and strengthen relationships with one another. We believe these relationships will help sustain PCMH transformation after the SHIP grant has ended. Calls provided enhanced time utilization, freeing up the time of administration and providers. These calls started in October 2016 with eight individuals from region seven, currently there are 28 individuals who participate in the calls across four of the seven health districts.

PCMH training: At the start of cohort three, EIPH PHD staff collaborated with PHD staff from Southeastern Idaho Public Health to hold a PCMH training. Clinics from all three Cohorts were invited to attend. This training provided clinics with the mindset and tools to transform in a shortened time. This training helped solidify PCMH ideas for clinics who have already progressed in their transformation and

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prepare them for the 2017 Standards. This training was a strategic activity for PCMH sustainability in our region. Topics included:

• NCQA standards • SHIP grant overview • Staff engagement • Medical health neighborhood • Huddles • Policy writing • PDSA cycles • Maximum EHR utilization

These strategies helped to provide solutions to potential problems faced by EHC members and SHIP clinics. Other challenges faced were competing programs, initiative fatigue, and lack of time to participate in EHC. Due to these challenges, as well as geographic challenges, EHC members decided to move monthly (60 min) meetings to quarterly (90 min) to help ease burden on members/clinics. QI specialist worked tirelessly to ensure other initiatives or programs were evaluated for their mutual purpose in the PCMH work. Programs/initiative's representatives were invited to attend EHC meetings or QI's would deliver program overviews and alignment tools/resources if they were identified to help with PCMH transformation.

C. Post-SHIP Focus Areas

C.1 Description of Identified Post – SHIP Focus Areas

Identify and describe your RC's focus areas after the SHIP funding period ends. [Questions embedded in this section can be used as a "discussion guide" to help identify your post-SHIP focus areas.]

1. Which activities has your RC invested in that should be continued post-SHIP?

a. Mentoring clinics through networking and care coordinator calls to help facilitate discussion among clinics.

2. How will those activities contribute to Idaho's Triple Aim of improving health outcomes, improving quality and patient experience of care, and/or reducing healthcare costs in Idaho?

a. Communication among providers helps to identify best practices to achieve Quadruple AIM. This was helped by QI specialist ability to help facilitate these calls and agendas.

3. Are there activities that should be "let go" because they did not yield the most value or for some other reason?

a. Monthly meetings are difficult due to geographic, time, restricted resources, subject matter experts limitations.

4. Has the RC identified any new activities not originally planned but that would contribute to the RC's goals moving forward?

a. Care coordinator call was not originally planned but implemented in Year 2 and has helped to provide mentorship between clinics.

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5. How will the RC's activities moving forward contribute to Idaho's triple aim of improving health outcomes, improving quality and patient experience of care, and reducing healthcare costs in Idaho?

a. See above

6. How will those activities contribute to your vision and/or mission and long-term goals?

a. Helping clinics achieve PCMH recognition and continue to improve on population health measures will help quadruple aim and that is ultimately our long-term mission.

7. Can these Identified Post-SHIP Focus Areas be replicated in other regions? If so, please explain how?

a. It can be replicated in other areas. Utilizing QI specialist or another neutral party to aggregate data, work as liaison between clinics, identify common gap areas among clinics and to help facilitate networking through different modalities will help continue this work.

D. Action Plan Template

D.1. Planning by Focus Area

For each focus area identified to be continued post-SHIP, use the enclosed template to plan and document what is needed to move forward. Complete a separate template for each focus area. Questions embedded in the column headers are intended as guides to help the planning process.

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

Final Progress Report

Goal 4

Prepared for
CMMI

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

The virtual PCMH model is a unique approach to developing PCMHs in medically underserved communities by training Community Health Workers (CHW), Community Health EMS (CHEMS) and integrating telehealth services into rural and frontier practices.

1. Major activities - CHW

- Stakeholder Engagement
  - Adopted a CHW definition, identified current CHW programs, obtained input from CHWs, and developed training recommendations for Idaho
- Training for CHWs
  - Adopted, adapted, and delivered (Idaho State University) the Massachusetts CHW training curriculum in live-online, in-person, and hybrid formats to seven cohorts of CHWs
  - Produced and uploaded 21 elective modules (Idaho State University) to provide health-specific training and professional development in online format
  - Trained 115 CHWs spanning all regions of the state
- Training for PCMH
  - Coordinated a 1-day CHW Learning Collaborative (2018) that brought together CHWs across the state, a nationally-recognized expert in CHW, and other stakeholders
  - Produced and uploaded a panel discussion featuring 5 CHWs
  - Multiple webinars as part of the PCMH mentorship program
    - "Community Health Workers in the Patient-Centered Medical Home Model"
    - Motivational Interviewing
    - Medication Adherence
- Grew a CHW Association of over 100 CHWs, supervisors and leaders across the state

Omissions or changes to project activities – CHW

- Training
  - In order to reach more communities, Spanish-language modules were developed
  - To respond to scheduling conflicts, the live-online course was shortened from 17 to 13 weeks and the remaining 4 weeks were changed to asynchronous online delivery.
  - In response to requests from some communities and clinics, the in-person and hybrid delivery formats were added
  - In response to requests, more health-specific elective modules were added to the curriculum. Topics include: COPD, medication adherence, oral health, tobacco cessation, opioid addiction, and more.

Changes in key personnel - CHW

- No changes to key personnel at Idaho State University who delivered the CHW training
- No changes to key personnel in Idaho Dept. of Health and Welfare Bureau of Community and Environmental Health
- Turnover in SHIP Goal 4 Project Manager did not affect performance of the CHW component

Changes in computer application -CHW

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

- No changes to the Learning Management System (Moodle) used by Idaho State University
- The online meeting platform was changed from Blackboard Collaborate to Zoom for improved performance.

Major activities - CHEMS

- Implementation of different models to support the integration of Communirt Health EMS into underserved communities and new ways of doing business never before done.
    - Region 1
        - Bonner County EMS
        - Boundary Ambulance
        - Shoshone County EMS
    - Region 2
    - Region 3
        - Canyon County EMS
        - Payette County EMS
    - Region 4
        - Ada County Paramedics
        - Donnelly Rural Fire Dept.
    - Region 5
    - Region 6
        - Blackfoot Fire and EMS
    - Region 7
        - Idaho Falls Fire Dept.

- Awarded ___ $2500 grants to support the integration CHEMS into communities across the state
- Training for CHEMS personnel
    - Developed Community EMT (CHEMS) course and delivered in live-online format to two cohorts (20 students) through Idaho State University
    - Produced and uploaded five health-specific modules through Idaho State University in online format
- Training for PCMH
    - Coordinated two 1-day CHEMS Learning Collaboratives (January and August 2018) that brought together CHEMS personnel across the state, nationally-recognized expert in CHEMS, and other stakeholders
    - Produced and uploaded a Webinar Series addressing topics such as motivational interviewing, data collection, and more
    - Produced and uploaded a panel discussion featuring personnel from 3 CHEMS agencies as part of the PCMH mentorship program

Omissions or changes to project activities – CHEMS

- Training
    - Health-specific elective modules were added to the curriculum. Topics include: COPD, medication adherence, oral health, tobacco cessation, opioid addiction, and more.

Changes in key personnel - CHEMS

- No changes to key personnel at Idaho State University who delivered the CHEMS training

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

- No changes to key personnel in Idaho Dept. of Health and Welfare Bureau of EMS and Preparedness
- Turnover in SHIP Goal 4 Project Manager did not affect performance of the CHW component

Changes in computer application -CHEMS

- No changes to the Learning Management System (Moodle) used by Idaho State University
- The online meeting platform was changed from Blackboard Collaborate to Zoom for improved performance.

2. Efforts to publicize results - CHW

- Presented annually at Idaho Public Health Association conference
- Presented annually at American Public Health Association conference
- Reported activities and progress to Idaho Healthcare Coalition
- Results shared with researchers from the State-level Evaluation Team
- Panel discussion and webinar uploaded to SHIP website and YouTube as part of PCMH mentorship series

2. Efforts to publicize results - CHEMS

- Reported activities and progress to Idaho Healthcare Coalition
- Results shared with researchers from the State-level Evaluation Team
- Panel discussion uploaded to SHIP website and YouTube as part of PCMH mentorship series

3. Goals Not Achieved - CHW

- Fell short of the goal to train 125 CHWs (trained 115)
- Did not award $2500 Virtual PCMH incentive payment for incorporation of CHWs into clinics

3. Goals Not Achieved - CHEMS

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4. Audiences – CHW and CHEMS

SHIP PCMH clinics

- Many of the 165 SHIP clinics are located in rural, and frontier, medically-underserved communities.
- Research conducted by the State-Level Evaluation Team (SET) highlighted specific examples of unique and positive contributions that CHWs and/or CHEMS made to PCMH clinics
    - CHWs: patient engagement, social determinants of health, the PCMH team, and health outcomes.
    - CHEMS: Medication/diet reconciliation, Fall prevention, Referral of patient with mental health issues to primary healthcare provider, Companionship to isolated homebound person, Appropriate use of health equipment, Referral to other community resources (SDOH), Access to primary care screenings, Post-hospital re-admission prevention, Referral to specialized care.

Rural and frontier, medically-underserved communities

- Idaho communities vary greatly in nearly all aspects. Communities range from urban, to rural, to frontier and in geographic reach. The majority of residents identify as white among a growing Hispanic population. Many Idahoans live with limited resources and food insecurity. Chronic diseases, accidents and suicide rank high in the most common causes of death. Some communities have significantly less grocery stores per capita than the state average, and many experience transportation concerns. Communities report community health benefit from nature paths, pools, and recreation centers. Many Idahoans lack health insurance; lack of coverage as well as high deductible plans are a significant concern. Furthermore, many communities face a shortage of physicians, behavioral health providers, and oral health professionals. CHWs and CHEMS have impacted communities by introducing initiatives (discussed above) which address patient health needs and social determinants of health.

5. Evaluation - CHW

CHW Course

- In January, 2017a researcher from the State-level Evaluation team spoke with two students and an instructor from the Fall, 2016 Community Health Worker course. All identified community needs assessment as one of the most valuable course topics. In different ways, and from different perspectives, all described the CHW as an important part of an interdependent patient-centered healthcare team. The instructor and the CHW reported that the course enhanced students' abilities to advocate on behalf of patients. Both students valued the opportunity to learn from other CHWs.
- The researcher made three recommendations: (1) integrate community health workers into the RC meetings to reinforce CHWs as an important component of the Virtual PCMH; (2) encourage providers to enroll in the course or consider a parallel ASHTO or CDC course to provide a more complete understanding of the role of CHWs to address the SDOH; and (3) explore how best to provide networking and professional development opportunities for CHWs.

CHWs in Idaho Case Study

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- In Fall, 2017 researchers from the State-Level Evaluation Team spoke with nine individuals involved with Idaho's CHW initiative. Three of the individuals are CHWs, three are supervisory CHWs, two are clinic administrators who supervise CHWs, and one is a physician. Responses reflect their different roles and unique perspectives.
- All nine described different ways in which CHWs affect patient engagement in preventive screenings, chronic disease management, health-promoting behaviors, and accessing healthcare. Nearly all described ways in which CHWs help address the social determinants of health (SDOH)—the kinds of problems physicians recognize as important and rely on CHWs to address. All explained ways in which CHWs contribute uniquely to the PCMH by both consolidating and expanding the work of the PCMH team, and by serving as the bridge between patients and the PCMH team. Some were able to describe a direct impact on health outcomes; others described indirect impact.

CHW Sustainability Project, SIM State Interviews

- In fall 2017, researchers from the State-Level Evaluation Team (SET) interviewed representatives from five SIM states and reviewed pre-recorded online modules from two additional states. The purpose was to identify key strategies and infrastructure that have been effective in states that seem to have made significant progress in developing a CHW workforce.
- Four themes and supporting information emerged from the interviews and reviews. The themes were: (1) formalization of the CHW role, (2) state-level governance, (3) stakeholder engagement, and (4) financing and funding.
- Based on the themes, researchers made four recommendations. The recommendations were: (1) strengthen stakeholder engagement, (2) introduce state legislation, regulation, and policy, (3) designate a state agency to oversee the CHW workforce, and (4) study the feasibility of a CHW certification and process.

Process Evaluation of Live-Online Training of Community Health Workers in Idaho

- Internal activities by course developers included pre-course assessment of competencies, mid-course evaluation of course, instructor and health-specific modules, and post-course assessment of competencies in addition to evaluation of course and instructor. Evaluators sought to gather data from all students enrolled in all sections.
- Feedback led to meaningful course adaptations, such as in-class discussions, change in meeting platform, switch to combination of synchronous and asynchronous instruction and development of health-specific electives.
- Student evaluation of course format and participation was positive
- Increase in self-rated competencies in areas such as (a) awareness of resources, (b) ability to discuss ACA, (c) ability to distinguish between risk factors, signs, and symptoms of heart attack and stroke, (d) awareness of screening tools to assess substance use, misuse, abuse, (e) prepared to discuss different cancer screenings, and (f) health-specific competencies
- Results reinforced value and effectiveness of live-online setting for CHWs in rural areas

CHEMS in Idaho Case Study

- In fall, 2017 and spring, 2018 a research associate (RA) with the State-level Evaluation Team (SET) spoke with individuals representing five CHEMS agencies, one hospital, and one family practice throughout the state. The individuals and agencies held different perspectives of CHEMS and were in different stages of implementation.
- Theme #1: Value of CHEMS demonstrated by nine specific events

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i. Medication/diet reconciliation based on CHEMS home visit
ii. Fall prevention based on CHEMS home visit
iii. CHEMS referral of patient with mental health issues to primary healthcare provider
iv. Companionship to isolated homebound person
v. Appropriate use of health equipment based on CHEMS home visit
vi. CHEMS referral to other community resources (SDOH)
vii. Access to primary care screenings based on CHEMS home visit
viii. Post-hospital re-admission prevention based on CHEMS home visit
ix. Referral to specialized care based on CHEMS home visit

- Theme #2: Low level of response from payers at the local level at this time. Payers must see value, yet numbers too small in rural areas.
- Theme #3: Motivation of CHEMS personnel stems from (a) desire to improve access, meet the needs of community members, and contribute to PCMH, as well as (b) recognition of mission and opportunity of EMS ("we're already there"), and.
- Theme #4: Barriers and challenges relate to legal limitation, allocation of time, establishing partnerships and data reporting.

6. Continuation of the Project – CHWs

- CHW course developers from Idaho State University plan to continue to train CHWs. They are exploring post-SHIP funding sources, such as sponsors, grants, fee-for-enrollment, embedding the course within college offerings or within PCMH clinics and community agencies. They are continuing to develop other formats of instruction, such as in-person and hybrid (in-person + online). Finally, they are continuing to translate more health-specific modules to Spanish.
- The Idaho Diabetes, Heart Disease and Stroke Prevention Program has taken the leadership of the Idaho Community Health Worker Association (currently over 100 members). By all indications, the Association will continue to develop in its mission to advocate for Idaho's Community Health Worker profession, elevate the work of our members, and nurture partnerships that lead to healthier communities.
- St. Alphonsus Health Alliance has taken steps to develop the Idaho Alliance for Community Health Workers (IACHW) which supports the mission of the Idaho CHW Association by promoting and advancing the CHW role among health partners and communities.

6. Continuation of the Project – CHEMS

- The Idaho Bureau of Emergency Medical Services and Preparedness will resume leadership of CHEMS. Stakeholders have committed to participate on the CHEMS workgroup which will continue to meet regularly.
- CHEMS course developers from Idaho State University plan to continue to train CHEMS personnel. A course is currently ongoing.
- CHEMS projects will continue as well. A pilot project in Lincoln County is currently being discussed.

7. Long-Term Impact – CHW

The project activities that were funded through the SHIP have served as a catalyst to organize and further propel virtual PCMH in rural and frontier medically-underserved communities throughout Idaho.

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- As a result of SHIP
  - 115 individuals are trained, and CHWs stretch across all regions of Idaho
    - Region 1 = 1
    - Region 2 = 8
    - Region 3 = 11
    - Region 4 = 34
    - Region 5 = 9
    - Region 6 = 5
    - Region 7 = 5
  - CHWs have formed a professional association to strengthen the profession. The CHW Association has over 100 members.
  - Providers have formed a CHW Alliance to advance the role among healthcare partners and communities
  - CHWs and PCMH healthcare teams have powerful stories to demonstrate an improvement to the health and well-being of individuals and communities in Idaho.

7. Long-Term Impact – CHEMS

The project activities that were funded through the SHIP have served as a catalyst to organize and further propel virtual PCMH in rural and frontier medically-underserved communities throughout Idaho.

- As a result of SHIP
  - 20 individuals representing EMS agencies and fire departments will receive Community EMT training. CHEMS programs will reach across most regions of Idaho
  - Personnel and leadership of EMS agencies, fire departments, communities and healthcare partners have collaborated to address local needs and issues.
  - CHEMS individuals and agencies have powerful stories to demonstrate an improvement to the health and well-being of individuals and communities in Idaho.

8. Grant Products with URLS - CHWs

CHW Workgroup

Kickoff Meeting Notes
http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHW/CHW%20Kick-off%20Meeting%20Notes%203-4-2015.pdf

CHW Input Gathering Meeting
http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHW/CHW%20Input%20Gathering%20Meeting%20Notes%206-19-15%20.pdf

Stakeholder Meeting Presentation
http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHW/CHW%20Stakeholder%20Meeting%20Materials%207-30-2015.pdf

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Stakeholder Meeting Notes
http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHW/CHW%20Stakeholder%20Meeting%20Notes%207-30-2015.pdf

CHW Training Recommendations
http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHW/CHW%20IHC%20Approved%20Training%20Recommendations%20(Nov%20%202015).pdf

Motivational Interviewing Training
http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20Tip%20Sheet.pdf?ver=2018-06-06-162208-697

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20Resources.pdf?ver=2018-06-06-162208-620

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20-%20Decisional%20Worksheet.pdf?ver=2018-06-06-163719-240

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20-%20Am%20I%20doing%20this%20right.pdf?ver=2018-06-06-162208-247

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20-%20Enlighten%20Exercise.pdf?ver=2018-06-06-162208-323

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20-%20Goal%20Setting.pdf?ver=2018-06-06-162208-417

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Motivational%20Interviewing%20-%20Readiness%20Ruler%20Plus%20Coaching%20Questions.pdf?ver=2018-06-06-162208-543

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Brief%20Action%20Planning%20Toolkit.pdf?ver=2018-06-06-162208-073

Health Literacy Training

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Health%20Literacy%20Toolkit.pdf?ver=2018-06-06-162208-167

2018 Learning Collaborative

http://ship.idaho.gov/Portals/93/Users/152/00/2200/CHW_Program_20180720.pdf?ver=2018-07-23-162713-843

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Addressing%20Social%20Determinants%20Through%20Care%20Coordination.pdf?ver=2018-07-23-162713-937

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http://ship.idaho.gov/Portals/93/Users/152/00/2200/Josh%20Campbell%20CHW%20LC%20Presentation%207_25_18.pdf?ver=2018-07-24-121610-037

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Diabetes%20Management%20Education.pdf?ver=2018-07-23-162714-013

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Linda%20Mikitish_Medication%20Adherence.pdf?ver=2018-07-23-162714-170

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Jayne%20Josephsen%20chw%20mi%20training.pdf?ver=2018-07-24-121041-977

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Sam%20Kenney_Oral%20Health.pdf?ver=2018-07-27-133002-210

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Pain%20Managememt%20and%20Opioid%20Addiction%20and%20Treatment.pdf?ver=2018-07-23-162714-247

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Carl%20Rush%20Idaho%20LC%20072518_150.pdf?ver=2018-07-27-132929-870

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Provider_CHW%20Relationship.pdf?ver=2018-07-23-162714-327

Training – Medication Adherence

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Medication%20Adherence%20webinar%20series%201%20of%203%20vs%2010-08-18.pdf?ver=2018-10-16-124825-300

https://www.youtube.com/watch?v=3BUFOImrr2M&feature=youtu.be

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Medication%20Adherence%20Webinar%202%20of%203.pdf?ver=2018-10-16-124846-330

https://www.youtube.com/watch?v=UGRrVzqhQpQ&feature=youtu.be

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Medication%20Adherence%20Webinar%203%20of%203.pdf?ver=2018-10-23-131737-547

https://www.youtube.com/watch?v=mGjp6QeV2vA&feature=youtu.be

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Actionplans.pdf?ver=2018-10-24-162148-847

http://ship.idaho.gov/Portals/93/Users/152/00/2200/SL%20CHF%20self%20management%20goals[4].pdf?ver=2018-10-24-162222-417

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http://ship.idaho.gov/LinkClick.aspx?fileticket=y2Ra60MmtmI%3d&portalid=93

http://ship.idaho.gov/Portals/93/Users/152/00/2200/preparing%20for%20MD%20visit.pdf?ver=2018-10-24-162410-760

CHW Video Links

http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/tabid/3054/Default.aspx

Evaluation - CHW Case Study

http://ship.idaho.gov/Portals/93/Users/152/00/2200/CHW%20Case%20Study%20Report.pdf?ver=2018-07-19-131533-897

Evaluation - CHW Case Study Graphic

http://ship.idaho.gov/Portals/93/Users/152/00/2200/SHIP_CHW_handout.pdf?ver=2018-07-19-093623-793

Evaluation - CHW SIM State Interview

http://ship.idaho.gov/Portals/93/Users/152/00/2200/CHW%20Sustainability%20Project-Report%20of%20SIM%20State%20Interviews_Final.pdf?ver=2018-12-04-093600-687

CHW Training Course

Student Application
http://ship.idaho.gov/WorkGroups/CommunityHealthWorkers/CHWTraineeApplication/tabid/3552/Default.aspx

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8. Grant Products with URLS - CHEMS

Project Charter

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Workgroup%20Project%20Charter%20VAY3.0D_06022017.pdf?ver=2018-03-21-115449-050

Workgroup

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Workgroup%20List_Updated%2012192017.pdf?ver=2017-12-19-150810-220

January 2018 Learning Collaborative

http://ship.idaho.gov/Portals/93/Users/152/00/2200/UPDATED%20Idaho%20SHIP%20-%20Zavadsky.pdf?ver=2018-01-23-101545-790

http://ship.idaho.gov/Portals/93/Users/152/00/2200/5.RCO_CHEMS%20Jan%2017%202018.pdf?ver=2018-01-23-101527-803

Data Collection Training

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Data%20Collection.pdf?ver=2017-05-24-141018-717

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Measures%20Workgroup%20Final%20IHC%20Approved%20Report%20May%202016.pdf

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Outreach%20Talking%20Points%20Final%205-3-16.pdf

Agency Contacts

http://ship.idaho.gov/Portals/93/Documents/CHEMS/SHIP%20CHEMS%20Agency%20Contacts.pdf?ver=2017-01-31-085102-577

CHEMS Administrator Training

http://ship.idaho.gov/Portals/93/Documents/CHEMS/SHIP%20CHEMS%20Agency%20Contacts.pdf?ver=2017-01-31-085102-577

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Outreach%20Presentation%20-%20EMS%20Agencies%20-%20Version%204.pdf?ver=2016-06-21-130204-647

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http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Mentoring.pdf?ver=2016-06-21-130204-553

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20Measures%20Workgroup%20Final%20IHC%20Approved%20Report%20May%202016.pdf?ver=2016-05-25-152552-510

http://ship.idaho.gov/Portals/93/Documents/CHEMS/CHEMS%20DRAFT%20Tiered%20Payment%20System%206-15-16.pdf?ver=2016-06-21-130204-383

Learning Collaborative Webinar Series

http://ship.idaho.gov/Portals/93/Users/152/00/2200/CHEMS_Behavioral%20Health%20Webinar.pdf?ver=2018-01-12-135749-143

http://ship.idaho.gov/Portals/93/Users/152/00/2200/CHEMS_Transitional%20Care%20Webinar.pdf?ver=2018-01-12-135951-480

http://ship.idaho.gov/Portals/93/Users/152/00/2200/Heart%20Failure%20Webinar.pdf?ver=2018-06-07-162338-610

Roundtable Discussion Video

http://ship.idaho.gov/WorkGroups/CommunityHealthEMS/tabid/3050/Default.aspx

9. Supporting Materials

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

HMA

HEALTH MANAGEMENT ASSOCIATES

Idaho Statewide Healthcare Innovation Plan Telehealth Grant Program

Final Report

PREPARED FOR THE
IDAHO DEPARTMENT OF HEALTH AND WELFARE

BY
JEAN GLOSSA, MD, MBA, FACP
JOHN O'CONNOR
MARY KATE BROUSSEAU, MPH

DATE
JANUARY 2019

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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

Introduction

Overview of the Idaho SHIP Telehealth Grant Program

The Idaho Department of Health and Welfare (Department), Office of Healthcare Policy Initiatives was created to manage a federal Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) grant received by the Department for the implementation of Idaho's Statewide Healthcare Innovation Plan (SHIP). SHIP was developed to redesign Idaho's healthcare system to improve Idahoan's health by strengthening primary and preventive care through the patient centered medical home (PCMH), and evolve from a fee-for-service, volume–based payment system of care to a value-based payment system that rewards improved health outcomes.

The Virtual PCMH model is Idaho's unique approach to establishing PCMHs in rural, medically under-served areas. Through the Virtual PCMH, the traditional PCMH healthcare team is expanded to include previously untapped existing local resources and remote resources technology. The creation of Virtual PCMHs in Idaho tested the impact of the core components of the Virtual PCMH: telehealth technology, Community Health Workers, and Community Health Emergency Medical Services (CHEMS), ultimately extending the PCMH care coordination model.

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. Many Idahoans have limited access to behavioral health and specialty services, particularly those living in one of the state's 35 rural or frontier counties. Telehealth is an important tool for providing access to essential services that may not otherwise be available in medically-underserved communities.

Telehealth Webinar Series

Telehealth support for the SHIP PCMH clinics began in July 2016 with a series of six (6) one-hour webinars to build the clinics' capacity, knowledge, and expertise to develop and implement their own telehealth program. The Department contracted with Health Management Associates (HMA) to create these webinars, along with a toolkit of associated resources. The tools included telehealth program development and implementation resources that complimented the webinars. The HMA team developed and delivered this series of six telehealth webinars that covered the topics listed here, starting with the importance of completing a demand analysis and readiness assessment as the initial steps when contemplating implementation of a telehealth program then covering specific areas of telehealth program development. Specific topics within the readiness assessment include equipment selection, reimbursement, program development, and evaluation and monitoring.

Webinar Series Topics

- *Demand Analysis:* Determining the Unmet Community Needs and Identifying Barriers for Using Telehealth
- *Readiness Self-Assessment:* Completing a Telehealth Program Readiness Assessment
- *Telehealth Reimbursement, Billing, and Coding:* Identifying and Understanding the Opportunities for Telehealth Revenue
- *Equipment Selection:* Strategies for Selecting Appropriate Telehealth Equipment
- *Program Development:* Framework and Best Practices for Developing a Telehealth Program
- *Evaluation and Monitoring:* Measuring the Impact of Your Telehealth Program

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Telehealth Grantee Program

The Department provided twelve sub-grant awards to eight clinics and one CHEMS agency through two rounds of grantmaking. These grants supported new or expanding telehealth programs that improve care, increase access to care, expand system capacity for serving patients with the care they need, and achieve efficiencies in health care delivery. Eligible recipients included participating SHIP PCMH sites, including CHEMS agencies to establish or expand the scope of telehealth operations, with the exact scale and type of telehealth operation left open for the applicant sites to define according to their organizational and patient population needs. Grantee requirements included an on-site meeting, regular meetings with the Department and/or the technical assistance (TA) contractors, and the submission of quarterly reports including minimum identified telehealth data indicators. As part of the application process, organizations were encouraged to reference the telehealth webinar series and complete an initial demand analysis and readiness assessment.

Summary of Technical Assistance

As part of the Virtual PCMH Telehealth Grantee program, HMA provided TA to the nine organizations, representing twelve sites across the state, to implement and expand telehealth programs. The HMA core project team worked collaboratively with the Department and each grantee to implement various elements of the project from kick-off to pilot completion, while supporting cross-site learning. The HMA core project team engaged additional subject matter expertise from within the firm as needed to supplement individual site activities and present learning collaborative content. Grantees engaged with technical assistance at different levels according to preference and capacity.

The framework for technical assistance included:

- The development and facilitation of individual site assessments and gap analyses;
- Regular coaching sessions to discuss program implementation status and address priority areas of need (including one in-person site visit); and
- Group learning through four interactive Learning Collaborative Webinars, available to grantees and other SHIP PCMH Cohort sites.

Site assessments: HMA coaches completed an onsite assessment for each of the SHIP Telehealth grantees. During these visits, the HMA coaches met with the program staff and providers. Each visit was unique, depending on the size and makeup of the program and the team, varying from a single provider to an entire multi-disciplinary team across several sites. These site visits proved invaluable to the process as they provided a more personal connection for the virtual technical assistance that would occur for the duration of the program and an opportunity to understand the challenges and identify potential solutions to address in the ongoing TA.

Virtual Coaching: The practices were offered ongoing technical assistance, including 1:1 monthly coaching meetings and ad hoc TA via emails throughout the month as issues arose. The coaches addressed the gaps identified during the site assessments and any additional challenges brought forth by the practices during the calls. HMA coaches shared telehealth program development tools with sites when needed as their programs evolved, including a readiness assessment, demand analysis tool,

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vendor selection tool, sample business plan, and example workflows. Additional HMA coaches were added to the team to provide more specific subject matter expertise when appropriate, such as around rural health and emergency medical services. For more detail by site, reference the Grantee Profiles section.

Learning Collaboratives: HMA presented and facilitated four Learning Collaborative Webinar sessions to support group learning about identified priority program needs and cross-site sharing. While the main audience for the webinars were the grantee programs, the Department opened it up to all SHIP PCMH sites and key telehealth stakeholders. Additional session-specific information is included below:

Telehealth Financing and Vendor Evaluation and Relationship Development – March 20, 2018

The first webinar focused on the two most prevalent issues identified during the initial assessments: reimbursement opportunities and vendor evaluation and selection. Along with walking through the details of the updated reimbursement matrix, George Gutierrez, Deputy Administrator, Idaho Medicaid, presented information on the Medicaid telehealth policies and reimbursement. Also, Chad Basham from HMA discussed key issues to address for relationship development with telehealth vendors and introduced a vendor assessment tool.

Sharing the Lessons Learned: Hearing from the Providers – June 20, 2018

The second webinar showcased two grantee programs, with representatives from Sandpoint Family Health Center and Coeur d'Alene Pediatrics. Sandpoint Family Health Center presented lessons learned from their small family practice pilot targeting telehealth for diabetic patients. Coeur d'Alene Pediatrics shared detail about their expansion project to include more providers in the telehealth program and serve children on-site in a residential safe haven. HMA facilitated the discussion and follow up question and answer session to highlight key best practices from each program.

Tele-Behavioral Health Part 1: Evidence Base for Implementation and Stories from the Field – August 16, 2018

Tele-Behavioral Health Part 2: The Clinician Leader Role in Program Development and Stories from the Field – September 11, 2018

The final two webinars focused on tele-behavioral health, a key component of many grantee programs. Dr. Marc Avery, new to HMA from University of Washington, presented research and evidence base, as well as checklists, to support tele-behavioral health program design, clinician leadership, and implementation. HMA also showcased two additional grantee programs, Latah Community Health and Terry Reilly Health Services, to share lessons learned from their pilot programs.

HMA received positive feedback from the sites on the utility and lessons learned from the other SHIP grantee presentations. As noted in the final recommendations of this report, it would be useful for the state to provide ongoing opportunities for providers and staff from telehealth programs (SHIP and others) to have a forum to share ideas and best practices.

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Telehealth Planning Meeting

On May 23, 2018, the Department hosted a telehealth planning meeting in Boise. The purpose of the meeting was to convene a diverse set of telehealth subject matter experts to identify and discuss barriers, challenges, and opportunities for advancing telehealth in Idaho. Over 40 telehealth stakeholders from across the state representing hospitals, urban and rural health clinics, health systems, CHEMS, government, insurance, telehealth consulting experts, associations, and academia participated. Through the convening, attendees-built consensus around the value and need for advancing telehealth services across Idaho. The group concluded that its best course of action is to seek the partnership of the Idaho Healthcare Coalition (IHC) to advocate on behalf of the future of telehealth in Idaho.

As the group moved on to identifying opportunities, there was general agreement about the potential of telehealth to help overcome the specific challenges of provider shortages and rural and frontier community isolation, which contribute to significant areas of underserved populations due to lack of access to care. They identified the models and applications for telehealth that can improve access to primary care and specialists, support patient and provider education, and share real time actionable data. Additionally, the group recognized that the complex issues surrounding telehealth must be addressed by stakeholder collaboration to thrive within a very complex healthcare system.

By the end of the day, there was emerging consensus that continued, coordinated growth of telehealth as a resource for addressing healthcare needs in the state is urgent. Participants considered it crucial that dialogue continue post-SHIP among stakeholders, particularly payers, and all were interested in continuing the dialogue.

Given the previously narrow scope of the now inactive Idaho Telehealth Council, its low membership, and lack of resources, participants agreed that another coordinating body with adequate capacity is needed to advance telehealth. Stakeholders decided to ask the IHC to advocate on their behalf, by communicating the need for the continued prioritization of telehealth to the Health Quality Planning Commission and asking their help in continuing the momentum of the telehealth work that has begun and finding potential solutions to identified challenges.

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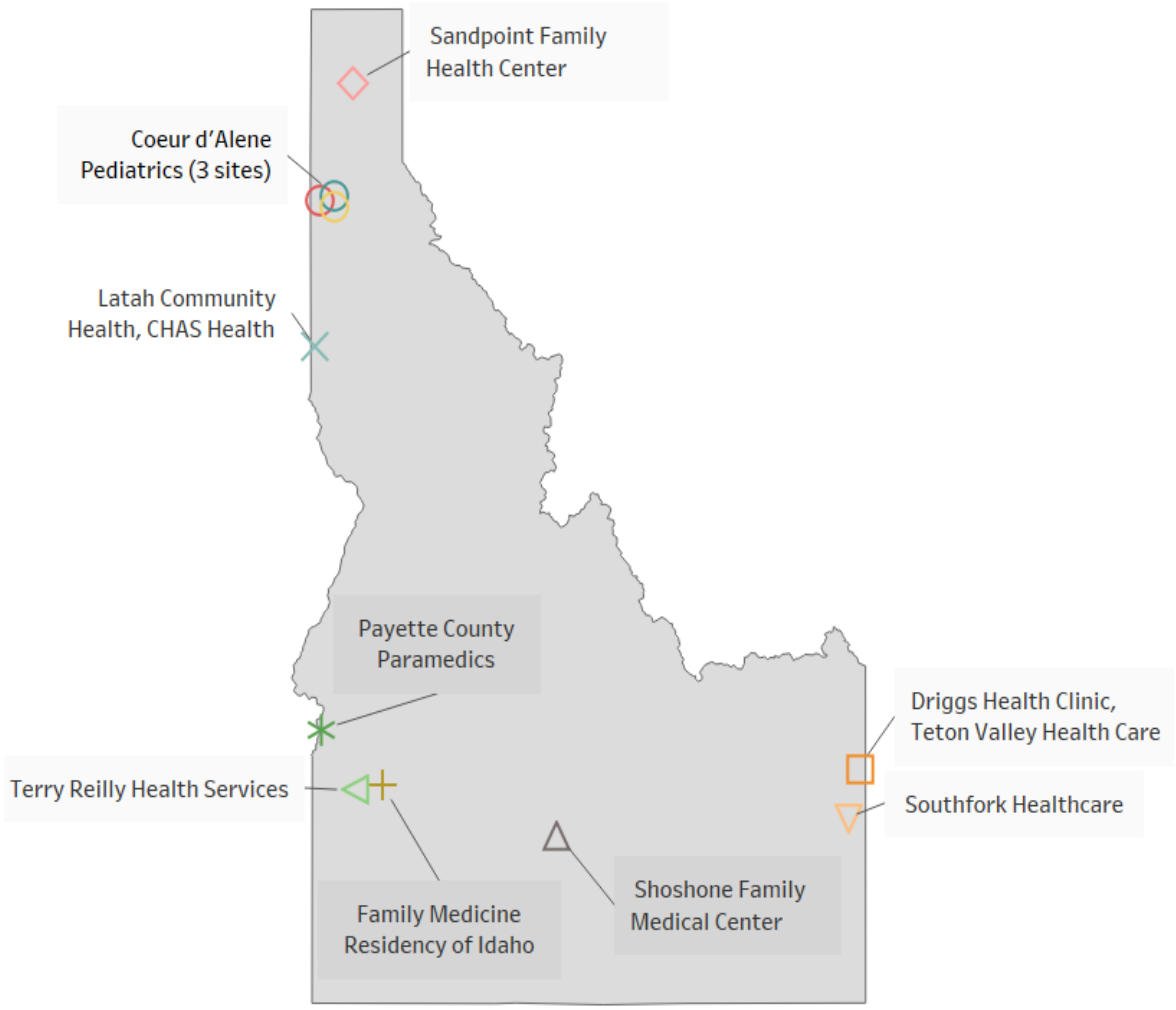
Telehealth Program Grantees Summary

The twelve SHIP Telehealth Program Grantees included both pilot and expansion projects with representation from across the state. Grantee organizations varied in staffing models and service population size, ranging from a one-provider shop to a large, multi-facility federally qualified health center with integrated behavioral and dental care. The majority of telehealth projects piloted video visit technology to support visits between a primary care provider and patient. In some cases, the patient was at another clinic location, but generally the originating site was in the patient home, office, car (parked, on the way to school for example), or in a residential safe haven facility.

Each grantee determined metrics to evaluate their unique telehealth program; however, at a minimum, the programs tracked the number of unduplicated patients served and the overall number of telehealth visits provided. This final report documents data reported through December 31, 2018. Below is the entire list of grantees, with more detailed grantee profiles to follow.



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Idaho SHIP Telehealth Program Grantees

Grantee Organization	Location(s)	Practice Type	Originating Site	Clinical Service
Coeur d'Alene Pediatrics (3 grants)	Coeur d'Alene, Post Falls, Hayden	Pediatric Primary Care Clinics	Patient Home or Children's Village (2 programs)	Primary Care
Driggs Health Clinic, Teton Valley Health Care, Inc.	Driggs	Hospital-Based Outpatient Clinic	Hospital-Based Outpatient Clinic	Oncology
Family Medicine Residency of Idaho	Boise	Residency Training Program	Patient Home or School-Based Health Center (2 programs)	Primary Care
Latah Community Health, CHAS Health	Latah	Federally Qualified Health Center	Patient Home or Clinic	Behavioral Health, Primary Care, Pharmacy Consultation
Payette County Paramedics	Payette	CHEMS	Patient Home	Community Paramedic Evaluation
Sandpoint Family Health Center	Sandpoint	Primary Care Practice	Patient Home	Primary Care
Shoshone Family Medical Center	Shoshone	Rural Health Clinic	Patient Home	Primary Care
Southfork Medical Clinic	Irwin	Primary Care Practice	Patient Home or Clinic	Radiology
Terry Reilly Health Services (2 grants)	Nampa	Federally Qualified Health Center	Clinics in Melba, Marsing, Homedale, Middleton	Behavioral Health, Nurse Triage

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Coeur d'Alene Pediatrics – Coeur d'Alene, Post Falls, and Hayden, Idaho

Coeur d'Alene Pediatrics (CdA Pediatrics) is the largest pediatric clinic in Idaho, serving children in North Idaho for over 30 years. The clinics provide patient-centered collaborative care with thirteen providers including a wide range of subspecialists in three state-of-the-art facilities.

Telehealth Expansion Program

Coeur d'Alene Pediatrics used funding to increase the overall number of telehealth appointments available, targeting Medicaid patients. The clinics started to offer telehealth services through three physicians in April of 2017. The expansion project increased the number of participating providers and expanded the types of telehealth appointments. Additionally, the program expanded to provide telehealth services onsite at a local children's residential safe haven, Children's Village. The core project team included the Director of Operations, the Practice Administrator, and a Physician/Owner. Telehealth services are provided for established patients through video visits, using the Chiron Health platform. Patients can be at home (or another desired location) and have a visit with a provider at a CdA Pediatrics clinic. For care provided at Children's Village, a nurse facilitates the visit on site with the young resident, using highly functional peripherals to convey information over to the provider at the CdA Pediatrics clinic. Using telehealth for the residents of Children's Village avoided the complicated and costly transportation requirements.

CdA Pediatrics received three SHIP telehealth grants to expand services across several sites, including the program at the Children's Village. HMA completed site visits to the CdA practice and to the Children's Village in May 2018 and provided ongoing monthly technical assistance throughout the project. During the site visits, and ongoing TA, CdA Pediatrics received support for program development and expansion, workflow development, consultation on best practices and on working with partners, and discussions on long-term program sustainability.

Program Results

Telehealth Program Metrics	Through December 2018
Number of patients receiving a telehealth visits	77
Number of telehealth visits	149
No-show rate for telehealth visits	Decreased from 8.3% to 5.26%
Percent of providers completing a satisfaction survey post telehealth visit	100%

Successes

- The number of providers offering telehealth appointments increased from three to six, with plans for continued expansion due to ongoing provider and patient interest.
- The no-show rates for telehealth visits decreased to below the overall no-show rates for all appointments.

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- The team developed workflows and initiated onsite care at Children's Village, decreasing the burden of staff time and transportation needed to bring a resident to the clinic, as well as disruptions to program scheduling and staff-to-child ratio maintenance.
- Over the course of the program, the practice identified a subset of their population, the autistic patient population and their parents, who were particularly adept at participating in telehealth visits. Because the telehealth visits were occurring in the patients' homes, with very little impact on the patient's schedule or surroundings, the providers reported that these visits were less stressful for the patient and more productive overall.

Challenge

- The team experienced barriers to finding the most effective and integrated peripheral tools to optimize care between Children's Village and the clinics.

Lessons Learned

- Work with your telehealth vendor and establish an ongoing relationship to improve integration with your health record, evaluation and quality improvement efforts, and workflows.
- Setting up a telehealth program requires a significant amount of time, especially when working with partners outside of your organization.
- Comprehensive workflows and policies and procedures support expansion of telehealth services and continued clinic team enthusiasm.
- Ensured payment for telehealth services supports both patient and provider engagement and program sustainability.
- Be cognizant of special populations that may be particularly well suited to telehealth.

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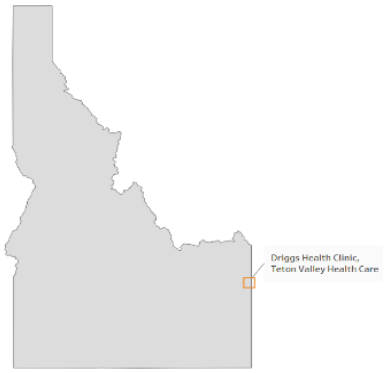
Driggs Health Clinic – Driggs, Idaho



Driggs Health Clinic (DHC) is a rural health clinic operated under the umbrella of Teton Valley Health Care, Inc., associated with Teton Valley Hospital and Victor Health Clinic. Teton Valley Hospital is a nonprofit, 13-bed hospital in rural Teton Valley, Idaho that employs 154 staff, is certified by Medicare as a Critical Access Hospital, and has served the Teton Valley community since 1938. The scope of primary medical, surgical, and diagnostic services, as well as preventive education and free community workshops, encourages the health and well-being of the local community members.

Telehealth Pilot Program

DHC applied for the SHIP telehealth grant to add a pilot tele-oncology program to their existing telehealth program. DHC has several other telehealth programs - burn, respiratory, pain, infectious disease, stroke, and ICU which includes partnerships with programs in Utah and Idaho. DHC launched this new pilot program to test tele-oncology services to coordinate treatment for clinic patients diagnosed with cancer, while managing the treatment plan locally and maintaining the patient relationship with the primary care provider. The program allowed the patient's primary care provider to remain in the treatment loop. DHC hired, trained, and integrated an oncology nurse navigator into the care team to coordinate patient treatments with the oncologists' oversight through tele-oncology. DHC partnered with the oncology department at Intermountain Healthcare, a not-for-profit health system based in Salt Lake City, Utah, and worked with Intermountain to promote these new services at a staff meeting, through social media, and the website. At the end of the grant period, DHC planned to determine if the pilot program measurably enhanced patient care and improved outcomes by keeping patients connected to their primary care provider and allowing them to remain in their homes, saving travel expenses and lowering stress levels during this very critical treatment period.

Given their experience with telehealth in their other established programs, the DHC team decided to use their internal resources for program development in lieu of HMA technical assistance after the first quarter of the SHIP telehealth grant program.

Program Results

Telehealth Program Metrics	Through December 2018
Number of patients receiving a telehealth visits	5
Number of telehealth visits	6
Wait time for visit	Max 7 days
Percent of patients completing a satisfaction survey post telehealth visit	80% completed survey, average 97.5% satisfied

Successes

- The team recruited and trained an oncology nurse navigator, developed a workflow, and trained the care team about the tele-oncology services.

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- The team worked with Intermountain Healthcare to provide set office hours for tele-oncology sessions as needed.
- Increased community awareness of telehealth program through marketing campaign. The program treated a patient needing hematology services, which was beyond the initial project charter, but within the scope of practice of the consulting provider.

Challenges

- Patient recruitment proved difficult, with most patients preferring in person visits despite the drive to Idaho Falls or Jackson, Wyoming.
- The set appointment time of once per week may have deterred patients due to the wait time of seven days.

Lessons Learned

- Despite having a telehealth program that provides remote oncology consultations that would allow a patient to receive care closer to home, patients may still prefer in person care despite the transportation challenges.
- The community benefit of providing quality care close to home is a strong motivator for telehealth program development and expansion.

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Family Medicine Residency of Idaho – Boise, Idaho

FAMILY MEDICINE RESIDENCY
OF IDAHO

Family Medicine Residency of Idaho (FMRI) has been serving the citizens of Idaho and the surrounding Intermountain West since 1974, with eight clinics in Ada and Canyon Counties. FMRI is both a Federally Qualified Health Center providing care for underserved and rural communities, and a medical residency training program with three-year residencies and a range of one-year specialty fellowships with a vision of producing outstanding family physician leaders for Idaho communities.

Telehealth Pilot Program

Through the telehealth grant, FMRI had two goals: to reduce barriers and improve access for patients at FMRI, with a primary focus on home-bound patients; and to reach more, and improve care to, ill school children at schools throughout the district via the Meridian Schools Clinic. To enhance the process for home visits, FRMI built infrastructure and training for the implementation of real-time transfer of information from a visiting nurse to convey patient condition, vital signs, and provide access for a visual examination to a physician at the FMRI site. FMRI also worked closely with the clinic nurse to build plans for a workflow and system for live support via telemedicine. A core goal of this telehealth model is to support care for students onsite at school locations re mote from the clinic to avoid the burden of unnecessary bussing.

Program Results

The ambitious plan to launch two distinct telehealth programs laid significant ground work for implementing and scaling telehealth services to advance the overarching goal of increasing health care access. The program for home-bound patients has been piloted with an established FMRI patient who agreed to be an early adopter, to work through any program development issues with the provider, and to provide feedback and suggestions to the FMRI telehealth team. The program is now ready to roll out to additional patients. The related, but separate program to provide services from the Meridien Schools Clinic has put long-term program development plans in place that include building the program with the collaboration and support of the school district. More work remains to be done before the school program moves into piloting, but a compelling use case has been developed for providing this type of remote care and consultation.

Program Results

Telehealth Program Metric	Through December 2018
Number of patients receiving a telehealth visit	6
Number of telehealth visits	7

Successes

- The team evaluated vendors and selected Chiron Health to provide a telehealth platform for both elements of the pilot program.
- FMRI developed an internal telehealth team including providers, the revenue cycle director, IT, and the quality improvement director to ensure alignment for systemwide design and implementation.

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- FMRI has developed strategic plans for developing and piloting the school telehealth program in advance of the beginning of the 2019-2020 school year.

Challenges

- The initial proposed vendor did not allow for a user-friendly patient interface, so the team had to choose another telehealth vendor, delaying initial implementation.
- The piloting of the program for home-bound patients only included one "pilot" patient, who unfortunately passed away following some initial testing of the model.
- Payment and reimbursement policies are sometimes vague, with inconsistencies across payers and limited information, so the team continues to investigate options for reimbursement for telehealth services to inform patient recruitment activities for the ultimate sustainability of the program.
- School based telehealth programs require the involvement and support of multiple stakeholders and additional regulations, which can impact the pace of the program's development and implementation.

Lessons Learned

- Careful vendor software and hardware assessments may prevent potential barriers down the line in workflow development and service delivery.
- Payer mix and reimbursement policies should be assessed in the program planning phase of developing a telehealth program to be financially sustainable.
- It takes a team to develop a successful and sustainable telehealth program – including HIT, providers, billing, and the patient.
- School based telehealth programs require the involvement of multiple stakeholders and new processes and policies.

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Latah Community Health – Moscow, Idaho

Latah Community Health opened in June 2013 and is part of a regional network of 13 non-profit federally qualified health center sites (collectively, CHAS Health). Latah Community Health is committed to providing whole-person, patient-focused primary and preventive health care.

Telehealth Pilot Program

In the summer of 2016, CHAS Health began to investigate home-based telehealth for the Latah community. 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.

Program Results

Telehealth Program Metrics	Through December 2018
Number of patients receiving a telehealth visit	35
Number of telehealth visits	131
Percent of providers completing a satisfaction survey post telehealth visit	100%
Percent of patients completing a satisfaction survey post telehealth visit	100%

Successes

- The CHAS telehealth team successfully created comprehensive workflows to support successful tele-behavioral health and dietician service delivery in Latah that are now driving expansion throughout the CHAS Health system.
- All Latah providers were dual-licensed in both Idaho and Washington to facilitate cross-border service delivery.

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- Strong organizational support and leadership buy-in facilitated enthusiasm and additional funding for increased program promotion and patient recruitment.
- The team identified a clinical provider champion and completed training for 100% of behavioral health clinicians on the utility and effectiveness tele-behavioral health.

Challenges

- Some individual providers required more support as compared to other peer providers in incorporating telehealth services into clinical workflows due to uncertainty about the quality of clinical care that would be provided via telehealth.
- Some types of services, such as tele-pharmacy services, demonstrated low patient interest with resultant higher no-show rates as compared to other telehealth service types.

Lessons Learned

- A strong provider champion was effective in driving patient identification and engagement, process improvement, and spread of telehealth activities among peer providers who may otherwise been unlikely to embrace telehealth care.
- Providers who are unfamiliar or hesitant to use telehealth can have an impact on the pace of telehealth uptake across the team. Their concerns should be acknowledged and addressed early and often.
- Use of telehealth job aids – such as a telehealth 'at a glance' – and repeated workflow trainings and telehealth team meetings were helpful in supporting the initiation of telehealth services.
- Behavioral health care was particularly amenable to telehealth service modalities, and thus represented a good starting point for building a telehealth array of services.
- It was useful to encourage providers to check acceptance directly with patients themselves as to whether telehealth-based services would be acceptable and/or desired rather than making assumptions that certain patients would reject the idea.

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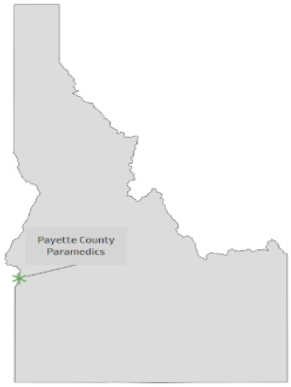
Payette County Paramedics – Payette, Idaho



Payette County Paramedics (PCP) is an ambulance district that provides 911 emergency services, Stand-by events, and Critical Care inter-facility transports. Payette County Paramedics provide Advanced Emergency care to the citizens of Payette County and surrounding areas through an ambulance and two crews of Emergency Medical Technicians and Paramedics. The ambulance is equipped to provide the highest level of pre-hospital and interfacility transport capability possible.

Telehealth Pilot Program

PCP developed plans to start a telehealth program to partner with an area hospital to enhance communication, decrease wait times, and reduce utilization of emergency services. The program model included the hospital making referrals to community paramedics upon patient discharge and the paramedics visiting a patient's home and becoming the eyes and ears of the physician. Using telemedicine, the paramedics would identify potential issues and instantly change the plan of care inside the home in coordination with the physician. The physician would also remotely prescribe and send orders over to the local pharmacy as needed without the patient needing to go into the physician's office. An additional goal was to directly admit the patient from an emergency scene instead of utilizing the local Emergency Department or to create a care plan with the patient and family to get appropriate follow-up care. Several other areas of telehealth were considered including jail afterhours healthcare access, social service referrals, cooperating with local family health clinics, and specialty care appointments. The core project team included the Lead Paramedic and the Director of PCP.

Program Results

Unfortunately, discussions with the hospital were not able to move to a commitment of partnership for the hospital as the provider partner in the PCP's proposed telehealth model. The Payette team has worked hard to develop an alternate partnership with another provider group to participate in the program and has had many program development conversations in the community with potential providers. Many discussions progressed, but no final agreement with a provider partner has been reached. As of the conclusion of the grant, the program had secured its hardware and vendor partner and developed operational workflows for its staff. Without a confirmed partner to deliver the care, PCP has been unable to pilot the program with patients in the field.

Success

- The team evaluated vendors, partners, and models for telehealth service delivery and payment options resulting in a robust operational plan that can serve as the foundation for telehealth program implementation upon the confirmation of a provider partner.

Challenges

- Despite promising conversations with a local hospital during the application process, PCP experienced difficulty in establishing a formal relationship with the hospital or a back-up health care

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provider, a required component for telehealth referrals, patient treatment, and destination decisions.

- Although there is the potential of as many as 3 patient referrals per day (including out of the jails) who could be treated or referred outside the ED by expanding the current community paramedic program to include telehealth, PCP lacked a physician and/or nurse practitioner to give the necessary medical oversight and to participate in telehealth consultations from the field.

Lessons Learned

- Building the telehealth business model requires a significant amount of time and resources, especially when working with external partners, which would be essential for a CHEMS telehealth model.
- Develop trust and buy-in from partners and community stakeholders to inform model development and to identify the service population.
- Since obtaining a licensed physician and/or nurse practitioner team to provide medical oversight is essential to operating a program like this, key program partner commitments should be confirmed in writing via an MOU or other written agreement.

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Sandpoint Family Health Center - Sandpoint, Idaho

Sandpoint Family Health Center (SFHC) is a physician owned clinic with five practicing family physicians and one nurse practitioner, operating for over 20 years. SFHC is recognized as a Level 3 Patient-Centered Medical Home and treats all ages from newborn to seniors, with an emphasis on serving the entire family.

Telehealth Pilot Program

SFHC launched a pilot telehealth project with the primary goal of improving rural patient centered access to primary care services in the location of their choosing. The target population included established patients with a diagnosis of diabetes with an A1c of 9 or over, insured by Medicaid or Regence Blue Shield, offering them routine diabetic follow up care from the convenience of their home or workplace using video visits powered by Chiron Health software. The video visits facilitated follow-up visits, medication questions, lab and test results, and responses to general questions. By the end of the grant period, the pilot program evolved to identify ways to engage all established patients and offer cash payment options for those without insurance coverage.

The core telehealth project team included a Lead Physician and Project Manager, with additional clinicians, billing, and front desk staff brought in as needed to assist with defined program elements. The project included the selection of the telehealth vendor, development of patient outreach and engagement materials, including brochures, website content, and a Chiron Health app user guide, and telehealth workflows and policies and procedures for the SFHC team.

One approach that was discussed was to offer this service to a local self-insured employer as a value-added benefit for just their employees and their dependents. The Sandpoint practice serves a significant number of Lighthouse employees. The clinical telemedicine model would not only be more convenient for individuals covered by the plan but could also reduce absenteeism and presenteeism (when employees are there in body but not in mind). Absenteeism may be due to the employees' own health condition, but also may be related to taking another family member to a doctor visit. Access to these telemedicine visits can also reduce the cost of emergency room visits that are for convenience sake (including the desire to avoid missing a day of work) rather than clinical urgency. Ultimately, given existing practice responsibilities, this option was not pursued.

Dr. Scott Dunn responded to the recent Centers for Medicare and Medicaid Services (CMS) Request for Information on Direct Provider Contracting Models. This primary care capitation model could support this telemedicine model on a multi-payer basis, but it is uncertain if it will be advanced by CMS. Even if it were, there are several uncertainties including whether Sandpoint's service area would be included, interest on the part of commercial and Medicare Advantage payers, and timing for implementation.

Program Results

Telehealth Program Metric	Through December 2018
Number of patients receiving a telehealth visit	15

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Number of telehealth visits	17
Percent of providers completing a satisfaction survey post telehealth visit	100%
Percent of patients completing a satisfaction survey post telehealth visit	Improved from 33% to 100%
Percent of completed telehealth visits without connectivity issues	100%

Successes

- The core team developed workflows and policies and procedures for long-term use and were quick to explore new ways to engage patients, regardless of payment source.
- The team drafted a proposal for negotiations with an employer-based plan which can be used again in future negotiations.

Challenges

- Patient recruitment proved difficult for SFHC due to patient preference to come into the office for visits and limited insurance coverage of telehealth as a covered benefit.
- Idaho Medicaid regulations are flexible enough to allow the practice to implement this model, but reimbursement rates are low.
- Since telehealth visits happened infrequently, the staff could not establish a regular rhythm for visits and therefore patient recruitment efforts did not spread significantly beyond the lead physician.

Lessons Learned

- Define your telehealth service population prior to program implementation, including surveying patients to verify interest. Many small practices have long, established relationships with patients who prioritize an in-person visit.
- Integrate telehealth services into your overall clinic operations. While the pilot may focus on a specific population, the provision of services to a broader patient panel supports long-term sustainability and success.
- It is not feasible for small practices to address telehealth payment policy issues on their own. Until multiple payers agree to incorporate telehealth as a covered benefit in their insurance plans, adoption of this cost-effective means of offering this member-centric alternative access to primary care will be stymied.

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Shoshone Family Medical Center – Shoshone, Idaho

Shoshone Family Medical Center is a Rural Health Clinic (RHC), serving as the only clinic in Lincoln County, Idaho, an area larger than Rhode Island. Shoshone offers integrated behavioral health and clinical pharmacy, with the mission to improve access to primary care services through use of a multi-disciplinary team approach to health care.

Telehealth Pilot Program

Shoshone implemented a telehealth pilot program with the primary goal of improving rural patient access to clinically appropriate primary and secondary care services in the location of their choosing using video visits. The initial target population was patients with a diagnosis of diabetes, focusing on those patients with an A1c of nine (9) or higher. Priority activities for the project included patient outreach and engagement and the implementation of TeleVISIT, a telehealth platform supported by the current electronic medical record (eClinicalWorks). The core project team included the clinic's medical director, clinic director, and support staff for project management. Leveraging their EMR platform's software, Shoshone was able use a software fully integrated with the patient medical records and scheduling. They started with one existing male patient and one existing female patient who met the clinical criteria but were also known to be high functioning, computer literate, and both willing to provide input and troubleshooting in a pre-launch phase.

Following a site visit and program assessment, HMA provided regular virtual TA through coaching calls. The HMA technical assistance team was able to add a RHC expert who had recently served at HRSA to provide specific subject matter expertise regarding RHC regulations and opportunities.

Program, Results

Telehealth Program Metrics	Through December 2018
Number of patients receiving a telehealth visit	2
Number of telehealth visits	2
Percent of providers completing a satisfaction survey post telehealth visit	100% - positive feedback
Percent of patients completing a satisfaction survey post telehealth visit	100% - positive feedback

Successes

- The team completed an all staff training on workflows to support program implementation, developed comprehensive patient collateral materials, and conducted outreach to promote tele-visits and their web portal app at the popular Lincoln County Fair.
- The team developed and distributed a patient engagement survey where 47% of current patients responding reported interest in using telehealth services.

Challenges

- There are barriers associated with out of state licensure fees and liability coverage to be able to serve their established patients who travel out of state regularly.

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- There were many eligible patients who declined to participate in the program despite provider and staff education and encouragement regarding telehealth.

Lessons Learned

- In smaller practices, there are many competing demands on more limited staff, so the amount of time necessary to develop, pilot, and scale a program can experience timeline setbacks with a small team.
- In some rural communities, many patients and families prefer to come into the clinic, despite the burden of travel and an expressed receptivity to care via telehealth.
- The complexities of eligible services and reimbursement rates for an RHC under Medicare are different than non-RHC sites and requires additional research.

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Southfork Medical Clinic – Irwin, Idaho

Southfork Medical Clinic (Southfork) is a solo practice rural health clinic owned and operated by a Nurse Practitioner, Wendy Swope. Established in 2015, Southfork provides comprehensive primary care to the residents of Swan Valley where the population swells from 800 residents year-round to over 3,000 in the summer. Emergency room or inpatient medical care requires over an hour drive.

Telehealth Pilot Program

Southfork developed their telehealth program to provide diagnostic imaging services via teleradiology to serve patients with traumatic injuries and respiratory issues. Obtaining an x-ray interpretation of a potential fracture, or a suspected pneumonia, provides critical information needed to determine the urgency of additional evaluation and treatment or whether to start care prior to transfer. Using non-SHIP funding sources, Southfork Medical Clinic secured a mobile x-ray machine for in-clinic and mobile diagnostic imaging. They contracted with a radiology practice to provide diagnostic interpretations. The lead provider completed registration, initial and ongoing training, and licensure requirements for the state and then initiated service delivery. Thus far, radiology services have included wrist, hand, leg, and collarbone imaging with only one patient sent to receive further care at the emergency department.

HMA made a site visit to meet with Wendy and review her program in May 2018 and during the grant period assisted with program design, establishment of workflows, consent and result notification; reviewed training and licensure requirements, radiology contract(s), and revenue cycle; and discussed sustainability beyond the SHIP grant.

Program Results

Telehealth Program Metrics	Through December 2018
Number of patients receiving a telehealth visits	14
Number of telehealth visits	20
Level of provider satisfaction with telehealth service delivery	100%
Increase in access to screening and/or specialty care (radiology services)	0-100%

Successes

- The lead practitioner reviewed two proposed contracts from area radiology groups and was able to identify a partner in alignment with program expectations and goals.
- Working with the radiology partner, the practice established workflows for clear data exchange, integration with the electronic health record, and follow-up for patients.

Challenge

- The initial delivery of equipment and software was delayed and incomplete, requiring additional time for program set-up.

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Lessons Learned

- Before setting up a telehealth program, identify a need in the community where telehealth can be a long-term and sustainable solution.
- Evaluate specialty care partners and equipment to ensure alignment with your telehealth program model before committing to a contract to prevent potential barriers down the line in workflow development and service delivery.

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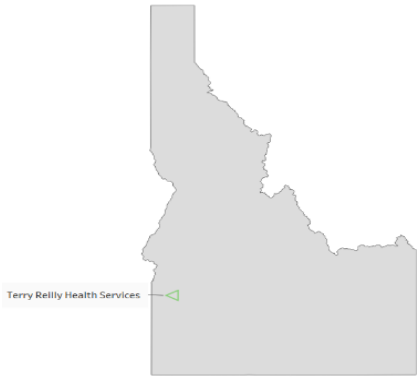
Terry Reilly Health Services – Nampa, Idaho



Terry Reilly Health Services (TRHS) is a private not-for-profit organization providing quality care to all, with discounted fees available based on family size and income. TRHS is a federally qualified health center that operates eight medical/behavioral health clinics, five dental clinics, and a detox/mental health and crisis facility located in the communities of Melba, Marsing, Homedale, Middleton, Caldwell, Nampa, and Boise.

Telehealth Pilot and Expansion Programs

TRHS received two SHIP telehealth grants to support one pilot program and one expansion program. The pilot designed and implemented a program to provide psychiatric consulting, psychiatric medication management, and counseling services to four rural clinics in the towns of Melba, Marsing, Homedale, and Middleton using a clinic-to-clinic model. Following a well-designed vendor selection RFI process, TRHS partnered with Medweb to provide software and technical assistance. The goal of the pilot was to increase patient access to needed behavioral health care and provide the clinicians practicing at these clinics with psychiatric consultation without traveling to one of the larger clinics in Boise and Nampa.

The telehealth expansion aimed to enhance a nurse triage and urgent care virtual services program by offering video teleconferencing between the patient and the triage nurse, while improving care and provider to the same four sites as the pilot. TRHS partnered with CIS Consulting/SnapMD to provide software and technical assistance to support the nurse to visually view patient vital signs and symptoms captured by the medical assistant handling the patient on site, with a goal to reduce wait times for appointments.

The core project team included the Director of Business Management, the Director of Quality Improvement, the IT Director, The Chief Medical Officer, and a cross-section of provider, technology, and operational leaders and support staff.

Program Results

Telehealth Program Metrics – ***Telepsychiatry pilot only***	Through December 2018
Number of patients receiving a telehealth visit	7
Number of telehealth visits	17

Successes

- The TRHS team performed an extensive vendor evaluation and selection process to identify a telehealth partner that aligned with pilot goals to then support expansion efforts as well.
- For both telehealth projects, the team established workflows and open communication with all TRHS staff to increase buy-in and optimize patient identification and recruitment activities. Communication included schedule monitoring, daily huddle reports, and client status updates between sites.

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- The team addressed the lack of rural delivery options by developing and launching a protocol and training process.

Challenges

- Staffing challenges prevented the expansion of the tele-psychiatry program beyond the pilot program and delayed the testing and launch of the nurse triage program expansion. However, TRHS learned from the pilot to identify the need for a tele-triage program with RNs.

Lessons Learned

- Busy multi-site primary care practices often have competing demands that make new program implementation a challenge.
- Strong champions in each role or in each location involved with the process are key to success. Staff and provider turnover are significant impediments to progress.
- Extensive preparation is needed at both locations for scheduling and directing patients without confusion for this new type of program. Logistical considerations should include careful training, well-planned scheduling process, robust communication to all staff with any workflow impact, updating any automated or non-automated reminder outreach with details specific to the telehealth workflow which often varies from routine visits, and making sure the patient is visible on schedules at the originating and distant site. Telehealth software can often be leveraged to simplify workflows when their full functionality is utilized.
- Specific to a telepsychiatry program with medication management, the originating site needs to be able to manage injectable psychiatric medications to serve patients who need them, which requires some complex policies and procedures to be developed as part of the program.

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Program Findings and Key Elements for Success

The Idaho SHIP Telehealth Grantee Program provided the opportunity for practices across the state to test innovative approaches to telehealth service delivery in multiple settings while targeting various patient populations. No two programs were the same, allowing for the state to learn from each pilot and expansion program to inform future telehealth initiatives regardless of region or service community.

Results reflected the variety of programs, with unique challenges and successes demonstrated in program design and implementation. However, there were common themes and findings shared between grantees as further described below. These findings and lessons learned that are summarized below represent the successes and challenges identified and, in some cases, overcome, by practice teams.

Model Development and Team Leadership Support are Critical First Steps

As part of the application, grantees developed an initial project plan which included a proposed model for telehealth service delivery. The more successful programs had a clearly defined scope of services, a committed core telehealth team to drive progress, and an understanding of the needed elements for sustainability. Optimally, these building blocks of a successful telehealth program are established prior to a commitment or contract for vendor services or before the purchase of telehealth equipment. This was not always the case in some of the SHIP telehealth grantees and some sites struggled or needed to make adjustments as a result.

The importance of a provider champion and a committed telehealth team cannot be understated. At least one provider champion with demonstrated enthusiasm and support for telehealth as a tool to improve access to care was identified early on with many of the SHIP grantees. These teams encouraged buy-in from the entire site(s) for the program and worked to develop clear workflows and policies and procedures specific to the new or expanded telehealth process. Some grantees experienced barriers with provider skepticism of the quality or potential impact of telehealth. Counter cultures can significantly impact the pace of telehealth adoption across an organization. Provider champions need to address these issues early and often by validating and addressing their concerns and providing education and evidence.

Specific to a telepsychiatry program with medication management as part of the scope, Terry Reilly Health Services learned that the originating site needs to be able to manage injectable psychiatric medications to serve patients who need them. This resulted in a requirement for the development of complex policies and procedures. Otherwise, many of these patients would still have been required to come to the urban clinic, undermining the goal of the program to reduce this travel burden. Once developed, extensive practice with the protocol for this workflow was needed at the rural clinics to avoid numerous interruptions to the Psychiatric Nurse Practitioners.

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Latah Community Health developed an initial project plan, including strategies for patient outreach and engagement and workflows for three types of telehealth services. The team tested and improved the workflows throughout the pilot period, especially specific to tele-behavioral health, and incorporated patient and provider feedback to create cheat-sheets for use within the clinic and for the installation of the Chiron app on a patient phone. Staff participation lead to increased provider interest and quick replication of the model at the other CHAS Health sites.

Payment for Telehealth Services Remains a Barrier

The most pressing barrier identified by grantees and by the larger group of stakeholders participating at the May planning meeting is the existence of a complex reimbursement landscape that has resulted in the inconsistent, or overall lack of, reimbursement for telehealth services beyond the recent progress made with Idaho Medicaid telehealth policies. Medicaid telehealth reimbursement that includes home (or another nonclinical location) as an originating site has been a significant advancement for telehealth adoption and was a focus of several of the SHIP grantees. Grantee programs with ensured payment for services, such as for pediatric care or specific Medicaid populations, were able to create more sustainable telehealth programs.

Finding sustainable revenue sources for telehealth programs was a challenge for all of the programs, but it was especially challenging for smaller independent practices with a predominately commercial population. It is not feasible for these small practices to address telehealth payment policy issues on their own. Until multiple payers agree to incorporate telehealth as a covered benefit in their insurance plans, adoption of this cost-effective means of offering this member-centric alternative access to primary care will be stymied. It would be useful for the Department to provide ongoing opportunities for providers and staff from telehealth programs (SHIP and others) to have a forum to share ideas and best practices and to strategize payment policy solutions.

Dr. Scott Dunn from Sandpoint Family Health Center spent a significant amount of time and effort exploring additional revenue sources for sustainability. This included staff time to reach out to commercial payers for each telehealth visit to verify coverage. This resource intensive process would be unsustainable over time but was necessary due to conflicting coverage and benefit structures that seemed to vary per patient. Sandpoint also explored presenting a separate proposal to a local self-insured employer as a value-added benefit for their employees and their dependents. Dr. Dunn also responded to the CMS Request for Information on Direct Provider Contracting Models. This primary care capitation model could support this telemedicine model on a multi-payer basis, but it is uncertain if it will be advanced by CMS.

External Stakeholder Engagement Can Get Complicated

Several of the SHIP grantees proposed telehealth projects that involved partnerships or relationships with organizations outside of the practices' business structure. This is a common model for telehealth programs that include separate entities that function as the originating or distant sites, or that involve additional clinical groups that provide consultations or report interpretations. Developing these relationships can be time consuming and complex, especially when some or all of the participants are new to telehealth.

Payette County Paramedics, despite promising conversations with a local hospital during the application process, experienced difficulty in establishing a formal relationship with the hospital. The Payette team has worked hard to develop an alternate partnership with another provider group to participate in the program and has had many program development conversations in the community with potential providers. Many discussions progressed, but no final agreement with a provider partner has been reached. Such a partnership is a required component for telehealth referrals, patient treatment, and destination decisions. This experience underscored the need to develop buy-in from partners and community stakeholders to inform model development, identify the service population, and confirm service partnerships via written agreements.

Family Medical Residency of Idaho developed strategic plans to serve sick school children throughout the school district at multiple elementary and middle schools with care from one nurse staffing the Meridien Schools Clinic. The program will increase access to care by eliminating the need to bus the children from other campuses but comes with the complication of needing to develop plans in collaboration with the school district, requiring additional time and meetings. The plan includes meeting with the District for developing buy-in on the program and its scope, to develop policies on parent/guardian notification and consent, the addition of telehealth into the annual consent form administered district-wide, and logistical and staffing considerations such as space and supervision for the student telehealth visits at the originating sites.

Vendor Selection and Relationship Development Support Sustainability

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A vital element of a telehealth program is the relationship developed with the telehealth vendor who provides the platform for service delivery. Many aspects of a telehealth program include the vendor as part of the implementation team, such as data collection to support clinic and billing operations and evaluation and the delivery of services without connectivity issues. The most successful programs established their telehealth model and program goals prior to selecting a telehealth vendor, to ensure alignment and ease of program set up, and continued regular communication with their vendor as the program evolved to tailor functionality and improve provider and patient satisfaction. When a practice needs to switch telehealth vendors, as occurred with one SHIP grantee, this slows the pace of implementation and growth.

At Terry Reilly Health Services, the Director of Business Management assessed their telepsychiatry program's technology and functionality needs, issued an RFP outlining a solicitation for bids and thoroughly reviewed the responses. They were able to negotiate the service and functionality they needed and avoided purchasing unnecessary services or modules through this process. Ultimately, the configuration of their EHR with their telehealth platform via SnapMD accomplished a sophisticated level of integration with the patient medical records, including scheduling. The team learned that some more advanced and newly released features can add value, such as leveraging the "Presenter Role" within SnapMD during a patient video platform visit to simplify the workflow. In this mode, the medical assistant can launch the platform under the patient's name when a scheduled appointment has timed out due to delays in start time. The alternative was being launched as an open session which lost the benefits of the integration with the patient's medical record.

At Family Medical Residency of Idaho, the program to serve home-bound patients ran into delays due to the initial proposed vendor not being compatible with the tablet hardware the clinic already owned and hoped to use as a user-friendly patient and home health aide interface. They tested WebEx as a cost-effective alternative that can be HIPAA-compliant when settings are correctly managed, but ultimately found it to be difficult to use and "clunky". Ultimately, they landed on Chiron Health as a vendor with the right product for their program, but the process to identify the best option significantly delayed initial implementation.

Provider Driven Patient Recruitment and Engagement is Important, but Not a Guarantee for Patient Participation

Define your telehealth service population prior to program implementation, including surveying patients to identify need, assess interest, and determine why a patient would want a telehealth service instead of, or in addition to, an in-person visit. It is important to be aware of special populations that may be particularly well-suited to telehealth.

However, even when telehealth programs help improve access to care and overcome barriers such as transportation issues, some patients who can keep in person appointments will still choose to do so.

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This came as somewhat unexpected finding for several of the SHIP grantees who assumed the convenience of a telehealth visit would be a particular attraction to patients. For some patients, even after trying a telehealth visit, they still preferred the in-person experience.

Driggs Health Clinic of Teton Valley Health Care offered tele-oncology visits and infusion appointments in their facility to decrease the travel burden for patients. However, despite the distance issues, several patients still chose to drive an hour or more for in-person oncology care.

Coeur d'Alene Pediatrics identified a subset of their population, the autistic patient population and their parents, who were particularly adept at participating in telehealth visits. Because the telehealth visits were occurring in the patients' homes, with very little impact on the patient's schedule or surroundings, the providers reported that these visits were less stressful for the patient and more productive overall.

Summary of Telehealth Service Data

12	161	349
Total Number of Grants	Total Number of Unduplicated Patients Served	Total Number of Telehealth Visits

Conclusion

The SHIP telehealth grant provided Idaho with a unique opportunity to test new and innovative models of telehealth delivery in rural and underserved areas. Each site had the opportunity to develop and test programs to best meet the needs of their communities. Although the level of success varied, the overarching lessons learned will benefit future work in Idaho's telehealth program development to support improved access to quality health care.

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

Project ECHO Idaho
Extension for Community Healthcare Outcomes

ECHO Idaho is led by the University of Idaho and WWAMI and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. ECHO Idaho's Behavioral Health in Primary Care Program is also supported in part under grant number SM081387 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Project ECHO (Extension for Community Healthcare Outcomes) is an educational resource empowering primary care provider in Idaho's remote or underserved communities to treat complex chronic diseases with specialist-level expertise.

- People need access to specialty care for their complex health conditions.
- There aren't enough specialists to treat everyone who needs care, especially in rural and underserved communities.
- ECHO trains primary care clinicians to provide specialty care services. This means more people can get the care they need.
- Patients get the right care, in the right place, at the right time. This improves outcomes and reduces costs.

The heart of the ECHO model™ is its knowledge-sharing networks, led by expert teams who use multi-point video conferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses and other clinicians learn to provide excellent specialty care to patients in their own communities. At this time, Project ECHO Idaho addresses two specialty care topics through a series of 1-hour sessions. The topics are:

1. Opioid Addiction and Treatment
2. Behavioral Health in Primary Care

The remaining pages of this report provide details of each series, including the specialists.

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

Opioid Addiction and Treatment Series

The purpose of this specialist panel series is to share best practices for treating patients with pain or opioid use disorder, connect with peers from around the state to discuss what really works, and get feedback on difficult patient cases from a panel of specialists.

Specialists include:

- **Amy Jeppesen, LCSW** Social Worker, Recovery 4 Life
- **Brenda Hoyt, NP** Nurse Practitioner, Raise the Bottom Idaho
- **Cathy Oliphant, PharmD** Pharmacist, ISU College of Pharmacy
- **Coire Weathers, MD** Psychiatrist, Lost River Wellness
- **Monte Moore, MD** Pain Specialist, Idaho Physical Medicine & Rehabilitation
- **Todd Palmer, MD** Family Medicine & Addiction Medicine, Family Medicine Residency of Idaho

2018 Sessions included:

1. ECHO for Addressing Opioid Addiction & Treatment
2. CDC Guidelines for Prescribing Opioids for Chronic Pain, Part I
3. CDC Guidelines for Prescribing Opioids for Chronic Pain, Part II
4. Taking a Pain History, Functional Assessment, Establishing a Pain Diagnosis & Pain Tracker
5. Opioid Use Disorder & Evidence Based Screening
6. Non-Pharmaceutical Treatment for Chronic Pain
7. Addiction Treatment Overview
8. Use of the Prescription Monitoring Program and Board of Pharmacy Metrics
9. Buprenorphine in Primary Care
10. Medical Cannabis for Chronic Pain
11. Fascial Distortion Model
12. Treating Depression and Anxiety in the Presence of Chronic Pain and/or Opiate Use Disorder
13. Naloxone: Saving Lives
14. Cognitive Behavioral Therapy for the Primary Care Provider in the Treatment of Chronic Pain
15. Urine Toxicology
16. Legal Considerations for Treating Opiate Use Disorder
17. Acupuncture
18. Opiate Use Disorders/Pain in Pregnancy

2019 sessions include:

LIFE SPAN

1. Diversion
2. Opiates and Chronic pain: Pediatric Considerations
3. Adolescents and Addiction

SUD, PAIN, PSYCHIATRY

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4. Idaho Trends and Resources / State of 'use' in Idaho
5. Opiate Use Disorder: What to know, What to do
6. How to Counsel Chronic Pain Patients Struggling with Opiates
7. OUD and Depression / Suicidality

CHALLENGES IN OPIOID MANAGEMENT

8. What's MAT got to do with it? Common Myths and Misconceptions
9. Setting up a Suboxone Clinic - Tips from the Field
10. Harm Reduction
11. Motivating the Unmotivated Patient: Motivational Interviewing
12. Short Term Opioids - How to Educate Patients
13. Patients on Very High Doses of Opioids
14. Pain Control in Geriatrics

PHARMACOLOGY

15. Methadone
16. Non Opiate Drugs for Treating Pain
17. Drug Interactions with Pain Meds
18. Safe Opiate Prescribing: Med calculation
19. When to use Long Acting Opioids

NON PHARMACEUTICAL TREATMENTS FOR PAIN

20. An Interdisciplinary Approach to Treating Pain/OUD
21. Exercise and Chronic Pain
22. Sleep

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

Behavioral Health in Primary Care

The purpose of this specialist panel series is to share best practices for treating common mental health conditions, connect with peers from around the state to discuss what really works, and get feedback on difficult patient cases from a panel of mental health experts.

Specialists include:

- **Coire Weathers, MD** Psychiatrist, Lost River Wellness
- Stephen Carlson, PharmD Pharmacist, Intermountain Hospital
- Tara Whitaker, MD Family Medicine Physician, Capital City Family Medicine
- Jeremy Stockett, LCSW Social Worker, St. Luke's Psychiatric Wellness Services
- Rachel Root, PhD LP Psychologist, Treasure Valley Psychology

2018 Sessions included:

1. Somatic Disorder and Somatization
2. Mood Disorders
3. Gender Dysphoria
4. Co-occurring Disorders
5. Geriatric Psychiatry and Considerations in the Primary Care Setting
6. Boundaries, Therapeutic Modalities and Therapy Referrals in Primary Care
7. Common Interactions and Dosage Considerations in Psychiatry
8. Perinatal Mood Disorders

2019 Sessions include:

LIFE SPAN

1. Medicinal Considerations in Pregnant and Postpartum Women
2. Adolescents and ADHD
3. Dementia and Nonpharmacologic Interventions
4. Dementia and Pharmacologic Interventions
5. Self-Care for Helpers

DISORDERS

6. Autism Spectrum Disorders
7. Autism Spectrum Disorders
8. Co-Occurring Disorders
9. Personality Disorders
10. Sleep Disorders
11. Sleep Disorders

MENTAL HEALTH CRISES

12. Adolescents and Suicide
13. Safety Planning
14. Community Resources for Mental Health Crises

TREATMENT OPTIONS

15. Long Acting Injectables

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

16. Evidence for Herbals and Supplements for Mood
17. CBT for Anger Management
18. Electroconvulsive Therapy

CONSIDERATIONS IN PRIMARY CARE

19. Chronic Medical Conditions and Mental Illness
20. Anxiety 1
21. Polypharmacy
22. Exercise and Mood: a Review of the Evidence

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

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

Final Progress Report

Goal 6

Prepared for
CMMI

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.

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Multi-Payer Workgroup (MPW) Planning

Prepared for the IHC, December, 2018

Statewide Healthcare Innovation Plan

Contents

- Multi-Payer Workgroup (MPW) History
- MPW Activities and Accomplishments
  - Data Collection
  - Quality Measure Set Alignment
- Healthcare Transformation Council of Idaho (HTCI) and MPW planning

MPW History

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Original MPW Charge from the IHC

The MPW was formed to advise and address the funding reform needs of SHIP. The workgroup's charge is as follows:

- Through collaboration across payers and providers, transform payment methodology from volume to performance-based value.
- Develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a PCMH through transition to an outcome-based payment system.

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Support for SHIP Goals

- Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.
- Goal 7: Reduce overall healthcare costs.

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MPW Membership

- Aetna
- Blue Cross of Idaho
- Department of Health and Welfare – Medicaid
- Essentia Health Clinics
- Futura Title and Escrow Corp (Self-Funded)
- Idaho Hospital Association
- Idaho Primary Care Association
- Molina Health Care of Idaho
- Mountain Health CO-OP
- Noridan Healthcare Solutions, LLC, Fargo
- PacificSource Health Plans
- Regence BlueShield of Idaho
- Select Health
- St. Alphonsus
- St. Luke's
- UnitedHealthcare

MPW Activities and Accomplishments

Data Collection

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Data Collection

Goal 6 Payer Financial and Enrollment Metrics

- Mercer collected data to compare enrollment and payment metrics from commercial payers, Medicare and Medicaid.
- Baseline CY2015 data was compared to CY2016 and CY2017 data.
- Beneficiary attribution went from 58% to 85%; Payments from 24% to 29%.
- Improvement to payment percentages expected in 2020 due to Medicaid roll-out of shared savings program.

Statewide Healthcare Innovation Plan

Data Collection

Goal 7 Financial Analysis

- Mercer collected payer data to determine the impact of changes occurring through the SHIP on the State's healthcare costs.
- Targeted areas for expected cost avoidance:
  - Generic prescription drug usage.
  - Impatient hospital admission & readmissions.
  - Emergency room usage.
  - Early deliveries.
  - General primary care savings.

Statewide Healthcare Innovation Plan

Data Collection

Goal 7 Financial Analysis

- Actual costs for the demonstration are projected to be over **$93.5 million lower** than if no intervention for SHIP or payment reform were taking place.
- SHIP financial goals continue to progress as expected after year two of the model test.
- Final report will be presented in December to MPW if data is submitted within the timeframe requested.

Recommended Next Steps – Data Collection

- The Multipayer Workgroup recommends continued data collection as follows:
  - Continue to track Idaho's progress in shifting to value-based payments. This provides information for all payers to see progress across the state in achieving a long-term, sustainable impact on the State's healthcare system.

MPW Activities and Accomplishments

Quality Measures Alignment

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Background

- Providers are accountable for multiple similar but different quality measures.
- Providers have requested that, within a focus area (e.g., chronic disease), measured outcomes be consistent across payers. This reduces burden and increases provider engagement without having to shift the frame of the measure.
- Implementation of a core measures set would reduce burden for providers.

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Quality Measures Survey

- The MPW developed a survey for payers to better understand which measures are currently used consistently across payers.
- Payers were surveyed on how they use HEDIS measures in paying for quality.
- The MPW considered using STARS for Medicare, but chose HEDIS because it is an established national standard and there was unanimous usage of HEDIS among payers on the MPW.

Statewide Healthcare Innovation Plan

Quality Measures Survey

- Purpose of the survey was to identify the measures and disease categories where there was most alignment across payers.
- Payers were asked which measures they currently use, and which they plan to start or stop using in the next 2 years.
- Based on the results of the survey an initial proposed core measure set of 12 HEDIS measures was identified.

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Survey Results – Top 12 Measures

Measure	Disease Category	Alignment Score[1]
Adult BMI	Prevention & Screening	10
Breast Cancer	Prevention & Screening	10
Colorectal Cancer Screening	Prevention & Screening	10
Medication Management Asthma	Respiratory	8
Controlling High Blood Pressure	Cardiovascular	10
Persistence of Beta-Blocker Treatment after a Heart Attack	Cardiovascular	8
Statin Therapy for Patients with Cardiovascular Disease	Cardiovascular	8
Disease Modifying Anti-Rheumatic Drug Therapy for RA	Musculoskeletal	8
Antidepressant Medication Management	Behavioral Health	8
Plan All-Cause Readmission	Utilization	10

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Why this Work Should Continue

- The MPW supports alignment of an Idaho core quality measure set beginning in 2020.
- Payers and providers think alignment is valuable
- Aligns with HTCI's function to:
  - Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation and to promote efficiencies in the collection, measuring, and reporting of quality measures.

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Recommended Next Steps

- Designate a multi-payer/provider workgroup or entity that:
  - Continues to pursue measure alignment.
  - Provides expert information to the HTCI on barriers and opportunities for delivery system and payment model alignment.
  - Identifies opportunities to surround and support providers (e.g., could identify areas with higher diabetes, then add resources to support providers in areas outside of their control or influence)

HTCI and MPW Planning

Statewide Healthcare Innovation Plan

HTCI Planning Questions

1. **What three (3) things do you think the HTCI needs to pay particular attention to as we work to transform Idaho's healthcare delivery system? From your perspective, what will most move Idaho's transformation forward?**

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HTCI Planning

Answers

1) <u>Collaboratively prioritize health outcome goals.</u>

It is important to achieve high value for patients with a focus on population health and value being defined as the health outcomes achieved per dollar spent. This goal is what matters for patients and unites the interests of all participants in the health care system.

HTCI Planning

Answers

2) Align payment structure to support these goals.

Continue the focus on value-based care that rewards healthcare providers for providing quality care to patients.

HTCI Planning

Answers

3) Focus on the process.

Through collaborative efforts, payers and providers will work synergistically to achieve these goals.

HTCI Planning

Question and Answers

2. **What are the biggest opportunities in your area that the HTCI can impact?**

- ***Capitalize on the collaboration established by the MPW.*** *This workgroup has served as a forum for connecting stakeholders to determine strategies for moving toward value-based payment models. Both payers and providers agree, it is important to continue to measure progress on Idaho's movement in value-based reimbursement. By doing this an inherent accountability and transparency is realized without any mandates. Addressing payer obligations to report measures while working to reduce provider burden through alignment of measures is critical.*
- ***Utilize existing healthcare foundations, or other foundations that collectively have a healthcare focus to support healthcare transformation.*** *Additional collaboration and potential financial funding is possible by bringing multiple foundations together to provide awareness of what has been accomplished by the SHIP and identify opportunities to advance the successes.*

Statewide Healthcare Innovation Plan

HTCI Planning

Question and Answers

3. **What are key barriers that the HTCI needs to be aware of as we promote transformation?**
   - Information is siloed.
   - Achievable and rational benchmarks.
   - Financing system.
   - Proprietary information (anti-trust).

HTCI Planning

Question and Answers

4. **What should the HTCI consider recommending to help overcome those barriers?**

- Information is siloed.

  Help providers with interoperability – the sharing and exchange of data. In some instances, the sharing of information is limited due to silos and in other areas the information is only shared within siloes. Certain systems and devices can exchange data and interpret that shared data but may not be able to share that data with the entity that needs the information to address the necessary actions to effectuate change.

Statewide Healthcare Innovation Plan

HTCI Planning

Answer to Question 4 continued

– Achievable and rational benchmarks.

Setting expectations too high can discourage engagement in transformation efforts and quality improvement. Ensuring that improvement can be rewarded from where providers are starting would be a more ideal approach to incentivize change.

Different regions have different needs and different providers have different levels of success and should be rewarded on their relative improvements. Recognizing a percent of improvement may need to be considered.

HTCI Planning

Answer to Question 4 continued

– <u>Financing system.</u>

It's well known FFS is migrating to value. Perhaps the focus should be more on the process than the goal – so rather than keep pointing at the goal of value (and even capitation) we should focus on the efforts to transition and transform and how they are (and aren't) coordinated.

Statewide Healthcare Innovation Plan

HTCI Planning

Answer to Question 4 continued

– Proprietary information (anti-trust).

Need to be mindful of anti-trust issues as we continue to collaborate and protect proprietary information, but it doesn't have to be a barrier if there is a good understanding of what can and what cannot be shared, much like how the MPW has been functioning.

MERCER
MAKE TOMORROW, TODAY

STATEWIDE HEALTHCARE INNOVATION PLAN (SHIP) PAYER FINANCIAL AND ENROLLMENT METRICS FOR GOAL 6 — JANUARY 2018

INTRODUCTION

The State of Idaho's (State's) multi-payer approach to shifting from fee-for-service (FFS) payments to value-based payment strategies is expected to achieve a long-term, sustainable impact on Idaho's healthcare system. In demonstration year 2, payers continued to move away from FFS and towards value-based payment through several methods, including:

- Pay-for-performance (P4P)
- Enhanced P4P
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-based payments
- Episode-based payments

In addition to the Patient Centered Medical Home (PCMH) model, payers are testing alternative models including accountable care organizations with many of the State's acute care hospitals. Payers also support total cost of care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits.

The multi-payer approach includes:

- Understanding each payer's need to design and implement payment models that they believe fit their organization's goals and are most effective for their beneficiaries and provider partners.
- Recognizing that system wide transformation to value-based purchasing will only occur across Idaho payers if payers are participating as leaders of the change rather than responding to mandates.

- Acknowledging that payment transformation may not occur quickly in Idaho. but, through partnership with payers, new reimbursement models will emerge that have a positive impact on the system statewide. Implementation of new reimbursement models representing at least 80% of the beneficiary population is the goal for the State and is underway.

To collect payer data for tracking Idaho's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup. The model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

BASELINE FOR IMPROVEMENT COMPARED TO DEMONSTRATION YEAR 1

The overarching aim of Idaho's integrated multi-payer PCMH model is to improve quality outcomes and beneficiary experience, which is expected to lower the cost of healthcare. Transforming from a FFS reimbursement model to payment models that incentivize quality outcomes and improved beneficiary experience is a key goal to achieve this aim. Evidence of the transformation to paying for value over volume will be shown by comparing the enrollment and payment metrics from commercial, Medicare and Medicaid payers throughout the State for each demonstration year.

Data Requests

To measure progress, the baseline of calendar year 2015 data was compared to calendar year 2016 data. Payers were asked for both years to provide percentages of beneficiaries and percentages of payments in the following categories:

- Category 1: FFS — no link to quality and value. Example is FFS payments.
- Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.
- Category 3: Value methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.
- Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.

To assist in compilation, the data request also asked for total dollars paid for medical services in both years. The data request forms did not change from year to year, but a one-page description of the updated Alternative Payment Model (APM) framework was provided for additional guidance to the payers.

Mercer's Client Confidentiality Agreement was signed by commercial payers and Mercer to ensure their data was protected and kept private. The agreement covers all four years of the demonstration. It was agreed that the data would be aggregated across payers so no individual payer data would be discernable.

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DATA COMPILATION

Upon receiving data from five of Idaho's largest payers, including Medicare and Medicaid, Mercer collected comparison data from public documentation, including KFF.org and statutory filings in the National Association of Insurance Commissioners format. Data was weighted for both enrollment and payment information by payers to combine the data and protect the privacy of commercial respondents.

Table 1. Percentage of Beneficiaries Per Category for 2015 versus 2016

CATEGORY	MEDICAID		COMMERCIAL & MEDICARE ADV.		MEDICARE		TOTAL	
	2015	2016	2015	2016	2015	2016	2015	2016
Category 1: FFS — no link to quality and value. Example is FFS payments.	100%	13%	21%	22%	8%	7%	42%	15%
Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.	0%	87%	73%	71%	72%	75%	51%	76%
Category 3: Methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.	0%	0%	4%	5%	20%	18%	6%	8%
Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.	0%	0%	2%	2%	0%	0%	1%	1%

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Table 2. Percentage of Payments (Paid or Accrued) Per Category for 2015

CATEGORY	MEDICAID		COMMERCIAL & MEDICARE ADV.		MEDICARE		TOTAL	
	2015	2016	2015	2016	2015	2016	2015	2016
Category 1: FFS — no link to quality and value. Example is FFS payments.	100%	99%	71%	68%	43%	45%	76%	75%
Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.	0%	1%	19%	19%	37%	37%	15%	16%
Category 3: Methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.	0%	0%	7%	9%	20%	18%	7%	7%
Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.	0%	0%	4%	4%	0%	0%	2%	2%

Analysis

In 2016, commercial and Medicare payers remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain sharing, risk sharing and population-based payments were completing their first year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. Payments were still primarily FFS and 2016 mirrored 2015. Anecdotal evidence suggests that payers and providers

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were hesitant to accept quality-based payments with risk due to the lack of beneficiaries assigned to each provider or were waiting to see the outcomes of initial assignments. Some payers required minimum levels of beneficiaries, such as 1,000 beneficiaries, before quality or risk-based payment arrangements replaced FFS. Medicare category 3 and 4 activity in 2016 was based on estimates from 2015 due to the unavailability of beneficiary count data for certain programs.

Medicaid continued the Health Connections PCMH program in 2017. The program includes four tiers with PMPM payments ranging from $2.50 to $10.00. While Medicaid members were attributed to primary care clinics, payments remained primarily fee-for-service in 2016. However, in 2018, Idaho Medicaid will expand Healthy Connections program to include shared savings for primary care practices through direct contracts and through participation with regional care organizations. Medicaid is implementing several programs that cover a broad range of healthcare transformation activities and population-based care management initiatives. The Healthy Connections Value Care White Paper from September 2017 outlines the use of shared savings programs, per member per month payments for PCMHs, and episodes of care payments. All Medicaid beneficiaries will be attributed to primary care, either through beneficiary choice or, if no choice is made, prior claims history or proximity to providers. In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the Advanced APM standard of “more than nominal financial risk”, allowing participating clinicians to pursue the APM with Medicare, as allowed under the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015.

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HEALTHY CONNECTIONS VALUE CARE PROGRAM UPDATE

January 31, 2019

Presented by:
Meg Hall, Healthy Connections Program Manager
Dr. Jeanene Smith, Medicaid Consultant, Quality
Greg Sonnenberg, Medicaid Consultant, Financial/Contract

Agenda

- High level overview Healthy Connections Value Care (HCVC) Program
  - Program Requirements
  - Overview Total Cost of Care Model
  - Overview Quality Measures and Methodology
  - Review Program Changes
  - Options for HC PCP's to participate
- Next steps

Why we need a new payment system

- Current payment system is not sustainable
  - Last year's Medicaid budget exceeded $2.4 billion and next year's is forecast to exceed $2.5 billion
- Medicaid in Idaho needs a better system of care that ties payments to quality
- The Dept. has been working diligently with Idaho hospitals, primary care providers and health plans to build a more accountable Medicaid program
  - Matt Wimmer, Medicaid Administrator - The government alone can only be a part of the solution and we have been working with healthcare providers to share the responsibility for delivering better health at a reasonable price
- **Important to move forward "together now" with provide led/collaborative payment reform as movement underway by others to address issue**

What is Healthy Connections Value (HCVC) Care?

- HCVC is a value and risk based reimbursement model with a yearend settlement payment based on financial and quality performance
- Goal – Work together under a provider/led collaborative model to improve quality and control costs
- Current payment structure remains in place:
  - Fee for service payments
  - HC PMPM (tier) payments to all HC Clinics

HCVC Program Entities

- Accountable Primary Care Organizations: Primary-care clinic providers who improve total cost of care and quality performance for their attributed Medicaid patients can earn a portion of those savings, or are held accountable for a level of risk.

- Accountable Hospital Care Organizations: An integrated network of providers that includes an acute care hospital serving large numbers of Medicaid patients who improve total cost of care and quality performance can earn a portion of those savings, or are held accountable for a level of risk.

HCVC Program General Characteristics

- Contracting entities classified into two categories, Primary Care based Organizations and Hospital based Organizations.
- Value and risk based reimbursement model with a year end settlement payment based on financial and quality performance.
- Financial performance, gain share and loss share based on a Total Cost of Care (TCOC) model.
- Quality performance evaluated primarily on a HEDIS based model
- TCOC calculated on covered lives attributed to the Contracting Entity based on Healthy Connections Service Location PCP assignment.

Year	Accountable Primary Care Organizations	Accountable Hospital Care Organizations
2019 – 2020	- Voluntary Participation - Open to practices with 1,000 lives or more - Participation requires limited risk of existing Primary Care Reimbursement (Healthy Connections payment) - Sharing of savings contingent on performance on quality measures and financial performance - Quality measures developed in collaboration with prospective accountable care partners	- Voluntary Participation - Open to organizations with 10,000 lives or more as attributed through owned or partner primary care - Participation requires transition to budget based reimbursement including limited risk - Sharing of savings contingent on performance on quality measures and financial performance - Quality measures developed in collaboration with prospective accountable care partners
2020 – 2021	- Voluntary Participation - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners	- Voluntary Participation - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners
2021 – 2022	- Mandatory participation - All primary care providers serving 10,000 members or more must accept an accountable primary care contract - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners	- Mandatory – for Hospital system with primary care networks must accept an accountable hospital care contract - Risk level increases - Quality measures adjusted based on collaborative input from all accountable care partners

	Accountable Primary Care	Accountable Hospital Care
Shared Savings	___% of savings Up to ___% of paid claims	___% of savings Up to ___% of paid claims
Shared Losses	____% HC Case Management Payment up to ____% Loss	____% of loss Up to ___% of paid claims
Minimum Quality Gate	Yes	Yes
Quality Measures	Applicable Value Care Measures	Applicable Value Care Measures
PCCM Payment	Same as current	Same as current
Minimum Members	1,000 (excluding duals)	10,000 (excluding duals)
Term of Agreement	3 year	3 year
Stop Loss (annual)	$100,000 per member	$100,000 per member
Member Assignment	Fixed Enrollment HC Process	Fixed Enrollment HC Process
Benchmark Development	HCVC Region	HCVC Region
Community Investment	5% of Shared Savings	5% of Shared Savings

Evolution HCVC Risk Path

- Current Medicaid trend in excess of 7% - not sustainable
- Annual HC Primary Care Case Management Payment - $18 M
  - This payment not effecting trend as anticipated
- Accountable Primary Care Organization risk path:
  - Moving HC Case Management fee to a performance based model
    - In event of loss, % HC Case Management fee at risk
- Accountable Hospital Care Organization risk path:
  - In event of loss, held accountable for a % of actual loss
- Share of Loss TBD and loss share will increase each year of the contract

Healthy Connections Total Cost of Care Formula

- $\frac{\text{2018 Calendar Year Regional PMPM}}{\text{2018 Calendar Year Regional Risk Score}}$ = Standardized Regional PMPM Benchmark
- Standardized Regional PMPM Benchmark X Performance Year (SFY20) VCO Risk Score = VCO Gross Target PMPM Benchmark
- VCO Gross Target PMPM Benchmark - VCO Performance Year (SFY20) Actual Paid PMPM = Gross Savings (Loss) PMPM
- Share of Loss TBD and loss share will increase each year of the contract

Healthy Connections Total Cost of Care Formula cont.

- If Savings, VCO share of Savings TBD but Savings share will increase each year of contract.
- If Savings, VCO Savings will be split equally into an Efficiency Pool and a Quality Pool for Settlement Payout.
- Efficiency Pool distribution will be paid out in full provided a minimum Quality Threshold is met.
- Quality Pool distribution will be based on performance on specific mutually agreed to Value Measures

HCVC – Program Exclusions

Total Cost of Care Exclusions:

- Pharmacy
- Managed Care Products
  (O/P behavioral health, Dental, Non-Emergent Medical Transport)
- Nursing Home & Intermediate Care Facilities
- Long-term Supports & Services

(Home & Community Based Services – AABD & DD Waiver, HCBS, for aged or individuals with disabilities)

Excluded Participants:

- Dual Eligible Participants
- Medicaid Expansion Participants (if it occurs)

EXAMPLE - HCVC Shared Savings

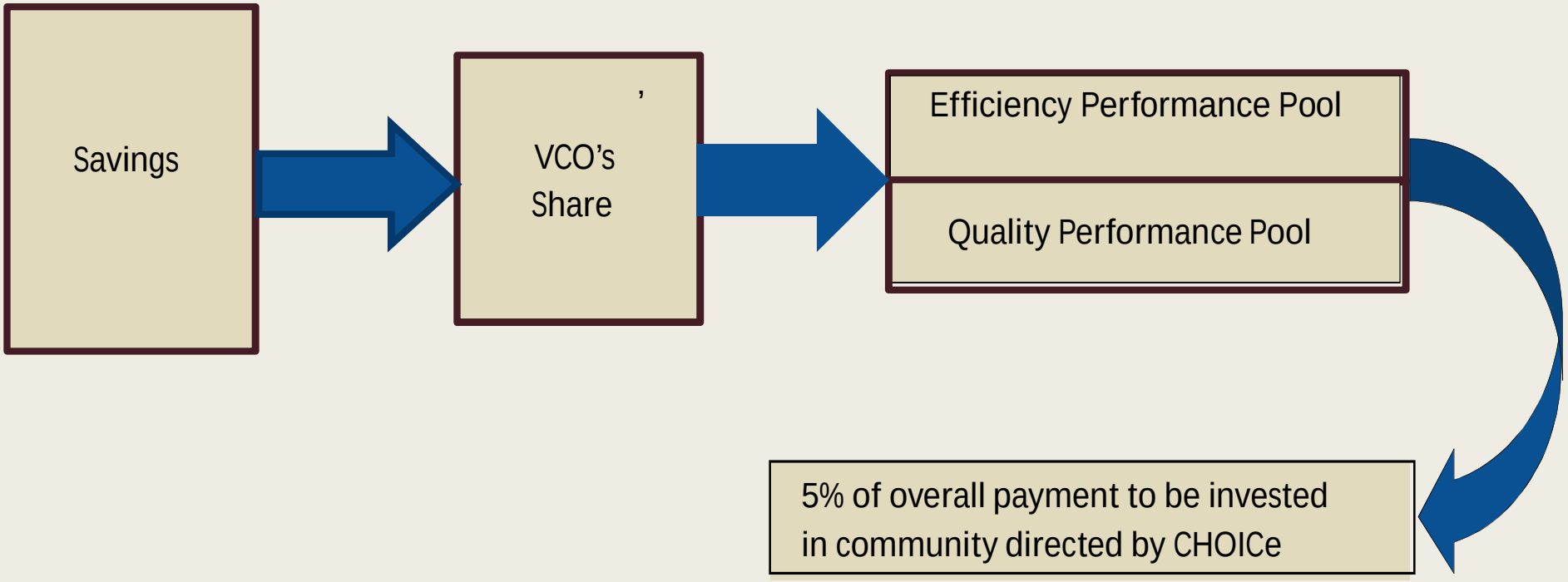
	APCO 1,000 Members	APCO 5,000 Members
VCO Target PMPM - SAMPLE	$275.00	$275.00
VCO Actual Spend PMPM	$265.00	$260.00
Actual Savings	$10.00	$15.00
Potential Savings (- 15% State Administrative Cost)	$8.50	$12.75
Maximum Savings – up to CAP of 5% (multiplied by actual spend)	$13.25	$13.00
Gross Savings	$8.50	$12.75
*Potential annual VCO Savings (Savings x Members x 12 months)	$102,000	$765,000

*VCO's will be obligated to use 5% of their overall shared saving payments to support community health management efforts.

EXAMPLE - HCVC Accountable Primary Care Risk

	1,000 Members Tier II	1,000 Members Tier IV	5,000 Members Tier II	5,000 Members Tier IV
VCO Target PMPM	$225	$225	$225	$225
VCO PMPM Spend	$235	$235	$235	$235
VCO Total Loss (amount x members x 12)	$120,000	$120,000	$600,000	$600,000
VCO Annual PCCM Payment	$40,000	$117,000	$165,000	$585,000
VCO 20% Risk PCCM Payment Cap	$8,000	$23,400	$33,000	$117,000
VCO Loss Cap 10%	$12,000	$12,000	$60,000	$60,000
VCO Risk Payment Amount	$8,000	$12,000	$33,000	$60,000

Value Care Payment Funding breakout



Continuous Improvement: Measure Set and Methodology will Evolve Over Time

- Idaho Medicaid will monitor and review the program's initial measures and methodology, in partnership with stakeholders to:
  - Assess if right combination of measures to incent improvement in quality, access and total cost of care for the Idaho Medicaid population
  - Ensure access is not impacted
  - Align with any shifts in national measure sets such as the Medicare quality programs for providers and hospitals
  - Track other gaps in care and behavioral health measures for future years' measure considerations
- As new measures are identified, it is likely that other measures will be retired from the list, either due to measurement concerns or progress.
- Measures will be updated annually prior to each performance year

Goals of the Value Care Program

- The goals of the program are to incentivize continuous improvement in measured performance areas:
  - Savings to be shared in the event of reduction in total cost of care
  - Efficiency and quality improvement will both be rewarded, each with a portion of the savings and with thresholds for performance payments
    - If no savings in total cost of care; no funding for the performance pools
    - All the organization's applicable measures are included in their performance measurement.
    - For each measure, performance against a baseline will be calculated, with incentive to increase incrementally with higher incremental performance toward a nationally-informed State target.
    - Efficiency performance payments will require at least maintaining quality of care
    - No quality incentive will be paid for performance on a measure that falls beneath its approved improvement target.

Performance Savings Payment Distribution

- A small percentage of the shared savings will be retained by the Department to support the administration of the program and data analytics.

- Of the remaining portion of the savings:
  - One half could be the earned through an “efficiency pool” of dollars which rewards lowering costs as long as quality of care is maintained.
  - The other half can be earned based on their performance on the specific value measures. These are focused on quality improvement and efficiency. This would be the “quality pool” of dollars
  - The participating entities will be obligated to use 5% of their overall shared saving payments to support community health management efforts. Those investments will be directed in partnership with the regional Community Health Outcomes Improvement Councils (CHOICe).

Eligibility for 2019 Value Measure Performance Payments if Savings Available

The 2019 threshold requirements, whether in the Healthy Connections Value Care accountable primary care or the accountable hospital portion will be:

- Demonstrated savings when compared with the previous measurement year
- Have at least 30 assigned participants for a measure to qualify for consideration of that measure
- Maintain baseline on at least 50% of the measures to be eligible for the **efficiency pool** portion of shared savings
- **Quality pool** performance is based on the improvement across the applicable value measures

Performance Improvement Target

- Each VCO's value measure improvement target will be published each year, based on the previous year's performance.
- **Aspirational Goal Benchmark**
  - State and national benchmarks will be identified for each measure, as available.
  - These benchmarks will be set at the 90th percentile for the state or nationally, whichever is higher.
- **Individualized Annual Improvement Target**
  - All organizations start from where they are at baseline (calendar year 2018) with annual individual improvement targets from baseline to the aspirational goal.
  - To meet a measure, an organization will need to demonstrate at least a 3% minimum improvement (floor) from their individual baseline. Improvement targets encourage continued, incremental year-over-year improvement toward the statewide benchmark over time.

Improvement Target

The improvement targets are based on the Minnesota Department of Health's Quality Incentive Payment System ("Minnesota method" or "basic formula")*. This method requires at least a 10 percent reduction in the gap between baseline and the aspirational goal benchmark to qualify for incentive payment. Stated as a formula

$$\frac{[\text{State Benchmark}] - [\text{VCO Baseline}]}{10} = X$$

Then: **[VCO Baseline] + [X] = Improvement Target**

Example: $$\frac{[\text{Well Child State or National Benchmark} = 70] - [\text{VCO A's Baseline} = 30]}{10} = 4$$

VCO A's Improvement target = Baseline of 30 + 4 = 34

The VCO must meet either the aspirational benchmark of 70% percent **OR** the improvement target of 34% percent to be awarded quality performance payment funds for this measure.

*More info re Minnesota method: http://www.health.state.mn.us/healthreform/measurement/QIPSReport051012final.pdf

Improvement Target must be at least the minimal Floor for Improvement

- A 3% "floor" or a minimum level of improvement is required before a VCO would meet the improvement target and be awarded the quality pool funds associated with that measure.
- If the improvement target calculation for a VCO results in a percent improvement that is less than the floor, the floor takes precedence and is applied instead of the improvement target calculation

Initial calculation* due to minimum floor	Improvement target	New Improvement target
$\frac{[70.0] - [50.6]}{10} = 1.94$	50.6 + 1.94 = 52.94	50.6+ 3.0 = 53.6

*Based on State's Aspirational goal = 70%; VCO B's baseline = 50.6%

What if the adjusted improvement target beats the statewide aspirational target?

Example with the breast cancer screening measure: if the state benchmark is set at 68.0 percent and a VCO has a baseline of 66.7

Initial calculation	Improvement target	New improvement target with floor applied
$\frac{[68.0] - [66.7]}{10} = 0.13$	66.7 + 0.13 = 66.8	66.7 +3 = 69.7

The calculated improvement target (69.7 percent) is higher than the established benchmark (68.0 percent). The VCO must only meet the benchmark of 68.0 percent to be awarded the quality pool funds for this measure. It does not need to meet the calculated improvement target when the improvement target is higher than the benchmark to qualify.

VCO with 13 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark or improvement target)	Quality Performance Payment Amount	VCO A: (13 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	**10**
Met at least 70%	80%	9
Met at least 60%	70%	8
Met at least 50%	60%	7
Met at least 45%	55%	6
Met at least 40%	50%	5
Met at least 30%	40%	4
Met at least 20%	30%	3
Met at least 15%	20%	2
Met at least 10%	10%	1
Met no targets	0	0

VCO with 9 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark / improvement target)	Quality Performance Payment Amount	VCO A: (9 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	**7**
Met at least 60%	70%	6
Met at least 50%	60%	5
Met at least 40%	50%	4
Met at least 30%	40%	3
Met at least 20%	20%	2
Met at least 10%	10%	1
Met no targets	0	0

VCO with 5 Applicable Measures Example		
Percentage of targets of Applicable Value Care Measures Met (achieving benchmark / improvement target)	Quality Performance Payment Amount	VCO A: (5 Applicable Measures) Number of Measures to Meet
Met at least 75% of applicable measures	**100%**	4
Met at least 60%	75%	3
Met at least 40%	50%	2
Met at least 20%	25%	1
Met no targets	0	0

Healthy Connections Value Measures	Source	IBM Watson #	Endorsed By
(Adult) DIABETES HBA1C TEST indicates whether a patient with type 1 or type 2 diabetes, aged 18 to 75 years, had a hemoglobin A1c test performed. This excludes patients with a diagnosis of gestational diabetes or steroid-induced diabetes.	Claims	93	NQF 57; Owned by NCQA
WELL CHILD VISITS (>5) IN FIRST 15 MOS MCD CHILD indicates the percentage of children, who turned 15 months old, and had more than five well-child visits with a primary care practitioner (PCP) during their first 15 months of life.	Claims	638	NQF 1392; Owned by NCQA
WELL CHILD VISITS AGE 3 TO 6 YEARS MEDICAID CHILD indicates the percentage of children, aged 3 to 6 years, who received one or more well-child visits with a primary care practitioner (PCP) during the measurement year.	Claims	632	NQF 1516; Owned by NCQA
WELL CARE VISITS ADOLESCENTS MEDICAID CHILD indicates the percentage of adolescents, aged 12 to 21 years, who had at least one comprehensive well-care visit with a primary care physician (PCP) or a gynecologist during the measurement year.	Claims	615	HEDIS; Owned by NCQA
INFLUENZA VACCINE indicates whether a Participant, aged 6 months and older, received an influenza vaccination during the latest complete October 1 through March 31 block of time. This excludes people with an allergy to eggs or a previous adverse reaction to the influenza vaccine.	Claims	179	NQF 041
BREAST CANCER SCREENING indicates whether a woman member, aged 52 to 74 years, had a mammogram done from 27 months prior to the measurement period to the end of the measurement period. This excludes women who had a bilateral mastectomy or two unilateral mastectomies.	Claims	90	NQF 2372

Ambulatory Care Emergency Dept Visits Calculates the number of emergency department (ED) visits per 1,000 enrolled months.	Claims	Non-Rule Measure	HEDIS
READMISSIONS WITHIN 30 DAYS AGE 18 TO 64 calculates the percentage of acute inpatient stays during the reporting time period, for patients aged 18 years and older, that were followed by an acute readmission for any diagnosis within 30 days of discharge.	Claims	Non-Rule Measure	NCQA
Elective Delivery - assesses patients with elective vaginal deliveries or elective cesarean births at >= 37 and < 39 weeks of gestation completed.	Reported by VCO	n/a	NQF 469; CDC; Owned by the Joint Commission
Catheter-associated urinary tract infections (CAUTI) Standardized Infection Ratio (SIR) of healthcare-associated, catheter-associated urinary tract infections (UTI) will be calculated among patients in bedded inpatient care locations, except level II or level III neonatal intensive care units (NICU). This includes acute care general hospitals, long-term acute care hospitals, rehabilitation hospitals, oncology hospitals, and behavior health hospitals	Report by VCO	n/a	NQF 138; CDC Steward; Hospital Compare
Clostridium difficile (C-diff) Standardized infection ratio (SIR) and Adjusted Ranking Metric (ARM) of hospital-onset CDI Laboratory-identified events (Lab ID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).	Report by VCO	n/a	NQF 1717; NHSN/CDC Steward
H CAHPS (Communication about medication) Before giving you any new medicine, how often did hospital staff tell you what the medicine was for	Report by VCO	n/a	CMS CAHPS Hospital Survey
H CAHPS (Discharge Information) During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?	Report by VCO	n/a	CMS CAHPS Hospital Survey

DHW will establish two Advisory Groups in each region

- CHOICe (Community Health Outcome Improvement Coalition)
  - Accountable for identifying opportunities to improve health and wellness, create health equity and address the social determinants of health in their communities
  - VCO's will be obligated to use 5% of their overall shared saving payments to support community health management efforts. Those investments will be directed in partnership with CHOICe
- Regional Care Collaboratives
  - Accountable for identifying healthcare needs across the region and seeking collaborations to improve cost, quality, utilization and data sharing.
  - Medical providers who hold value-care contracts

- Advisory Group Management
  - DHW will facilitate the meeting, manage the agenda and establish topics for discussion
  - Advisory groups are non-governing and have no formal legal structure

HCVC – Options to participate

- Organization or Network - You can participate in the Medicaid HCVC program with organizations or networks that you know and trust

- Maintain independent practice status and contract directly with the Department or affiliate with other providers to meet minimum member requirements
  - Must form limited liability legal entity and sign Joint Operating Agreement

- Participate now
  - Important to move forward "together now" with a provider led/collaborative payment reform model, as movement underway by others to address issue
  - Opportunity to be rewarded for PCMH transformation efforts to date

Upcoming Dates

- March – Final HCVC contract available
- March – HC PCP Fixed Enrollment information issued
- April - HC Member Fixed Enrollment notices sent
- March-May – Execution new HC Coordinated Care Agreements
- April 30, 2019 – last day to submit HCVC contract for 7/1/19 go live
- July 1, 2019 – Healthy Connections Value Care & Fixed Enrollment – go live

Next Steps

- E-mail MedicaidValueCare@dhw.Idaho.gov for the following:
  - To provide input on draft HCVC program design
  - To submit your statement of interest to participate effective 7/1/2019
    - Once available, a cost/quality dashboard report will be sent to the clinic
  - To indicate interest in affiliating with other HC Independent providers to participate in HCVC Program
    - View HC Provider Network Listing at www.heatlhyconnections.Idaho.gov

Contact Information

- HCVC Program E-Mail – MedicaidValueCare@dhw.Idaho.gov

- Meg Hall, Healthy Connections Program Manager
  - E-mail Meg.Hall@dhw.Idaho.gov
  - Phone (208) 665-8844

- Healthy Connections website www.healthyconnections.Idaho.gov

Thank you, thank you for your time and interest –
YOUR INPUT IN THE FINAL DESIGN PHASE OF THE HCVC PROGRAM IS CRITICAL AS WE MOVE FORWARD TOGETHER TO BUILD A MORE ACCOUNTABLE MEDICAID PROGRAM

MERCER
MAKE TOMORROW, TODAY

IDAHO STATEWIDE HEALTHCARE

Multi-Payer Work Group, Financial Analysis and Payment Transformation Best Practices

JANUARY 27, 2019

Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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1

Best Practices and Lessons Learned

Background

Idaho intends to lower the overall cost of healthcare for Idahoans by transforming the way healthcare is delivered. As such, one of the goals of the SHIP was to shift payments from volume-based payments to payments based on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care. The PCMH model has been described by policymakers and clinicians across the country as a cornerstone of health system transformation. As part of the model test, the DHW, together with the Idaho Healthcare Coalition, engaged Mercer to analyze financial metrics for population health in Idaho.

In 2015, Mercer received a contract to assist the IDHW in managing the tasks associated with the grant. Some of those tasks included facilitating Multi-Payer work group meetings to gain support for sharing financial data, to collect and report environmental-level financial results, and to track the movement of payers away from fee-for-service (FFS) toward paying for value. This report identifies some of the lessons learned from those tasks and recommends best practices for similar projects.

Understanding Required Reporting

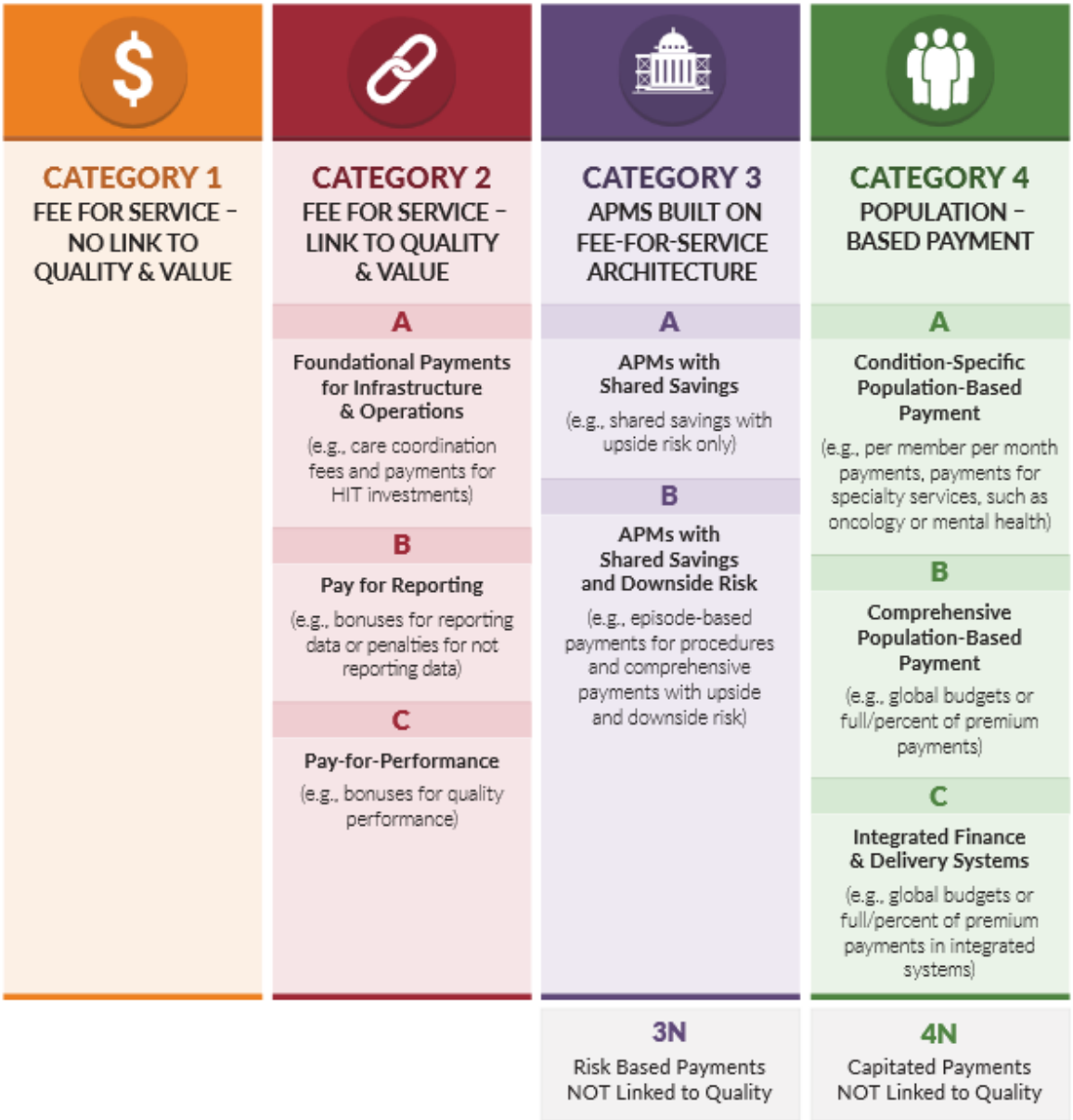
The SHIP grant included requirements for calculating the return on investment (ROI) for CMMI and for measuring Idaho's progress in moving away from FFS toward paying for value. Idaho's PCMH model included a fixed fee payment to qualifying practices, attribution of a membership base, and either risk-sharing or shared savings payments. These metrics were shared with stakeholders, including payers, primary care providers, hospital systems and any other members of the Multi-Payer work group.

The stakeholders and Mercer identified total cost of care per-member-per-month costs as the metric we would track over time to determine CMMI's ROI. To track progress in moving away from FFS to value, CMMI required metrics reporting for membership attribution to non-FFS programs as well as dollars spent in non-FFS programs. To track the level of risk applied to providers, the stakeholders used the Health Care Planning and Learning Action Network (HCP-LAN) alternative payment method (APM) framework[1].

[1] Health Care Payment Learning & Action Network (HCP LAN) Alternative Payment Model APM Framework. 2017. http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

The HCP-LAN APM framework, shown in Figure 1, provided a national standard for definitions of the levels of progress moving toward paying for value that payers and providers were familiar with. The assigned categories show the varying levels of risk and reward for providers from payers. Payers reported members attributed to each level along with actual dollars paid at each level.

Figure 1: HCP-LAN APM Framework



Developing Consistent Tools for Collecting Data

Mercer sent commercial, Medicare and Medicaid payers the same survey in Appendix A to gather calendar year results for each year of the demonstration. We believe using a consistent reporting template was a best practice. Consistent reporting allowed comparisons between each year while allowing scrutiny of data for reasonableness. Having a consistent reporting template also allowed payers to use and re-use data queries year over year. Despite the approach, extra time was needed every year because of inconsistencies in reporting and changes in the environment in Idaho. For example, in 2015 and 2016, Idaho introduced their health insurance marketplace, which caused a significant number of adults to realize they were eligible for Medicaid. The influx of relatively healthy Medicaid beneficiaries caused anomalies in the PMPM total cost of care data.

Mercer also developed consistent reporting to collect member attribution data by payer and amounts paid for non-FFS medical expenses using the HCP-LAN APM framework. Again, the consistent reporting allowed Mercer to track Idaho payer progress moving from paying for volume to paying for value.

Gathering Consensus and Commitments to Share Data

Prior to rolling out the data requests, Mercer worked with the Multi-payer work group members to gather consensus and identify the level of detail payers were willing to provide. Working with payers to identify the level of detail was a significant contributory factor to the success of collecting data, and is believed to be a best practice.

While Medicaid data is mostly public, Medicare data required approval of the Center for Medicare and Medicaid Services (CMS) to allow the Idaho Medicare Administrative Contractor (Noridian) to provide data timely. Additionally, the commercial payers were protective of possible competitive advantages around contracted rates, so only high level detail was available, similar to, but slightly more detailed than filing formats from the National Association of Insurance Commissioners.

The payer representatives from Medicare, Medicaid, and the top four commercial payers provided feedback. All but one agreed to provide data and agreed to Mercer's non-disclosure agreement and provided data consistently throughout the term of the grant. As participation in SHIP activities was voluntary for commercial payers, some required repeated requests to provide the data. However, in the end, all payers who committed to provide data actually provided data.

Allowing Additional Time to Identify Data Inconsistencies

Despite consistent data requests with instructions that did not change, the environment in which payers collected data did. Upgrades to data warehouses, coding instructions for claims, and personnel changes from people pulling the data causes anomalies to appear in the data. These instances typically resulted in 30-day delays in re-running and reporting results.

Giving Stakeholders a Chance to React to Results

Prior to presenting reports to the Idaho Healthcare Coalition, the payers and members of the Multi-Payer work group were allowed to review results. Twice, they identified anomalies that required collection of new data. The reports often resulted in animated conversations that consumed the majority of time at the work group meetings where the information was presented. However, in seeing the results, payers and providers often desired, and were willing to discuss, providing more detailed data in a controlled environment.

Using Mercer as an independent third party to collect and report the data allowed payers to provide data without fear of misuse or reporting through open-records request which IDHW, as a state agency, could be subjected. We believe the use of an independent third party to collect and analyze the data facilitated the participation across public and private payers and, as such, is a best practice.

Using Projected Data When Reporting Results

Return on Investment (ROI) was calculated using the following formula:

$$\text{ROI} = \frac{\text{(Gain from Investment – Cost of Investment)}}{\text{Cost of Investment}}$$

Cost of investment was identified as the grant IDHW received. To calculate the gain from investment, Mercer estimated what would have happened without intervention by using nationally reported trends from the CMS Office of the Actuary (OACT). Because OACT reports actual data plus projections two years after data is final, the projection of what would have happened without intervention was highly speculative. Additionally, because the final report was due upon completion of the grant, the last year of data was incomplete. Payers reported only seven months of data with three months of runout for demonstration year 4. Mercer recommends updating the results after final data is available with at least six months of runout for actual data and actual trends from OACT when available.

Appendix A: Data Request

Data Request Template Sent to Payers on 3/2/2017:

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the grant Idaho received. Therefore, we are sending you the exact same template sent in 2015 and request that you send us updated results for calendar year 2016. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

For those whose current agreement needs updating, I've also attached the standard Mercer Client Confidentiality Agreement for review by you and your legal teams to ensure your data is protected and kept private. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

We'd like to start receiving data on **March 31st** to meet the CMMI reporting requirements due at the end of April. If you're unable to meet that date, please let me know when you think you can get the template completed. We appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!
Scott Banken, CPA

	Medicaid/CHIP				Private/Other		Medicare		
	Adult	Child	Dual Eligibles (Only)	Disabled/Elderly (Without Duals)	Individual	Family	Dual Eligible	Fee for Service/Non-Duals (Parts A and B)	Medicare Advantage Part C
Member Months									
Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Emergency Dept	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Urgent Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Primary Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Specialty Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Diagnostic Imaging/X-Ray	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Laboratory Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dialysis Procedures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Other (e.g., PT, OT)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Skilled Nursing Facility	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Custodial Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ICF/MR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home and Community-Based Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Behavioral Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Prescription Drugs (Outpatient)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Category of Service Logic

Use the following logic in order to classify claims and expenses.

Emergency Dept.

837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981

837P or CMS1500: Procedure codes 99281-99285, G0380-G0384, G0390

Urgent Care

837I or UB04: Revenue code 0456

837P or CMS1500: Procedure codes S9083, S9088 and/or Place of Service code = 20

Dialysis

837I or UB04: Revenue codes 082x-088x

837P or CMS1500: Place of Service = 65 or Rendering Provider Type = ESRD Treatment or Dialysis Facility

Inpatient Hospital

837I or UB04

Bill Type: 011x or 012x

BH is to be split out into the BH bucket by revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204,

Outpatient Hospital (excludes ER)

837I or UB04

Bill Type: 013x or 083x

SNF

837I or UB04: Bill Type 02xx

Professional Primary Care

837P or CMS1500: Rendering Provider Type: Family Practice, General Practice, Internal Medicine, Pediatrics, Preventive Medicine, Geriatrics

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf

Professional Specialty Care

837P or CMS1500: Rendering Provider Type: Allergy&Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology

http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf
Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties. Only CMS Specialty Codes 01 - 99 are to be included.

Professional Other

837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care.

Diagnostic Imaging/X-Ray

837P or CMS1500: Procedure Codes 70000-79999

Lab Services

837P or CMS1500: Procedure Codes 80000-89999

DME

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data.

HH

837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989

837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161,

POS = 05 or Provider Type = Home Health Agency

Custodial Care

837P or CMS1500: POS = 13, 14, 32, or 33

or Procedure Code: 99324-99339

ICF/MR

837I or UB04: Bill Type 065x or 066x and

Diagnosis codes 317.x-319.x for MR

BH

837P or CMS1500: Primary diagnosis codes 290-319 (excluding ICF claims)

837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204,

HCBS	HCBS Services from Waiver Application:
	Residential Habilitation
	Respite
	Supported Employment
	Community Support Services
	Financial Management Services
	Support Broker Services
	Adult Day Health
	Behavior Consultation/Crisis Management
	Chore Services
	Environmental Accessibility Adaptations
	Home Delivered Meals
	Non-Medical Transportation
	Personal Emergency Response System
	Skilled Nursing
	Specialized Medical Equipment and Supplies

Prescription Drugs
NCPDP or presence of NDC code.

Other
All other claims that don't fall into the above COS.

Acronym Glossary, Service Category Logic and Billing Code Supplement

for the Idaho Statewide Healthcare Multi-Payer Workgroup, Financial Analysis and Payment Transformation Best Practices Report

Conducted by Mercer - January 27, 2019

ACRONYM GLOSSARY	
APM	Alternative payment method
BH	Behavioral Health
CMMI	Center for Medicare & Medicaid Innovation
CMS	Center for Medicare and Medicaid Services
COS	Category of Service
CPA	Certified Public Accountant
DHW	Department of Health and Welfare (same as IDHW)
DME	Durable Medical Equipment
ER	Emergency Room
ESRD	End-Stage Renal Disease
FFS	Fee-for-service
HCBS	Home- and Community-Based Services
HCP-LAN	Health Care Planning and Learning Action Network
HIT	Health Information Technology
HH	Home Health
ICF/MR (ICF/IID)	Intermediate Care Facility for Individuals with Mental Retardation Intermediate Care Facility for Individuals with Intellectual Disabilities is the current code utilized by CMS
IDHW	Idaho Department of Health and Welfare (same as DHW)
OACT	Office of the Actuary
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
PCMH	Patient-Centered Medical Home
OBGYN	Obstetrics and Gynecology
ROI	Return on investment
SHIP	Statewide Healthcare Innovation Plan
SNF	Skilled nursing facility

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MARSH & McLENNAN COMPANIES

CATEGORY OF SERVICE LOGIC	
THE FOLLOWING LOGIC WAS USED TO CLASSIFY CLAIMS AND EXPENSES.	
EMERGENCY DEPT.	
	837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
	837P or CMS1500: Procedure codes 99281-99285, G0380-G0384, G0390
URGENT CARE	
	837I or UB04: Revenue code 0456
	837P or CMS1500: Procedure codes S9083, S9088 and/or Place of Service code = 20
DIALYSIS	
	837I or UB04: Revenue codes 082x-088x
	837P or CMS1500: Place of Service = 65 or Rendering Provider Type = ESRD Treatment or Dialysis Facility
INPATIENT HOSPITAL	
	837I or UB04
	Bill Type: 011x or 012x
	BH is to be split out into the BH bucket by revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204,
OUTPATIENT HOSPITAL (EXCLUDES EMERGENCY ROOM)	
	837I or UB04
	Bill Type: 013x or 083x
SKILLED NURSING FACILITY (SNF)	
	837I or UB04: Bill Type 02xx
PROFESSIONAL PRIMARY CARE	
	837P or CMS1500: Rendering Provider Type: Family Practice, General Practice, Internal Medicine, Pediatrics, Preventive Medicine, Geriatrics
	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf
PROFESSIONAL SPECIALTY CARE	
	837P or CMS1500: Rendering Provider Type: Allergy & Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology
	http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties. Only CMS Specialty Codes 01 - 99 are to be included.
PROFESSIONAL OTHER	
	837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care.
DIAGNOSTIC IMAGING/X-RAY	
	837P or CMS1500: Procedure Codes 70000-79999
LAB SERVICES	
	837P or CMS1500: Procedure Codes 80000-89999

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DURABLE MEDICAL EQUIPMENT (DME)	
	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html
	DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data.
HOME HEALTH (HH)	
	837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989
	837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161,
	POS = 05 or Provider Type = Home Health Agency
CUSTODIAL CARE	
	837P or CMS1500: POS = 13, 14, 32, or 33
	or Procedure Code: 99324-99339
INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH MENTAL RETARDATION (ICF/MR) [CODE CURRENTLY BEING UTILIZED BY CMS IS ICF/IID INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELECTUAL DISABILITIES]	
	837I or UB04: Bill Type 065x or 066x and
	Diagnosis codes 317.x-319.x for MR
BEHAVIORAL HEALTH (BH)	
	837P or CMS1500: Primary diagnosis codes 290-319 (excluding ICF claims)
	837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204,
HOME- AND COMMUNITY-BASED SERVICES (HCBS)	
	HCBS Services from Waiver Application:
	Residential Habilitation
	Respite
	Supported Employment
	Community Support Services
	Financial Management Services
	Support Broker Services
	Adult Day Health
	Behavior Consultation/Crisis Management
	Chore Services
	Environmental Accessibility Adaptations
	Home Delivered Meals
	Non-Medical Transportation
	Personal Emergency Response System
	Skilled Nursing
	Specialized Medical Equipment and Supplies
PRESCRIPTION DRUGS	
	NCPDP or presence of NDC code.
OTHER	
	All other claims that don't fall into the above COS.

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MARSH & McLENNAN COMPANIES

BILLING CODE SUPPLEMENT

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProgramBasics.pdf

Embedded Hyperlink	Complete URL
CMS Regulations & Guidance	https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html
Contact Your State Medicaid Office With Questions	https://www.medicaid.gov/about-us/contact-us/contact-state-page.html
Dual Eligible Beneficiaries Under Medicare and Medicaid	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244469.html
Easy-To-Read Infographics on Common Medicaid Questions	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/infographics.html
Extra Help With Medicare Prescription Drug Plan Costs	https://secure.ssa.gov/i1020/start
Key Messages and Tips	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/key-messages-and-tips.html
Medicaid & CHIP Coverage Tool	https://www.healthcare.gov/medicaid-chip
Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/infograph-Medicaid-EPSDT-[August-2015].pdf
Medicaid Federal Policy Guidance	https://www.medicaid.gov/federal-policy-Guidance
Medicaid Program Integrity Education	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html
Medicare Billing: 837I and Form CMS-1450	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN006926.html
Medicare Billing: 837P and Form CMS-1500	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN006976.html

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Embedded Hyperlink	Complete URL
Medicare Coverage Database	https://www.cms.gov/medicare-coverage-database
Medicare Parts A & B Appeals Process	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243294.html
Medicare Secondary Payer Provisions	https://learner.mlnlms.com
MLN LMS	https://learner.mlnlms.com
MLN Matters® Articles	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters Articles
MLN News & Updates	https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html
MLN Provider Compliance	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
MLN Provider-Supplier Enrollment Educational Products	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProvider SupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf
MLN Publications	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html
Social Security Administration	https://www.ssa.gov/benefits/medicare
State Overviews	https://www.medicaid.gov/state-overviews
The Medicare Learning Network® (MLN) Learning Management System (LMS) FAQs	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN909182.html

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MARSH & McLENNAN COMPANIES

Goal 7: Reduce overall healthcare costs:

Final Progress Report

Goal 7

Prepared for
CMMI

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IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN PROJECTED FINANCIAL RESULTS

REQUIRED REPORT FOR GRANT- 1G1CMS331399

JANUARY 8, 2019

MAKE TOMORROW, TODAY

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1
EXECUTIVE SUMMARY

Idaho's Statewide Healthcare Innovation Plan (SHIP) is designed to improve the health of all residents of Idaho by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care.

To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Model Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze and measure financial results for the State's population health in an effort to determine the impact of changes occurring through the SHIP on the State's healthcare costs and an estimated return on investment (ROI) for the Center for Medicare and Medicaid Innovation (CMMI). This report is to fulfill the requirement of reporting ROI for grant CMS-1G1-14-001.

It is important to note that Mercer measured results at a statewide level. While the SHIP likely influenced the results, the State's payers and providers are implementing a number of other delivery and payment strategies with the goal of improving health outcomes and lowering costs. Thus, the dynamic environment in which the SHIP is being implemented limits the ability to determine the impact of the changes in healthcare costs that can be attributed solely to the SHIP. However, based on national research that shows decreased cost trends resulting from the PCMH model, the SHIP is believed to be a significant contributor to the impacts identified through this analysis.

The Idaho Department of Health and Welfare (IDHW) projects spending roughly $35.0 million of the Model Testing grant, and there is still more work to do to complete the transition to the PCMH model in Idaho. Annual reported expenditures increased from 2015 to 2018 by $874 million. However, the analysis shows projected cost avoidance to be $213.6 million or 1.2% of reported annual expenditures, to show an ROI of 510.2% overall for the CMMI model test grant. For government business, Medicare and Medicaid together showed cost avoidance of $122.6 million for an overall ROI of 250.2%. These results exceed the estimated cost avoidance submitted with the grant application of $89 million over 3 years representing 0.5% of annual expenditures.

LIMITATIONS OF ANALYSIS

In preparing this document, Mercer has used and relied upon data supplied by commercial, Medicare and Medicaid payers in Idaho and CMS Office of the Actuary(OACT). The participating

payers and CMS OACT are responsible for the validity and completeness of this supplied data and information. Mercer reviewed the data and information for consistency and reasonableness. In Mercer's opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this analysis may need to be revised accordingly. All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Since projections of cost avoidance relied heavily on projections of data for trend and for completing 2018 actual results, Mercer recommends revisiting the 2018 calculations of cost avoidance and ROI after actual data is available.

2
INTRODUCTION

Idaho's SHIP is designed to improve the health of all residents of Idaho by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare. Idaho's SHIP is promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the PCMH model of care.

To support testing Idaho's SHIP, Idaho applied for and received a federal SIM Model Test grant. The four-year grant was comprised of an initial year of preparing to implement the model and referenced as Award Year (AY) 1. The following three years of the grant are to test the model's impact, including the financial impact on Idaho's healthcare system. The "Model Test Years" correspond to AYs 2 through 4.

While the PCMH model was selected to be tested through the SHIP, there are other important delivery and payment approaches being implemented by payers with the common goal of improved health outcomes and lower costs. The largest commercial payers in the State have all implemented alternatives to fee-for-service (FFS) payments to incentivize and reward quality and improved health outcomes. These payment models include:

- Pay-for-Performance
- Enhanced Pay-for-Performance
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments
- Episode-Based Payments

In addition to the PCMH model, commercial payers are testing alternative payment models. Examples include accountable care organizations with many of the State's acute care hospitals, total cost of care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits. Payers are also aligning their product portfolios so that payment methodologies and value-based reimbursement are more aligned

with product designs that guide members to providers delivering high quality care. They are also working to expand value-based programs in an effort to align reimbursements, empower providers with data, focus on overall health, and establish shared decision making between patients and their physicians. Together, payers and providers are developing the infrastructure to support partnerships to be successful in new payment arrangements and align payment systems with benefits, network design, and consumer engagement.

Medicaid, Idaho's largest public payer, is expanding the payment reform model in Idaho by incentivizing participation in the PCMH model. Medicaid is encouraging value-based purchasing through the development of accountable Regional Care Organizations where physicians, providers and hospitals join together to create a regional system of care. Through both models, healthcare providers are rewarded for delivering better care instead of being paid for providing more care regardless of outcomes.

The combined efforts of Idaho's commercial payers, Medicaid, Medicare, and the SHIP to implement delivery and payment models that incentivize and reward quality care will continue to have a significant impact on improving the health of residents of Idaho beyond the end of the grant testing period. In addition, as demonstrated through this financial analysis, there is evidence these combined efforts are bending the cost curve of the State's healthcare system.

3
BACKGROUND

As part of the SIM grant, IDHW, together with the Idaho Healthcare Coalition, engaged Mercer to analyze financial metrics for the State's population health in an effort to determine the impact of healthcare cost changes occurring through the SHIP. This financial analysis also fulfills a grant requirement as the Centers for Medicare and Medicaid Services (CMS) Innovation seeks to understand the financial impact of healthcare delivery and payment models being tested across the nation.

Idaho's SHIP model testing is occurring within a dynamic health system environment. As such, this analysis is limited in that the impact of the SHIP PCMH model on utilization and costs cannot be isolated. Furthermore, while the population health metrics selected for this analysis are those that are most expected to be impacted by the PCMH model, it is expected these metrics are also impacted by other payer models being implemented in Idaho. Regardless of these inherent limitations, national research supports the assumption that the PCMH model is a significant contributor to the findings of this financial analysis.

GRANT YEAR VERSUS CALENDAR YEAR

The grant period runs from February 1, 2015 through January 31, 2019 and is divided into award years as described above and shown in Table 1 below. For ease of data collection and participation from the payers, Mercer is collecting and calculating data on a calendar year (CY) basis without adjusting for the lagging grant month. Therefore, although the Model Test years begin on February 1 and end on January 31, CY projections were not adjusted for the lagging month.

TABLE 1: REFERENCES TO TIME PERIODS

FINANCIAL ANALYSIS YEAR DATA/ GRANT YEAR	GRANT AY	MODEL TEST YEAR
CY 2015 / February 1, 2015 through January 31, 2016	AY 1	Baseline (Year 0)
CY 2016 / February 1, 2016 through January 31, 2017	AY 2	Year 1
CY 2017 / February 1, 2017 through January 31, 2018	AY 3	Year 2
CY 2018 / February 1, 2018 through January 31, 2019	AY 4	End of Model Test (Year 3)

In 2013, as part of the grant applications, and again in 2015, Mercer projected cost mitigation through trend reductions from the implementation of the PCMH model over the Model Test period. The areas expected to be impacted by the PCMH model were generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general

primary care savings. The cost savings assumptions were based on research from similar PCMH impact studies. Cost increases associated with new PCMH operations being implemented were also built into the model.

Table 2 below identifies the cost mitigation assumptions.

TABLE 2: COST TARGETS, MILESTONES AND SAVINGS FOR PUBLIC/ PRIVATE POPULATIONS COMBINED

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Early Deliveries (in weeks 37–39 of gestation)	5% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1%–4% of total NICU admissions ($40 thousand – $70 thousand/admit) are preventable with later deliveries	0.56% reduction in inpatient hospital utilization for Medicaid child per year[1]
Generic Drug Use	Generic fill rate of 85%	Each 1% improvement in generic fill rates reduces total pharmacy spend (0.5%–1.0% Medicaid, 0.5%–1.0% commercial)	0.17% reduction in prescription unit costs for Medicaid and commercial per year over 3 years[2]
Hospital Readmissions	5%–10% reduction	20% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for commercial[3]

[1] Ohio Perinatal Quality Collaborative 39-Weeks Delivery Charter Project (2008) https://opqc.net/node/157

[2] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

[3] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Acute Care Hospitalizations	1%–5% reduction	PCMHs reduce with IMPACT[4] & Intensive Outpatient Care Programs training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for commercial[5]
Non-Emergent Emergency Department (ED) Use	5%–10% reduction in total ED use	10%–30% of ED visits are non-emergent	1.0% reduction in ED utilization for all payers[6]
General Primary Care Savings	Reduction in utilization	Savings typical when moving to a care management setting	0.5% reduction for Medicare and Medicaid for Specialists, Physical therapy, Occupational therapy and Radiology; 0.25% in Durable Medical Equipment (DME) for Medicaid Duals, 0.25% for Medicare Duals[7]

As part of the model testing grant application, Mercer built a comparison model of care using medical expense data supplied by IDHW for 2013 and 2014 incurred expenses, the CMS for 2012 and 2013 incurred expenses, three of the four largest commercial payers for 2014, and Mercer's proprietary commercial claims database. Mercer also used commercial payers' public filings, as available from 2013 and 2014. Costs were trended forward using trend rates based on the U.S. Consumer Price Index (CPI) for medical care services to align reporting periods, yielding a baseline

[4] IMPACT is an evidence-based depression care program developed by the University of Washington. Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered free thanks to the generous support of the John A. Hartford Foundation.

[5] Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

[6] Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. JAMA Internal Medicine, Report Abstract published online, September 9, 2013 viewable at http://archinte.jamanetwork.com/article.aspx?articleid=1735895

[7] Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

for comparison of CY 2015 as the Baseline. Trend assumptions for each Model Test year were derived from the National Health Expenditure projections from the CMS OACT and from Mercer's proprietary commercial claims database. The results showed a projected cost savings of $89 million over the model testing period, representing 0.5% of annual expenditures.

4

METHODOLOGY FOR DETERMINING COSTS AVOIDED

To collect the data for the analysis, commercial, Medicare, and Medicaid payers were surveyed annually using consistent category of services classifications and definitions included in Appendix A. For all four years of the test, Mercer collected self-reported, summarized data from three of the four largest commercial payers in the state along with Medicaid and Medicare. Medicare data for dual-eligible and Medicare Part C members for CY 2015 and 2016 were provided by Noridian Government Solutions, the Idaho Medicare carrier. Commercial data was weighted and summarized to avoid disclosing any proprietary cost data that may jeopardize any reporting commercial payer's competitive advantages.

A baseline was created for calendar year 2015 to project what would have happened had the SHIP not been implemented. The 2015 baseline projection used in the original estimate for CMMI was based on 2012 through 2014 data. Mercer found CY 2013 and CY 2014 data were significantly different for all payers compared to 2015 actual data. As a result, Mercer rebased the projected cost avoidance starting from actual 2015 per member per month (PMPM) data by collecting 2015 data from Medicare and Medicaid and from the commercial payers through their public filings. Mercer re-projected the 2015 baseline again using updated trend assumptions from the OACT in 2017.

To allow for sufficient runout of claims, Mercer collected annual data for 2016 and 2017 beginning in July of the following years, and data from January through July of 2018 with runout through October, in November of 2018.

Mercer compiled the reported data and calculated PMPM costs by demographically similar member groupings by payer types. The groupings by payer are listed in Table 3 below. The PMPMs were compared to the 2015 projected baseline data to measure annual PMPM trends to remove the effect of shifts in membership.

TABLE 3: PAYER GROUPINGS

MEDICAID	COMMERCIAL	MEDICARE
Adults	Group	Dual Eligible
Children	Individual	Fee For Service/Non-Dual (Parts A and B)
Dual Eligible		Medicare Advantage
Disabled/Elderly		

Since 2018 only included seven months of data, Mercer calculated completion factors to project the complete 2018 year. The completion factors were based on available quarterly insurance filings for all reporting payers in Idaho to allow for seasonality and further runout of 2018 claims.

Mercer trended the baseline PMPMs from 2015 using trend data from OACT National Health Expenditure (NHE) tables available on the CMS website.[8] Mercer assigned and grouped the category of services found in the data request to align with NHE tables to identify the trends to use in projecting PMPMs had the SHIP not been implemented. Actual trends from 2016 and projected trends from 2017 and 2018 were used.

PMPMs were then multiplied by the actual member month counts reported to calculate total costs. The total actual costs were then compared to the projected costs using the NHE trends to determine costs avoided by category of service by year.

[8] NHE tables can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Tables.zip

5

FINANCIAL ANALYSIS AND KEY OBSERVATIONS

Medicaid actual PMPM growth was highest for Aged/Disabled (17.7%) and Dual Eligible (12.1%) members while Other Adults (non-dual, non-disabled) actually decreased by 5.8% over the testing period. The commercial individual population showed the highest PMPM growth of all participant categories at an astounding 41.1% while commercial family trends only grew by 3.5% over the testing period. Medicare growths were more consistent, ranging from 10.2% to 15.0%.

TABLE 4: ACTUAL PMPMS

PARTICIPANTS	2015	2016	2017	PROJECTED 2018*
MEDICAID				
Children	$262.18	$265.87	$271.51	$287.43
Dual Eligible	$1,392.94	$1,405.23	$1,437.51	$1,561.03
Aged/Disabled (non-dual)	$2,145.39	$2,207.54	$2,265.95	$2,525.92
Other Adult	$422.70	$410.47	$407.09	$398.13
COMMERCIAL				
Individual	$403.38	$530.14	$558.63	$569.21
Family	$375.52	$347.91	$381.42	$388.52
MEDICARE				
Dual Eligible	$756.49	$876.43	$790.41	$870.19
FFS	$412.54	$425.64	$432.23	$454.50
Medicare Advantage	$756.23	$849.44	$818.63	$856.71

*2018 Data projected for all of 2018 using actual results through July 31, 2018 with runout through October 31, 2018

To project what would have happened without the intervention of the model test, NHE trends were used to project PMPMs forward from the 2015 baseline. The results are shown in Table 5. All growth rates were between 11.3% and 17.0% over the testing period. Note that NHE trend data included projected trends for 2017 and 2018 and does not take into account shifts in membership.

TABLE 5: PROJECTED PMPMS FROM NHE TRENDS

PARTICIPANTS	2015	2016	2017	2018
MEDICAID				
Children	$262.18	$274.32	$284.44	$302.47
Dual Eligible	$1,392.94	$1,442.64	$1,470.78	$1,551.16
Aged/Disabled (non-dual)	$2,145.39	$2,242.23	$2,321.20	$2,466.04
Other Adult	$422.70	$440.53	$457.38	$485.23
COMMERCIAL				
Individual	$403.38	$427.21	$449.46	$472.04
Group	$375.52	$397.62	$418.25	$439.40
MEDICARE				
Dual Eligible	$756.49	$772.63	$802.05	$844.46
FFS	$412.54	$422.02	$437.56	$459.32
Medicare Advantage	$756.23	$774.43	$806.24	$851.32

Multiplying the member month totals by the differences in the PMPMs in Tables 4 and 5 results in projected cost avoidance. The rate changes shown in Table 6 include all categories of service and not just those identified by the savings assumptions used in Mercer's original projection. There is no direct correlation that can be drawn from this analysis between the changes in these cost categories and the PCMH model. However, based on research from similar PMCH impact studies, the PCMH model likely had some influence on these results[9].

TABLE 6: PROJECTED COST AVOIDANCE IN MILLIONS

PARTICIPANTS	2016	2017	2018	TOTAL
MEDICAID				
Children	$22.1	$33.9	$36.7	$92.7
Dual Eligible	$12.0	$11.0	$(3.3)	$19.7
Aged/Disabled (non-dual)	$7.4	$12.0	$(12.9)	$6.5
Other Adult	$18.8	$33.9	$54.9	$107.6

[9] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

PARTICIPANTS	2016	2017	2018	TOTAL
COMMERCIAL				
Individual	$(129.8)	$(140.2)	$(130.3)	$(400.3)
Group	$186.3	$125.4	$179.6	$491.3
MEDICARE				
Dual Eligible	$(47.1)	$5.3	$(11.6)	$(53.4)
FFS	$(7.2)	$11.2	$10.4	$14.4
Medicare Advantage	$(52.7)	$(8.7)	$(3.5)	$(64.9)
Total	$9.8	$83.7	$120.1	$213.6

Changes in membership due to environmental factors such as the increase in Medicaid Adult Other population, the Medicare FFS population and commercial individual population and decreases in commercial group population likely played a role in the fluctuations in PMPMs. Reported member months are shown in Table 7.

TABLE 7: REPORTED MEMBER MONTHS

PARTICIPANTS	2015	2016	2017	2018
MEDICAID				
Children	2,514,224	2,614,066	2,618,276	2,441,124
Dual Eligible	309,047	320,435	330,005	333,189
Aged/Disabled (non-dual)	205,855	212,392	217,537	214,805
Other Adult	582,021	626,637	673,363	630,237
COMMERCIAL				
Individual	1,222,091	1,261,180	1,284,680	1,340,765
Group	4,560,579	3,748,770	3,405,951	3,528,652
MEDICARE				
Dual Eligible	419,706	453,841	454,408	449,487
FFS	1,926,669	1,994,524	2,101,690	2,161,231
Medicare Advantage	624,663	702,649	700,803	649,087
Total	12,364,855	11,934,495	11,786,713	11,748,576

6
CONCLUSION

Idaho's SHIP model testing is occurring within a dynamic health system environment, therefore, the results of this analysis cannot be directly attributed to the impact of the SHIP PCMH model on utilization and costs. These metrics are also impacted by other payer models being implemented in the State, changes occurring in membership enrollment, and changes in members' utilization of services.

While reported costs increased from 2015 to 2018 by $874.0 million, the cost trend of 14.9% was lower than NHE projected trends which indicates a level of cost avoidance. When combining the actual CY 2016 results reported for three of the four largest commercial payers, Medicare and Medicaid show overall costs running lower than projected by $213.0 million.

The cost avoidance assumptions for hospital, emergency department, specialty care, lab, and diagnostic imaging all showed overall rate improvements, showing a total cost savings of $676.3 million. However, commercial and Medicare payers did not realize the projected cost avoidance for generic drug usage, as pharmacy costs were an astounding $496.0 million more than projected by NHE trends.

IDHW projects to spend roughly $35.0 million of the Model Testing grant, and the transition to the PCMH model in Idaho is not complete. However, noting there is no direct correlation between the cost avoidance estimates and the SHIP model test, the cost avoidance total of $213.6 million shows an ROI of 510.2% overall for the grant, representing 1.2% of reported annual expenditures. For government business, Medicare and Medicaid together showed cost avoidance of $122.6 million for an overall ROI of 250.2% for the grant.

Since projections of cost avoidance relied heavily on projections of data for trend and for completing 2018 actual results, Mercer recommends revisiting the 2018 calculations of cost avoidance and ROI after actual data is available.

APPENDIX A

DATA REQUEST

Example of Data Request Template Sent to Payers on March 2, 2017

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the grant Idaho received. Therefore, we are sending you the exact same template sent in 2015 and request that you send us updated results for calendar year 2016. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

For those whose current agreement needs updating, I've also attached the standard Mercer Client Confidentiality Agreement for review by you and your legal teams to ensure your data is protected and kept private. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

We'd like to start receiving data on **March 31, 2017** to meet the CMMI reporting requirements due at the end of April. If you're unable to meet that date, please let me know when you think you can get the template completed. We appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

TABLE 8: EXAMPLE OF CY 201X

	MEDICAID/CHIP				PRIVATE/ OTHER		MEDICARE		
	Adult	Child	Dual Eligible (Only)	Disabled/ Elderly (Without Duals)	Individual	Group	Dual Eligible	FFS/ Non-Duals (Parts A and B)	Medicare Advantage Part C
Member Months									
Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Emergency Department	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Urgent Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Primary Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Specialty Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Diagnostic Imaging/X-Ray	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Laboratory Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dialysis Procedures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Other (e.g., PT, OT)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Skilled Nursing Facility	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Custodial Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ICF/MR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HCBS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	MEDICAID/CHIP				PRIVATE/ OTHER		MEDICARE		
	Adult	Child	Dual Eligible (Only)	Disabled/ Elderly (Without Duals)	Individual	Group	Dual Eligible	FFS/ Non-Duals (Parts A and B)	Medicare Advantage Part C
Behavioral Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Prescription Drugs (Outpatient)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

CATEGORY OF SERVICE CLASSIFICATIONS

Use the following logic in order to classify claims and expenses.

EMERGENCY DEPARTMENT	
	837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
	837P or CMS1500: Procedure codes 99281-99285, G0380-G0384, G0390
URGENT CARE	
	837I or UB04: Revenue code 0456
	837P or CMS1500: Procedure codes S9083, S9088 and/or Place of Service code = 20
DIALYSIS	
	837I or UB04: Revenue codes 082x–088x
	837P or CMS1500: Place of Service = 65 or Rendering Provider Type = ESRD Treatment or Dialysis Facility
INPATIENT HOSPITAL	
	837I or UB04
	Bill Type: 011x or 012x
	BH is to be split out into the BH bucket by revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204
OUTPATIENT HOSPITAL (EXCLUDES ER)	
	837I or UB04
	Bill Type: 013x or 083x
SNF	
	837I or UB04: Bill Type 02xx
PROFESSIONAL PRIMARY CARE	
	837P or CMS1500: Rendering Provider Type: Family Practice, General Practice, Internal Medicine, Pediatrics, Preventive Medicine, Geriatrics
	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf

PROFESSIONAL SPECIALTY CARE	
	837P or CMS1500: Rendering Provider Type: Allergy & Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology
	http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties Only CMS Specialty Codes 01–99 are to be included
PROFESSIONAL OTHER	
	837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care
DIAGNOSTIC IMAGING/X-RAY	
	837P or CMS1500: Procedure Codes 70000–79999
LAB SERVICES	
	837P or CMS1500: Procedure Codes 80000–89999
DME	
	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html
	DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data
HH	
	837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989
	837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161
	POS = 05 or Provider Type = Home Health Agency
CUSTODIAL CARE	
	837P or CMS1500: POS = 13, 14, 32, or 33 or Procedure Code: 99324–99339
ICF/MR	
	837I or UB04: Bill Type 065x or 066x and Diagnosis codes 317.x-319.x for MR
BH	
	837P or CMS1500: Primary diagnosis codes 290–319 (excluding ICF claims)
	837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204

HCBS SERVICES FROM WAIVER APPLICATION	
	Residential Habilitation
	Respite
	Supported Employment
	Community Support Services
	Financial Management Services
	Support Broker Services
	Adult Day Health
	Behavior Consultation/Crisis Management
	Chore Services
	Environmental Accessibility Adaptations
	Home Delivered Meals
	Non-Medical Transportation
	Personal Emergency Response System
	Skilled Nursing
	Specialized Medical Equipment and Supplies
PRESCRIPTION DRUGS	
	NCPDP or presence of NDC code
OTHER	
	All other claims that don't fall into the above COS

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333 South 7th Street, Suite 1400
Minneapolis, MN 55402
www.mercer.com

MARSH & McLENNAN COMPANIES

Final Progress Report
Sustainability

Prepared for
CMMI

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STATEWIDE HEALTHCARE INNOVATION PLAN

SUSTAINABILITY PLAN – PART 2

ROADMAP FOR SUSTAINING SIM INVESTMENTS

IDAHO DEPARTMENT OF HEALTH AND WELFARE
OFFICE OF HEALTHCARE POLICY INITIATIVES

SUBMITTED AUGUST 30, 2018
REVISED NOVEMBER 8, 2018

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

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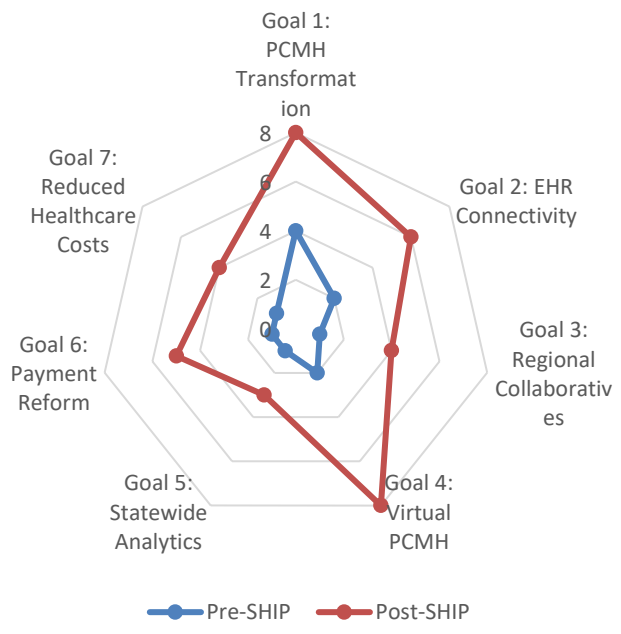
A.Introduction

In May 2018, Idaho prepared Part 1 of its Post-Statewide Healthcare Innovation Plan (SHIP) Sustainability Plan (Sustainability Plan Part 1), which contained an analysis of how Idaho has deployed SHIP, the progress and impact achieved, and a description of new priorities for delivery and payment transformation post-SHIP. As Idaho draws closer to the end of the SHIP grant period, the Idaho Department of Health and Welfare (IDHW) and its stakeholders, including the Idaho Healthcare Coalition (IHC), have continued conversations regarding how SHIP activities and investments will be sustained. Over the past three years, SHIP has enabled the state to accelerate its transformation efforts to improve the way Idahoans receive care and build the necessary infrastructure to maintain and advance these changes. Moving forward, the activities and investments that began under SHIP will evolve into the next phase of transformation to achieve Idaho's end state vision of a healthcare system that reflects the Quadruple Aim of improved population health, better experience of care, reduced costs, and improved clinician experience.

This document represents Part 2 of Idaho's SHIP Sustainability Plan (Sustainability Plan Part 2) and begins to lay a roadmap for the next phase of healthcare transformation. Idaho's maturity and capabilities have increased dramatically thanks to the opportunity to test and fully implement SHIP as illustrated in Figure 1. The Sustainability Plan Part 2 is the result of planning efforts that have and will continue to involve a broad array of stakeholders, including the IHC. This plan leverages the strengths and successes of SHIP and the Idaho healthcare community writ large. In April 2018, the IHC reviewed the original end state vision developed by stakeholders in 2013 and determined that it continues to be a relevant expression of the desired outcomes of healthcare transformation in Idaho. To accomplish this end state vision, the IHC members identified priority focus areas for continued transformation that include, but are not limited to:

Figure 1: Idaho Healthcare Transformation Maturity



- Further implementation of payment models that reward outcomes and quality of care.
- Align common quality performance measures across payers.
- Continue to support practices as they move to the Patient-Centered Medical Home (PCMH) model.
- The state's continued role to convene and facilitate collaboration across stakeholders.
- Improve data exchange and analytics to both support care coordination and monitor quality.
- Local and regional support for continued transformation.

Where SHIP activities and investments will continue to align with these priorities, IDHW and its partners are interested in exploring ways for those activities to become self-sustaining. However, the reality is that, lacking alternative funding sources, many activities will end at the conclusion of the grant period.

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Idaho is working to identify potential replacement funding that includes local, state, and federal grants, state general funds, other state funds such as tobacco settlement funds, foundations, etc. In addition, opportunities to leverage existing resources where linkages to SHIP activities are possible are being pursued. Idaho is committed to continuing its journey of healthcare transformation, and IDHW and stakeholders are working together to identify resources needed to sustain the SHIP investment that has helped propel transformation this far.

The partnership between IDHW and stakeholders continues and will continue to be the driving force post-SHIP. The IHC has focused on advising on SHIP activities and overseeing the progress of transformation throughout the four-year SHIP grant period. The IHC's work will conclude in December 2018 and a new advisory body will begin in January 2019 to promote and support continued transformation post-SHIP. Development of the new advisory body is occurring under the IHC to ensure that historical issues and future needs and planning are appropriately passed from the IHC to the new advisory body.

Alignment of the delivery system and payment models to promote healthcare system transformation will continue to be a priority focus post-SHIP. Over the past four years, Idaho's SHIP funds have been used to track movement from fee-for-service (FFS) models to alternative payment models that reward value over volume of services across Idaho public and private payers. Post-SHIP, Idaho's multi-payers will continue to work with providers to advance value-based payment (VBP) models, and the Multi-Payer Workgroup will continue to serve as a forum for public and private payers to discuss strategies for continued payment reform. For example, Idaho Medicaid will be implementing new VBP models through its Healthy Connection program, and the impact of the program will be tracked and then shared with private payers through the Multi-Payer Workgroup. Idaho is also exploring opportunities to maintain the annual analysis that tracks Idaho's progress in moving away from FFS to VBP models. Post-SHIP, the Multi-Payer Workgroup also will continue the recent work it has begun to align core quality metrics across payers to create efficiencies in the collection, measuring, and reporting of quality metrics.

Promotion of the PCMH model and other delivery system models that promote better care and outcomes will continue to be a post-SHIP priority. With the support of the SHIP, 163 clinics have transformed from the traditional primary care delivery model towards the team-based PCMH model that focuses on the whole person and coordination of care. Idaho's providers participating in SHIP consistently credit SHIP-funded PCMH technical assistance and support they received as being responsible for much of their success. Idaho will maintain some of this technical assistance, such as a resource library and clinic-to-clinic mentorship, but the hands-on coaching from national and local experts that has helped so many primary care clinics to date may not be available to clinics that are transforming to the PCMH model post-SHIP. As noted earlier, funds needed to continue these invaluable supports are being sought through grants, legislative budget requests, and other avenues. However, full funding is not anticipated so the support provided post-SHIP will be at a smaller scale than currently provided.

Another critical resource post-SHIP will be continuing the infrastructure provided at the state level. IDHW and its Office of Healthcare Policy Initiatives (OHPI) has staffed and supported the IHC and its workgroups, provided communication across payers and providers to help align efforts, and provided guidance and expertise across multiple areas that impact the state's healthcare transformation, such as data governance and quality metrics. Without infrastructure support, Idaho's healthcare transformation will not maintain its steady progress and could, in fact, lose much of the momentum gained with the

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SHIP investment. IDHW is working to secure funds for the OHPI positions, and OHPI is expected to staff the new advisory body and its workgroup. It will continue to serve as experts in Idaho's strategic planning, coordination and alignment of transformation activities and collaboration across stakeholders. IDHW hopes to continue to provide support through OHPI at the same level it is currently provided. This includes providing both subject matter expertise in transformation and initiative experience that contributes to the state's maturity in this space.

Data exchange and analytics has been one of the most challenging aspects of Idaho's healthcare transformation. At the beginning of the SHIP grant, Idaho's HIE and statewide HIT infrastructure was very limited. The SHIP investments made in the state's HIE have created a foundation that will eventually support the data exchange and analytics needed to evaluate quality metrics and improve care coordination. Post-SHIP, the state's HIE will implement a new system architecture, with a new platform being a critical component. The new platform and overall system architecture will allow IHDE to accept claims data and provide data to payers through a new data services layer, which will support providers' participation in VBP initiatives, including Medicaid's new payment models. While this work will be started as part of SHIP, the transition to the new platform and creation of the data services layer will continue post-SHIP. Throughout SHIP, OHPI has played an important role in supporting the state's HIE, providers, and stakeholders as Idaho worked toward achieving adequate levels of data exchange and analysis. Post-SHIP, OHPI will continue to support the state in this effort.

The Regional Collaboratives (RCs) are another important component of Idaho's SHIP. RCs support quality improvement, population health initiatives, and PCMH transformation at the local level. The development and success of the RCs have varied, with some RCs being fully established today and developing a roadmap for their future, and other RCs struggling to perform their functions. Post-SHIP, some of the RCs are looking to participate in Idaho Medicaid's Regional Care Coalition (RCC) model. This will allow them to build upon the successes they have achieved thus far and expand their role in Idaho's health system. Because the RCC model will be rolled out across the state, other RCs may stall or flounder until the RCC is established in their area. The Public Health Districts (PHDs) and IDHW Division of Public Health are looking for ways to continue to support all seven RCs due to the importance of local expertise and knowledge of population health and regional health issues.

The SHIP investment has helped launch and propel Idaho's healthcare system transformation. Idaho is committed to maintaining the momentum gained through SHIP. It is working to find financial support for priority activities, leverage other resources in the state to support delivery and payment system transformation and, as needed, determine the degree to which future activities can be scaled without threatening to stall or slow Idaho's healthcare transformation.

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B.Analysis of SHIP Activities

OHPI and its partners embarked on a comprehensive analysis to identify: (1) which investments the State seeks to continue "as-is" because they contribute to Idaho's goals for the next phase of healthcare transformation, (2) which activities may evolve in order to better align with goals moving forward, and (3) which activities will cease at the end of SHIP.

In completing this analysis, OHPI reviewed the operational effectiveness of SHIP activities and investments (i.e., how well it worked during the SHIP period) and considered the goals and resources for the next phase of health system transformation (i.e., how well the activity or investment aligns with goals and available resources moving forward). The data sources for this analysis included:

- PCMH Sustainability Planning Workshop
- Regional Collaborative (RC) Transition Workshop
- RC Survey and Draft Transition Plans
- IHC Survey
- IHC Transformation Sustainability Workgroup
- Health Information Technology (HIT) Stakeholder Engagement
- State Evaluation Team
- Idaho Telehealth Planning Meeting
- Learning Collaboratives (PCMH/Community Health Worker [CHW]/Community Health Emergency Medical Services [CHEMS]/Telehealth)
- Contractors and Technical Assistance Partners

What follows are the results of this analysis, organized by primary driver of the SHIP and by secondary driver, which correspond to the goals for SHIP activities.

B.1. Primary Driver 1: Accelerate Establishment of the PCMH Model of Care

B.1.1. Goal 1

A cornerstone of Idaho's SHIP was the transformation of primary care practices across the State into PCMHs. The PCMHs serve as the vehicle for delivery of primary care services with the patient and their families at the center. They provide a foundation for Idaho's healthcare transformation that is focused on preventive care, keeping patients healthy, and stabilizing chronic conditions.

There are 163 active primary care clinics in Idaho's SHIP. Through this investment, Idaho's earlier PCMH pilot efforts (prior to SHIP) have successfully spread to more rural and urban clinics across Idaho. SHIP grant dollars brought individualized, hands-on training, technical assistance, and PCMH expert coaching to assist practices in this transformation, as well as staff at the State level and on-the-ground in the local PHD offices across Idaho to coordinate these efforts with other regional, SHIP, or IDHW activities to maximize effectiveness and collaboration across Idaho's delivery system. SHIP also initiated clinic-to-clinic mentorship opportunities for clinics to share best practices and innovations and provided financial resources to reimburse costs associated with the PCMH model. Providers repeatedly note that transformation of this many clinics within a three-year period could not have been achieved without SHIP support.

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The expansion of the PCMH model through SHIP is anticipated to have long-term positive impacts on Idaho's healthcare system. This is supported by recent studies of adoption of the PCMH model. In 2015, aggregated outcomes from 28 peer reviewed studies, state government programs, and industry reports demonstrated the following improvements in healthcare outcomes:[1]

- 17 found improvements in cost
- 24 found improvements in utilization
- 11 found improvements in quality
- 10 found improvements in access
- 8 found improvements in satisfaction

In 2016, further review of the evidence showed an additional 21 studies with cost reductions and 23 studies with evidence of reductions in utilization.[2]

Idaho is committed to continuing support for PCMH transformation after SHIP and expects this support will continue to yield results and a return on investment. In April 2018, IHC members identified priority focus areas for continued transformation, including continuing to support practices as they move to the PCMH model. As Idaho focuses on reducing costs and moving its delivery systems to value-based care, consideration of sustaining and spreading the PCMH transformation achieved so far will be an invaluable foundation.

In January 2018, OHPI invited a broad group of stakeholders to participate in a PCMH sustainability workshop. All the stakeholders in attendance saw value in the work that has been done thus far, are proud of Idaho's accomplishments in a relatively short period of time and are committed to continuing the momentum beyond the grant period. The group developed the following strategic intent statement that identifies what Idaho will try to accomplish to enhance sustainability of the PCMH model in Idaho:

Idaho aims to double the number of PCMH-recognized practices by January 2024 by partnering with payers and other stakeholders in expanding value-based reimbursement supported through State leadership and broadening resources at the regional level.

In addition, the group defined four initiatives to support reaching the strategic intent:

1. Build on the current SHIP infrastructure and business model.
2. Build on our work in value-based reimbursement.
3. Build alignment in direction, goals, measures, and policy.
4. Build our ability to educate and communicate with practices and consumers.

---

[1] Nielsen, M. et al. January 2015. Milbank/PCPCC Annual Report (overview of studies since Sept 2013); available at https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015

[2] Nielsen, M. et al. February 2016. Milbank/PCPCC Annual Report; available at https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf

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OHPI, in collaboration with the IHC, is determining how to proceed with the group's recommendations based on feasibility, required resources, and affiliated timelines. Within these discussions, OHPI and the IHC are considering the needs of providers and practices as they work towards implementing the PCMH model. Clinics have highly valued the training and technical assistance support they have received through SHIP from the subject matter expert coaches and the Public Health District (PHD) SHIP staff. Following are details of Idaho's sustainability plans to date in each major SHIP activity area related to PCMH transformation.

Clinic Reimbursement Payments for PCMH Transformation

SHIP dollars have been supporting clinics with payments to offset staff time away from patient care or the need to bring in additional staff to adopt the PCMH model. Idaho's model of supporting providers has demonstrated that payments are a critical lever towards adoption of the model. While the State had many early adopters of PCMH, many of the 163 clinics would not have moved to the new model without financial incentives provided under the SHIP grant.

Activity Status Post-SHIP: Reimbursement payments will not continue post-SHIP due to lack of an ongoing source of funding. Financial support for clinics will be payer-directed, according to each payer's programs or incentive structure for PCMH transformation. Through its Healthy Connections program, Idaho Medicaid will be one of the first payers to pay based on PCMH as it moves to shared savings and eventual risk payments to groups of PCMHs. This will be an expansion of the current tiering of payments under Healthy Connections. Financial support through Medicaid's Healthy Connection Value Care program will support that portion of the clinics' patient population, and other payers will have their own infrastructure for incentive payments for other aspects of the clinics' patients.

At this time, other payer efforts to support PCMH are less clearly identified, with some engaging with the PCMH sites for their role in a local accountable care organization (ACO) for populations or other VBP activities. Post-SHIP, a new stakeholder advisory body (discussed later in this document) and the Multi-Payer Workgroup will continue to meet with payers to discuss potential collaborative efforts to support PCMH adoption. Their current work towards more aligned quality metrics will be an important companion to future VBPs. Providers have identified issues related to the requirement of measuring and reporting on differing sets of quality metrics to achieve any incentive payments, often requiring a large administrative burden on small, mostly rural clinics. Alignment of expectations of payers will be important moving forward.

Next Steps: OHPI will continue to monitor Medicaid's plans for PCMH payments, as well as other payer's efforts. OHPI will evaluate mechanisms for partnering with Medicaid to provide a centralized source of information about payment opportunities through the existing PCMH pages of the SHIP website to aid clinics in seeking resources.

PCMH Training and Technical Assistance

SHIP provided training and technical assistance to clinics as they implemented the PCMH model through educational webinars, on-site visits, and hands-on coaching, as well as face-to-face sharing through learning collaboratives each year. Expert technical coaching was coupled with, and complemented by, on-the-ground support from the PHD Quality Improvement (QI) Specialists. Technical assistance from subject matter experts, which consisted of doctors and Family Nurse Practitioners, enhanced provider engagement. This valuable support to clinics allowed provider-to-provider peer support that is not always available through other PCMH training programs and appeared to increase buy-in to the model.

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Through coaching calls and on-site visits, sharing experiences provider-to-provider was valuable to not only the providers, but also to help clinic staff work with providers through changes in workflow and culture.

The QI Specialist was familiar with the SHIP region and was a link for the clinics to connect with other community resources and population health efforts. Through the partnership with PCMH technical experts, QI Specialists received cross-training in PCMH concepts. Maintaining the current QI Specialists would be valuable, as the three years of the Model Test has led to education, training, and enhanced skills at assisting practices in PCMH transformation, with significant knowledge of the recognition program requirements, and integrating public health with primary care clinics.

Evaluations of the clinical training and technical support have been positive over the Model Test period, particularly among clinics with less infrastructure to support their transformation efforts. In addition, PCMH recognition programs have undergone changes, primarily the National Committee for Quality Assurance (NCQA) PCMH Standards, which were significantly upgraded and altered recently. Unlike past years, the clinics will now be on an annual cycle to provide documentation and demonstrate adoption of the six concept areas of the standards. The training and technical assistance was valuable this year to help translate the changes and assist on the enhanced requirements. Support to clinics has provided opportunities to keep the clinics updated on changes and translated that to workflow changes needed.

Activity Status Post-SHIP: There is no clearly identified funding for IDHW to sustain the PCMH training and technical assistance in the current manner. IDHW's PCMH technical assistance contract will not continue post-SHIP, and coaching and training opportunities will end with Cohort 3.

However, there is a desire for this type of support to continue in some manner going forward. It will be important to maintain some continued training and technical assistance going forward to continue to nurture clinics that have been involved in SHIP over the past years. There are concerns about Cohort 3, which had a high percentage of clinics with no previous experience with the PCMH model, and a large percentage of clinics in rural locations, and who are unaffiliated with a hospital system or other administrative supports. Many of the SHIP clinics have also been undergoing electronic health record (EHR) changes that have delayed implementation of key aspects of the model and obtaining the needed documentation and reports required by national PCMH recognition bodies such as NCQA.

Ongoing resources will also be needed to help translate the model to additional providers. Clinics go where they trust to get help. Several SIM states have pulled together all entities currently providing technical assistance to see how they could align moving forward as their SIM efforts have concluded. Building on the strong relationships developed under SHIP, ongoing QI efforts and other technical assistance available could be cataloged, and stakeholders convened to discuss how best to align to support sustainability of PCMH transformation. OHPI could then help to distribute that information more broadly.

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This type of support will be critical to helping clinics be successful in Medicaid's Healthy Connections Value Care initiatives, which could then yield shared savings for the clinics to become more self-sustaining in the new model of care. There are other advantages to the State if PCMH practices are more likely to take on Medicaid patients who often have complex conditions and require care coordination to avoid unnecessary hospitalizations, emergency room visits, and duplicative expensive testing. Not only can dollars be saved, but access can be improved for Medicaid enrollees. Improved health can assist the patients in managing their chronic diseases and conditions better to lead more productive and active lives.

Next Steps: OHPI will explore current QI activities underway in Idaho to assess any potential linkages with PCMH model support post-SHIP. Potential areas to explore include:

- ***Working closely with Medicaid's Healthy Connections team*** to link efforts on education and trainings to position clinics for optimal success under the Heathy Connections Value Care payments and savings sharing.
- ***Working with Qualis, the Idaho Medicare quality organization,*** to assess how their technical assistance efforts on improving quality of care for success at the Quality Payment Program could be linked to support adoption of the PCMH model.
- ***Working with the QI staff and the PHDs to assess efforts to sustain PCMH training efforts.*** The PHDs are looking for alternative funding sources to maintain the QI staff positions. OHPI will explore how efforts to implement Medicaid's RCCs could be coordinated to support ongoing QI efforts at the regional level and in collaboration with efforts to continue collaboration across the delivery system, such as the activities occurring in some regions through their Medical-Health Neighborhood (MHN) efforts.
- ***Exploring additional efforts to support PCMH adoption,*** particularly any trainings or technical assistance currently or potentially available through the health plans, hospitals and health systems, and their foundations. Alignment of efforts could be more effective than having clinics approached by many stakeholders and would help stretch limited resources. This could be explored through the new stakeholder advisory body and the Multi-Payer Workgroup.
- ***Exploring any statewide or local opportunities to continue learning collaborative efforts focused on the skills needed to move to the PCMH model.*** The State could act as a clearinghouse of opportunities being offered nationally, in the State, or locally. This will also involve exploring any potential funding opportunities to support either in-person or virtual learning opportunities.
- ***Working with other areas within IDHW to assess potential resources and collaboration.*** For example, clinics identified behavioral integration as a critical next step for advanced PCMHs, and requested step by step support for integrating behavioral health. Efforts could be focused on finding grant opportunities for clinics interested in behavioral health integration in partnership with IDHW's Division of Behavioral Health. VBPs could assist this focus on mental health and substance abuse, including any opportunities through new Federal initiatives focused on the opioid crisis. Another potential focus of collaboration would be any other IDHW efforts focused on oral health to promote integration of oral health in the PCMH clinics.
- ***Assessing opportunities to support PCMHs through telehealth, including efforts with Project Extension for Community Healthcare Outcomes (ECHO).*** OHPI will evaluate ways to provide education to clinics on how telehealth can support clinics in fulfilling the requirements of national PCMH recognition.

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PCMH Readiness Assessment and Transformation Plan

Coupled with the clinical training and technical assistance, SHIP invested in several other tools to support clinics and monitor their progress. These tools included a Readiness Assessment of the clinic both before and after a cohort year along with goal-setting and tracking through a Transformation Plan that could be shared with the clinic teams, the subject matter expert coaches, and the QI Specialist. Readiness Assessment and Transformation Plan information was collected and available through a web-based PCMH Portal. While some clinics developed their own tools to track their progress, overall clinics reported they appreciated being able to see the vision of what their team wanted to accomplish in the Transformation Plan.

Activity Status Post-SHIP: The State will not continue use of the PCMH Readiness Assessment or Transformation Plan tools since completion of the tools was a requirement for reimbursement payments, which will end after the SHIP grant. The State will lose its ability to monitor the PCMH clinics' progress once Cohort 3 ends, and will need to develop alternative approaches.

Although the State will not continue the use of the tools, the Readiness Assessment and Transformation Plan tools could continue to be valuable for the clinics themselves. Clinics have the ability to download and print their information currently on the Portal. Moving forward, many clinics will need to transition to new 2017 NCQA standards for which the current Readiness Assessment is designed. As more seasoned clinics make this transition to maintain their NCQA status, the PCMH Readiness Assessment will come to be more valuable to more clinics. Some monitoring of the recognition standards will need to be coupled with it to ensure any needed updates.

OHPI will explore ways to make the information on the Portal historically accessible. Having information on the experience during SHIP could be helpful if Idaho pursues other grant opportunities, for research purposes, or if Idaho decides to further publicize the data and results during SHIP.

Next Steps: OHPI will explore potential alignment on the tools, particularly with Healthy Connections and other payers. OHPI will reach out to payers to assess what clinics are required to submit for VBP, and to explore any interest in collaboration around maintaining the Readiness Assessment aspect of the Portal. OHPI will also explore potential future alignment around use of the Transformation Plan tool. The State Evaluation Team will complete coding of the notes in the Transformation Plan goals and objectives to better understand trends. OHPI will explore if any further evaluation or knowledge extraction from the Portal notes and other documentation will be useful to ongoing transformation efforts.

OHPI will also work to determine where the Readiness Assessment and Transformation Plan information will reside post-SHIP. There is interest in keeping this information available for existing SHIP clinics. The clinics (especially Cohort 3 clinics) could continue to use the tools to document their progress until they seek full national recognition.

PCMH Portal Resource Library

In addition to tracking information on the Readiness Assessment and Transformation Plan, the Portal was also used to communicate about educational webinars and in-person learning collaboratives. Resources from these events were made available on the Portal, and toolkits and compilations of resources by topic were also published on the Portal to support clinics in educating their staff and providers on their journey of PCMH adoption. The Portal contained:

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- PCMH webinars and mentorship webinar materials (PowerPoints and transcriptions)
- Learning collaborative materials and a set of video recordings from the most recent learning collaborative
- Miscellaneous resources based on key topics for PCMH and links to other resources
- Toolkits, including resource links, videos, and guides on topics such as an introduction to the PCMH model designed for new staff at a PCMH clinic, and soon to be completed work on PCMH adoption best practices and patient engagement resources
- Materials related to participation in SHIP, such as how to be a SHIP clinic and how to use the Portal

Over the three years of the Model Test, OHPI and its partners learned a lot about how to build a Resource Library for clinics and to keep the Resource Library organized. Initially, the Resource Library was more of a repository for necessary materials and required activities. Access to the portal to get to the resources was a challenge. Over time, efforts were directed to make the Portal more user-friendly, thinking about the clinic as the primary user.

Activity Status Post-SHIP: OHPI has formalized a contract with The College of Health Sciences at Boise State University (Boise State) for ongoing hosting and maintenance of the Resource Library, which will be called the Learning Management System (LMS). Boise State sees the Resource Library as a valuable resource to their healthcare professional students who are pursuing continuing education credits. Boise State is interested in using the LMS materials to develop further curricula and educational modules for their students. Boise State will engage external subject matter experts to: (1) review existing content in the SHIP Resource Library, (2) perform subsequent reviews of content, and (3) identify gaps and recommendations for priority content development. Initially, Boise State plans to develop and add a “Data 101” module and a “Finance and Project Management” module to the LMS.

In addition to Boise State’s maintenance of these important resources, Medicaid, other payers, and other stakeholders might be interested in the resources as they continue work towards VBPs. There is interest in exploring the concept of a “PCMH learning lab” partnership between OHPI, Boise State, and Medicaid. The availability of stable funding to make this a common statewide resource will be an important consideration.

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Table 1 – Potential LMS End Users Post-SHIP

Potential LMS Users Post-SHIP
Primary care clinics, including Healthy Connections clinics and SHIP clinics
Payers
IDHW Medicaid Healthy Connections
IDHW Division of Public Health, Bureau of Rural Health
PHDs
Qualis
IHDE
IPCA Quality Improvement staff
Other stakeholders

Next Steps: OHPI will continue work to secure a stable home for PCMH resources for ongoing use and continued development. This will include:

- ***Finalizing transition of the Resource Library to Boise State.*** OHPI, Boise State, and the current PCMH Contractor will finalize the transition of the Resource Library to Boise State.
- ***Expand resources available through the Boise State LMS.*** Following transition of the Resource Library, Boise State will add new resources to the new LMS. For example, Boise State will add workforce development tools to help Idaho assess its workforce development needs at a macro level. Boise State will also add a tool to help individuals assess their competencies in healthcare professions.
- ***Explore how to keep existing SHIP clinics, additional clinics, and others informed about the transition and any new additional resources***. Through SHIP, the resources in the library have been kept up to date and made available to participating clinics. OHPI will work with Boise State and others to determine how clinics will be able to access the resources in the future. OHPI will also work with the IDHW Division of Public Health and the PHDs to ensure links to the LMS are included in materials.
- ***Explore potential funding to support maintenance and additional resources***. Boise State will be developing a sustainability plan to support maintenance and development of this resource post-SHIP.
- ***Support local initiatives to promote health workforce development.*** The LMS will include a link to tools that will support workforce development projects identified by the Treasure Valley Health Careers Council. The projects are part of the Council's innovative and transformative career pathways program that will connect education, training strategies, and support services that enable individuals to secure industry-relevant certifications and advance to higher levels of employment.

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Clinic to Clinic Mentorship

In (AY) 3, greater emphasis was placed on enhancing opportunities for clinic-to-clinic mentorship related to PCMH transformation topics. The Idaho PCMH Mentorship Subcommittee was established and charged with developing a framework to promote clinic-to-clinic peer mentorship activities in Idaho.

The primary mentorship forum that was developed was a mentorship webinar series to link clinics together and share lessons learned on specific topics not otherwise covered in the educational webinars and learning collaboratives. The mentorship webinars provided an opportunity for clinics to hear how their peers were tackling issues and activities on the ground, share their best practices, and make connections across the regions. The mentorship webinars were heavily attended, entirely voluntary. Contact information was shared and many of the "mentors" were contacted following the events for more information or to obtain copies of helpful documents for PCMH transformation.

Activity Status Post-SHIP: As IDHW plans for the loss of SHIP funding to support PCMH training and technical assistance, the role and value of clinic-to-clinic mentorship becomes even more critical. OHPI is interested in exploring opportunities to bring clinics together virtually to share lessons learned and build relationships. An updated mentorship framework document can serve as a guide for efforts to sustain the mentorship efforts.

It will be important to ensure materials developed to date continue to be available. Materials from the mentorship webinars could be included into the PCMH Resource Library and maintained by Boise State, as noted above. A summary of the webinar approach will be updated with the second year of the series of events, including the mentors' contact information, and will also be made available. As the State looks at all these tools, it intends to ensure that there are clear plans and strategies to keep the most pertinent information available and continue to support the mentorship efforts. A lot of valuable information was collected over the three years of the grant, with much of it retaining its value for at least the next several years.

Stakeholder engagement will be critical moving forward to ensure the next iteration of mentorship opportunities is built with clinics in mind. The Idaho PCMH Mentorship Subcommittee could continue to champion mentorship efforts. Many of the members are early adopters and champions of the PCMH model since before the SHIP grant and can provide guidance. State staff support beyond Medicaid will be valuable to keep a broad perspective and engage clinics through the relationships built during the SHIP grant years.

OHPI has identified several options for sustaining mentorship opportunities; initial efforts could focus on providing a platform for clinics to connect virtually (e.g., through calls or webinars), share ideas, and share contact information. Over time, mentorship opportunities could grow into more peer-to-peer direct mentorship, including by subject matter experts as resources are found. Grant funding or other funding could be used to pay clinics for the time of their clinic staff or providers to conduct peer-to-peer visits.

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Mentorship on EHR usage in support of PCMH transformation is anticipated to be an area of need moving forward. OHPI is interested in exploring partnerships for developing and maintaining EHR user groups in Idaho that could connect clinics around EHRs, building off initial efforts at the Cohort 3 learning collaborative. EHR vendors may be interested in partnering in this effort. The PHDs and IPCA may also be potential partners. Finally, OHPI is interested in working with Boise State to evaluate clinic needs for mentoring related to EHR usage, and potential curriculum development that would serve as a resource for clinic staff to learn how to pull reports in their EHRs to support their PCMH transformation.

Next Steps: OHPI will work on the following during the remainder of the grant period:

- ***Ensure the mentorship framework is updated*** to include what is happening across the State, including regional initiates and the webinars. This will involve re-engaging the Idaho PCMH Mentorship Subcommittee.
- ***Assess clinic mentorship and other educational needs.*** OHPI has developed a survey focused on mentorship needs that will be distributed to SHIP clinics. The results of the survey, combined with evaluations from the recent learning collaborative, will inform topics for the last three scheduled mentorship webinars in late fall, as well as focus areas for mentorship after the end of the SHIP grant.
- ***Explore opportunities to maintain mentorship going forward,*** as described above.

Sustaining the Role of the State in Future Transformation

As discussed in our Sustainability Plan Part 1, SHIP has accelerated delivery and payment reform in Idaho. A key lesson learned from the Model Test is the need for an ongoing, focused effort to coordinate and collaborate across initiatives, and convene stakeholders for the success of statewide healthcare transformation. Support and coordination across efforts can increase knowledge across initiatives, find synergies to efficiently drive change and build relationships across the delivery system and all its stakeholders. PCMH transformation is an important example of this. OHPI has spearheaded IDHW's efforts to accelerate PCMH transformation by serving as a neutral convener to bring together stakeholders, oversee implementation of projects to support practice transformation, and ensure financial resources are appropriately disbursed to incentivize change.

Moving forward, the sustainment of PCMH transformation will require continued support and coordination. In the absence of these roles, there is a significant risk that progress will not continue, and critical functions will either not be performed or will not be effectively coordinated.

Activity Status Post-SHIP: Potential options for the State's role post-SHIP include:

- ***Serve as a hub,*** transitioning from having worked with the three SHIP cohorts to promoting PCMH more broadly and connecting stakeholders to associated efforts. As a hub, the State could assess other activities across the State, including other grant opportunities that would benefit clinics' transformation and provide linkages to clinics. The State could work with stakeholders to inform and educate clinics statewide and share resources to support QI such as ongoing learning collaboratives, mentorship efforts, the PCMH Resource Library, and tools.

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- ***Monitor transformation to inform leadership, payers, and other stakeholders***. As a hub, the State would continue to maintain contact with cohort clinics and could work with Medicaid to continue to track the number of clinics that are nationally recognized. Future phases of evaluation would inform progress among PCMH clinics and how they can reduce healthcare costs. Ongoing evaluation could identify needed next steps and assistance to support the adoption of the PCMH model statewide.

Next Steps: Efforts are underway to develop a potential structure and funding for maintaining OHPI in some capacity to function as a hub and monitor of healthcare transformation. Budget development is underway ahead of the next IDHW budget request and legislative session in January 2019. The rest of the grant period will be spent exploring this and other avenues for continuing support to PCMH transformation.

B.1.2. Goal 4

Idaho's Virtual PCMH model was designed to accelerate establishment of the PCMH model of care in areas with significant healthcare workforce shortages. By expanding access to team-based care through development and establishment of new medical workforce personnel (i.e., CHWs and CHEMS), and through the expanded use of telehealth technology, Idaho was able to advance the PCMH model through the innovative Virtual PCMH model designation.

As described in the Sustainability Plan Part 1, the early SHIP grant years focused on developing the Virtual PCMH model framework and developing the infrastructure to support the model. Once the beginning infrastructure was established, Idaho shifted its focus to recruiting individuals to be trained as CHWs and CHEMS, promoting clinics' adoption of the Virtual PCMH model, providing opportunities for clinics to pilot telehealth in the clinic and technical assistance to be successful, and establishing a Project ECHO site in Idaho. Accomplishments attained through these SHIP investments include:

- Established 46 Virtual PCMHs in geographically isolated and underserved communities.
- Established and supported in-State training programs for CHWs and CHEMS personnel.
- Established 11 telehealth pilot projects in Primary Care Clinics and one CHEMS agency.
- Established a contract with Health Management Associates to provide telehealth technical assistance to SHIP supported telehealth sites.
- Supported implementation of Idaho's first Project ECHO Hub.

IDHW and the IHC have been analyzing the impact of the Virtual PCMH model and identifying strategies to maintain and advance promising components of the model that will help establish PCMH team-based care throughout the State. The analysis and planning includes discussions with providers and other stakeholders to gauge interest in utilizing CHWs, CHEMS, and Project ECHO in their practice or community, discussions with payers to determine their interest in financially supporting delivery models that utilize components of the Virtual PCMH model, and discussions with other partners, such as the Health Quality Planning Commission, to identify additional opportunities to support sustainment of SHIP investments to accelerate establishment of the PCMH model. Discussion of the analysis and planning to date follows and includes options evaluated to sustain support of the Virtual PCMH core components.

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Establishing Virtual PCMHs

As of August 30, 2018, 46 Virtual PCMH designations have been made. With the designation, clinics received up to $2,500 to help offset the cost of establishing the Virtual PCMH model. Additional Virtual PCMH designations will be made prior to the end of SHIP.

Activity Status Post-SHIP: Idaho will not continue the designation process or continue to provide financial assistance to clinics due to the lack of resources following the expiration of the SHIP grant.

Next Steps: Although Virtual PCMH designation and financial support will not continue post-SHIP, the core components of the Virtual PCMH model will continue to be supported and advanced, as described in more detail below.

Training CHWs and CHEMS

As described in the Sustainability Plan Part I, Idaho has made a significant investment in training CHWs and CHEMS personnel. Working with Idaho State University (ISU), a CHW curriculum and training course was developed. The cost of course delivery was covered using SHIP grant dollars, enabling over 75 individuals to receive the training as of August 30, 2018. Through partnerships with community organizations, 13 health-specific modules (HSMs) were developed with an additional eight HSMs still under development to further individualize the training. In collaboration with IDHW, Public Health Bureau of Community and Environmental Health's Diabetes, Heart Disease, and Stroke Prevention Program, the Public Health Bureau of Rural Health and Primary Care, and the CHW Association, a CHW in-person learning collaborative was held on July 25, 2018 and is being planned as an annual event going forward.

Ada County has been an important partner in training and establishing the CHEMS workforce. Ada County paramedics developed templates, tools, and resources used by CHEMS agencies statewide to recruit CHEMS personnel. They also provide technical assistance and peer mentoring to Emergency Medical Service (EMS) agencies interested in building CHEMS program. The CHEMS program continues to engage more agencies throughout the State.

Training CHEMS personnel in the future is expected to include standardized CHEMS training and learning collaboratives. The Public Health Bureau of Emergency Medical Services & Preparedness (BEMSP) is planning to contract with the Paramedic Foundation and partner with the Foundation to collect data and standardize the training. The BEMSP will also support further development of the CHEMS infrastructure needed to establish trained CHEMS personnel in Idaho's medical workforce (see section below).

In collaboration with IDHW Division of Public Health, a CHEMS in-person learning collaborative was held January 17, 2018 and is being planned as an annual event going forward.

The Community Emergency Medical Technician (CEMT) model has emerged during SHIP as an important component of CHEMS. The CEMT works in collaboration with local public health agencies, primary care, and specialty care providers by assessing and evaluating community services and systems in order to identify gaps in healthcare services in both urban and rural, medically-underserved communities. CEMTs help fill gaps in local healthcare by using existing EMTs/advanced EMTs (AEMTs) in expanded roles. CEMTs may focus on providing primary care, post-discharge follow-up care, integration with local public health agencies, and/or providing education and health promotion programs. ISU, in collaboration with

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the IDHW Division of Public Health offers a CEMT core course that includes 39 hours of live on-line or in-person learning plus an additional nine hours of asynchronous HSMs for a total of 48 hours of coursework.

Activity Status Post-SHIP: Efforts to increase the CHW and CHEMS workforce in Idaho will continue. Training for CHWs will continue to be offered by ISU, but individuals may need to cover the cost of their training. Planning is also underway to identify resources to support an annual learning collaborative for CHWs.

The current live-online Idaho CHW curriculum and the instructor manual will be transformed by ISU into a hybrid (synchronous/asynchronous) CHW training course. The hybrid course will consist of a combination of three live-online classes and nine weeks of asynchronous coursework totaling 12 weeks or 39 hours. The conversion will include syllabus, power point slides, case studies, exams and quizzes. Video clips and audio clips will be included in the class. Additionally, ISU will take five existing Idaho CHW HSMs curricula and translate them into Spanish so that it can be delivered asynchronously online. Translation will include syllabus, power point slides, case studies, quizzes and evaluation questionnaires.

State certification for CHWs has been considered but is not being pursued at this time. Idaho is working with the CHW Association, established by the IDHW Division of Public Health Bureau of Community and Environment Health (BCEH), to further evolve the Association's functions and role in supporting the Idaho CHW workforce.

Data reported by CHWs has been collected to track the CHW scope and potential impact of CHWs on the workforce. Data collection will not continue post-SHIP, but the data collected during the SHIP grant will be analyzed to determine if this information could be used to help providers and payers better understand the scope of CHWs' responsibilities and potential benefits.

Next Steps: IDHW Division of Public Health will continue to support expansion of CHWs and adoption of CHWs in the workforce. As noted above, planning regarding future training of CHWs and CHEMS have been developed and continue to evolve. The major obstacle Idaho encountered in integrating trained CHWs and CHEMS personnel in the healthcare workforce is the lack of payment models that incorporate these trained medical personnel. This continues to be an issue and will be a priority focus post-SHIP. Discussions with payers regarding implementing payment models that include CHWS and CHEMS will continue. Recently, there has also been some promising progress in this area as one payer has shown interest in implementing a payment model that includes CHWs.

Building Infrastructure for CHEMS

Idaho's recognition of the value that CHEMS can bring to the healthcare workforce began before SHIP, but SHIP and the relationships developed have played an important role in advancing the establishment of CHEMS and linking CHEMS personnel to the delivery system. Today, over 10 EMS agencies have begun implementation of their CHEMS initiatives. However, for CHEMS personnel to be active participants in the State's healthcare delivery system, the CHEMS infrastructure must continue to evolve.

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Activity Status Post-SHIP: The Idaho BEMSP will continue to work with Ada County Paramedics and other interested emergency services organizations to develop tools to support CHEMS agencies. There are ongoing discussions with other organizations that may also be interested in housing and disseminating CHEMS-related information to help educate primary care practices and community organizations regarding the benefits of CHEMS personnel.

Next Steps: Ongoing planning includes identifying additional partners to support the development of the CHEMS infrastructure and payment models that incorporate CHEMS personnel. Some payers in Idaho have expressed an interest in such payment models; for example, using CHEMS personnel to serve individuals dually eligible for Medicare and Medicaid. The IDHW Division of Public Health is fully committed to the establishment of CHEMS and will be providing leadership and direction post-SHIP.

Telehealth/Project ECHO

Despite a constantly changing healthcare landscape in Idaho, SHIP clinics have established 11 telehealth pilot projects in seven clinics through SIM investments. In addition, a CHEMS agency has begun a telehealth pilot project, the first in Idaho. These are major accomplishments achieved through Idaho's SHIP. Once the establishment of the telehealth pilot programs is complete, the programs will be self-sufficient post-SHIP as they should be able to bill for the telehealth services they provide.

The launch of Project ECHO was another major accomplishment. OHPI worked with the University of Idaho WWAMI program to implement the hub-and-spoke knowledge-sharing network in Idaho. The first ever Idaho ECHO hub addresses the opioid crisis by expanding workforce capacity to provide best practice specialty care and reduce health disparities in rural and underserved communities. The goal is to create a network of Idaho providers equipped to enhance patient care, treatment, and management of opioid abuse. Next SHIP sponsored ECHO sessions will include Behavioral Health.

Activity Status Post-SHIP: Idaho is developing processes and tools to share information about telehealth projects that can be used by other clinics interested in expanding use of this technology. This would include description of projects and contact information for those interested in learning more. Through the PCMH transformation contractor (Briljent) and the technical assistance subcontractor (HMA), technical assistance has been offered via webinars for clinics interested in expanding their use of telehealth technology. Technical assistance through HMA will no longer be available, but HMA webinars developed during SHIP may be stored on a website where they can be accessed as a continued resource.

Support for telehealth expansion will continue but sources of support will change. The financial support available to providers funded through the SHIP grant will no longer be available. Support for the Telehealth Council provided by OHPI will also be discontinued. Instead, the Health Quality Planning Commission has been asked to provide support for telehealth expansion.

SHIP investments supported start-up costs (excluding equipment) and personnel costs for Project ECHO. Going forward, the University of Idaho will continue to provide the platform for Project ECHO.

Next Steps: The University of Idaho will work with an advisory body to identify health areas that Project ECHO will next address in Idaho. Future funding sources will also be considered, including discussions within IDHW on potential sources of financial support. The Health Quality Planning Commission will identify next steps for supporting telehealth expansion.

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B.2. Primary Driver 2: Increase the Use of HIT and HIE

The lessons learned, and the infrastructure established for statewide data analytics have laid groundwork for further growth in the next stages of healthcare transformation. In addition to the specific tangible achievements of SHIP, OHPI filled an important role as a facilitator and coordinator for collaboration among HIT stakeholders. Through these efforts, Idaho has seen an increase in stakeholder involvement, transparency and collaboration, which are all critical elements to Idaho's sustainability and continued progress towards HIE and data analytics.

B.2.1. Goal 2

Continuing Maturation of Idaho's HIE

Increasing the use of HIT and HIE in Idaho has been a challenging area of the SHIP grant implementation. As noted in Idaho's Sustainability Plan Part 1, challenges and lessons learned led to course corrections in order to make progress towards strengthening infrastructure, building capacity, and connecting providers to the HIE. Although the targets were not achieved as originally envisioned, meaningful progress was made that can serve as a launching pad for continued HIT and HIE development in Idaho post-SHIP. The SHIP grant has enabled the IHDE to solidify its organization and technical infrastructure, including the hiring of additional staff, the creation of processes and procedures, and the creation of a sustainable technical roadmap.

Activity Status Post-SHIP: The investments in IHDE made through SHIP have positioned IHDE to sustain the gains that have been made and support future growth of Idaho's HIT and HIE efforts. The critical future tasks for IHDE include providing continued support for existing clinic and hospital connections, building new connections with additional providers, enhancing the HIE infrastructure, and developing new functionalities that provide value to IHDE's stakeholders as a means of securing additional financial sustainability.

Next Steps: Through the remainder of the SHIP period, IHDE will continue building out key components of their plans to enhance their infrastructure. IHDE is working on implementing a new platform and new communications service layer by the end of the SHIP period. The communications service layer will centralize connections into the HIE environment controlled by IHDE and provide the infrastructure for message intake and delivery of all data coming into and out of the HIE. This infrastructure change eliminates connections to IHDE being vendor-dependent and provides IHDE with the flexibility to change a vendor without impacting any provider connections. This change addresses an architectural flaw that has impeded IHDE's past progress and supports future growth and sustainability.

IHDE will also complete the first steps in building out a new data service layer, targeting completion in 2019. The data services layer will allow IHDE to maintain specific attributions required by participants, such as payers, and present clinical data back to the participants based on their individualized requirements. This infrastructure change is critical to IHDE's ability to support the needs of the payers who wish to obtain clinical data for their members. The data services layer also positions IHDE to be part of any future data analytic reporting needs for providers. By fulfilling a critical data need for the payers, the data services layer is also enabling IHDE to create a new revenue stream, which is critical to their sustainability. As mentioned above in Section B.1.1, Boise State will be adding modules to the LSM to help providers improve their capacity for using data.

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While supporting the SHIP efforts, IHDE was able to collaborate and establish new relationships with other state HIEs. This collaboration contributed to IHDE's design of their enhanced infrastructure. IHDE was able to apply lessons-learned in other states and identify best practices and solutions that would move Idaho's HIE forward. IHDE will continue to collaborate in this way as they seek new opportunities to strengthen their infrastructure and increase their value-add to Idaho's HIE. IHDE is currently evaluating ideas such as ingesting payer data, advance directives, and prescription drug monitoring programs. IHDE will also continue to work with the Strategic HIE Collaborative (SHIEC), the national collaborative representing HIEs. The ability to collaborate with other Idaho HIE efforts balanced with the ability to look outside the boundaries of Idaho is critical to IHDE's long-term success.

Continuing to Connect Providers to the HIE

A major accomplishment of the SHIP grant was establishing clinic HIE connections, which resulted in increased exchange of clinical data to support improved opportunities to coordinate patient care. SHIP provided financial assistance and technical support to clinics as they established connections to IHDE. There are 79 clinics with established full, bi-directional connections with IHDE as of August 2018. It is projected by the end of the grant, 132 clinics will have established full, bi-directional connections. An additional 24 clinics are projected by the end of the grant to have a one-directional connection. IHDE has enhanced hospital engagement efforts. One new hospital has recently connected with IHDE and six additional hospitals are considering establishing connections by the end of the SHIP grant.

Activity Status Post-SHIP: With the SHIP funding ending, the clinics will now be responsible for the EHR charges associated with connecting to IHDE. Medicaid will continue to support their portion of the cost through HITECH 90/10 funding. IHDE will continue to support existing connections by conducting quality assurance site visits, providing enhanced training and offering customer service. IHDE will also build new connections with clinics, hospitals, and other providers.

Next Steps: IHDE will continue to work with clinics, hospitals and other providers to build connections.

Creating a Statewide HIT Plan

SHIP provided an important catalyst for developing a statewide HIT plan for Idaho. Through the development of a SHIP HIT plan, which was a requirement of the SIM grant, OHPI filled a critical role that was previously lacking in Idaho by organizing, supporting, and coordinating the many stakeholders that contribute to and are impacted by HIT. The resulting SHIP HIT plan was an important milestone and provides a foundation for the development of a comprehensive statewide HIT plan that will set a strategic vision for the State and outline the resources and activities needed to achieve that vision.

Activity Status Post-SHIP: Organizing, supporting, and coordinating stakeholders around the creation of a comprehensive Statewide HIT Plan will be a necessary role moving forward. Currently, Medicaid is working on its HIT plan. Any future efforts around a statewide HIT plan will need to incorporate and leverage any individual, distinct plans that might be in development. With the experience and relationships created and enhanced during SHIP, OHPI would be well-positioned to provide organization, support, and coordination moving forward, and to represent the Department in broader stakeholder engagements. OHPI could also provide support for implementation of the resulting statewide HIT plan within IDHW if additional resources were needed. However, OHPI's ability to fulfill these roles moving forward is dependent on the availability of funding to support the office.

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Next Steps: Through the remainder of the SHIP grant, OHPI will work with its intra-agency partners and external stakeholders to explore the idea of developing a statewide HIT plan. Currently OHPI is attempting to identify State resources to fund a position that could support efforts around developing and supporting the implementation of a statewide HIT plan, should internal and external stakeholders unify around those tasks.

Stakeholder Engagement

SHIP played a critical role in increasing the level of stakeholder engagement in HIT- and HIE-related efforts in Idaho. With SHIP support, stakeholder workgroups were convened and met regularly throughout the Model Test period to inform the development of HIT and HIE activities. Stakeholders offered their technical expertise and perspective, which was an invaluable "on the ground" asset that helped ensure HIT and HIE efforts were developed to meet the unique needs of Idaho's Model Test and the Idaho stakeholder community, particularly providers and other end-users. Stakeholders also helped coordinate across efforts to reduce duplication and maximize the impact of SHIP's HIT and HIE activities.

As SHIP progressed, the workgroups evolved from a Clinical Quality Measure (CQM) Workgroup and a HIT Workgroup to a combined SHIP Data Governance Workgroup in AY3. A new charter was developed that reflected both the clinical and data perspectives and the operational needs of the next phase of the project. The SHIP Data Governance Workgroup continued to meet through the end of the grant and provided important input, particularly related to the data analytics infrastructure and processes under Goal 5.

Activity Status Post-SHIP: Moving forward, stakeholder engagement in HIE and HIT will continue to be a priority. Stakeholder engagement on efforts such as the Statewide HIT Plan (described above) will be important to making sure the plan is broadly representative of stakeholder's perspectives and is responsive to their needs and goals moving forward.

Next Steps: In the remaining months of the SHIP grant, the SHIP Data Governance Workgroup will evaluate its role moving forward and the membership needed to carry out its functions in the next phases of transformation. It is anticipated that the role of the SHIP Data Governance Workgroup will evolve. One potential strategic direction for the group would be an increased focus on overall statewide HIT planning, adding an operational and practical component to the larger HIT conversation. The SHIP Data Governance Workgroup will explore options moving forward in their remaining meetings during the grant period. The new stakeholder advisory body will determine what standing stakeholder workgroups will be needed moving forward, including the Multi-Payer Workgroup and possibly an ongoing data governance/HIT stakeholder workgroup.

Stakeholder engagement related to aligning clinical quality metrics among payers has already shifted to the Multi-Payer Workgroup, which will continue to provide a forum for gathering payers and providers on a wide range of topics including measure alignment, as described in more detail in the following section. Idaho will continue to recognize that data and payment reform initiatives are interconnected and as such the alignment of metrics will continue to require collaboration between the two stakeholder workgroups.

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B.2.2. Goal 5

Statewide Data Analytics

Data analytics has been one of the most challenging components of SHIP. The initial goals and success measures for the statewide data analytics were extremely aggressive and optimistic based on the number of SHIP clinics connected to the HIE and the quality of the data available. It became evident early in the project that the work required to get actionable quality data was underestimated. SHIP continued to move forward with developing the data analytic infrastructure while making course corrections to provide additional focus on building HIE connections and improving data quality. These course corrections proved to be successful for completing the HIE connection builds but were not sufficient for obtaining actionable CQM reports.

In AY4, OHPI completed a detailed review of the progress of the data analytic reports and determined that a major course correction was needed. Alternative sources of data analytic reporting of CQMs were identified. The primary source of CQM data will be the Medicaid CQM reporting developed to support the Medicaid shared savings initiatives. This will be supplemented by information from the IDHW Division of Public Health, the State Evaluation Team and Behavioral Risk Factor Surveillance System (BRFSS) data. This approach, that focuses on leveraging the Medicaid CQM data and other reporting resources, enables SHIP to produce meaningful analytics within the grant timeframe, and represents a positive step towards Idaho's long-term goal of better aligning quality measures.

Table 2 – SHIP Clinical Quality Measures

Area	Measure
Tobacco Prevention	**Cigarette smoking** - Prevalence of adults who are classified as cigarette smokers. **Smokeless tobacco use** - Prevalence of adults who report using chewing tobacco, snuff, or snus. *Source: BRFSS data through IDHW's Division of Public Health.*
Obesity	Prevalence of adults who have a BMI of 30 or more. *Source: BRFSS data through IDHW's Division of Public Health.*
Diabetes	Diabetes HbA1c Test (NQF57)
Depression	Depression Acute Phase Therapy (NQF105)
Depression	Depression Continuation Phase Therapy (NQF105)
Immunization	Childhood Immunization Status *Source: CDC, National Immunization Survey*
Vaccine	Influenza Vaccine (NQF41)

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Area	Measure
Access to Care	Provided via SHIP State Evaluation Team
Screenings	Colorectal Cancer Screening
Screenings	Breast Cancer Screening
Well Child	Well Child Visits in First 15 Months of Life
Well Child	Well Child Visits Age 3 to 6
Well Child	Well Child Adolescent (NCQA/HEDIS)
ADHD	ADHD Drug Initiation Phase Visits (NQF108)
ADHD	ADHD Drug Continuation Phase Visits (NQF108)

Activity Status Post-SHIP: Idaho will continue working to align quality measures across payers. The Multi-Payer Workgroup will provide a forum for payers and providers to work together to align measures moving forward. Medicaid will continue to provide data to providers to inform quality management and help identify areas in need of improved performance.

Next Steps: Members of the Multi-Payer Workgroup have acknowledged the importance of normalizing around measures as providers and payers work towards but continue to be in various stages of VBP. The Multi-Payer Workgroup has established the HEDIS measure set as the basis of normalizing the quality measures. The Multi-Payer Workgroup will be distributing a survey to all payers about the status of their measure reporting and priorities. The survey will capture feedback on what needs to be done to sustain and advance efforts. The Multi-Payer Workgroup will use the results of this survey to establish next steps, with a target of aligning on a common set of quality measures by 2020.

In September 2018, Medicaid will start sharing CQM reports with providers via an online portal on the measures linked to the Medicaid shared savings program.

B.3. Primary Driver 3: Establish Seven Regional Collaboratives

B.3.1. Goal 3

Seven RCs serve as the local advisors of SHIP, focusing on integrating the MHN, providing guidance on regional QI activities, and supporting PCMH transformation at the local level. Since the RCs were developed under SHIP, a primary focus of activity has been on developing and establishing each RC, including identifying members and conducting strategic planning.

Over the four-year grant period, each RC has formed and evolved uniquely. A July 2018 survey of RC members and PHD SHIP staff supporting and/or interacting with the RCs captured the range of

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experiences and reflections on the RCs' success. The RC survey also asked members to describe their RC's most notable accomplishment and their biggest challenges.

The survey was distributed via email to 165 RC members in July 2018. Thirty-five survey responses were received (21% response rate). Sixty six percent of the respondents were RC members or part of the RC Executive Team. Other respondents were the PHD SHIP staff.

Themes of notable accomplishments identified through the survey included strengthening community relationships, collaboration, and partnership and specific local projects, such as behavioral health integration and suicide prevention. In identifying challenges and obstacles, several respondents noted the lack of data made it difficult for the RC to make informed decisions regarding local health needs and appropriate population health improvement strategies.

The RC survey contributed useful information to Idaho's analysis of the impact of the SIM investment in regional SHIP support and in the State's planning for post-SHIP activities. Below are key findings from the survey.

- 83% of respondents indicated their RC was successful or very successful in providing local leadership and support for healthcare transformation.
- 66% indicated their RC was successful or very successful in the development of the MHN.
- 68.5% indicated their RC was successful or very successful in improving population health to achieve the Triple Aim.
- 74% indicated the level of difficulty in fulfilling their function was challenging or very challenging.
- 65% of non-PHD staff respondents indicated the technical assistance and administrative support their RC received in achieving their goals was helpful or very helpful.
- 51% indicated it is likely or very likely their RC or an RC-like group will continue after the SHIP grant ends.
- 17% indicated it is unlikely or not likely at all their RC or an RC-like group will continue after the SHIP grant ends.

The RCs have also provided IDHW with drafts of their post-SHIP transition plans. The transition plans will address if and how the RC plans to continue working on developing their local RC, integrating the MHN, and providing local support for PCMH transformation post-SHIP. While the RC transition plans will not be finalized until December 2018, information from the initial drafts has provided useful insight on each RC's thoughts regarding the continuation and focus of the RC post-SHIP.

Activity Status Post-SHIP: The results of the RC survey and the draft RC transition plans, as well as IDHW's analysis and discussions regarding sustainability yields the following picture of how each RC focus area will evolve:

- **Supporting PCMH transformation at the local level.** Throughout the four years of SHIP, the clinics participating in their RCs have consistently noted the value of the QI Specialist in helping support their PCMH transformation, along with the coaching and support they received from the PCMH transformation contractor (Briljent) and their PCMH technical assistance subcontractor (HMA). With the expiration of the SHIP grant, funding for the QI Specialist and other PHD SHIP team staff will no longer be available. The PHDs are looking for alternative funding sources and are developing a budget request to support continuation of staff to support the clinics and RCs. In addition, as noted under Driver 1, Idaho is looking for ways to leverage resources developed

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under the SHIP grant (e.g., webinars, Resource Library, etc.) and clinic-to-clinic mentorship to continue support to clinics in their PCMH transition.

- **Integrating the MHN.** Several survey respondents noted integrating the MHN has proceeded slowly and additional work is needed. Nonetheless, a commitment to continue work in this area was expressed by a several RCs. It is anticipated the RCs that exist post-SHIP will continue to work on integrating the MHN as all RCs acknowledge that, to provide whole person care, close coordination between primary care and MHN participants is critically important. Since it is unknown whether the PHD SHIP team positions will be successful in obtaining continued funding, PHDs are exploring whether there are other resources that can be used to help support MHN integration post-SHIP.
- **Providing Guidance on Regional QI.** As noted earlier, the lack of data available to the RCs made it difficult to provide guidance on regional QI. Medicaid will provide information that can be useful at the regional level. The IDHW Division of Public Health is looking for ways to support regional level activities, such as supporting alignment of community health planning and assessment and providing regional level data.

Next Steps: The RCs will complete their transition planning by the end of December 2018 and identify activities to continue post-SHIP and resources needed to carry out their transition plans. IDHW and the new stakeholder advisory body will work with the RCs to help identify ways to leverage existing supports and potentially new resources through State or grant funding.

B.4. Primary Driver 4: Align Value-Based Payments across Payers

B.4.1. Goal 6

One of Idaho's major accomplishments has been convening the State's largest private payers, Medicare, and Medicaid to agree on a framework for measuring progress in moving from FFS payments to VBP models. As described in the Sustainability Plan Part I, the Payer Reporting Framework was developed by the IHC Multi-Payer Workgroup. Using this framework, payers have submitted data annually since 2015 to an independent third party (Mercer Government Human Services Consulting) for analysis. The financial analysis shows progress in lowering cost trends and a willingness for payers to provide data at a level that would not jeopardize competitive advantages.

Activity Status Post-SHIP: The Multi-Payer Workgroup, established under SHIP, has successfully convened payers and providers over the four-grant period and provided a forum to discuss strategies for moving toward VBP models, including identifying and implementing delivery system models that align with VBP models. While the PCMH model was identified in SHIP as a cornerstone of Idaho's healthcare transformation, payers have noted there are other alternative delivery system models that can be used to align payment with quality care. Post-SHIP the Multi-Payer Workgroup will continue to regularly meet and share strategies around moving to delivery system models that align with VBP. It is anticipated that the Multi-Payer Workgroup will become a workgroup under the new advisory body post-SHIP.

Recently, Idaho conducted a survey of payers regarding the use of HEDIS metrics for measuring quality and use in provider reimbursements. The purpose of the survey was to identify where alignment exists today across payers and what opportunities there might be for future alignment. The Multi-Payer Workgroup will continue to serve as a forum for payers and providers to explore opportunities to align quality metrics. The Multi-Payer Workgroup will meet monthly and this important work will be staffed by OHPI.

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At this time, it is unknown whether Idaho can continue to conduct the financial analysis that monitors multi-payer progress toward VBPs as the SIM funds supporting this work will expire in 2019. Idaho is evaluating potential options for continuing to monitor progress in moving towards VBP.

Next Steps: The Multi-Payer Workgroup will continue to provide a forum for commercial and public payers and providers to discuss aligning delivery system models with VBP strategies and aligning quality metrics. It is anticipated the Multi-Payer Workgroup will report to the new advisory body post-SHIP and the workgroup will continue to be staffed by OHPI. Options to continue monitoring the State's progress in moving away from FFS to VBP will continue to be explored.

B.4.2. Goal 7

The Multi-Payer Workgroup also played a pivotal role in evaluating the financial impact of new delivery and payment models on Idaho's healthcare system. Through the workgroup, payers came to an agreement regarding what data would be submitted and the schedule for submission to conduct the analysis. The analysis includes the population of three of the four largest commercial payers in Idaho, Idaho Medicare, and Idaho Medicaid. The reported populations across these payers represent roughly 1.1 million of Idaho's 1.6 million residents. The analysis shows that actual costs for SHIP demonstration are projected to be over $93.5 million lower than if no intervention for the SHIP or payment reform were taking place. This analysis both reaffirms Idaho's goals to continue healthcare transformation and provides vital information that can be used to build the business case for continued transformation.

Activity Status Post-SHIP: The financial analysis was conducted using SHIP grant dollars. With the expiration of the grant, it is expected that the multi-payer, independent analysis will end. However, individual payer analysis may be able to provide information in the future regarding the financial impact of healthcare transformation on Idaho's healthcare costs.

Next Steps: IDHW and private payers will continue to look for opportunities to continue measuring the impact of healthcare transformation on the State's healthcare costs. Replacement funding to conduct the financial analysis supported by SIM funding is being explored.

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C.Idaho's Post-SHIP Plan to Further Health System Transformation

C.1. Post-SHIP Plan

As described in the previous section, there are several activities and investments that began under SHIP which warrant sustained resources beyond the project period, as these activities will continue to support Idaho's end state vision for its healthcare system. The following chart represents an inventory of SHIP activities and investments that are targeted for continuation. For each activity/investment, OHPI and its partners have begun to identify who "owns" the activity after SHIP concludes, what resources will be needed, potential funding sources, and other inputs needed to support the activity moving forward. During the remainder of the SHIP grant period, OHPI and its partners and stakeholders will further refine these plans to support an effective transition of activities moving forward.

1.1. Goal 1

1.1.1. Financial support for clinics to transform to the PCMH model

Owner: Payers
Resources Needed: Varied depending on payer
Potential Funding Resources: Payer reimbursement models and/or aligned project grant funding
Other Inputs needed: Support from the new stakeholder advisory body and Multi-Payer Workgroup regarding potential collaborative efforts to support PCMH adoption

1.1.2. Centralized source of information about payment opportunities to support the PCMH model

Owner: OHPI, Medicaid Healthy Connections, & Boise State University
Resources Needed: Up-to-date information regarding payer support for PCMH model, platform for distributing information to clinics, funding
Potential Funding Resources: To be identified
Other Inputs needed: Support from the public health districts and other stakeholders

1.1.3. Catalog of QI efforts and other technical assistance available regarding the PCMH model

Owner: Potentially OHPI
Resources Needed: Up-to-date information regarding QI and technical assistance resources, platform for distributing information to clinics, funding
Potential Funding Resources: To be identified
Other Inputs needed: Potential linkages with Medicaid's Healthy Connections Program, Qualis, etc.

1.1.4. Continued support for PCMH transformation (potentially linkages to existing resources, continued webinars and/or learning collaboratives, telehealth, etc.)

Owner: Potentially OHPI, PHDs, Medicaid, other partners
Resources Needed: Training and technical assistance resources, funding
Potential Funding Resources: To be identified
Other Inputs needed: Opportunities to align resources where possible

1.1.5. Availability of historical information regarding SHIP PCMH Readiness Assessment and Transformation Plans

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Owner: OHPI
Resources Needed: Platform for storing historical information, funding
Potential Funding Resources: To be identified
Other Inputs needed: Results of State Evaluation Team coding of Transformation plan notes, potential further evaluation or knowledge extraction from the Portal notes and other documentation

1.1.6. PCMH Readiness Assessment and Transformation Plan tools

Owner: Potentially payers
Resources Needed: Based on which payers are interested in adopting the tools
Potential Funding Resources: Payer funding
Other Inputs needed: Based on which payers are interested in adopting the tools

1.1.7. PCMH Portal Resource Library

Owner: The College of Health Sciences at Boise State University
Resources Needed: Technical and funding resources for ongoing hosting and maintenance of the Resource Library
Potential Funding Resources: SHIP funding to support initial transition, then Boise State funding on ongoing basis and potential subscription model for users
Other Inputs needed: Mechanism for clinics to access the resources in the future, partners (e.g., Bureau of Rural Health, Division of Public Health, PHDs, IPCA, etc.) to disseminate information about the Resource Library

1.1.8. Clinic-to-clinic Mentorship

Owner: Potentially OHPI
Resources Needed: Funding, staff resources, updated mentorship framework, platform for clinics to connect virtually
Potential Funding Resources: TBD, potentially grant funding
Other Inputs needed: Stakeholder engagement (potentially via Idaho PCMH Mentorship Subcommittee)

1.1.9. PCMH "hub"

Owner: Potentially OHPI
Resources Needed: Funding and staff resources
Potential Funding Resources: SHIP funding to support initial transition, then Boise State funding on ongoing basis and potential subscription model for users
Other Inputs needed: Stakeholder engagement, relationships with PCMH resources/initiatives

1.2. Goal 2

1.2.1. Continue Expansion of IHDE

Owner: Idaho Health Data Exchange
Resources Needed: Funding and staff resources
Potential Funding Resources: Medicaid, Hospitals, Clinics & Private Payers
Other Inputs needed:

1.2.2. Support existing connections to IHDE and continue to connect providers

Owner: Idaho Health Data Exchange
Resources Needed: Funding and staff resources
Potential Funding Resources: Medicaid via HITECH funding, provider resources will cover the EMR charges associated with connecting to IHDE
Other Inputs needed:

1.2.3. Coordinate health IT strategy in Idaho

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Owner: IDHW (facilitates stakeholder group)
Resources Needed: TBD, potentially the SHIP Data Governance Workgroup or its successor and a newly crafted charter
Potential Funding Resources: TBD
Other Inputs needed:

1.3. Goal 3

1.3.1. Continued development of the RCs

Owner: RCs, according to their individual transition plans
Resources Needed: Funding and support according to each RC's transition plan
Potential Funding Resources: Varied
Other Inputs needed: Varied

1.4. Goal 4

1.4.1. CHEMS Training

Owner: Idaho Bureau of Emergency Medical Services & Preparedness
Resources Needed: Funding, staff resources, standardized CHEMS training curricula and materials, potentially learning collaboratives
Potential Funding Resources: TBD, potential payer support for CHEMS
Other Inputs needed: Partnership with Paramedic Foundation

1.4.2. Tools to Support CHEMS Agencies

Owner: Idaho Bureau of Emergency Medical Services & Preparedness
Resources Needed: Tools, mechanism for distributing the tools (Bureau's website)
Potential Funding Resources: To be identified
Other Inputs needed: Potential additional partners who can distribute the tools

1.4.3. Share information about telehealth projects with clinics interested in expanding use of this technology

Owner: Bureau of Rural Health and Primary Care
Resources Needed: Processes and tools, portal of existing materials
Potential Funding Resources: Utilization of existing sustainability efforts and web portal presence
Other Inputs needed: None identified

1.4.4. Continued expansion of telehealth

Owner: Health Quality Planning Commission (HQPC)
Resources Needed: Staff
Potential Funding Resources: Will be evaluated at the November meeting of the HQPC
Other Inputs needed: None identified

1.4.5. Project ECHO

Owner: University of Idaho
Resources Needed: Ongoing staff and programmatic support
Potential Funding Resources: University of Idaho and participants
Other Inputs needed: None identified

1.5. Goal 5

1.5.1. Statewide HIT Plan

Owner: OHPI
Resources Needed: Funding and staff resources
Potential Funding Resources: Medicaid HITECH & general funds

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Other Inputs needed: Strategic vision, stakeholder engagement

1.5.2. Normalizing quality measures among payers

Owner: MPW
Resources Needed: OHPI Staff
Potential Funding Resources: Payers
Other Inputs needed: None identified

1.6. Goal 6

1.6.1. Continued engagement of the Multi-Payer Workgroup

Owner: MPW
Resources Needed: OHPI Staff and logistics support
Potential Funding Resources: General funds and/or grant funding
Other Inputs needed: None identified

1.7. Goal 7

1.7.1 New Stakeholder Advisory Body

Owner: MPW
Resources Needed: Charter, business model, OHPI staff support, stakeholder engagement, funding
Potential Funding Resources: Potential grant and other funding options are being researched
Other Inputs needed: None identified

1.7.2. Healthcare transformation infrastructure and support

Owner: OHPI
Resources Needed: Funding, staffing, finalized description of roles and functions
Potential Funding Resources: Potentially state funds, and state and federal grants
Other Inputs needed: None identified.

C.2. Governance and Stakeholder Engagement

Multi-Stakeholder Advisory Body

Idaho attributes much of its success to the value it places on stakeholder input and the guidance and expertise stakeholders have provided through the IHC and its workgroups. It is, therefore, not surprising that stakeholders will continue to advise Idaho's healthcare transformation post-SHIP.

At the May 2018 IHC meeting, the IHC established the Transformation Sustainability Workgroup and charged the workgroup to "develop recommendations for a post-Statewide Healthcare Innovation Plan (SHIP) Transformation Sustainability Business Case, including the development of a draft charter for a multi-stakeholder advisory body for the ongoing healthcare delivery transformation efforts." In addition, the IHC provided further instruction to the workgroup to:

> *"…deliver a draft charter for the new multi-stakeholder advisory body to the full IHC, which will include recommendations regarding the following:*
>
> — *Roles and responsibilities of the Advisory Board, to include scope of the activities to be overseen by the new body*
> — *Any specific goals, initial deliverables, milestones and timeframes*
> — *Membership composition, including number of members and their representation categories, selection of a chairperson process, and terms of membership*

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- *Meeting frequency and what constitutes a quorum*
- *Ability to establish advisory or technical subcommittees as needed*

The Transformation Workgroup began meeting immediately after being established by the IHC and established an aggressive meeting schedule of every two to three weeks in order to accomplish the important tasks of creating a charter and business case for a post-SHIP multi-stakeholder advisory body.

The draft charter will go to the IHC for review and approval on September 12, 2018. At that time, the IHC is expected to approve the charge and functions of the new advisory body developed by the workgroup and outlined below:

- CHARGE: Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.
- FUNCTIONS:
    - Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
    - Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
    - Serve as a convener of a broad-based set of stakeholders.
    - Identify delivery system barriers that are preventing healthcare transformation, prioritize, and recommend solutions.
    - Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
    - Recommend and promote strategies to reduce overall healthcare costs.
    - Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.
    - Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
    - Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.
    - Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
    - Promote efficiencies in the collection, measuring, and reporting of quality metrics.

The proposed name of the new advisory body, the Healthcare Transformation Council of Idaho, will also be considered and likely approved at the September 2018 IHC meeting. Recommendations regarding membership on the Council, including chair and co-chair, are being developed by the workgroup and will be presented to the IHC at the September and October meetings. December 2018 will be the final meeting of the IHC and the new Council will convene its first meeting in January 2019.

The workgroup was also charged to develop a business case for the Council. The workgroup will conclude development of the business case and present it to the IHC for review and approval in November 2018. As instructed by the IHC, the business case created will:

> *"…outline the needed next steps to advance the healthcare delivery system transformation efforts in Idaho that i) focus on whole-person care and ii) align business practices to drive the statewide goal*

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of achieving the triple aim of improved health, improved healthcare and lower costs for all Idahoans. This will build on what SHIP has accomplished to date and focus on the following:

- *Further implementation of payment models that reward the value of care and bend the cost curve*
- *Improve data exchange and analytics to both support care coordination and monitor quality*
- *Align common quality performance measures across payers*
- *Continue to evolve practices as they continue to move to new models of care, including the patient-centered medical home and regional care organizations."*

OHPI

OHPI is the backbone of Idaho's healthcare transformation infrastructure. A small but expert staff has coupled their delivery and payment transformation system knowledge and skills with strong, solid relationships with payers, providers, and stakeholders to successfully provide essential technical assistance, support, and monitoring of Idaho's SHIP. IDHW, the IHC, and other stakeholders recognize the critical importance of continued infrastructure support to maintain the progress made through SHIP and to continue to advance transformation of the State's delivery and payment system.

As Idaho's transformation continues, there will be both existing and new activities that require staffing and support by OHPI. For example, behavioral health integration is seen as an important component of the next phase of Idaho's transformation, and OHPI staff will be working closely with IDHW behavioral health, the new advisory Council, and other stakeholders to support advancement of integration. Other focus areas for transformation will be identified as the new Council begins its work in January 2019 and OHPI, as the staff for the Council, will be on-hand to provide research, technical assistance, assist with strategic planning and work plan development, and other needed infrastructure support. IDHW is working to secure funding for OHPI staff in order for this support to continue post-SHIP; this includes a budget request to the Governor and legislature.

Because of the important role that IDHW plays in Idaho's healthcare system transformation, OHPI is also well-positioned to serve as the liaison between IDHW's strategic healthcare transformation planning and efforts and community and statewide partners. Through SHIP, OHPI has developed strong relationships with community and statewide partners and is very knowledgeable about delivery and payment system changes taking place at the clinic and payer level. Post-SHIP, OHPI staff will use their knowledge and relationships to help align transformation system efforts across public and private healthcare systems, share local and national best practices, and connect providers to resources available through IDHW and other State resources.

C.3. Challenges and Risks

A significant challenge to Idaho's post-SHIP activities to advance healthcare transformation is the lack of funding to support needed infrastructure. Staffing of the new stakeholder advisory council and its workgroups and continued technical assistance and support for delivery system transformation is necessary not only for transformation to continue but also to avoid losing the momentum and progress made through SHIP. As noted above, IDHW is working to secure funding for OHPI as the OHPI staff has the expertise and relationships needed to successfully provide infrastructure and support. A legislative budget request is being developed to secure funding for ongoing support at the regional level for PCMH transformation. Research is being conducted to determine whether local, State, or Federal grants could

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support continued transformation efforts. Without financial support, there is a real and significant risk that Idaho's transformation will decline and stall.

C.4. Alignment with Other State and Federal Programs

To promote alignment with other State and Federal programs during SHIP, IDHW, and its stakeholders created and maintained an inventory of statewide QI initiatives present in SHIP cohort clinics. In addition, IDHW has sought opportunities for aligning SHIP with other State and Federal initiatives. Some more recent examples of this work are:

- Working with Qualis regarding supporting rural clinics in compliance with the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015.
- Working with the Idaho Oral Health Alliance to promote oral health integration among SHIP cohort clinics.
- Continuing to partner with Medicaid's Healthy Connections program.
- Farley Policy Center Project for Behavioral Health Integration in primary care.

In the remainder of the grant period, OHPI will identify any new or additional opportunities to partner or align with State and Federal programs and engage partners, as appropriate. After SHIP, the continued identification of related State and Federal initiatives will become even more important to stretch limited resources and find additional resources to support the next phase of healthcare transformation. Leveraging the experience gained and relationships built through SHIP, this could continue to be an appropriate role for OHPI moving forward.

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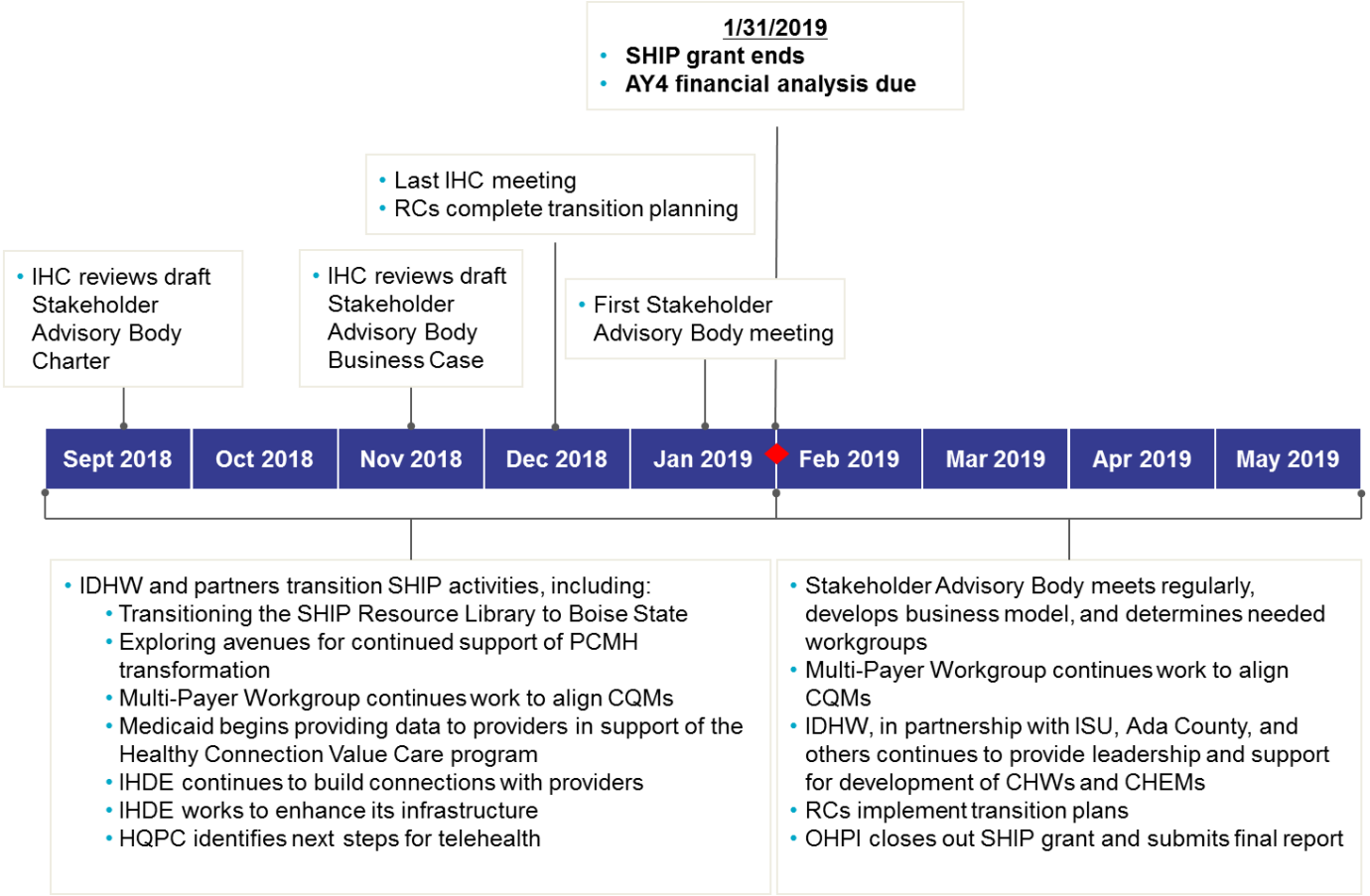
D.Transition Timeline

Moving forward, OHPI and its partners will work to implement next steps through the Post-SHIP transition. The timeline below depicts the major activities and milestones that are expected to occur over the next nine months.

Figure 1 – Timeline



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Statewide Healthcare Innovation Plan

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

Sustainability Initiatives

SHIP Videos

View the videos below to learn about Idaho's healthcare transformation successes and why efforts need to continue?

https://youtu.be/GJls9H6NcWs - Video 1 - What was the SHIP project all about?

https://youtu.be/slBPgg47NSk - Video 2 – Why is healthcare transformation still needed?

https://youtu.be/M75ZaQlQdXI - Video 3 - What was the SHIP operations team role?

Office of Healthcare Policy Initiatives (OHPI)

Idaho has the chance to be a leader in affordable healthcare.

Office of Healthcare Policy Initiatives

Goal: *Make healthcare affordable and accessible by moving from a fee-for-service system to value-based reimbursement*

SHIP goal (the past): *Build an infrastructure that allows primary care clinics to thrive in a new value-based payment system.*

SHIP accomplishments:

- ✓ 164 Primary Care clinics adopted the Patient Centered Medical Homes (PCMH) model of care.
  - ➢ These new clinics mean that 2/3 of Medicaid participants are served by advanced primary care clinics.
  - ➢ 120 new clinics connected to the Idaho Health Data Exchange.
  - ➢ Over 700,000 Idahoans' healthcare has been positively impacted by these clinic transformations.
- ✓ Produced a bend in the Idaho cost curve of **$213.6M** over four years.
- ✓ Established 12 additional telehealth programs statewide.
- ✓ OHPI provided leadership to public and commercial payers so payment data could be used to track outcomes.

HTCI goal (the future): *Expand payment reform to hospitals/specialists and solve the unique rural healthcare delivery problems.*

Healthcare Transformation Council of Idaho (HTCI) functions:

- ✓ Accelerate the shift to paying for outcomes rather than paying for volume.
- ✓ Build infrastructure that allows payment reform to be sustainable for providers.
- ✓ Expand the sharing of data to prevent unnecessary expenses and improve health outcomes.
- ✓ Harness the enthusiasm from payers and providers to create initiatives that execute on Idaho solutions.

OHPI (the catalyst): *The OHPI ensures the initiative to transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs is achieved.*

OHPI's vision*:*

- Only the department has the trust to get competing payers and providers to convene to agree on necessary changes and then allow themselves to be measured against a goal.
- The changes necessary to deliver an affordable healthcare system to our citizens require a fundamental shift in the business models, clinical models, and financial models for payers and providers.

OHPI's role in transformation:

- ✓ Use the OHPI staff's acquired expertise in researching and writing grants to assist the HTCI in obtaining Public/Private funding for initiatives.
- ✓ Support the Healthcare Transformation Council of Idaho and the workgroups that provide subject matter expertise.
- ✓ Offer technical assistance to providers interested in PCMH transformation.
- ✓ Hold payers and providers accountable by tracking the money saved and increase in percentage of payments moved to value-based arrangements.

Office of Healthcare Policy Initiatives
Visioning Session
December 7, 2018
9:00 a.m. – 4:00 p.m.
Meeting Summary

On Friday, December 7, 2018, staff from the Office of Healthcare Policy Initiatives (OHPI) met to discuss OHPI's transition from a federally-funded program supporting the State Healthcare Innovation Plan to a state-supported office that focuses on healthcare transformation across Idaho. Meeting objectives included discussing status of the OHPI budget request and other funding considerations for the new phase; identifying OHPI support functions for HTCI; and brainstorming new initiatives or functions OHPI can support or lead moving forward.

Budget Update

- The draft budget was submitted to the Governor's Office, as well as the business case/budget justification. The Governor's Office requested that the budget be restructured, with less funding being provided by the state. This review process is slightly more complex given the administration transition.
- There are other budget requests being submitted by the University of Idaho and the public health districts to support healthcare transformation initiatives. It will be critical to distinguish OHPI's role and services from these initiatives in order to show why OHPI is necessary and deserving of funding.
- Representation on the Joint Finance-Appropriations Committee is still to be determined, but will likely influence the review and approval process.
- Approval to receive grant funding is easier to obtain, and grant dollars have already been built into the budget. There are also additional resources to pull from within the Department. With regard to grants, there has been communication from leadership that nothing is necessarily off the table, but approval will still be required.
- While the Triple Aim will still guide healthcare transformation efforts, there needs to be more definitive goals. Currently, the goal is for 80% of healthcare reimbursements to be value-based rather than fee for service.
- In order to demonstrate OHPI value, there will need to be specific initiatives identified beyond support for HTCI, as well as metrics to capture outcomes. Both internal and external talking points will need to be developed in order to explain these different OHPI functions.
- There are also opportunities for OHPI to provide cross-divisional support within DHW. One consideration is that the Division of Public Health is involved in numerous population health initiatives that may become less necessary as healthcare reform becomes more successful.

Current Activities and Coordination

- HTCI will identify three initiatives they would like to focus on, but meetings do not start until February. Priorities may take some time to fully identify, but "pain points" could be discussed early.
- OHPI will need to manage staffing abilities and capacity through the close out of SHIP and transition until the funding landscape is fully understood.

Grant Funding Discussion

OHPI staff brainstormed areas to focus initial research for grant and other funding opportunities.

- There may be some legacy topics identified through the review of PCMH activities during closeout. Data may show where there was success, and where there were challenges that still need to be addressed.
- Mentorship and patient engagement are two topics garnering attention that may be ripe for support.
- Track national trends and current federal policy and determine if there is a connection to Idaho issues.
- Foundations may have funding available tied to specific initiatives or priorities.
- Grant applications will likely need to be tied to either an HTCI initiative or a major initiative of the Department.
- As capacity allows, a funding analysis template and proposal template will be developed.
    - Look to other states for examples of templates
    - Templates should be customizable and include a risk analysis
- Where does funding to support HTCI initiatives come from if OHPI does not secure grants?
    - We don't have an answer on this yet
    - Timing and syncing of grant funding will be a Department issue
- Other topics to consider pursuing
    - Social determinants of health
    - Opioid Addiction/Substance Use
    - Work force development
- Funding Sources
    - General funds
    - Grants
        - Apply, implement, manage
        - Rank based on readiness
        - Topic specific
        - New = weak
    - Healthcare infrastructure funding
    - Seek out funding that supports efforts to address challenges SHIP faced
        - Data/interoperability
        - Payment reform
    - Foundations
    - Fee for service

Communication Needs/Gaps

Throughout the meeting, OHPI staff identified communication needs and topics they would like to develop a plan to address at future meetings.

- Need consistent language describing transition and future of OHPI by February 1
- Need to gain support from other division administrators by July 1
- Need to develop message regarding internal capabilities beyond administration of contracts

    - Creditability comes from experience
    - Strong project management framework and skills
    - Could provide services that generate revenue
- Develop perception of OHPI as a trusted advisor

<u>OHPI Services and Functions</u>
Staff identified anticipated services and functions in support of HTCI, as well as initiatives they are interested in pursuing independent of HTCI.

HTCI and Work Group Functions

- Administrative prep and planning for HTCI and Work Group meetings
    - Leadership Development and Membership Recruitment
    - Keep record of attendance
    - Draft meeting minutes
    - Develop and provide member orientation
    - Develop documents and supporting materials
    - Manage logistics
    - Provide technology support/coordination
- Respond to meeting action items and follow up
- Executive planning
    - Regular planning calls with Dr. Epperly and Dr. Pate
- Support (3) work groups
    - Meeting facilitation
    - Additional coordination and logistical support
- Communication with members
- Member support and coordination
- Survey members
- Develop, collect and evaluate metrics
- Manage website/repository
- Legal support to the Attorney General's office
- Federal research and analysis
- Annual Reports

Potential New Functions and Services

Convener/Collaborator

- Serve as a neutral convener – Collaborator – Supporter of public + private partnerships
- Break down silos and develop mechanisms for fully integrating health throughout communities
    - Convene people and resources to discuss and problem solve issues related to social determinants of health
- Centralized hub for research and data integration within DHW
    - Support coordinated funding and programming

    - Aggregate data and demonstrate outcomes
    - Help interpret and utilize data
    - Help connect and funnel resources
- Provide a statewide coordination and support role
    - Different level of coordination and types of activities compared to PHDs
    - Need to distinguish the need and value of statewide efforts
- Subject matter experts (in certain realms)
- Cross-state collaboration

Services Associated with Specific Initiatives

- Conduct and support environmental scans
- Continue to identify, assess, and evaluate gaps/needs in Idaho and develop opportunities for addressing them
    - Obesity
    - Opiods
    - Access to care in rural, migrant, and marginalized communities
    - Patient engagement
    - Mentorship
    - Workforce development
- Incubate ideas/initiatives and then embed them into other Divisions; add capacity to divisions

Ongoing Services

- Organizational Change Management (internal and external services)
    - Training
    - Support
- Grant application and implementation support
- Program management services
- Health IT coordination
- Partner with office of communications
- Consumer/Patient advocacy and education
    - Healthcare 101
    - Navigating the system
- Strategic planning for healthcare initiatives

Healthcare Transformation Council of Idaho (HTCI) Successor Organization to the Idaho Healthcare Coalition (IHC)

Multi-Stakeholder Advisory Body Charter

- IHC established and tasked the Transformation Sustainability Workgroup to:
  - Develop a charter for a new multi-stakeholder advisory body
  - Develop a business case for the new advisory body
- New advisory body to convene in January 2019

Charter

Name

Healthcare Transformation Council of Idaho

Charge

Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.

Functions

- Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
- Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
- Serve as a convener of a broad-based set of stakeholders.
- Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.
- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
- Recommend and promote strategies to reduce overall health care costs.

Functions

- Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.
- Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- Promote efficiencies in the collection, measuring, and reporting of quality metrics.

Subcommittees/Working Groups

- The Council may establish advisory or technical committees as needed to focus on specific and timely efforts that directly impact the achievement of Idaho's healthcare transformation activities.

Membership and Composition

- Payers
- Primary care clinicians
- Hospital representatives
- Medical/Surgical Sub-Specialist
- Consumer representative
- Representative from Idaho's Public Health Districts
- Representative from each of the following organizations:
  - Idaho Department of Health and Welfare
  - Idaho Hospital Association
  - Idaho Medical Association
  - Idaho Primary Care Association
  - Idaho Academy of Family Physicians
- Up to 3 At-Large members

Member Selection & Terms

- Governor appointed members and chairs
- Staggered terms:
  - Initial appointments are for 3 years, 4 years, & 5 years
  - Ongoing appointments for 3 years
  - Terms can be renewed for up to two 3 year terms
- Individuals from the following organizations are not subject to term limits:
  - IDHW
  - Idaho Hospital Association
  - Idaho Medical Association
  - Idaho Primary Care Association
  - Idaho Academy of Family Physicians

Expectations of Members

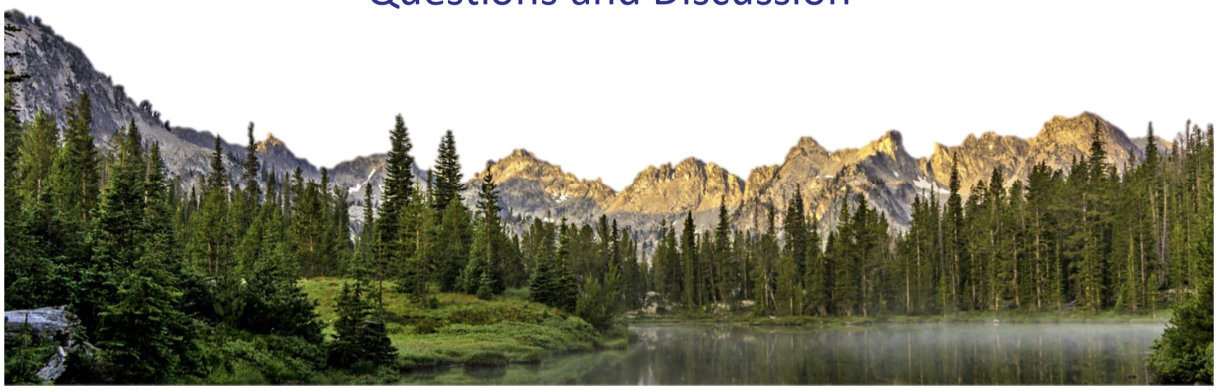
- Representatives from organizations must be in a senior leadership position. If the representative is not the CEO/President from the organization, the individual must be a subject matter expert, on the entities' senior leadership team, and in a decision-making position.
- Members must participate in 75% of all meetings scheduled within the calendar year.
- Members' designee may participate in up to 25% of the meetings scheduled within the calendar year.
- Members are encouraged to send the same designee to the meetings instead of different individuals.

Meetings and Staffing

- The Council will meet at least quarterly.
- Meetings will be public.
- IDHW will sponsor the Council and the IDHW Office of Healthcare Policy Initiatives will serve as staff to the Council.

Statewide Healthcare Innovation Plan

Questions and Discussion



Business Case
for the
Healthcare Transformation Council of Idaho

To successfully transform Idaho's healthcare system, we need strategies that are based on the input of multiple stakeholders who have a thorough understanding of the values and culture of our State. This is the mission of the Healthcare Transformation Council of Idaho (HTCI). **The HTCI convenes Idaho stakeholders with a wide range of healthcare delivery system expertise and experience, who work together to champion accessible, high-quality, affordable health.** The Council is comprised of payers, providers, healthcare associations, government agencies, and a healthcare "consumer" community member. Together, the Council members embrace Idaho's values and culture in their work to transform our State's health and healthcare through Idaho solutions.

Background and Vision: Idaho's Healthcare Delivery System is Ready for Change

For decades, Idaho's healthcare system has been focused on quantity, not quality. Healthcare costs are straining the budgets of the State, private businesses, and Idaho families. Healthcare services are fragmented and often duplicated. Cost of care does not always equate to an improved or desired health outcome. Our State faces severe workforce shortages across healthcare professions. The result is ever-rising healthcare costs and an unequal distribution of healthcare resources across the State that creates inequities in healthcare access and health outcomes.

In 2007, Idaho stakeholders initiated a vision to shift the healthcare delivery system from rewarding volume to rewarding value, which would improve access to care, decrease costs, and promote better health. From 2013 to 2018, stakeholders developed and implemented this vision from the roadmap described in the State Healthcare Innovation Plan (SHIP). Through a federal State Innovation Model (SIM) grant, stakeholders evolved and expanded the team-based model of primary care — the Patient-Centered Medical Home (PCMH). The PCMH works by coordinating care across teams of providers and addressing multiple needs of patients and their families to improve their health. SHIP also worked to connect entities in the medical-health neighborhood and enhanced critical health information technology infrastructure. Idaho's SHIP efforts successfully lowered the cost of healthcare by $93 million over four years.

This success is due, in part, to understanding the values and culture of our State, setting realistic expectations, and garnering the commitment of healthcare system stakeholders and innovative leaders. As Idaho plans for the next stages of change, the thoughtful, realistic approach embraced by SHIP will continue through the work of the HTCI. The approach and strategies of the Council will identify barriers and opportunities for change, promote strategies to address obstacles, implement new activities to further advance transformation, and, as always, maintain flexibility at every level to shift strategies when needed.

HTCI Membership

The HTCI will allow all stakeholders to come together to sustain the good work underway and continue healthcare transformation. The HTCI's 25 stakeholder members and co-chairs are appointed by the Governor. The Council members will apply their broad and varied expertise in health and healthcare delivery to guide Idaho's healthcare transformation. Members include:

- **Payers.** HTCI membership includes three of Idaho's private payers, as well as self-funded plans and Medicaid. HTCI will engage payers as strong partners in Idaho's efforts for delivery system

transformation and will provide a venue to coordinate the payer community within the dynamic and changing healthcare finance environment.

- **Clinicians**. HTCI will include representatives from medical/surgical sub-specialists, behavioral health, and primary care who bring the key "on-the-ground" views of clinicians who see patients and their families every day.
- **Hospitals.** The voice of the hospitals, including one each from a health system, a non-critical access community hospital, and a critical access hospital, will be an important component of the HTCI.
- **Associations.** Idaho's medical association, hospital association, nursing association, primary care association (which represents community and rural health centers) and family physicians' academy will bring additional perspectives from a variety of clinical settings throughout the State.
- **Public health districts.** A representative from the local public health districts will provide expertise in community health and the behaviors and factors that significantly influence a person's or populations' health status.
- **Consumer member.** Brings the person-centered perspective of those seeking care and navigating our "fractured system." Their presence helps ensure that solutions will benefit all residents of Idaho.
- **Idaho's Department of Health and Welfare (IDHW).** IDHW is a key member of HTCI, as well as a sponsor of its work. IDHW's strategic objectives align with the work of the Council to transform Idaho's healthcare delivery system to promote healthier Idahoans.

HTCI Works to Improve Outcomes and Care for all Idahoans

- The HTCI will develop strategies to promote health equity for all Idahoans, not just Medicaid participants or those with chronic conditions or complex health needs. Using accurate and timely data and information, the initiatives will be outcome-oriented and time-defined. The HTCI's work will: Span across payers, recognizing that the same healthcare delivery system serves all Idahoans across Medicaid, Medicare, and private payers. The same system must also serve the uninsured.
- Examine how to influence environmental, cultural, and social factors that will improve people's health outside the clinic or hospital walls by integrating the work of the local health districts and State public health into the delivery system transformation.
- Address Idaho's healthcare workforce shortages through new workforce models involving community health, emergency medical services and telehealth. Improving the community-based healthcare workforce will enable Idahoans to receive quality care and stay healthier, which will reduce the need for expensive emergency room visits or institutional services.

HTCI's Functions

The HTCI will:

- Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
- Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
- Serve as a convener of a broad-based set of stakeholders.
- Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.

- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
- Recommend and promote strategies to reduce overall healthcare costs.
- Utilize accurate and timely data to identify strategies and drive decision-making for healthcare transformation.
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
- Promote whole-person integrated care, health equity, and recognize the impact of social determinants of health.
- Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- Promote efficiencies in the collection, measuring, and reporting of quality metrics.

How HTCI Will Conduct its Work

The Council will engage with healthcare stakeholders and experts to build partnerships that drive organizational and statewide policy changes to achieve healthcare transformation. Council members will also provide in-kind support through their participation.

Starting in 2019, HTCI will hold public meetings at least quarterly and will produce regular reports that will be important in future iterations of healthcare policy and programs for Idaho. Staffing and administrative support for the Council and its workgroups will be provided by the IDHW's Office of Healthcare Policy Initiatives (OHPI). This will involve providing support for HTCI meetings, gathering data, policy, and program information, and providing support for other activities to ensure the HTCI is able to assess and advise Idaho transformation efforts.

The HTCI members will identify strategies and initiatives, including any needed workgroups, and will identify success measures. Regular communication by HTCI will ensure transparency and report on the progress of Idaho's delivery system transformation.

The Council will also assess the sources of support for the work, which will involve seeking private and/or government investments, grants, shared savings, and other possible funding streams. Additional advisory or technical committees may be established as needed to focus on specific healthcare transformation efforts. While some efforts may require funding or legislative actions, some approaches might require collaboration and cooperation across the delivery system. By involving representatives from across the healthcare delivery system, the HTCI will have the bandwidth to drive the needed changes.

Everyone around the HTCI table has a stake in the success of transformation.

Statewide Healthcare Innovation Plan

Feedback Matrix 1 of 4

Function	Feedback
Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.	**Workgroup Survey (Nov 2018)** • Promote collaboration in the healthcare community. • CHOICe model development.
	IHC Survey (March 2018) • Having common, aligned goals was identified as a key to future transformation.
	PCMH Sustainability Workshop (Jan 2018) • Build on the current SHIP infrastructure and business model. • Build on our work in value-based reimbursement. • Build alignment in direction, goals, metrics and policy. • Build our ability to educate and communicate with practices and consumers.
Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.	**Workgroup Survey (Nov 2018)** • Evaluation of efforts to transform healthcare to a value-based system.
	IHC Survey (March 2018) • Stakeholder group helps accelerate the process of transformation, holds stakeholder neutrality and anti-trust protection, is a convener of variety of stakeholders and perspectives to drive transformation, is needed to drive and sustain partnerships. • The following aspects worked well during SHIP: providing a forum for developing common goals and leadership for transformation, collaboration and coordination between providers and payers, interest groups, Data group and Multi-Payer group.
	PCMH Sustainability Workshop (Jan 2018) • Build on the current SHIP infrastructure and business model • Assess and prioritize what parts of infrastructure should remain. • Extend IHC existence.
Serve as a convener of a broad-based set of stakeholders.	**Workgroup Survey (Nov 2018)** • Communication among payers, providers, and stakeholders. • Promote collaboration in the healthcare community.
	IHC Survey (March 2018) • Continued collaboration was identified as a key to future transformation.
	PCMH Sustainability Workshop (Jan 2018) • Build on the current SHIP infrastructure and business model. • Assess and prioritize what parts of infrastructure should remain. • Extend IHC existence.

Statewide Healthcare Innovation Plan

Feedback Matrix 2 of 2

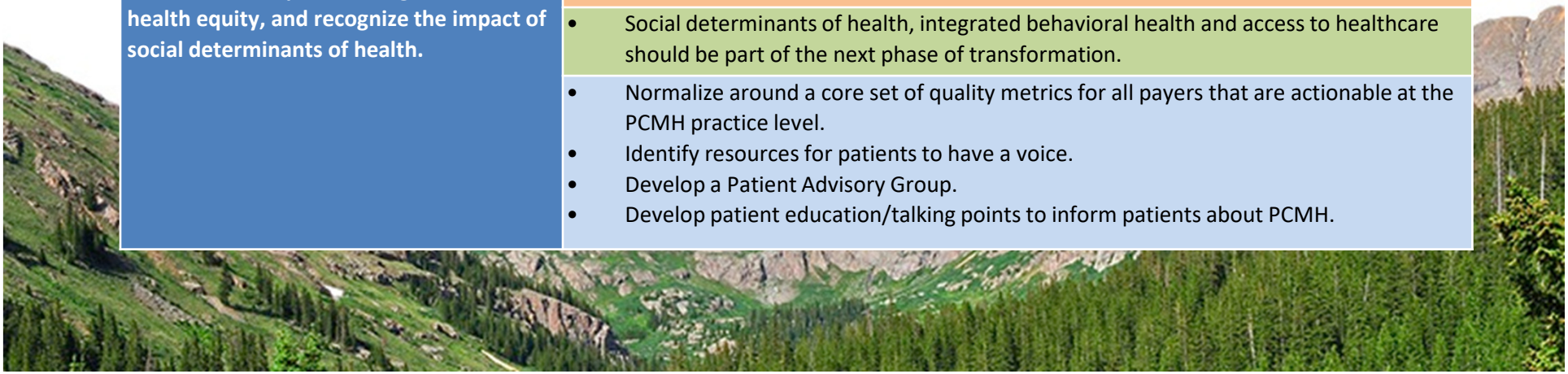
Function	Feedback
Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.	**Workgroup Survey (Nov 2018)** • Promote collaboration in the healthcare community.
	IHC Survey (March 2018) • Next phase of transformation should focus on: Medical-Health Neighborhood, patient-centered care, PCMH training and technical assistance. • Respondents felt that access to healthcare, integrated behavioral health and social determinants of health should be part of next phase of transformation.
	PCMH Sustainability Workshop (Jan 2018) • Integration of the medical neighborhood including specialists and hospitals. • Health IT viability and interoperability including statewide data to clinical information and claims.
Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.	**Workgroup Survey (Nov 2018)** • Payment reform. • Evaluation of efforts to transform healthcare to a value-based system.
	IHC Survey (March 2018) • Next phase of transformation should focus on payment transformation/reform.
	PCMH Sustainability Workshop (Jan 2018) • A standardized approach to incentive payments. • Not discussing price, but rather discussing adjustment of where dollars are being spent.
Recommend and promote strategies to reduce overall health care costs.	**Workgroup Survey (Nov 2018)** • Payment reform.
	IHC Survey (March 2018) • Respondents felt that payment transformation should be a focus of continued development. • Respondents felt that overall control of healthcare costs including specialty care, pharmaceuticals, and hospitals/ancillary care should also be part of the next phase of transformation.
	PCMH Sustainability Workshop (Jan 2018) • A standardized approach to incentive payments. • Not discussing price, but rather discussing adjustment of where dollars are being spent.

Statewide Healthcare Innovation Plan

Feedback Matrix 3 of 4

Workgroup Survey (Nov 2018)	IHC Survey (March 2018)	PCMH Sustainability Workshop (Jan 2018)

Function	Feedback
Utilize accurate and timely data to identify strategies and drive decision-making for healthcare transformation.	• Secure data collection/storage, meaningful analysis, and functional exchange of information.
	• Respondents believed that HIE development to support data exchange and analytics should be accomplished during the next phase of transformation.
	• Normalize around a core set of quality metrics for all payers that are actionable at the PCMH practice level.
Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.	• Promote collaboration in the healthcare community. • CHOICe model development.
	• Social determinants of health and access to healthcare should be part of the next phase of transformation.
	• Build alignment in direction, goals, metrics and policy. • Standardize paths of support for localized providers to local/state leadership, and local/state leadership to local providers.
Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.	• Training and support for providers and clinics.
	• Social determinants of health, integrated behavioral health and access to healthcare should be part of the next phase of transformation.
	• Normalize around a core set of quality metrics for all payers that are actionable at the PCMH practice level. • Identify resources for patients to have a voice. • Develop a Patient Advisory Group. • Develop patient education/talking points to inform patients about PCMH.



Feedback Matrix 4 of 4

Workgroup Survey (Nov 2018)	IHC Survey (March 2018)	PCMH Sustainability Workshop (Jan 2018)

Function	Feedback
Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.	• N/A
	• N/A

	• Build our ability to educate and communicate with practices and consumers by:
	  • Identifying members for a Workforce Training Task Force.
	  • Establishing relationships with all academic entities to establish training for anyone working in the global healthcare system.
	• Add value-based reimbursement content to medical and healthcare professionals training constructed around normalized metrics.
	  • Create an education sub-committee.

Orientation Overview

Objective 1: Provide background on Idaho's transformation efforts to date

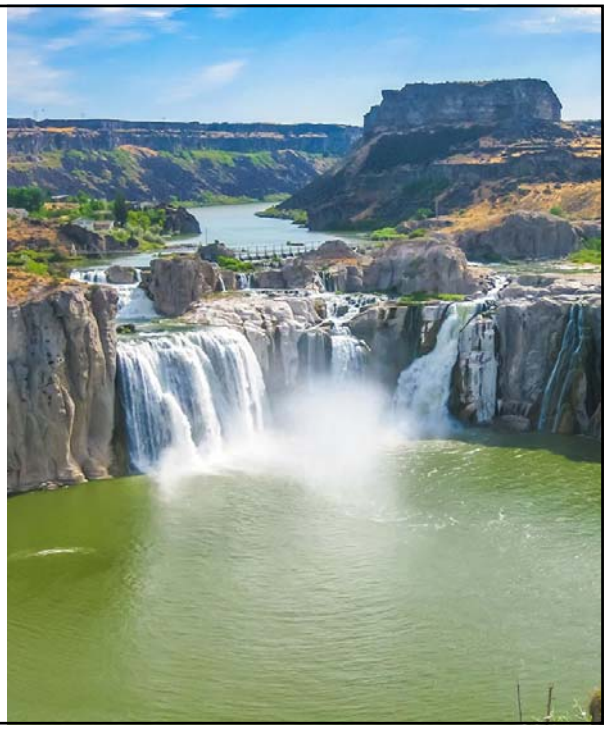
Objective 2: Provide an overview of the Healthcare Transformation Council of Idaho (HTCI)

Objective 3: Review membership expectations and logistics

Objective 4: Introduction to Office of Healthcare Policy Initiatives (OHPI) and its staff members

Objective 1:

Provide background on Idaho's transformation efforts to date



Background

HTCI
Healthcare Transformation Council of Idaho

2007
Gov. Otter convenes Health Care Summit

2008
Gov. Otter tasked Select Committee on Health Care

2008
Idaho Health Data Exchange established

2010
Idaho Medical Home Collaborative established

2013
Idaho awarded CMMI Planning grant to develop SHIP

2014
Gov. Otter establishes Idaho Healthcare Coalition (IHC)

2015
Idaho begins 4-year CMMI Test Model Grant implementing SHIP

2019
SHIP concludes; HTCI begins

for more information please visit www.SHIP.Idaho.gov

Statewide Healthcare Innovation Plan

GOAL 1:
Transform practices into PCMHs

GOAL 2:
Improve care coordination through EHRs and health data connections

GOAL 3:
Establish 7 regional collaboratives to support integration with the medical-health neighborhood

GOAL 4:
Improve rural patient access through virtual PCMHs

GOAL 5:
Build a statewide data analytics system

GOAL 6:
Align payment mechanisms

GOAL 7:
Reduce overall health-care costs

for more information please visit www.SHIP.Idaho.gov

Statewide Healthcare Innovation Plan

What is the SHIP and what did it accomplish?

https://youtu.be/GJls9H6NcWs

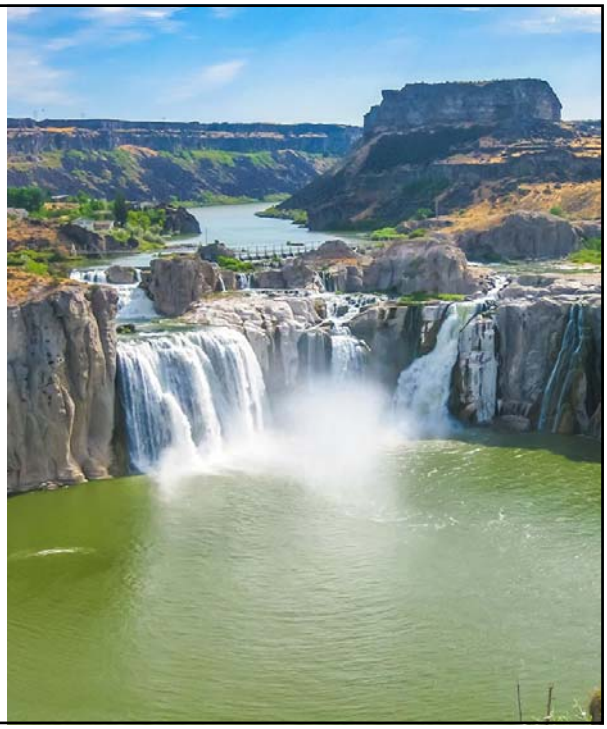
Idaho Healthcare Coalition (IHC)

- Reviewed progress of SHIP in implementing initiative goals
- Provided subject matter expertise for the implementation of plan deliverables
- Chartered workgroups and advisory groups for specific activities
- Enhanced member, stakeholder, and public understanding of the system change through educational topics

for more information please visit www.SHIP.Idaho.gov

Objective 2:

Provide an overview of the Healthcare Transformation Council of Idaho (HTCI)



Aligning with Gov. Little's vision

"…we should … do what we can to make affordable, accessible, quality healthcare available to all Idahoans."

"We must pursue strategies that contain healthcare costs. I intend to continue developing Idaho solutions that bring healthcare costs down for all Idahoans."

Governor Brad Little

State of the State Address

January 7, 2019

Why is healthcare transformation still needed?

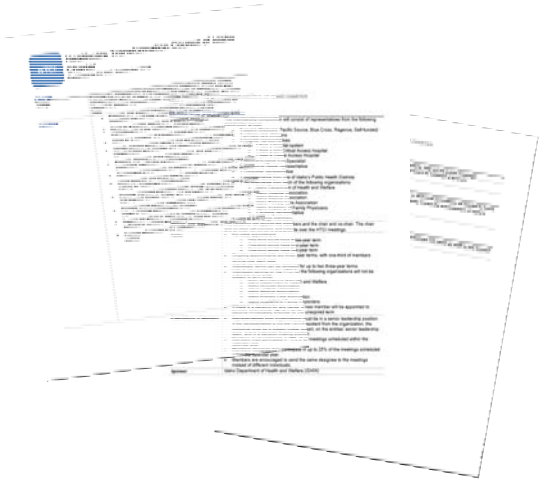
https://youtu.be/slBPgg47NSk

HTCI Mission

- Convene Idaho stakeholders with a wide range of healthcare delivery system expertise to work together to champion accessible, high-quality, affordable healthcare
- Identify opportunities and barriers for change, and develop strategies and activities to address obstacles and advance healthcare transformation
- Examine how to influence environmental, cultural, and social factors that will improve people's health

HTCI Charter

- The governor will appoint members and co-chairs (Proposed)
- The co-chairs will convene and preside over the HTCI meetings



Charge:

Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.

HTCI Functions

- Identify opportunities for innovation that will help shape the future of healthcare
- Utilize accurate data to identify strategies and drive decision making for healthcare transformation
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health
- Support the efforts in Idaho to provide a workforce that is sufficient in numbers and training to meet the demand
- Serve as a trusted source to drive improvements in the healthcare delivery system
- Identify barriers that are preventing transformation and recommend solutions
- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation
- Recommend and promote strategies to reduce overall health care costs
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans

Governance and Workgroups

- As initiatives are prioritized, selected and resourced, HTCI will provide the framework and monitoring of implementation and healthcare system transformation
- Workgroups will be needed at various times to include expertise and stakeholders beyond the ranks of HTCI
  - Each workgroup will establish a charter, deliverables, timeline and membership
  - HTCI approval of the charter is required
  - Routine updates to HTCI are expected from the Chair or co-chair of the workgroup
  - As key deliverables are produced, the workgroup chair/co-chair will work with the OHPI team and co-chairs of HTCI to get these on the meeting agenda
- If there is a specific topic you wish to see on the agenda for HTCI, simply reach out to the OHPI team; it will be included in routine planning meetings with the co-chairs of HTCI

HTCI Membership Composition

- Two co-chairs (Proposed)
- **Payers**: three of Idaho's private payers, as well as a self funded plan and Medicaid
- **Clinicians**: representatives from primary care, behavioral health, and medical/surgical sub-specialties
- **Hospital representatives**: from a health system, a community hospital, and a critical access hospital
- **Association representatives**: Idaho's medical association, hospital association, nursing association, primary care association and family physicians
- A **public health district** representative
- A **consumer member**
- A representative from Idaho's Department of Health and Welfare (**IDHW**)
- At-Large members

2019 HTCI Membership Structure (Proposed)

- **Co-Chairs**
  - Ted Epperly, Family Medicine Residency of Idaho
  - David Pate, St. Luke's Health System
- **Payers, Medicaid, Self-Funded**
  - Matt Bell, PacificSource Health Plans
  - TBD, Regence BlueShield of Idaho
  - Drew Hobby, Blue Cross of Idaho
  - Matt Wimmer, Idaho Division of Medicaid
  - Kathy Brashear, Self-Funded Insurance Plans
- **Primary Care Clinicians**
  - Keith Davis, Shoshone Family Medical Center
  - Scott Dunn, Family Health Center of Sandpoint
  - Karl Watts, St. Alphonsus Medical Group
- **Behavioral Health Representative**
  - Andrew Baron, Terry Reilly Health Services
- **Hospital Representatives**
  - Patt Richesin, Kootenai Care Network
  - Dennis Carlson, Bear Lake Memorial Hospital
- **Medical/Surgical Sub-Specialist**
  - Mike Hajjar, St. Luke's Health System
- **Public Health District**
  - Nikki Zogg, Southwest District Health
- **Consumer Representative**
  - Denise Chuckovich
- **Organizations**
  - Lisa Hettinger, Idaho Department of Health & Welfare
  - Larry Tisdale, Idaho Hospital Association
  - Susie Pouliot, Idaho Medical Association
  - Yvonne Ketchum-Ward, Idaho Primary Care Association
  - Neva Santos, Idaho Academy of Family Physicians
  - Randy Hudspeth, Nursing Leaders of Idaho
- Up to 3 At-Large members (TBD)

Objective 3:

Review membership expectations and logistics

HTCI Membership Expectations

- Members must participate in 75% of all meetings scheduled within the calendar year
  - Attendance in person or virtual
  - Members' designee may participate in up to 25% of the meetings scheduled within the calendar year
  - Members are encouraged to send the same designee to the meetings instead of different individuals. Simply send an email before the meeting to OHPI@dhw.Idaho.gov designating your proxy for the meeting – documentation of this is essential
- The Council will meet at least quarterly; they will be public meetings
- 50% of the membership must be present to establish a quorum

HTCI Membership Terms

- For initial appointment:
  - One-third have three-year terms
  - One-third have four-year terms
  - One-third have five-year terms
- Ongoing appointments are three year terms, with one-third of members turning over each year
- Individuals' terms can be renewed for up to two three-year terms
- Individuals serving on the HTCI for the following organizations will not be subject to term limits:
  - Idaho Department of Health and Welfare
  - Idaho Hospital Association
  - Idaho Medical Association
  - Idaho Primary Care Association
  - Idaho Academy of Family Physicians
- If there is a vacancy for any cause, a new member will immediately be appointed for the unexpired term

HTCI Meeting Schedule 2019

- To begin, HTCI will meet monthly for first three months
  - Kickoff on February 21
  - March 21, 2019
  - April 18, 2019
- Change to the third Thursday every other month beginning in June
  - June 20, 2019
  - August 15, 2019
  - October 17, 2019
  - December 19, 2019
- Calendar invitations will come from the Office of Healthcare Policy Initiatives (OHPI)
  - Will include call-in and screenshare options for each meeting
- Meetings held from 3:00 – 5:00 PM Mountain Time/ 2:00 – 4:00 PM Pacific Time
  - at IDHW Central Office (450 W. State Street, Boise)

HTCI Meeting Logistics

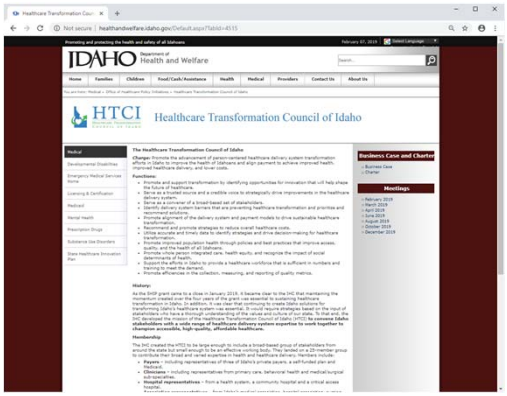
- Meetings are open to the public and will follow open meeting laws
- The physical location of each meeting will be published on the calendar, agenda and digital appointment emailed to each member. We will attempt to keep the location consistent

  Health and Welfare Central Office
  450 West State Street
  Boise, ID 83720

- Check in with Security upon arrival
- Those unable to attend in person may join virtually via webinar and phone. The meeting URL and dial-in number are published on the calendar and agenda
- Meeting materials will be loaded to the website and a link emailed to you prior to each meeting. It is recommended you review the material ahead of the meeting.
- A physical binder of material will be provided to members at the meeting. Please leave your binder after each meeting.

Website

HTCI.dhw.Idaho.gov



The Healthcare Transformation Council of Idaho webpage is hosted on the Department of Health and Welfare website under the Office of Healthcare Policy Initiatives

The page contains helpful information including:

1. Downloadable copies of core documents (charter, functions, business case)
2. Calendar of upcoming meeting (HTCI & subcommittees)
3. HTCI Meeting documents (agenda, minutes and attachments)
4. Helpful links to other resources

The page information will change and be enhanced over time. It is recommended you bookmark this page.

Objective 4:

Introduction to Office of Healthcare Policy Initiatives (OHPI) and its staff members

Office of Healthcare Policy Initiatives

IDAHO DEPARTMENT OF HEALTH & WELFARE
OFFICE OF HEALTHCARE POLICY INITIATIVES

- HTCI will be supported by the Idaho Department of Health and Welfare – Office of Healthcare Policy Infinitives (OHPI)

OHPI logistic functions include:

- Scheduling
- Email communications
- Agenda publication
- Meeting minutes
- Action item follow-up (if applicable)

Website Links

HTCI
Healthcare Transformation Council of Idaho

OHPI.dhw.Idaho.gov

The OHPI webpage is hosted on the Department of Health and Welfare website. It is the parent page of the HTCI webpage.

The page information will change and be enhanced over time. It is recommended you bookmark this page.

Questions & Feedback

Office of Healthcare Policy Initiatives
ohpi@dhw.Idaho.gov
MAIN: 208-334-0600

Individual Staff Contact Information

Casey Moyer
Program Administrator
casey.moyer@dhw.Idaho.gov
208-334-5581

Kym Schreiber
Project Manager
kymberlee.schreiber@dhw.Idaho.gov
208-334-5577

Ann Watkins
Grants Contract Officer
ann.watkins@dhw.Idaho.gov
208-334-5579

Meagan Graves
Administrative Assistant
meagan.graves@dhw.Idaho.gov
208-334-5585

Statewide **Healthcare Innovation** Plan

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

Goal 1

Sustainability Planning Workshop

Patient Centered Medical Home Sustainability Workshop

January 11-12, 2018

Mary Ann Herny
Kymberlee Schreiber

State Healthcare Innovation Plan

IDAHO DEPARTMENT OF HEALTH & WELFARE

PCMH TRANSFORMATION TEAM

Workshop Goals

- Assess where we are and where we want to be
- Identify key challenges and opportunities
- Define “sustainability”
- Select key areas of focus for 2018

PCMH TRANSFORMATION TEAM

Participant Attendees

Participant	Organization
Laura Arjona	Blue Cross of Idaho
Jeff Crouch	IDHW
Dr. Keith Davis	Shoshone Family Medical Center
Dr. Allen Dobson	Community Care of North Carolina
Dr. Ted Epperly	Family Medicine Residency of Idaho
Katie Falls	Mercer
Meg Hall	IDHW – Medicaid Healthy Connections
Jayne Josephsen	Boise State University
Charity Kennedy	PacificSource
Ashley Knight	PacificSource
Janet Reis	Boise State University
Linda Rowe	Qualis Health
Madeline Russell	IDHW-SHIP
Dr. John Schott	St Luke's Health Partners
Kymberlee Schreiber	IDHW – SHIP
Dr. Jeanene Smith	Health Management Associates
Ann Watkins	IDHW – SHIP
Dr. Karl Watts	Saint Alphonsus Medical Group
Cynthia York	IDHW – SHIP
Nikole Zogg	Southwest District Health

Observers
Jimmy Hague, Boise State Univ.
Burke Jensen, IDHW - SHIP
Janice Lung, University of Idaho
Casey Moyer, IDHW - SHIP
Joey Vasquez, IDHW - Medicaid
Shenghan Xu, University of Idaho
Julie Wall, IDHW - Medicaid

Facilitation Support
Nick Blake, Briljent
Grace Chandler, Briljent
Lisa Gouin, eHealthcare Consulting
Mary Ann Herny, Briljent
Dawn Juker, University of Idaho
Chelsea Stevenson, Univ. of Idaho
Molly Volk, University of Idaho

PCMH TRANSFORMATION TEAM

Opening Remarks and a Challenge

Dr. TedEpperly

- In five years, **Idaho's PCMH initiative has gone from infancy to adolescence to adulthood**. This energy and enthusiasm is key to continuing transformation.
- We need to get it right on three levels: **at the state policy level, at the regional and community levels, and at the practice level** (which is team-based and patient-centered) to create a platform for a truly integrated healthcare system.
- Dr. Epperly challenged the group to **think about going beyond simple maintenance** as they considered sustainability.

Our Approach

Trends and Themes

Challenges and Opportunities

Strategic Intent

Align with and extend current goals

Strategic Initiatives

Action Items

PCMH TRANSFORMATION TEAM

Where Are We?

- The SHIP program goal was to transform 165 clinics to Patient Centered Medical Homes, and there are now 163 clinics currently participating.
- As of 1/11/2018 there are approximately 81 recognized PCMH clinics in the State of Idaho.
- Approximately 70 clinics are bi -directionally connected to IHDE.
- Partnerships and collaborations have been developed which will be useful over the long term in promoting sustainability.
- Key concerns were focused on funding and resource availability beyond the SHIP grant.

PCMH TRANSFORMATION TEAM

Trends and Themes

- Consistency
- Interoperability/compatibility
- Continuity of the current infrastructure for practice support
- Development of the business model

PCMH TRANSFORMATION TEAM

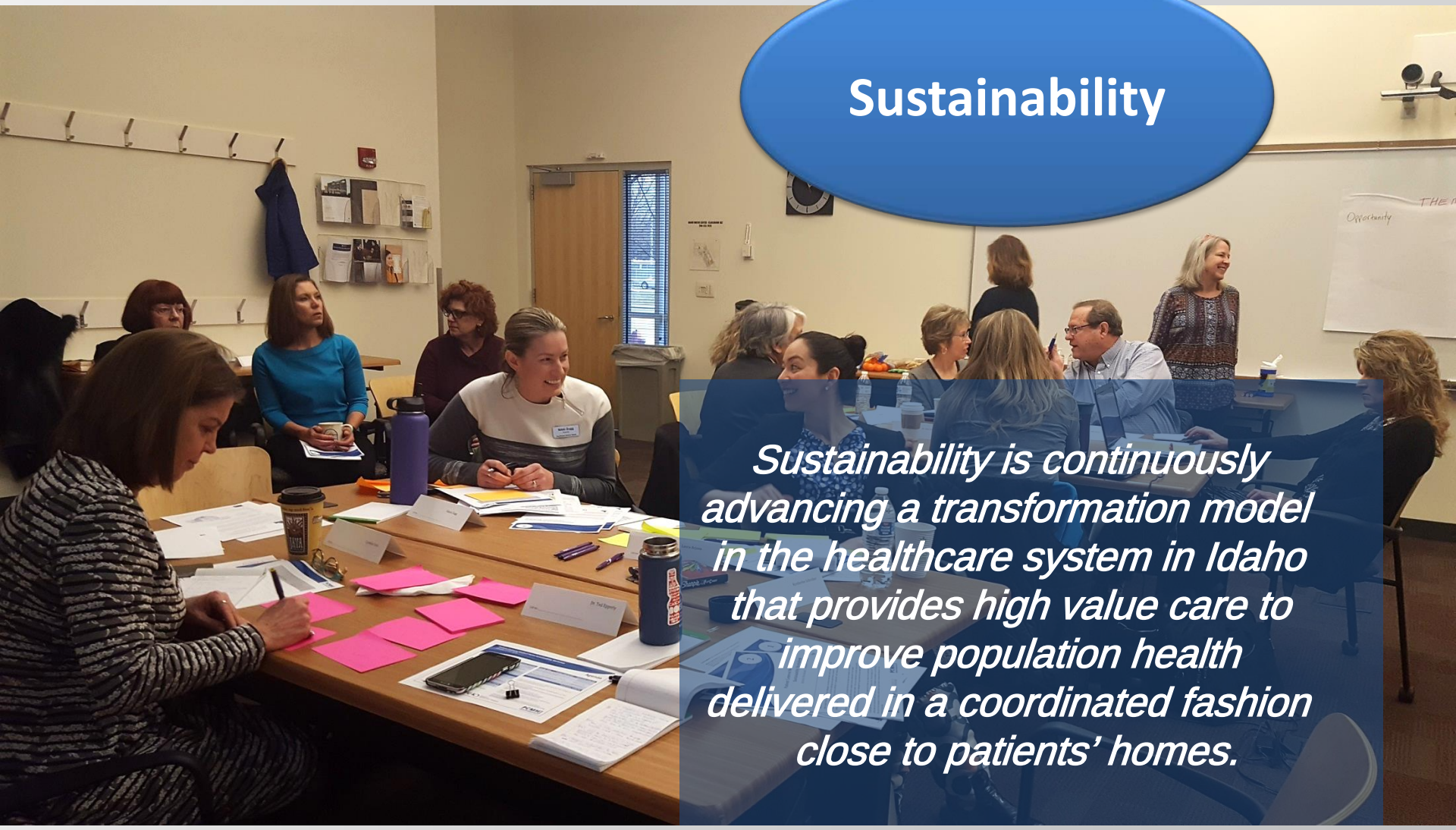
Challenges and Opportunities

Ranked Scores

Ranked on the basis of:
- Benefit to patients
- Benefits to providers
- Impact on sustainability
- Complexity of implementation

Score	Challenge/Opportunity
152	Address training and education/communication
151	Identify stakeholders and align goals and direction
143	Capitalize on existing work in value-based reimbursement
141	Build on current SHIP infrastructure
138	Share data to make better decisions
133	Integrate medical health neighborhoods
130	Procure data to document change in patient health and costs of care
128	Adequate resources to make access to data available real-time across all stakeholders
128	Address funding challenges
127	Use and build on existing SHIP business model
126	Develop shared metrics and reporting
123	Statewide connections to information/HIE
115	Create policy that supports collective direction and state requirements
79	Address varying EMR platforms
73	Address competitive market driving variability

Definition of Sustainability



Sustainability

Sustainability is continuously advancing a transformation model in the healthcare system in Idaho that provides high value care to improve population health delivered in a coordinated fashion close to patients' homes.

PCMH TRANSFORMATION TEAM

Strategic Intent Statement

Idaho aims to double the number of PCMH recognized practices by January 2024 by partnering with payers and other stakeholders in expanding value -based reimbursement supported through state leadership and broadening resources at the regional level.

PCMH TRANSFORMATION TEAM

Summary of the Group's Decisions

Idaho aims to double the number of PCMH recognized practices* by January 2024 by partnering with payers and other stakeholders in expanding value-based reimbursement supported through state leadership and broadening resources at the regional level.			
To accomplish this, we will identify key stakeholders and work with them to:			
1. Build on the current SHIP infrastructure and business model	2. Build on our work in value-based reimbursement	3. Build alignment in direction, goals, metrics and policy	4. Build our ability to educate and communicate with practices and consumers

** As of 1/11/2018, the time at which the intent statement was developed, there were approximately 81 recognized PCMH practices in the State of Idaho.*

PCMH TRANSFORMATION TEAM

What's Next

- Initiative ideas and plans will be reviewed by IDHW leadership and SHIP Operations
- The recommendations will be brought to the IHC for evaluation and the IHC may delegate further review of a recommendation by a particular workgroup.
- IDHW and/or SHIP may also determine to move forward with any recommendation based on its feasibility, required resources, and implementation timeline.

PCMH TRANSFORMATION TEAM

Thank You!

State Healthcare Innovation Plan

IDAHO DEPARTMENT OF HEALTH & WELFARE

PCMH TRANSFORMATION TEAM

Statewide Healthcare Innovation Plan

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

Goal 1

Sustainability Initiatives

Goal 1

1) NCQA Education Webinar Series go to http://ship.idaho.gov/PCMH/tabid/3068/Default.aspx#tabs_dnn_ctr13637_JQueryTabs-3 to access all 6 recordings.

2) Video Panels Interviews on

http://www.ship.idaho.gov/PCMH/tabid/3068/Default.aspx#tabs_dnn_ctr13637_JQueryTabs-1

PCMH Transformation from Physician Champions, Clinic Administrators, Clinicians, Care Coordinators, Community Health Workers, and Community EMS agencies

3) Healthy Connections PCMH Support through IDHW Medicaid
http://healthandwelfare.idaho.gov/Default.aspx?TabId=216

4) Qualis Health will continue support to Idaho primary care clinics through their CMS Medicare Contract http://www.qualishealth.org/our-services/quality-improvement-safety

5) Oral Health Alliance – continued integration of oral health in primary care
http://www.idahooralhealth.org/oral-health-integration

6) Boise State University Idaho Health Connect Learning Resource Site – 135+ SHIP Goal 1 artifacts archived for continued use by clinics and launch of value-based payment curriculum education services for clinic staff

Boise State University Learning Resource Site

SHIP

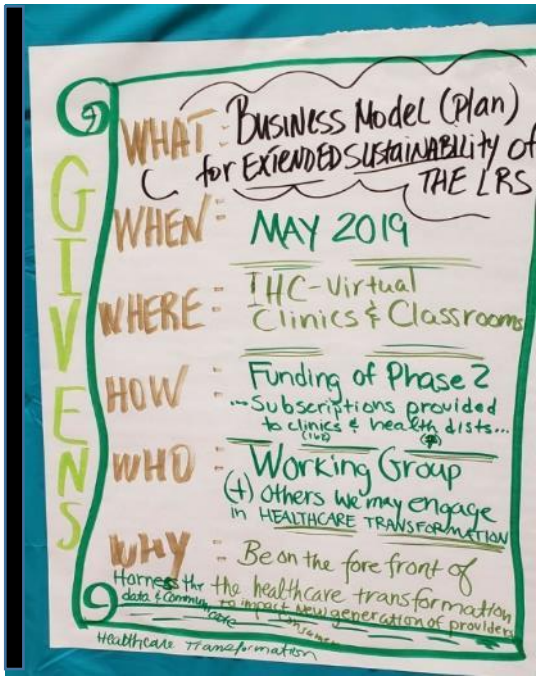
PHASE 2 ACTION PLAN JANUARY 17, 2019

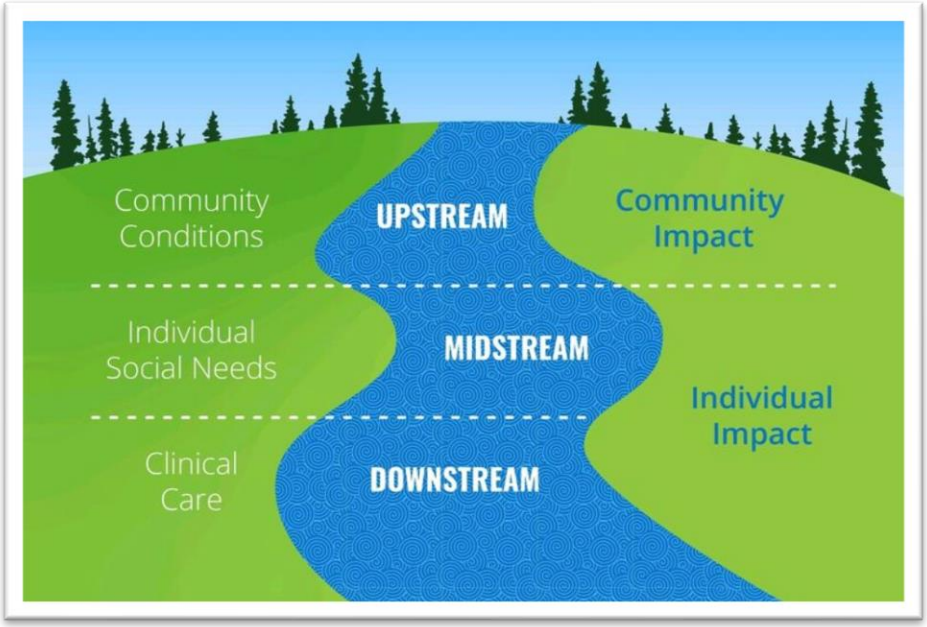
OVERVIEW Ideas that emerged from the sharing of the Historic Perspective, Grant update, External Partners, Internal Partners, LRS/Communication Plan, Project Overview, and Business Plan.

Boise State's Role	Consumer of LRS	Consumer: Patient Focus	Clinic/Provider Focus	Workforce Development	Defining The How & Why of Healthcare Transformation
Internal – curriculum development & implementation (Gayla's findings) Advertising BAPH & CEH Alignment of CQ measures streamlined communication skill development Data Plan/manuscripts consolidating and dissemination Faculty/student alignment in projects Develop HEP/PH/ Aging etc. trainings LRS IHC used for networking / partnerships building for clinics & learners	HER and LMT resources of clinics Create a newcomer page Tracking benefits of LRS Handbook for public health & primary care integration / utilization "best practices" How of communicating among small clinics – logistics SME (external) feedback POST LRS going live Foster partnerships for integrated learning Examples of success Oregon or WA PCMH clinic – Example: Found in resources "webinar" (best practices) Create a visual timeline (journey of key events, pain points, future) Chelsea filmmaking capture the stories Sharing successes Basic skill development for small providers (e.g. downloading files, basic assessment of data) Use the building blocks as a click thru	Sell benefits of PCMH to public (motivation) Consumer choice: old vs new Tools for PCMHs to educate consumers (website and materials for PTS Building communities create connections… How do you give physicians an hour back each week? Facility Incentivization "Awards / Certs' Consumer IDing Pcmh facilities. Cultural transformation of health Go beyond healthcare	RAF serving…LRS Develop book for value-based outcome (VBP) Broader understanding of VBP / improved communication to clinicians directly impacted Provider input on "jagged" edges Capture provider input Develop community of practice How to talk to providers about VBP… a) patient outcome improvement; b) scorecard; c) reimbursement	Too much paperwork; deployment of resources; address staff turnover retention / job satisfaction Identify resource contacts Connect current workforce with incoming workforce	Know the why with adoption to have buy in improves outcomes patient is forgotten Assessing & integrating Current resources assume the "how" Break apart different components core actions

AFTERNOON OF DAY 1 – ACTION PLANNING

GIVENS:	
WHAT:	Business Model (Plan) for extended sustainability of the LRS
WHEN:	May 2019
WHERE:	IHC – Virtual Clinics & Classrooms
HOW:	Funding of Phase 2 Subscriptions provided to 162 clinics and 7 health districts
WHO:	This Working Group and others we may engage in the healthcare transformation
WHY:	Be on the forefront of the healthcare transformation to impact consumer and new generation of providers. Harness the data and communicate.

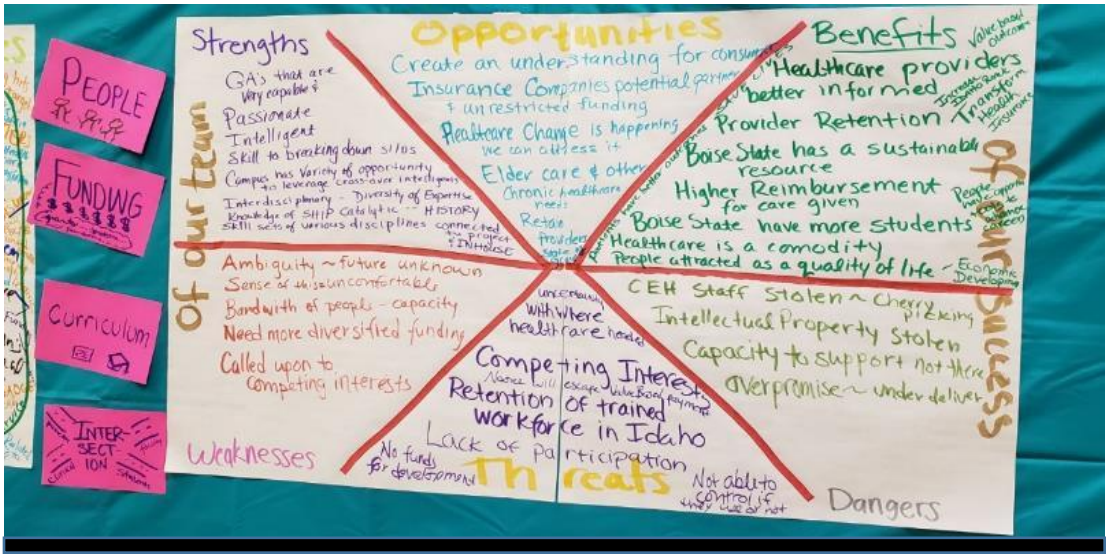




FUTURE POSSIBILITIES

Future Possibilities
FUN
Quantitative reasoning
IHC exemplary & continues to grow
Consumer understands what insurance covers
Publication
Procedures for establishing community partnerships
Emerging PHD program
Consumer navigation is easier
Cool plan executed
Consumers are making better decisions
Scorecards are known by consumer
Toolkit distributed
Grads are leaders in healthcare transformation
25 clinics continue subscription
More awareness by consumer increases demand
Buzz in general population
New certificate for students to take
Brian is “WOW-ed” by the passionate people
Full curriculum begins to fill the needs by adding new module
Students are groundwork to the new way – related to real world
INSURANCE companies provide funding
Consumers know how to stay healthy outside of healthcare system
Marketed and understood
Talk with faculty to include
HOT spotters “ high riskers” valued
Messaging hit target
Healthcare transformation
Publication
Disseminate info on HOW
Quantitative reasoning
IHC exemplary and continues to grow

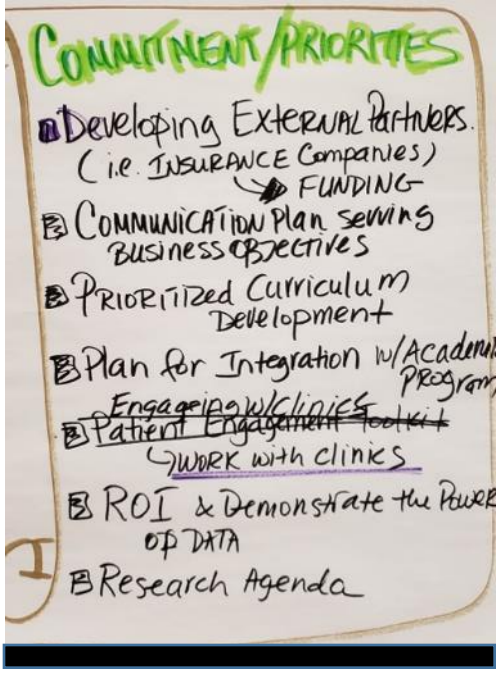
SWOT ANALYSIS



Of our team	STRENGTHS	OPPORTUNITIES	BENEFITS	... of our success
	GAs that are very capable Passionate/intelligent Skill to breaking down silos Campus has a variety of opportunity to leverage cross-over intelligence Interdisciplinary diversity of expertise Knowledge of SHIP catalytic – history Skill sets of various disciplines connected to project & in house	Create an understanding for consumers Insurance companies' potential partner & unrestricted funding Healthcare change is happening – we can address it Eldercare and other chronic healthcare needs Retain providers … state is growing	Patients have better outcomes – save lives Value based outcome Healthcare providers better informed Provider retention Increase Idaho rank Transform health insurance Boise state has a sustainable resource Higher reimbursement for care given Boise state have more students Healthcare is a commodity People attracted as a quality of life – economic development	
	WEAKNESSES	**THREATS**	**DANGERS**	
	Ambiguity ~ future unknown Sense of this is uncomfortable Bandwidth of people – capacity Need more diversified funding Called upon to completing interests	Uncertainty where healthcare is headed Competing interests No one will escape Value Based Payment Retention of trained workforce in Idaho Lack of participation No funds for development Not able to control if they use system or not	CEH staff stolen ~ cherry picking Intellectual property stolen Capacity to support not there Overpromise ~ under-deliver	

COMMITMENTS & PRIORITIES

COMMITMENT / PRIORITIES
DEVELOPING EXTERNAL PARTNERS (I.E. INSURANCE COMPANIES … FUNDING)
COMMUNICATION PLAN SERVICE BUSINESS OBJECTIVES
PRIORITIZED CURRICULUM DEVELOPMENT
PLAN FOR INTEGRATION WITH ACADEMIC PROGRAM
ENGAGING WITH CLINICS / WORK WITH CLINICS
ROI & DEMONSTRATE THE POWER OF DATA
RESEARCH AGENDA



TEAMS

COMMUNICATIONS, CURRICULUM (LRS & ACADEMIC), PROJECT DEVELOPMENT, PARTNERSHIP DEVELOPMENT, RESEARCH

Team/ Coordinator	Next Mtg.	JAN	FEB	MAR	APR	MAY	Resources Needed	Communication Needs	SUCCESS Indicator
COMMUNICATIONS: Brian, Chelsea, Lizzy	1/22/19 Tues am!	Clarifying budget #s & messaging to ensure biz/ comms. align	Cross-promote SHIP/CEH learning opportunities/ programs Determine best way to disseminate projects/ updates to clinics	Share success stories with clinics… best platform to disseminate these stories Develop case study messaging (data testimonial) to communicate value of LRS	Development of metrics to track user participation w/LRS		Allocated time… Brian 25% Chelsea 100% Lizzy 25%		Meeting TBD – goals, using tools & metrics • Google Analytics (tools) • Active Subscribers on Canva (metric) • E-News subscribers (matrix)
CURRICULUM (LRS & ACADEMIC): *Jamie & (Alicia), Ruby, Joanna, Gayla*	Tuesdays 1/22 9:30-10:30am	LRC Develop Curriculum team Academic Module Development (Janet / Ruby)	ID Learning Obj. Prioritize first modules	Create a curriculum map Update current resources (on IHC)		Updating Curriculum & building new curriculum Plan for second set of modules	Faculty buy-in TIME GA assistance Alicia	Weekly meeting shared drive email as necessary smoke signals	LRS … #Modules Academic – Curriculum Mapping plan

TEAMS

COMMUNICATIONS, CURRICULUM (LRS & ACADEMIC), PROJECT DEVELOPMENT, PARTNERSHIP DEVELOPMENT, RESEARCH

Team/ Coordinator	Next Mtg.	JAN	FEB	MAR	APR	MAY	Resources Needed	Communication Needs	SUCCESS Indicator
PROJECT DEVELOPMENT: *Maria, Danae, Brad, Amber, Lillian*	TH 1-24 @ 9:30am	Doing right now! (ownership/accountability) Create a project plan – deliverables plan – to see what everyone doing or needs to be done Google Folder Reporting Rules Matrix 1x/month update Action Plan (Brad) Report on UStore MOU (Lillian)	Develop a consistent regularly scheduled communication medium (Google Folder… Reporting rules for project / timeline forms Leveraging GAs into priorities		Identify costs for ROI – all finance staff Brad check with Ryan Email Jan1 Develop an evaluation plan & to measure benefit – demonstrate value – continuous quality improvement U Store MOU updated (Lillian) Research ROI success stories – sell to investors (Brad)		Google Time		All groups know their roles and complete their tasks

TEAMS

COMMUNICATIONS, CURRICULUM (LRS & ACADEMIC), PROJECT DEVELOPMENT, PARTNERSHIP DEVELOPMENT, RESEARCH

Team/ Coordinator	Next Mtg.	JAN	FEB	MAR	APR	MAY	Resources Needed	Communication Needs	SUCCESS Indicator
PARTNERSHIP DEVELOPMENT: *Andy N, Liilian, Tiffany, Ann, Janet, Alicia*	1/25/19 pm		Create descript of partner opportunities Planning meeting with Ann W. for talking points for key stakeholders	ID Partnerships & barriers to partnerships (funding, research) ID 3 doable CMEs – answers the why use Contact external stakeholders – insurance companies Identify potential partnerships & barriers to partnerships ID partners and opportunities	Meet with partners Identify potential partners	Assess stakeholder needs for curriculum development (gaps) Develop External Partnerships Endorsement	Ann Watkins Ted Epperly David Pate New Director of IDHW	Work closely w/project mng. group (ROI & Fee structure) Work closely w/comm. Team to work with stakeholders Full group check-in 	Endorsement from 5-10 partners at system level. Possible organization level.

TEAMS

COMMUNICATIONS, CURRICULUM (LRS & ACADEMIC), PROJECT DEVELOPMENT, PARTNERSHIP DEVELOPMENT, RESEARCH

Team/ Coordinator	Next Mtg.	JAN	FEB	MAR	APR	MAY	Resources Needed	Communication Needs	SUCCESS Indicator
RESEARCH: *Molly Volk,* Marcus Chapa, Caile, Jessie, Kirk	1/30/19 @ 11am		Research NC Program – GAs building clinic capacity Leverage student research efforts to engage stakeholders… Research & Lit. Review		Identify components of RSCH Agenda	Investigate Feasibility to Mine current SHIP data Identify research / Pub opportunities	Janet to access SHIP data & code book A GA Assistance of Terry Madda Albertson Library	Talk through our walls ZOOM Open Doors	Identify 4 publications opportunities. APHA Identify RSCH components – connect with journals Connect with other GA's (Marcus, Dannae, Andy, Tiffany) get their research Write a summary on NC program (Jessie 1/30) Have a draft of 1 publication

Statewide Healthcare Innovation Plan

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

Goal 2 & Goal 3

Sustainability Initiatives

Goal 2

1) Clinic Connections to Idaho Health Data Exchange continuing through Idaho DWH Medicaid HiTech Contract with CMS

Goal 3

Rhonda D'Amico, Public Health District 6 in Southeast Idaho is implementing 5.2.1.0. Healthy Children initiative. The program, originating in Maine, promotes four evidence-informed recommendations: five fruits and veggies per day; no more than two hours of screen time per day; one or more hours of physical activity; and zero sweetened drinks including the promotion of drinking water. Additional resources can be found at https://5210.psu.edu/ including toolkits and materials. This is an initiative being undertaken by the Region 6 RC supporting their medical-health neighborhood.

STATEWIDE HEALTHCARE INNOVATION PLAN

Regional Collaborative Post-SHIP Transition Plan Focus Areas

October 2018

Regional Collaborative	District SHIP Manager	1. Focus Area	2. Focus Area	3. Focus Area
District 1 **Panhandle Health District**	Steve Holloway sholloway@phd1.idaho.gov	Organizing and Holding Regional PCMH Meetings	Facilitate Regional QI Project's	Promoting PCMH Model of Care
District 2 **North Central Health District**	Kayla Sprenger ksprenger@phd2.idaho.gov	Continue to convene clinics and support ongoing mentoring between clinics		
District 3 **Southwest Health District**	Rachel Blanton rachel.blanton@phd3.idaho.gov	Care Coordination	Medicaid and ACO alignment	Behavioral Health Integration
District 4 **Central Health District**	Melissa Dilley mdilley@cdhd.idaho.gov	Care Coordination	Medicaid and ACO alignment	Behavioral Health Integration
District 5 **South Central Health District**		Resource Directory		
District 6 **Southeastern Health District**	Rhonda D'Amico rdamico@siph.idaho.gov	Regional Quality Improvement Specialist	Workforce Development training with ISU Division of Health Sciences	Suicide Prevention
District 7 **Eastern Health District**	James Corbett jcorbett@eiph.idaho.gov	Networking and Collaboration facilitated by QI Specialist		

REGIONAL COLLABORATIVE SURVEY

IDHW conducted an online survey for the Regional Collaborative (RC) in July 2018

The survey was distributed via email to 165 RC members in July 2018. The team received 35 survey responses (21% response rate).

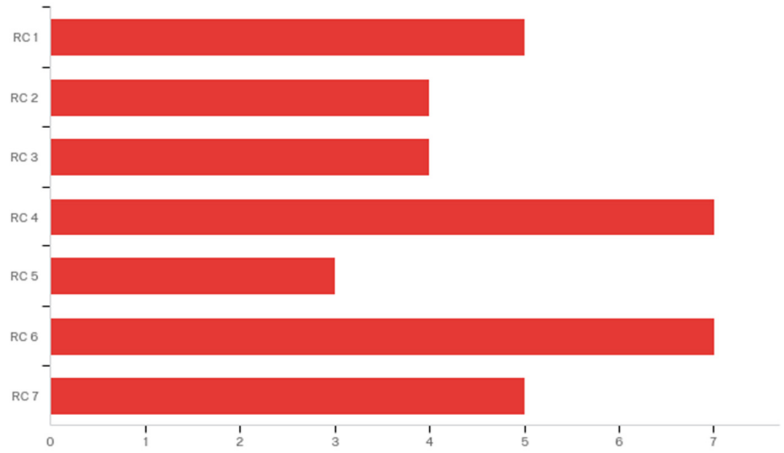
Statewide Healthcare Innovation Plan

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

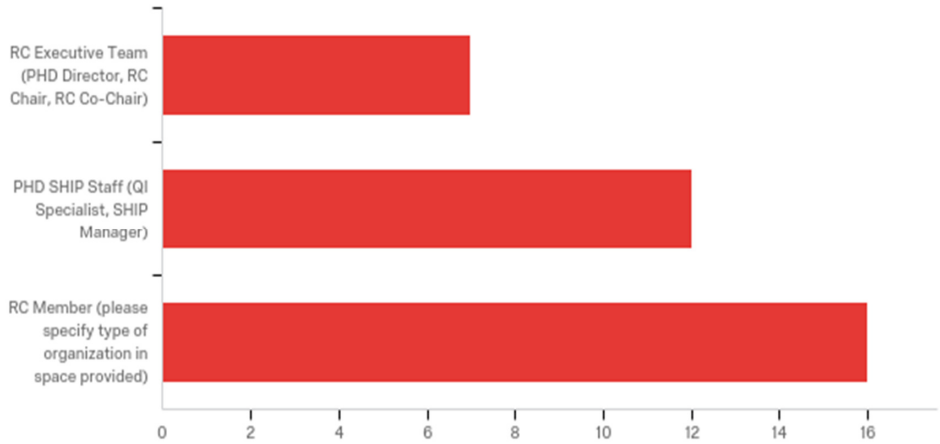
THE LANGDON GROUP

qualtrics

SURVEY RESULTS: RESPONDENT PARTICIPATION IN RCs



SURVEY RESULTS: RESPONDENT ROLES IN THE RCs

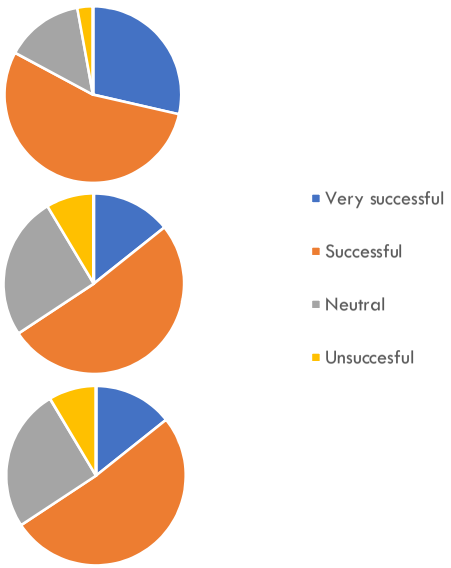


SURVEY RESULTS: SUCCESS IN ACCOMPLISHING GOALS

29 of 35 respondents (83%) indicated that their RC was very successful (10) or successful (19) in providing local leadership and support for healthcare transformation.

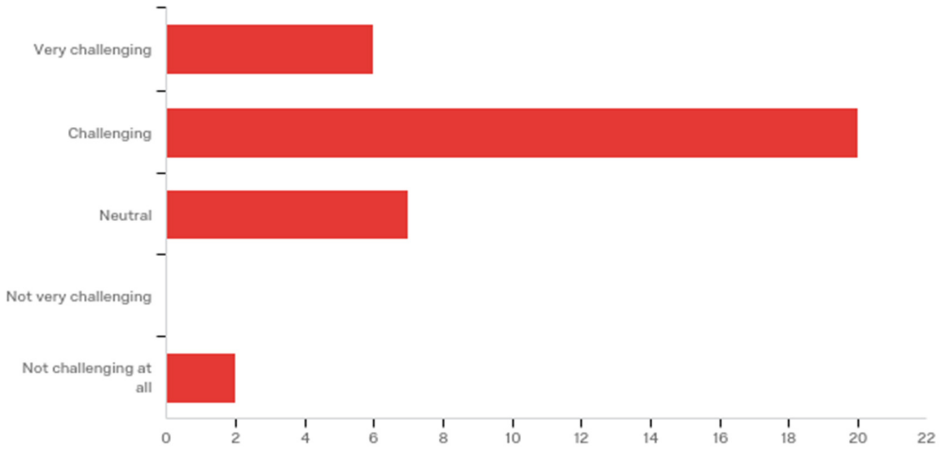
23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health neighborhood.

24 of 35 respondents (68.5%) indicated that their RC was very successful (5) or successful (19) in improving population health to achieve the Triple Aim.



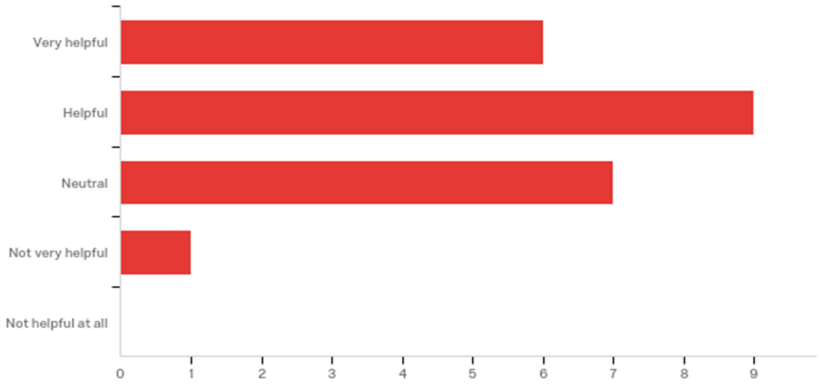
SURVEY RESULTS: LEVEL OF DIFFICULTY

26 of 35 respondents (74%) indicated that the level of difficulty in fulfilling their function was challenging (20) or very challenging (6).



SURVEY RESULTS: TECHNICAL ASSISTANCE AND ADMIN. SUPPORT

15 of 23 of non-PHD staff respondents (65%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (6) or helpful (9).



OTHER SURVEY RESULTS (HIGHLIGHTS)

18 of 35 respondents (51%) indicated that it is very likely (5) or likely (13) that their RC or an RC-like group will continue after the SHIP grant ends (6 indicated it is unlikely or not likely at all).

Other

QUESTIONS?

Idaho Department of Health and Welfare
State Health Innovation Plan
Regional Collaborative (RC) Survey

Survey Objectives

The Idaho Department of Health and Welfare conducted a survey for the Regional Collaborative (RC) to provide a neutral forum for feedback regarding the functionality of the RCs since the onset of the State Health Innovation Plan (SHIP). The function of the RC is to provide local leadership and support for healthcare transformation, strengthening of the Medical Health Neighborhood, and improving population health to achieve the Triple Aim. The Langdon Group refined and finalized the survey and participated in developing, distributing, gathering, and tabulating the results. The Langdon Group prepared a report to highlight some of the findings from the survey.

Administering the Survey

The survey was completed online by RC participants and contained questions on roles in each individual RC, length of member participation with the RC, RC performance, difficulties, accomplishments, challenges and obstacles, RC technical and administrative support, and future plans.

Survey Implementation

The Public Health District SHIP managers identified their RC members. The survey was distributed via email, July 2, to 165 RC members. The Langdon Group received 35 survey responses (21% response rate).

RC Participation and Roles

Through the SHIP, there have been a total of seven operational RC's in Idaho. RC-4 and RC-6 had the most survey respondents at seven, while RC-5 had the least survey respondents at three. Every RC had at least one survey respondent that fell into the role of PHD SHIP staff. RC-2 and RC-7 did not have any survey responses from RC Executive Team members, and only RC-5 did not provide any survey responses from an RC member. Only three respondents had participated for less than a year with their RC; 11 respondents had one-to-two years of participation experience; and, 20 respondents had three-to-four years of participation with their RC.

Survey Barriers and Assumptions

- Many Cohort 3 clinics have little to no experience with RC's;
- Schedule and time-frame for responses: the survey was administered over the 4th of July holiday and respondents were given a limited time to respond; and,
- Unknown sender: the survey was meant to be anonymous and was provided by a third-party; this could have reduced the number of RC members that saw the email (sent to spam) or were reluctant to respond to an email with a link.

Survey Results (Highlights)

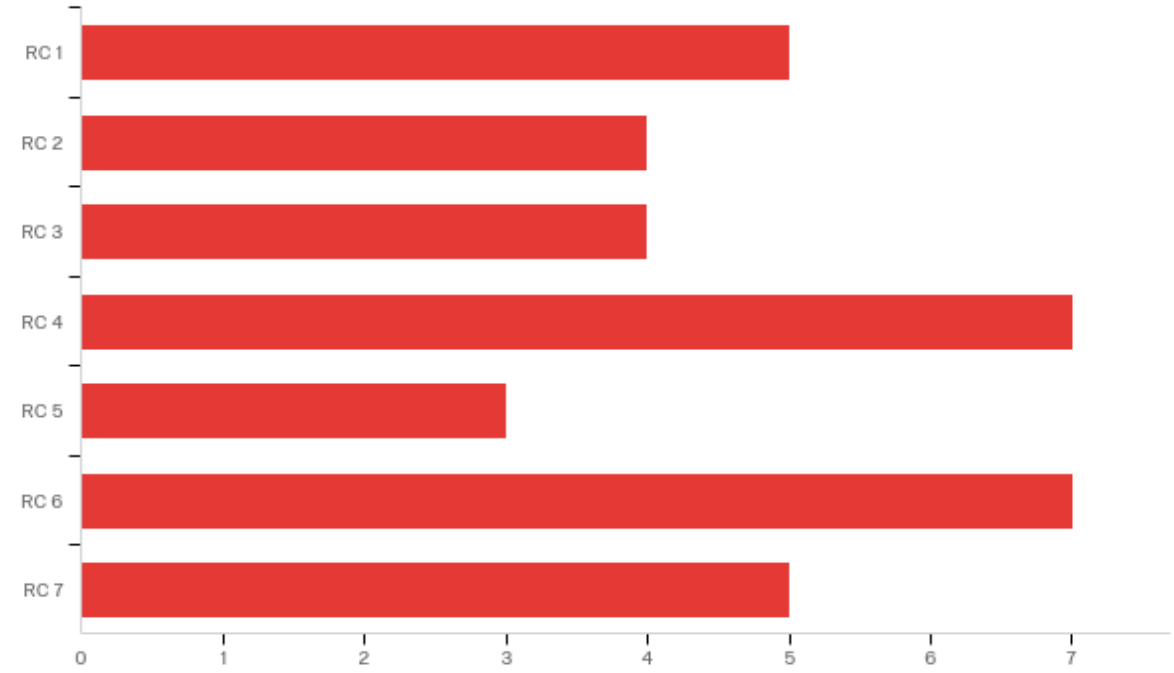
- 29 of 35 respondents (83%) indicated that their RC was very successful (10) or successful (19) in providing local leadership and support for healthcare transformation.
- 23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health neighborhood.
- 24 of 35 respondents (68.5%) indicated that their RC was very successful (5) or successful (19) in improving population health to achieve the Triple Aim.
- 26 of 35 respondents (74%) indicated that the level of difficulty in fulfilling their function was challenging (20) or very challenging (6).
- Of those that responded that the level of difficulty was very challenging:
    - 2 are RC Executive Team, 2 are PHD SHIP Staff, and 2 are RC Members;
    - 3 (50%) indicated that their RC was very successful (1) or successful (2) in providing local leadership and support for healthcare transformation;
    - 2 (33%) indicated that their RC was very successful or successful in the development of the medical-health neighborhood (2 indicated that their RC was unsuccessful);
    - 2 (33%) indicated that their RC was very successful or successful in improving population health to achieve the Triple Aim (2 indicated that their RC was unsuccessful); and,
    - 5 (83%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (3) or helpful (2).
- 26 of 35 respondents (74%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (11) or helpful (15).
- 18 of 35 respondents (51%) indicated that it is very likely (5) or likely (13) that their RC or an RC-like group will continue after the SHIP grant ends (6 indicated it is unlikely or not likely at all).

- **Survey Results (data)**

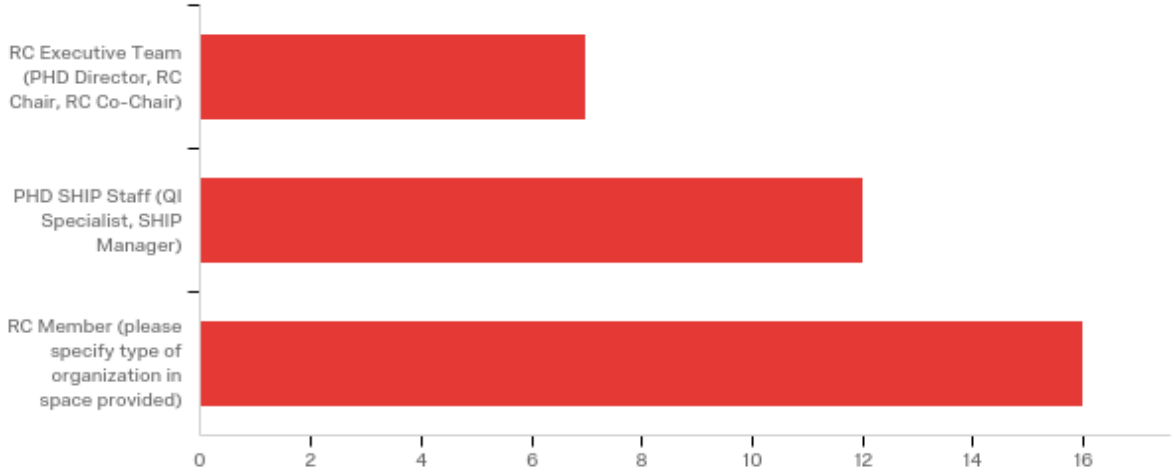
		1. With which RC do you participate?								
		RC 1	RC 2	RC 3	RC 4	RC 5	RC 6	RC 7	Total	Percent of Total
2. Please select the group that best reflects your role in the RC.	RC Executive Team (PHD Director, RC Chair, RC Co-Chair)	1	0	2	1	2	1	0	7	20%
	PHD SHIP Staff (QI Specialist, SHIP Manager)	1	1	1	3	1	2	3	12	34%
	RC Member (please specify type of organization in space provided)	3	3	1	3	0	4	2	16	46%
	Total	5	4	4	7	3	7	5	35	100%
3. How long have you been participating with your RC?	Less than 1 year	1	0	0	0	0	1	1	3	9%
	1-2 Years	2	2	1	3	1	1	1	11	31%
	3-4 Years	2	2	3	4	2	5	3	21	60%
	Not currently active	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
4. How would you measure the performance of your RC in providing local leadership and support?	Very successful	1	1	2	0	0	4	2	10	29%
	Successful	4	2	2	5	0	3	3	19	54%
	Neutral	0	0	0	2	3	0	0	5	14%
	Unsuccessful	0	1	0	0	0	0	0	1	3%
	Very unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
5. How would you measure the performance of your RC in the development of the medical-health neighborhood?	Very successful	1	0	1	1	0	1	1	5	14%
	Successful	2	3	2	3	0	4	4	18	51%
	Neutral	1	1	1	2	2	2	0	9	26%
	Unsuccessful	1	0	0	1	1	0	0	3	9%
	Very unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
6. How would you measure the performance of your RC in improving population health to achieve the Triple Aim?	Very successful	1	0	1	0	0	2	1	5	14%
	Successful	3	2	1	4	1	5	3	19	54%
	Neutral	1	1	2	2	1	0	1	8	23%
	Unsuccessful	0	1	0	1	1	0	0	3	9%
	Very Unsuccessful	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
7. What was the level of difficulty for your RC in fulfilling their function as described above?	Very challenging	1	0	0	2	2	0	1	6	17%

		1. With which RC do you participate?								
		RC 1	RC 2	RC 3	RC 4	RC 5	RC 6	RC 7	Total	Percent of Total
	Challenging	3	3	4	4	1	4	1	20	57%
	Neutral	1	1	0	1	0	2	2	7	20%
	Not very challenging	0	0	0	0	0	0	0	0	0%
	Not challenging at all	0	0	0	0	0	1	1	2	6%
	Total	5	4	4	7	3	7	5	35	100%
10. How helpful was the technical assistance and administrative support your RC received in achieving their goals?	Very helpful	1	0	1	3	2	1	3	11	31%
	Helpful	3	2	2	3	0	3	2	15	43%
	Neutral	1	2	1	1	1	2	0	8	23%
	Not very helpful	0	0	0	0	0	1	0	1	3%
	Not helpful at all	0	0	0	0	0	0	0	0	0%
	Total	5	4	4	7	3	7	5	35	100%
13. How likely is it that your RC or an RC-like group continue after the SHIP grant ends?	Very likely	0	0	1	1	0	2	1	5	14%
	Likely	2	2	2	4	0	1	2	13	37%
	Neutral	3	1	1	2	0	4	0	11	31%
	Unlikely	0	1	0	0	1	0	2	4	11%
	Not likely at all	0	0	0	0	2	0	0	2	6%
	Total	5	4	4	7	3	7	5	35	100%

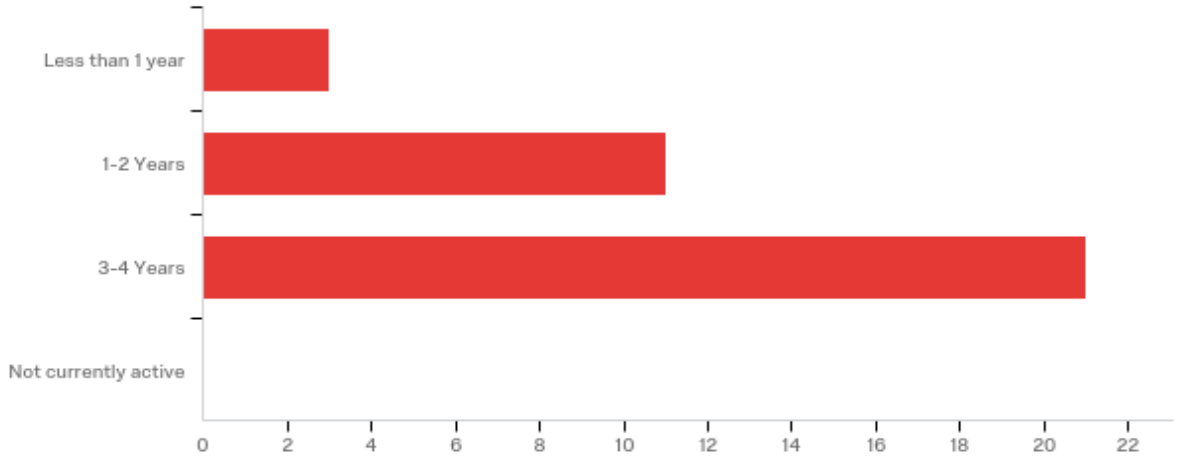
1. With which RC do you participate?



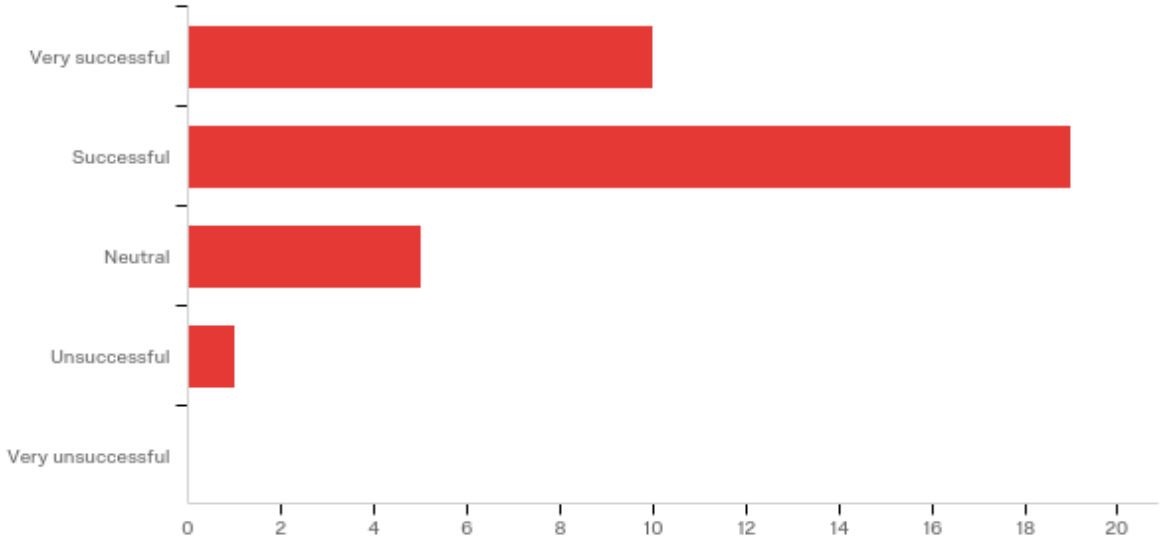
2. Please select the group that best reflects your role in the RC.



3. How long have you been participating with your RC?

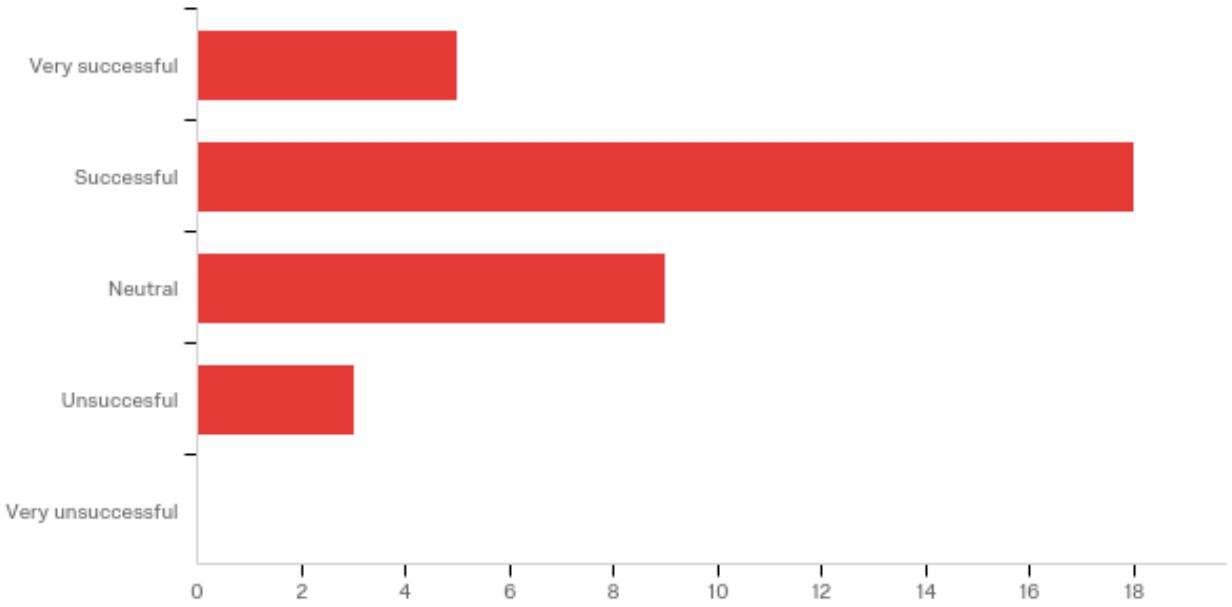


4. How would you measure the performance of your RC in providing local leadership and support for healthcare transformation?

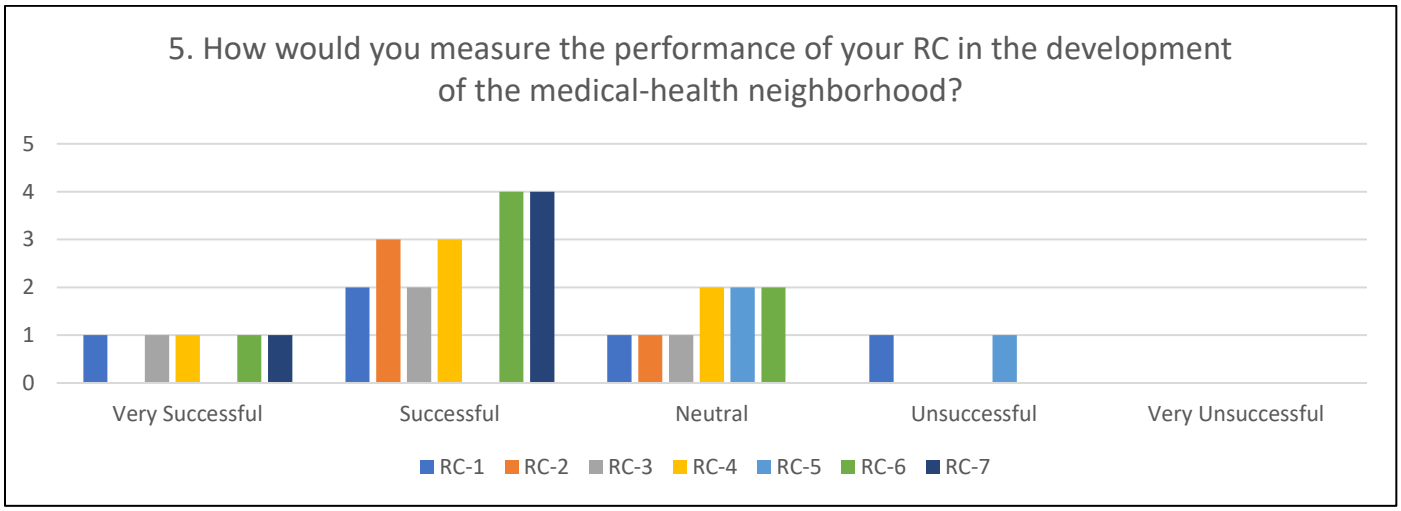


#	Answer	%	Count
1	Very successful	28.57%	10
2	Successful	54.29%	19
3	Neutral	14.29%	5
4	Unsuccessful	2.86%	1
5	Very unsuccessful	0.00%	0
	Total	100%	35

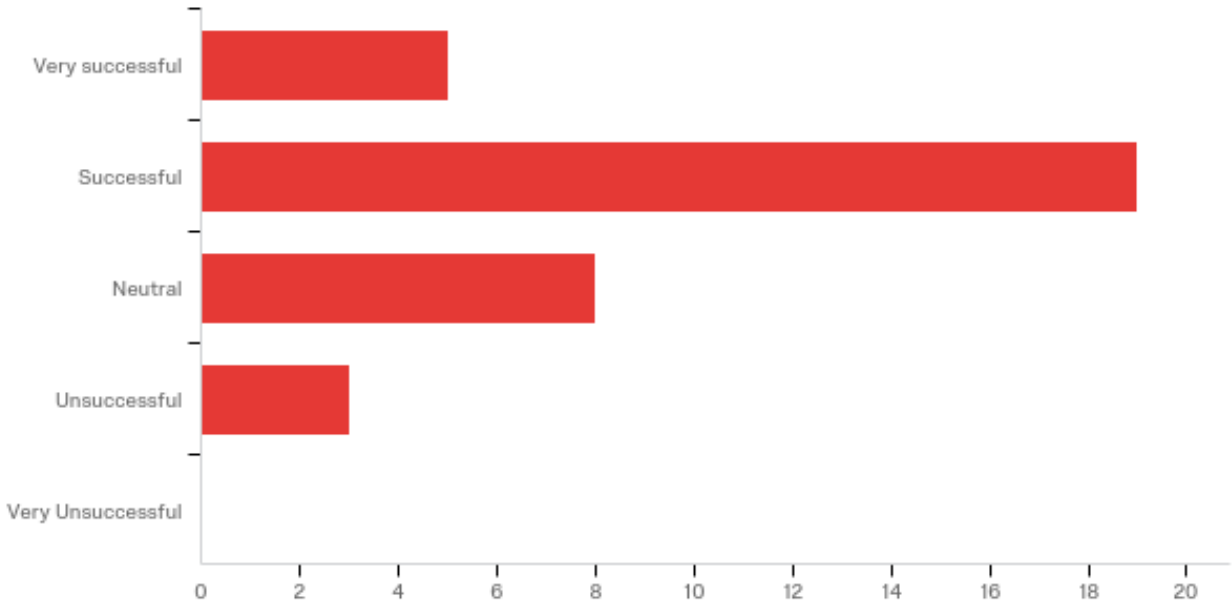
5. How would you measure the performance of your RC in the development of the medical-health neighborhood?



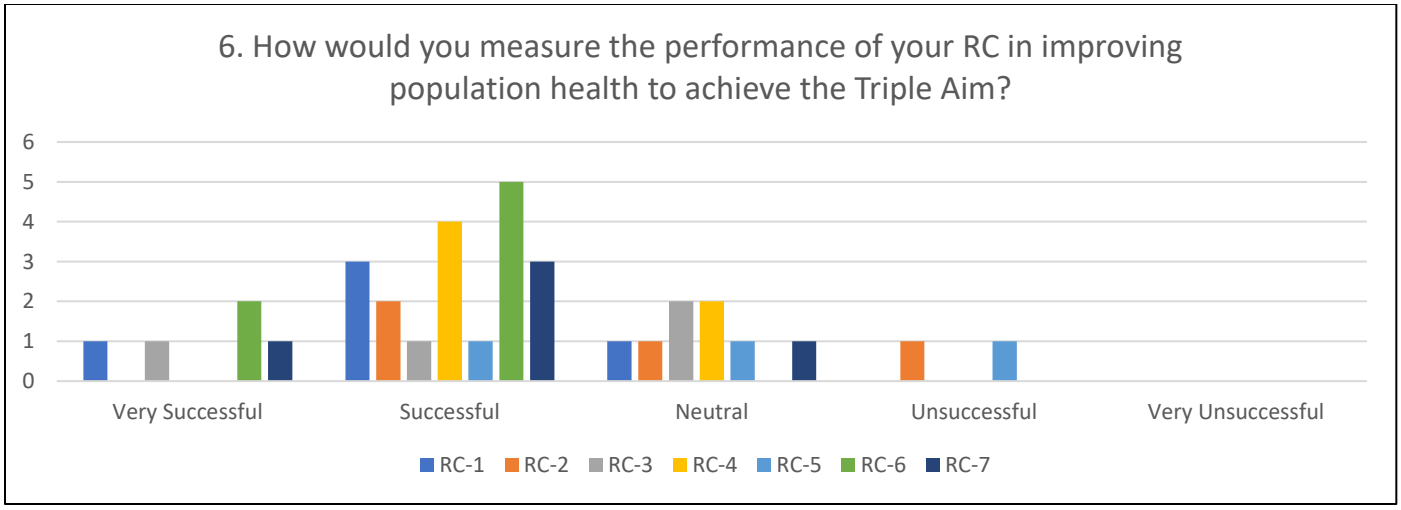
#	Answer	%	Count
1	Very successful	14.29%	5
2	Successful	51.43%	18
3	Neutral	25.71%	9
4	Unsuccessful	8.57%	3
5	Very unsuccessful	0.00%	0
	Total	100%	35



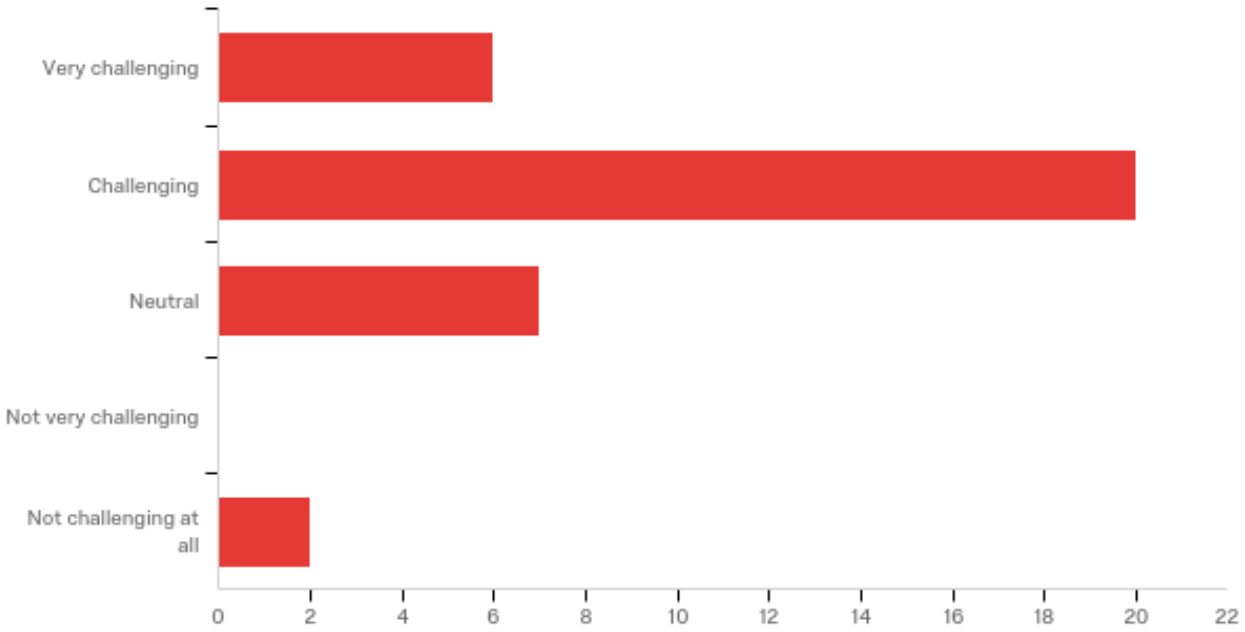
6. How would you measure the performance of your RC in improving population health to achieve the Triple Aim?



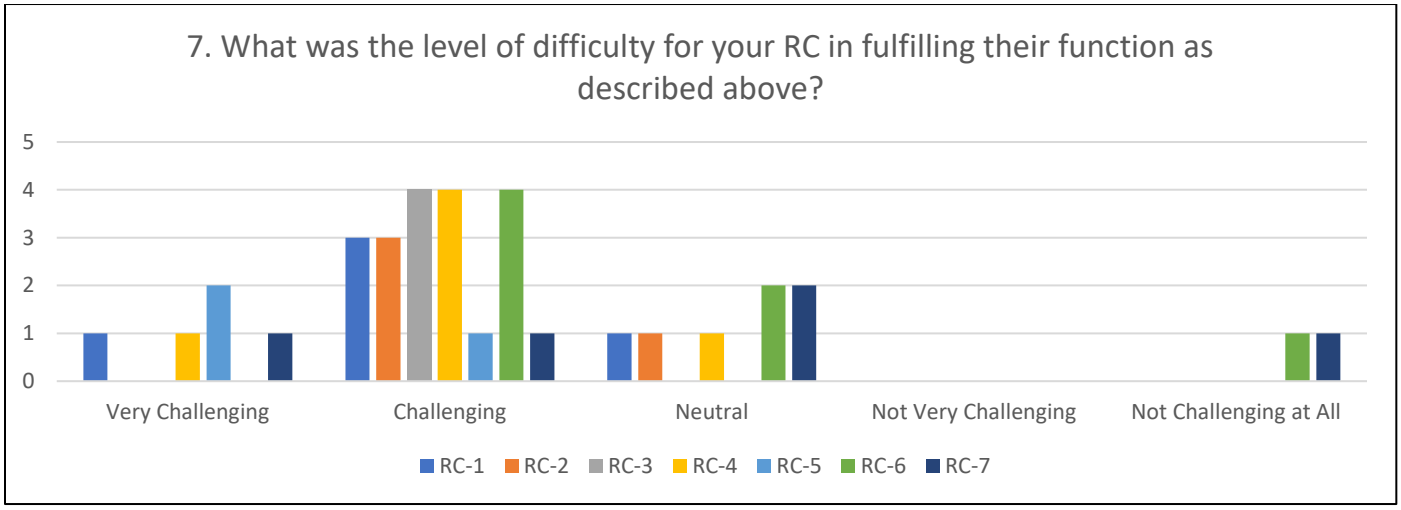
#	Answer	%	Count
6	Very successful	14.29%	5
7	Successful	54.29%	19
8	Neutral	22.86%	8
9	Unsuccessful	8.57%	3
10	Very Unsuccessful	0.00%	0
	Total	100%	35



7. What was the level of difficulty for your RC in fulfilling their function as described above?



#	Answer	%	Count
1	Very challenging	17.14%	6
2	Challenging	57.14%	20
3	Neutral	20.00%	7
4	Not very challenging	0.00%	0
5	Not challenging at all	5.71%	2
	Total	100%	35



8. What do you consider to be your RC's most notable accomplishment(s)?

8. What do you consider to be your RC's most notable accomplishment(s)?
Supporting the cohorts in integrating Behavioral Health
Greater awareness of community resources to support the health needs of our citizens beyond the traditional health care setting. A collective desire among active RC members to meaningfully connect people to community health supports.
Establishing strong community support
Collaborations in community resources and population tracking
Bringing in knowledgeable community partners to present to RC members
Caregiver Integration Project, MHN meetings for Diabetes, Collaboration, PCMH Support, etc.
Our organization has gained local knowledge and shared local resources. Finding out how other clinics are serving patients helps us learn and grow.
Bringing partners together
Their expertise on the concepts and what is needed to meet the requirements.
Getting multiple clinics to achieve PCMH designations who had not completed PCMH prior to this time.
Regional QI project
Offering education on regular basis
SHIP Clinic Collaboration with relevant topics and experts available to present as well as platform to link new with mature clinics; and Mentoring, Telehealth & CHW's
The staff has been very responsive to all my questions. I really like when the RC brings in outside resources.
The collaborative efforts with community partners
Mental health
Workgroups that were formed, and the work they completed
MIPS score of 100
Education for all members
Our chairperson networked with clinics in an effort to recruit for SHIP and RC membership. We also developed a Community Resources Guide for anyone to use when seeking or referring services.
Diabetes improvement project
transformation of clinics to PCMH
Addressing unmet behavioral health needs in our primary schools.
Bringing our clinics together for specific meetings geared towards their PCMH needs to support one another, care coordination job shadowing and mentoring, educating the medical health neighborhood on PCMH, educating ISU health care programs (Nursing, Nurse Practitioners, Pharmacy, Medical Assistants, Health Care Administration) on the PCMH model to foster sustainability, facilitating a regional suicide prevention training, facilitating a PCMH Training for our Cohort 3 Clinics where both the PHD staff and Physician Champions/RC Chair and Co-Chair presented.
Gathering representatives from so many primary care clinics across the region to meet together to discuss problems, solutions, and resources.

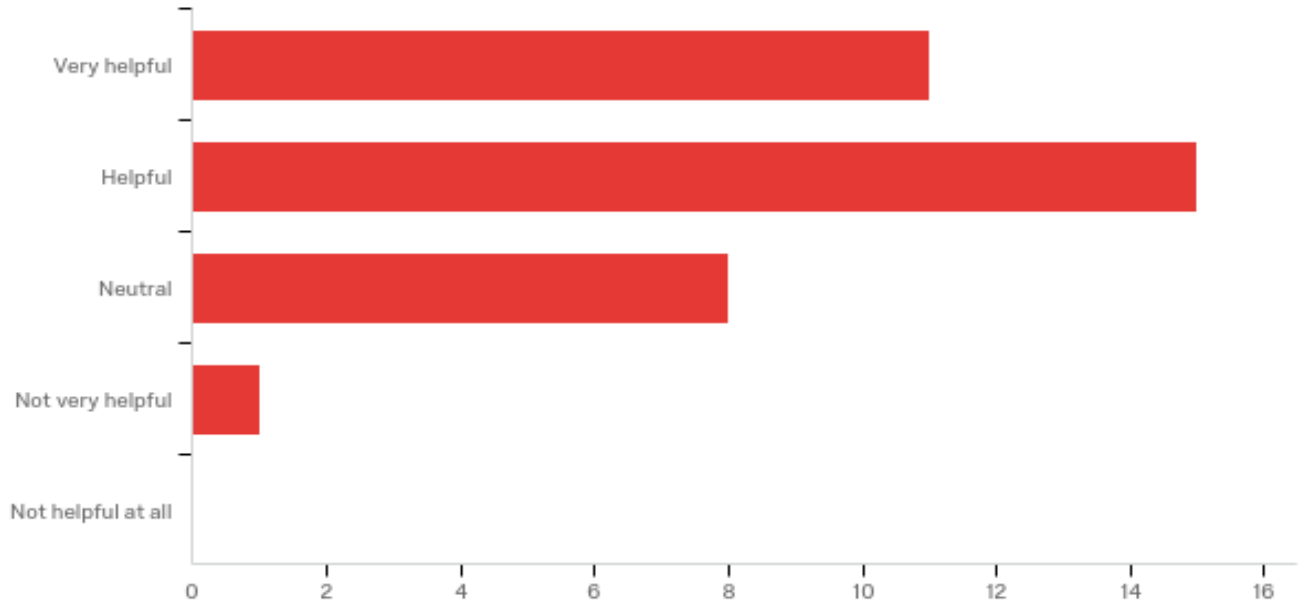
8. What do you consider to be your RC's most notable accomplishment(s)?
Establishing PCMH across N Idaho. Promoting collaboration
Bring clinic staff together to network and share learning about local resources and PCMH transformation
Their knowledge and understanding to help our clinic achieve our goals.
PCMH Clinic transformation, suicide prevention work, connections made between clinics and organizations that address social determinants of health.
Safe space for clinics to share best practices and glean ideas from each other.
Assistance with providing education and support to medical practices
Behavioral health portfolio (Healthy Minds Partnership, IIBHN, Let's Talk series)
Suicide symposium, crossed regions
Reaching out to the other clinics and getting them either PCMH (NCQA) certified or on the road to it.

9. What was the biggest challenge or obstacle your RC faced?

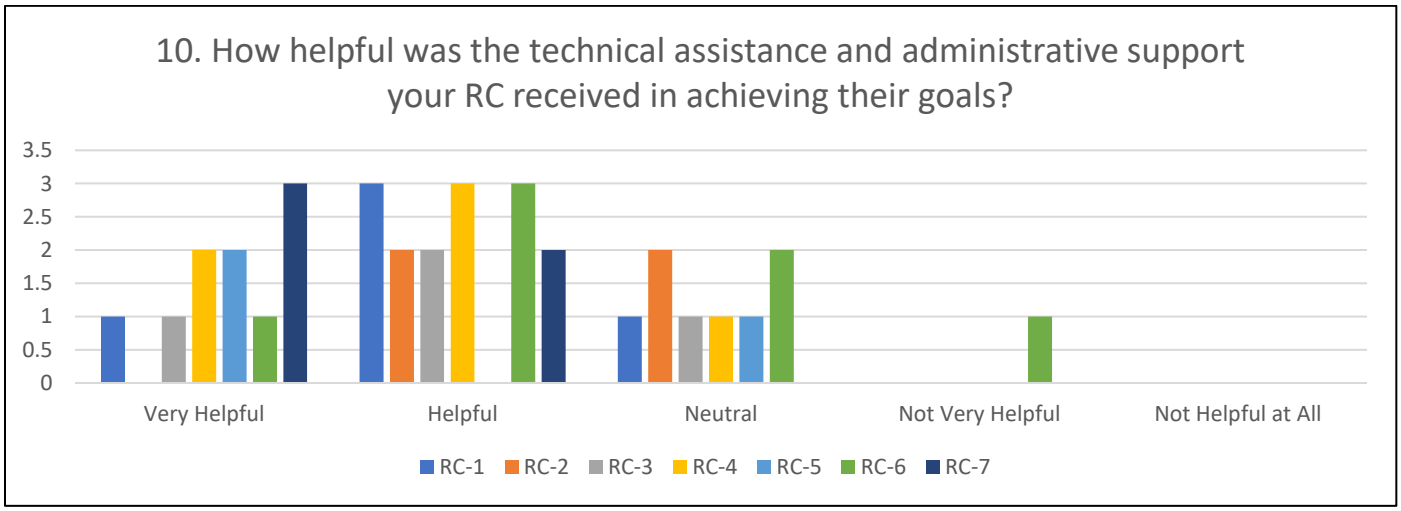
9. What was the biggest challenge or obstacle your RC faced?
Data
Determining a method by which people can be meaningfully connected to community health resources that can track the referrals, document that there is follow through, and measure outcomes.
too much debate, not enough action
The massive needs of the community
Bringing together and aligning large healthcare systems and other organizations with competing interests
Available data to make informed decisions
At first, the most difficult part was ensuring that the involved clinics were using data in the same way and able to compare appropriately.
Getting everyone to participate
NCQA
No data from the IHDE from which to set goals and work on the population through a medical neighborhood.
The medical health neighborhood was challenging to tackle. We started, but it will take more time.
Time available to participate in calls. It may have been helpful to record sessions for later playback
Lack of anticipated data to drive Regional Population Health Management efforts
All the different EMRs the health centers are on
Keeping needed members at the table and engaged
Sustainability

9. What was the biggest challenge or obstacle your RC faced?
Not having the data needed to start measuring changes
PCMH recognition
Fully implementing all goals
membership/participation/motivation
Getting physician leadership and buy in at each practice
lack of member participation
The lack of claims/encounter data to make planning decisions and monitor outcomes/impact.
Our biggest challenge was overcoming the barriers of competing interests that organizations experience. There were multiple clinics that were not necessarily ready to participate in SHIP. We had difficulty in engaging some individuals/organizations but this could be due to the fact that they were truly not ready to implement PCMH transformation. However, despite the difficulties, this did not stop us in reaching out to engage them.
Scheduling and taking staff out of the clinic to meet, especially those located at a farther geographical location.
Access to care
Finding topics that apply to all clinics in attendance and staff members from the clinic, example: something that isn't just Ped specific or only applies to office managers and not the providers
Understanding regulations and policies to better our patient care.
Competing quality improvement demands placed on clinics, sustainability post-SHIP,
Scheduling with RC Chair's to find time in their working schedule.
Creating sustainable programs that impact change
Data
membership
I didn't feel like the Medical Neighborhood was something that worked out well.

10. How helpful was the technical assistance and administrative support your RC received in achieving their goals?



#	Answer	%	Count
1	Very helpful	31.43%	11
2	Helpful	42.86%	15
3	Neutral	22.86%	8
4	Not very helpful	2.86%	1
5	Not helpful at all	0.00%	0
	Total	100%	35



11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?

11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?
The CDHD staff and the coaches that assisted the clinics.
Having leadership and guidance from the district SHIP manager and staff to set agendas for the leadership team and the RC meetings. The SHIP staff organization presentations about community health resources and performing research between meetings needed to advance the work of the RC.
not sure
Having staff
public health district support
PHD staff convening, facilitating meetings, QI Specialist reporting and dissemination of information.
I'm unaware
Public health team coordinating meetings was very valuable
The State patient surveys.
The in-person support of helping clinic achieve PCMH designation.
CDE educational support for QI project
Not sure about what assistance was received.
Very organized, meaningful and relevant agenda items for both RC and PCMH clinic meetings
NCQA is a very helpful resource
NA
Rachel has been incredible! Without her we would be dead in the water
Rachel did a great job in seeking support and resources for the RC
Help with NCQA
Presenters and external resources who provided education
I do not believe we asked for or received any TA or admin support.
Admin support at PHD.
convening meetings, finding speakers
I'm not sure what this questions is asking. The district SHIP staff were awesome. Our RC received little technical assistance or administrative support from SHIP Central or other sources.
Our RC Leadership, specifically our Physician Champions brought expertise and extensive experience in PCMH. Their experience and willingness to help others through the process built trusting relationships between clinics so they could share their experiences, barriers, and successes. Our leadership spent time with those new to PCMH by meeting with their practices in person to talk about PCMH and gain buy-in to the model.
The behind the scenes work of the QI Specialists and bringing needed resources into our RC meetings to provide information to the primary care clinics.

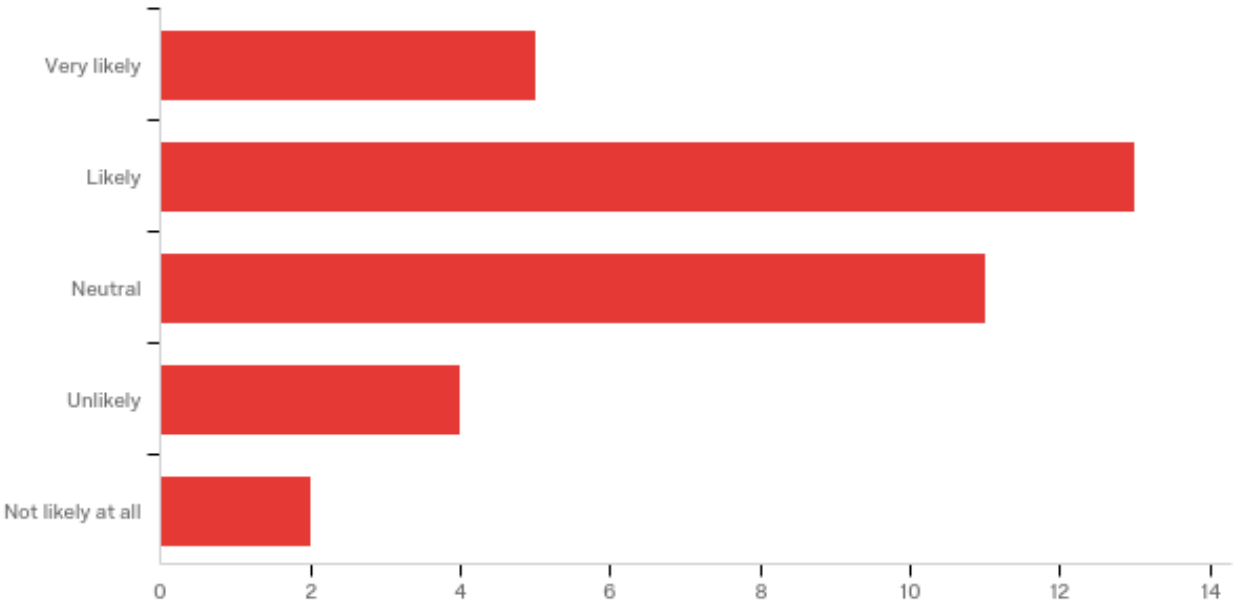
11. What type of technical assistance and administrative support that your RC received did you find the most helpful in achieving their goals?
Program info
Learned how to pull certain reports on different EHRs, also connected clinics with similar EHRs so that they could help one another. Shared different examples and tools that other clinics have used
They did a SHIP crash course at the beginning that helped with overview of program.
Enthusiasm and knowledge of RC Chairs and Co-chairs was critical to the function of the RC. The QI Specialist's unique knowledge of the transformation status, challenges, and successes of each of the SHIP clinics was very helpful in providing the RC leadership team a big picture perspective of PCMH growth and development in our region.
n/a
Didn't really receive technical support (from our vantage point), but some support thru education.
Scheduling and facilitation
n/a
The support from the Public Health Department was awesome. The support from Briljent (is that how you spell it) and their advisor phone calls was not very helpful.

12. In the future, what could be done differently to help your RC to better achieve their goals?

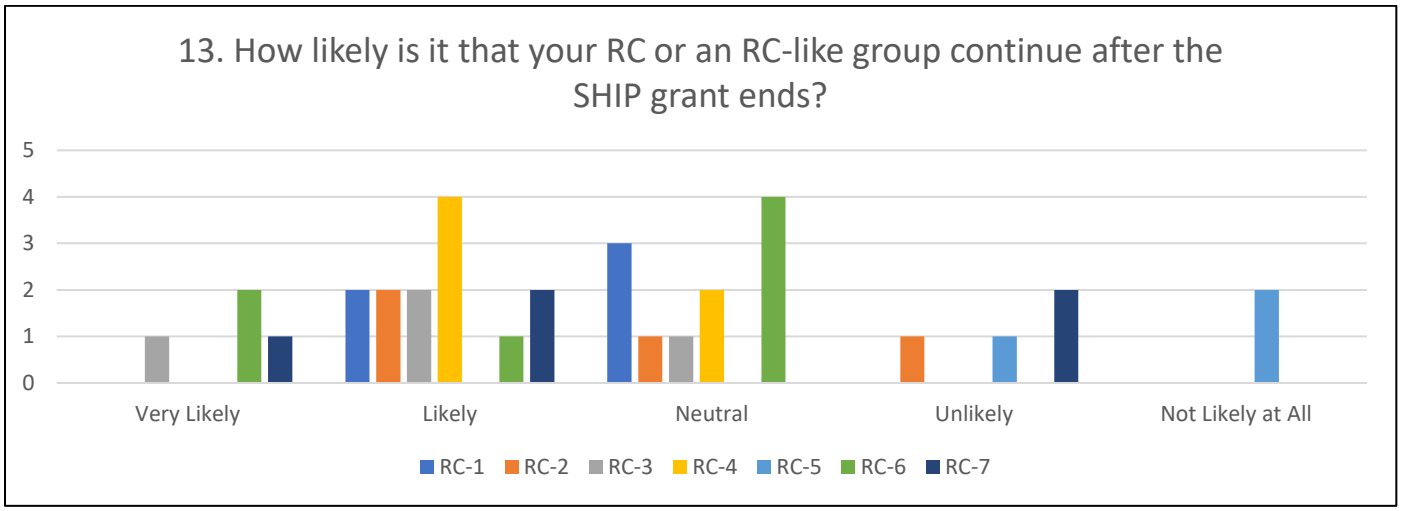
12. In the future, what could be done differently to help your RC to better achieve their goals?
more action oriented goals
As noted earlier, we are challenged with identifying processes that could be integrated into our health care and social services systems to ensure that people who need help are actually connected to resources and improve their situation. Our group has been working on this for more than year, but we have not outside support to know what options we might have other than those brought forward by the SHIP team or members of the RC.
a clear and defined goal. We spent too much time trying to figure out what we could or should do and entertaining every reason why the idea wouldn't work, and then we'd start again with a new idea.
More help with data management and staff
access to data
Data, ongoing support for operations/administrative support
I'm unaware
Nothing differently I don’t think, but we just need to keep up with meeting and pursuing goals.
Better training from NCQA
Find differential funding from insurers/payors for PCMH designation in order to incent clinics to maintain PCMH and get the IHDE functional
Involve more community stakeholders committed to health care transformation
recording sessions for future listening.
The SHIP staff was presented with challenges in bringing all the RC members up to speed specific to understanding the RC's function and goals
Collaboration with local specialists on referrals
NA
More time 3yrs is inadequate to make changes we are hoping for
Access to data, if possible
Better it support to coordinate IHDE and EMRs
Ongoing meetings after SHIP "expires"
I do not believe we could have done anything differently. Clinics had the QI for transformation help. And lack of motivation/participation is not something you can force.
Marketing the projects and resources to the physicians and other providers beyond the admin staff
1) Access to data, 2) Sustainable funding, and 3) 2-3 shared statewide goals/measures that all RC could influence
To help us better achieve our goals, it would have been beneficial to have better access to data. Some of our clinics didn't have great accessibility to data through their own EMR and experienced many barriers and had to create separate systems to get the data (for some clinics this process took over a year alone to achieve). Setting realistic goals would have been helpful for our clinics as well. PCMH Transformation is expected to take 12 months for a clinics according to NCQA experts, however when they are required to participate in other activities along the way (webinars, collaboratives, coaching calls, QI specialist interaction, Healthy Connection visits, IHDE communications etc.), the time frame should have extended to allow for these activities as well. I believe it would have helped reduce

12. In the future, what could be done differently to help your RC to better achieve their goals?
staff frustration and burnout with transforming to the PCMH model. If we aligned better with organizations from the very beginning it may have made the transition or "warm hand off" to other entities, such as Medicaid smoother.
Financial resources would be helpful.
Maintain permanent staff
I'm not sure
Help with initial organization of our clinic. We were given a lot of information and paperwork at the beginning that needed organized.
Improved reimbursement opportunities that support PCMH transformation activities (care coordination, patient outreach, patient education, etc.) would be helpful. Improved alignment between payors, regulatory agencies, and PCMH accrediting bodies is critical for sustaining the work.
n/a
Creating programs with lasting change instead of just convening every quarter to discuss issues and topics.
More focus at the beginning
sustainability, and including all medical provider types
Focus on clinics getting their certifications via the quality specialists at the public health departments

13. How likely is it that your RC or an RC-like group continue after the SHIP grant ends?



#	Answer	%	Count
1	Very likely	14.29%	5
2	Likely	37.14%	13
3	Neutral	31.43%	11
4	Unlikely	11.43%	4
5	Not likely at all	5.71%	2
	Total	100%	35



14. How do you envision your RC evolving in the future?

14. How do you envision your RC evolving in the future?
we are talking about a future project supporting the community schools in our region
We hoped to have support from the Medicaid Value Care program in regard to funding from shared savings or front end loaded by Medicaid (so we didn't have to wait for shared savings) and take over the function of the CHOICe advisory boards. This is uncertain and the dates have been pushed back for implementation of the Value Care program. I could see the concept of the CHOICe groups fitting well with the RC structure, but the lack of funding to continue having administrative support for the RC will make it very difficult to continue after the grant.
I would like to see the MHN concept come to life. I think we're still trying to figure out what the MHN really is.
Don't know
Focus more on the MHN
Alignment with Medicaid ACO Transformation and potentially using shared savings funding for community projects.
We have really enjoyed the collaboration the RC provides and hope that continues.
More partners joining so our group is more inclusive and can be a stronger collaborative and voice for health care and patients
Support for sustainability of NCQA recognition.
I envision this area evolving into and RCO model to contract with Medicaid on a capitated model of care
Not sure. It depends if someone is facilitating the group, members' time, and financial support.
I am not sure
Possibly more involved in assessing provider/community needs to achieve triple aim and serving as a great resource to seek funding to support transformation
I would like to see additional care management training and it would be helpful as an RC to work with local specialists on referrals and getting reports back.
Continuing with emphasis on population health and to offer a distinct role in our community for the promotion of better health for all ages
Combine with region 4
To provide support to communities
Continue collaborating
Hopefully we continue to meet.
I do not believe our RC can be sustained. Monthly meetings were reduced to every other month. The bi-monthly meetings were reduced to quarterly meetings. The next step is bi-annual meetings and, in my opinion, The RC does not have a purpose.
The health district relationship matures, the visibility to the community grows, the regional QI improves
if RCO is available, this will be the place for RC activities
I see it becoming a part of CHOICe and continuing to identify top priorities that can help move Idaho closer to achieving the triple aim.
Since we have identified that for our region the RC will likely not be sustainable, we hope to continue to develop connections between the RC members so they can reach out to each other for continued transformation support.

14. How do you envision your RC evolving in the future?
Additionally, we will continue as a PHD to help foster healthcare transformation through the implementation of our other grants that focus on working with clinics in the areas of chronic disease, comprehensive cancer, etc.
The RC needs a neutral organization leading it and getting all of the clinics together. Public health is useful because they know about so many resources and can act as the connector for the clinics. They know which clinics could mentor the others, etc. I don't see the RC evolving in the future if there isn't an organization like public health who is willing to lead it.
Continue to promote system integration
Clinics working together with already existing relationships and networking to work together and answer questions
Monthly check-ins to see how we are doing and if we are still on track with the program
We have two major healthcare systems in our region, one of which has a quality improvement organization that includes several SHIP clinics. Those clinics will likely continue to collaborate with PQA. The other system is not likely to join this quality improvement organization. Public health has several contracts that include the convening of health coalitions. These public health programs can/will encourage participation by SHIP clinics and will continue to work toward specific clinical improvement goals.
The RC will likely be absorbed by other existing coalition and workgroups.
Our CIN intends to move forward with our pop health initiatives using some of the connections gained thru the medical health neighborhood.
Combining with RC3 and aligning with major public and private payers
Adding more provider type/specialties, to include all for greater impact. Discuss issues pertaining to our area, including all aspects of care.
Focusing on having the quality specialists help clinics who are interested with PCMH/NCQA certification. And having the quality specialists know that she can call on other members of the present collaborative to help give presentations or touch base with those who are trying to progress. I don't see anything happening with the Medical Neighborhood other than what the Public Health Department already does.

15. What is the type of support you would need in the future to sustain your regional activities?

15. What is the type of support you would need in the future to sustain your regional activities?
admin and project management support
I believe the current members of our RC would continue to volunteer their time as well as our leadership team beyond the grant period. The main issue is funding needed to provide ongoing administrative and technical support and guidance so that the RC has a clear purpose and the ability to identify resources to achieve goals.
we need the support of the clinics that are transforming...we need to know what they need and what they would find most helpful. We had a few clinics represented but mostly health systems.
Staff, data management, meeting organization
Funding for operational support and data
Administrative/operations support, a neutral space to convening multiple partners.
Unsure
The coordinating of the group by public health is invaluable. If left in private practice hands it won't happen. Time to make it grow and develop is always a challenge as well, but it’s pretty hard to create more of that.
Quarterly meetings to keep clinics up to date on changes in NCQA requirements.
See above, there needs to be a way to pay for doing care differently (i.e., non-RVU based pay for maintaining the health of populations of people).
Convening organization and financial support
More input on topics to be discussed.
Administrative support as well as convener to support RC and create the ongoing link and relationship to the Statewide effort
Not sure
Money/funds to support/sustain this important effort
$ and administrative support
Having a facilitator to convene meetings, create a vision for the group and workplan
It support for integration of data exchange
Someone to continue to organize.
Motivation. Guidance. Leadership.
Need admin support at the PHD regional level.
.
Funding and some form of structure or leadership at the state or regional level
In order to sustain the depth of work that has been done through our RC we would need a funding mechanism. We can continue to foster transformation through other grants as I described above, but we cannot solely focus on PCMH transformation and MHN development in the same capacity as we have over the past 3 years. It takes dedicated staff time towards this effort to meet with clinics, help them identify resources and strategies for transformation. It also takes dedicated staff time to convene the collaborative and develop relationships between the clinics and medical health neighborhood partners to work towards population health goals as a region.

15. What is the type of support you would need in the future to sustain your regional activities?
The QI Specialist offered the most benefit because of their work with all of the clinics and ability to share resources that clinics may or may not have known they needed.
Continue to remote collaboration
Financial, some kind of common goal as clinic learn more about PCMH and become recognized they don't need as much support plus they have already networked they need less help from the RC
Tracking progress
An organizational framework, continued state leadership, continued provider champion support, a regional QI specialist/community liaison
n/a
Continued educational resources and grant funding for financial assistance if available.
admin support to help convene
leadership
Funding to keep the Quality Specialists going.

REGIONAL COLLABORATIVE SURVEY

IDHW conducted an online survey for the Regional Collaborative (RC) in July 2018

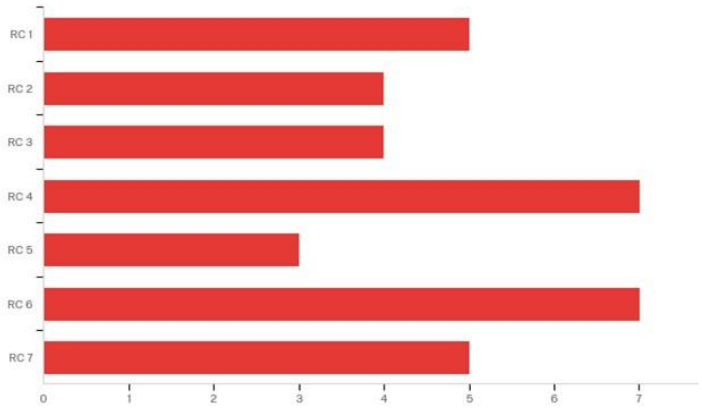
The survey was distributed via email to 165 RC members in July 2018. The team received 35 survey responses (21% response rate).

Statewide Healthcare Innovation Plan
Improved health, improved healthcare, and lower cost for all Idahoans

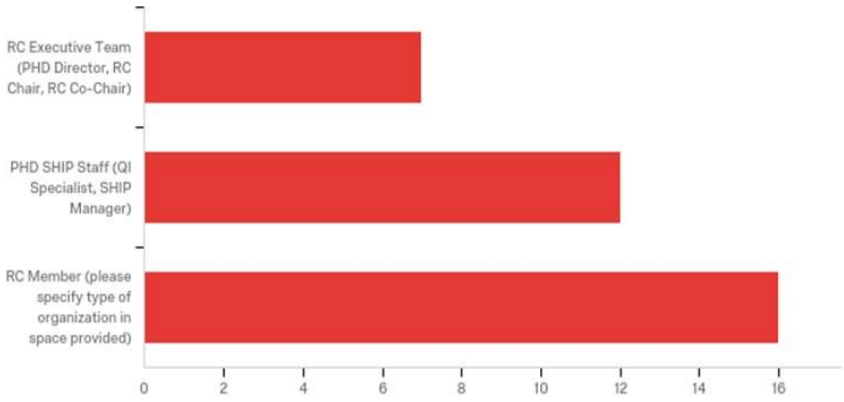
THE LANGDON GROUP

qualtrics

SURVEY RESULTS: RESPONDENT PARTICIPATION IN RCs



SURVEY RESULTS: RESPONDENT ROLES IN THE RCs

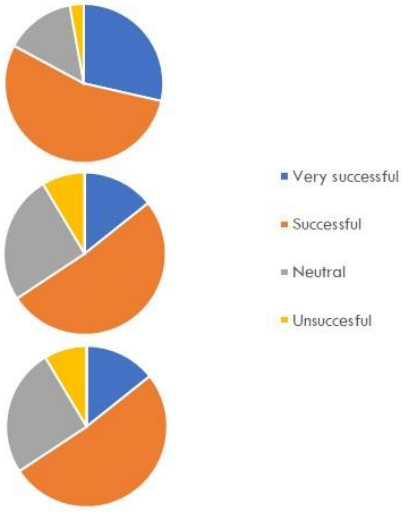


SURVEY RESULTS: SUCCESS IN ACCOMPLISHING GOALS

29 of 35 respondents (83%) indicated that their RC was very successful (10) or successful (19) in providing local leadership and support for healthcare transformation.

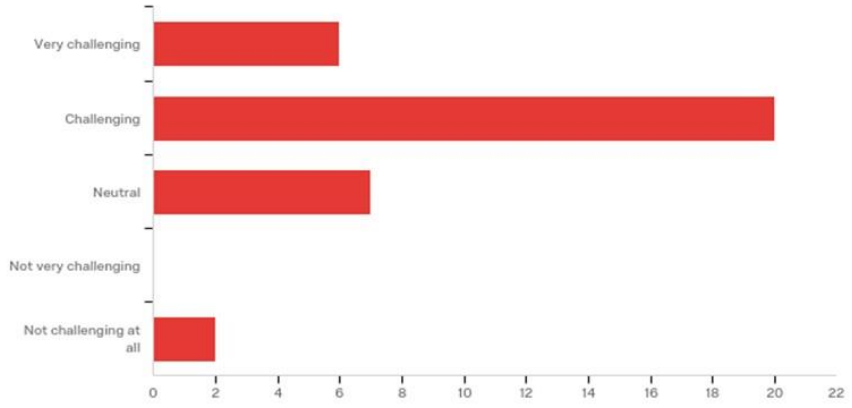
23 of 35 respondents (66%) indicated that their RC was very successful (5) or successful (18) in the development of the medical-health neighborhood.

24 of 35 respondents (68.5%) indicated that their RC was very successful (5) or successful (19) in improving population health to achieve the Triple Aim.



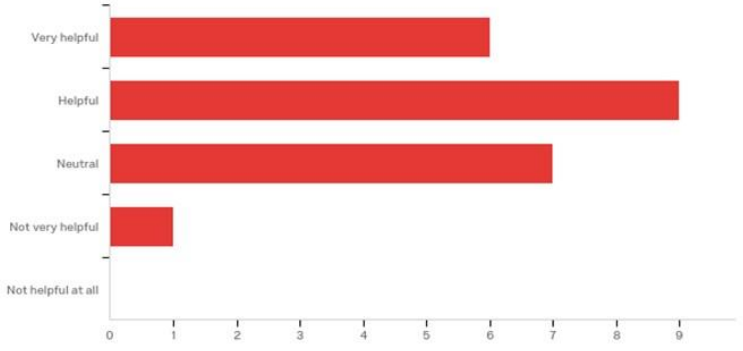
SURVEY RESULTS: LEVEL OF DIFFICULTY

26 of 35 respondents (74%) indicated that the level of difficulty in fulfilling their function was challenging (20) or very challenging (6).



SURVEY RESULTS: TECHNICAL ASSISTANCE AND ADMIN. SUPPORT

15 of 23 of non-PHD staff respondents (65%) indicated that the technical assistance and administrative support their RC received in achieving their goals was very helpful (6) or helpful (9).



OTHER SURVEY RESULTS (HIGHLIGHTS)

18 of 35 respondents (51%) indicated that it is very likely (5) or likely (13) that their RC or an RC-like group will continue after the SHIP grant ends (6 indicated it is unlikely or not likely at all).

Other

QUESTIONS?

Statewide **Healthcare Innovation** Plan

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

Goal 3

Sustainability Initiatives

(Continued)

1) Care Coordination Network – continuing support provided by the Federal Reserve Board https://www.idcarenetwork.com/

2) PHD3 and PHD4 Regional Organization – discussions are continuing to merge the regional collaboratives in Districts 3 and 4. A charter and business plan have been developed to foster continued collaboration and a funding model has been developed. Funding opportunities are being solicited to continue support of this initiative.

3) PCMH Student Education Series – Idaho State University and Public Health District 6 launched a program to educate health sciences majors in various disciplines as far as the Patient Centered Medical Home. These one-day educational events have continued post SHIP to educate students to the concepts of team-based care, care coordination and care management where the patient is actively involved and engaged in their health care.

4) Suicide Prevention Program – PHD6

The suicide prevention program initially started by Public Health District 6 (PHD6) as a SHIP initiative in their district has been continued as an ongoing program The PHD6 SHIP Manager was hired to implement and design this program.

5) Health Home Initiative – PHD 7
https://depts.washington.edu/nwbfch/archives/medical-homes-idaho-3-lessons-learned

6) Live Better Idaho – https://www.livebetteridaho.org/ Social Determinants of Health Initiative through DHW

7) Blue Cross of Idaho Foundation – Behavioral Health Integration in Schools
https://www.bcidahofoundation.org/impact/

8) Division of Behavioral Health Program with Optum – Integration of Behavioral Health Services for Medicaid Recipients through school programs

9) IIBHN – PHD 1, PHD3, PHD4 and PHD 6 & 7

Aligning and Advancing Integrated Behavioral Health

Across the State of Idaho

A Stakeholder's Report DECEMBER 2017

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER

IDAHO DEPARTMENT OF HEALTH & WELFARE

Emma Gilchrist, MPH
Lina Brou, MPH
Stephanie Kirchner, MSPH, RD
Stephanie Gold, MD
Jonathan Muther, PhD
Shale Wong, MD, MSPH

Eugene S. Farley, Jr. Health Policy Center
University of Colorado School of Medicine

December 2017

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Background

Idaho is redesigning its healthcare system with a state innovation model grant from the Center for Medicare and Medicaid Innovation. The goals of Idaho's State Healthcare Innovation Plan (SHIP) are to improve Idahoans' health by strengthening primary and preventive care through the patient centered medical home (PCMH), and evolve from a fee-for-service, volume-based payment system of care to a value-based payment system that rewards improved health outcomes [1].

Whole person, patient-centered care requires meeting both physical and behavioral health needs. The separation of physical and behavioral health is costly and results in poorer health outcomes. With PCMH transformation efforts underway with SHIP and previously in the Medical Home Collaborative, there are opportunities to better integrate behavioral health.

The Farley Health Policy Center advances policy to integrate systems that address the wholeness of a person, their physical, behavioral and social health in the context of family, home, community and the healthcare system. The FHPC works with states to understand achievable policy actions to improve the integration of behavioral health across health and healthcare systems. With support from the Robert Wood Johnson Foundation, the FHPC partnered with the Idaho Department of Health and Welfare-Division of Behavioral Health to provide assistance to advance integration of behavioral health in Idaho. Through a series of conversations to better understand current efforts and needs, the FHPC and Division of Behavioral Health began planning for a stakeholder convening with the aim to align a statewide vision for integrated care and to identify action steps for moving forward collectively.

The Division of Behavioral Health organized the participant invitee list, starting with stakeholders from the Idaho Healthcare Coalition and the State Healthcare Innovation Plan (SHIP) Behavioral Health Integration Workgroup. To gather input from stakeholders and prepare for the convening, invited participants received an online survey to help develop the proposed vision, define current barriers and assets to integrating behavioral health, and values to guide effective integration. Respondents were also asked to review and provide additions to a list of stakeholders in Idaho working on integrating care. Survey responses were synthesized and presented in aggregate at the convening. Findings shaped the goals for the day and guided content for the discussions.

Data from Medicaid's fee-for-service claims database and from Optum's Idaho Behavioral Health Plan (fiscal year 2016) were analyzed to establish a baseline understanding of behavioral health services in Idaho and to inform the convening's discussion. Behavioral health diagnoses for analysis included mental health disorders and substance use disorders. See Appendix A for data analysis methods. These data were presented at the convening, providing a broad overview of the epidemiology of behavioral health among Idaho's Medicaid population to inform how integration efforts may be directed to those in need of behavioral health services.

The stakeholder convening was held on Thursday, November 9, 2017 in Boise, Idaho. The convening agenda and list of participants are found in Appendix B and C. In addition to the participant survey and behavioral health data, presentations included cost and clinical outcomes of integrated care and best practices for operationalizing integration. Breakout sessions focused on community and state strengths and gaps; prioritization of activities; and building relationships among participants for future work to advance behavioral health integration across Idaho.

This report describes the survey and claims data collected and analyzed, as well as the discussion and action items prioritized during the convening.

Vision and Values

The following vision statement and values were written and tailored to reflect the specific input collected from Idaho state leadership and convening participants:

Vision: *All Idahoans are able to receive affordable and quality care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.*

Values:

- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services across the state, including rural and frontier areas.
- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Providers sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and providers should remain open to innovation and collaboration to best meet the needs of patients and families.

Behavioral Health Data

In 2015, more than 43 million Americans experienced a mental health issue, 20.8 million experienced a substance use disorder, and 8.1 million experienced both [2]. Within the healthcare delivery system in 2014, there were 65.9 million visits to physician offices and 5 million emergency department visits for patients with a primary diagnosis of a mental health disorder [4, 5]. Additionally, there has been a staggering increase in the age-adjusted rate of suicide, up 24% from 1999 to 2014 [3].

At the state level, 20% of Idahoans experienced a mental health issue which is slightly higher than the national prevalence of 18% [4]. With regard to substance use, 8.1% of Idaho's adult population reported substance dependence or abuse, equivalent to the national prevalence in 2014-15 [4]. Over a third (37%) of adults in Idaho self-reported having poor mental health status. Thirty-three percent of Idaho's overall population is low-income [5], a well-documented risk factor for behavioral health issues and a barrier for healthcare access.

Insurance coverage is an important marker of behavioral healthcare access. Figure 1 shows the distribution of health insurance coverage in Idaho for 2015; 48% of the population was covered by employer-based insurance, 18% Medicaid, 14% Medicare, 11% uninsured, 8% non-group, and 1% other public insurance. From 2013 to 2015, the uninsured rate for Idaho decreased from 15% to 11%, corresponding with the implementation of the Patient Protection and Affordable Care Act (ACA). Medicaid/CHIP enrollment also increased in Idaho since the implementation of the ACA.

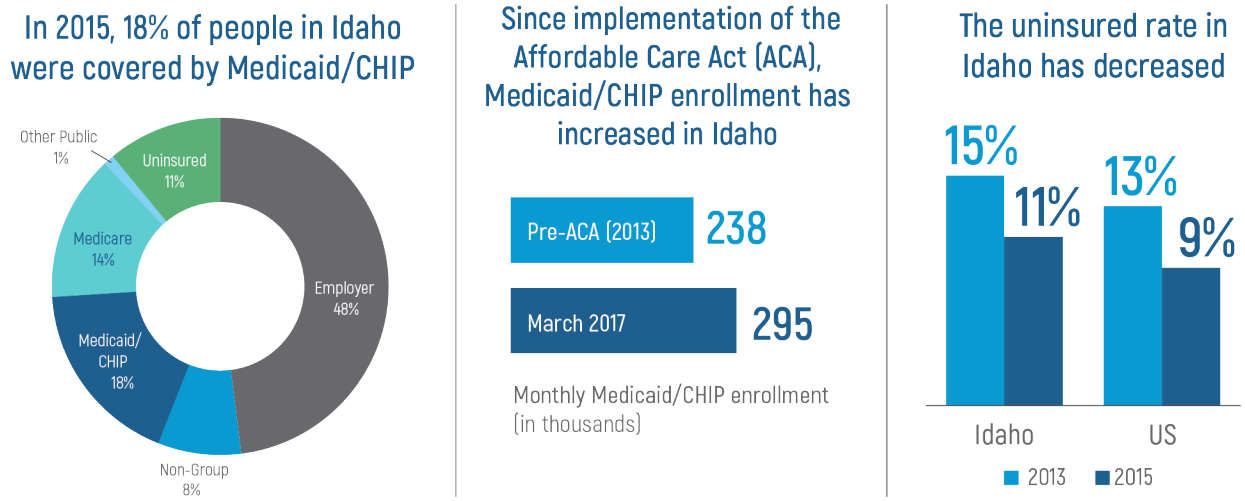

Figure 1. Health Insurance Trends in Idaho [5]

Medicaid's Role in Behavioral Health

As the single largest payer in the United States for behavioral health services, including both mental health and substance use services, Medicaid plays a critical role in the integration of behavioral health. In 2009, Medicaid accounted for 26% of behavioral health spending in the United States [6].

While one in five Medicaid beneficiaries had behavioral health diagnoses, they accounted for almost half of total Medicaid expenditures in 2011, with more than $131 billion spent on their total cost of care [6].

Medicaid – State of Behavioral Health in Idaho

In fiscal year 2016, 277,657 Idahoans were enrolled in Medicaid (22.1% of the total state population). Medicaid spending totaled $2.1 billion in 2016, and 1 in 6 dollars spent overall in

the health system was in Medicaid. According to the Kaiser Family Foundation, 16% of the state general fund spending in Idaho is for Medicaid and 46% of all federal funds received by Idaho are for Medicaid. Almost all (93%) of Medicaid beneficiaries in Idaho are in primary care case management [5]. Behavioral health services are carved-out in a managed care plan managed by Optum, the Idaho Behavioral Health Plan. This plan does not include inpatient behavioral health services.

For FY 2016, within fee-for-service (FFS) claims, 108,185 (39%) Medicaid members had either primary or secondary behavioral health diagnoses. Among Medicaid managed care enrollees in the Idaho Behavioral Health Plan (IBHP), 49,970 (17%) had primary or secondary behavioral health diagnoses. With an average of 301,458 IBHP members with a Medicaid benefit, only 29,507 Medicaid members utilized IBHP behavioral health managed care services. This means fewer than 10% of IBHP members with a Medicaid benefit utilized behavioral health managed care services. Thus, there is a significant opportunity to address this discrepancy between need for behavioral health services and access to behavioral health care. Nearly eight percent (7.7%) of members with a primary or secondary behavioral health diagnosis in the FFS model were diagnosed with serious mental illness (SMI), defined as having bipolar disorder, schizophrenia, or other psychotic disorders; while for the managed care model, 16% of members were diagnosed with a SMI as either their primary or secondary diagnosis. The need for both physical and behavioral health services for those with diagnosed SMI requires acute attention to access and coordination of care.

Regarding expenditures, $387 million was spent in FY16 on FFS members with behavioral health diagnoses, which accounts for 27.6% of total FFS costs. Figure 2 describes the services that make up the cost of claims for these Medicaid members. Nearly half are outpatient services (including 12.3% for home health; 6.4% for office-based; 8.2% for school-based; and 0.4% for emergency services); 19% to pharmacy; 12% each to residential and intermediate treatment; 9% to inpatient services; and 1% to other costs including medical equipment, labs, and radiology.

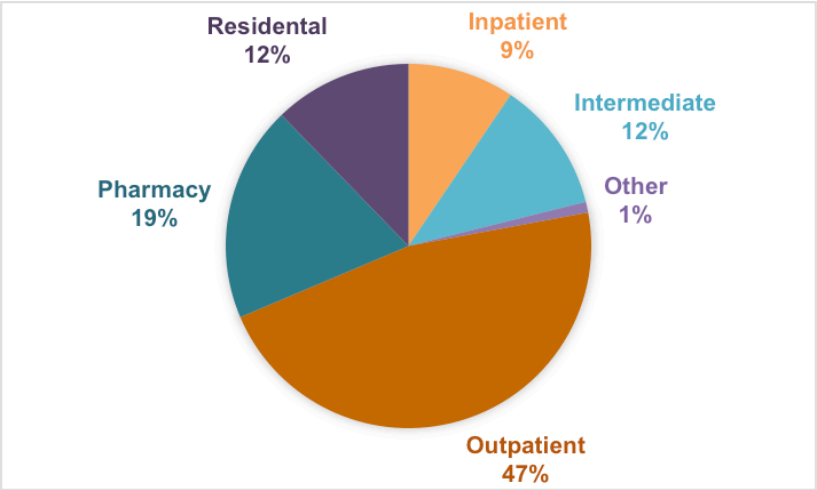

Figure 2. Sites of Service for FFS Behavioral Health Claims, FY16.

Figure 3 shows the annual cost per member by region and stratified by FFS and managed care organization (MCO) claims, and by severity of disease defined as SMI or non-SMI (MCO denotes the Idaho Behavioral Health Plan). Because the data used for this analysis comes from two different de-identified sources, the number of members that overlap between FFS and MCO data is unclear. This figure is intended to demonstrate cost variation by region and severity of illness rather than direct comparison between FFS and MCO data.

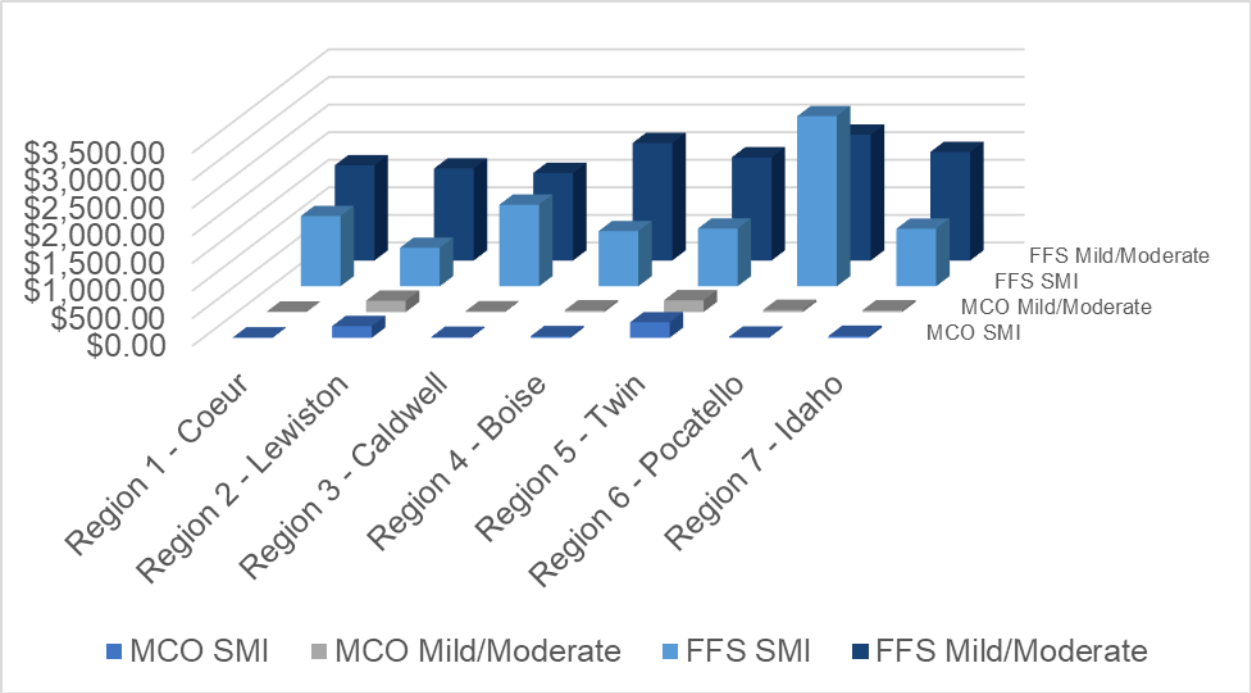

Figure 3. Annual Cost per Member by Region

Collating data from multiple, fragmented sources creates challenges for data management and analysis. Integration of systems to align data collection and measures is essential in addition to integration of payment and delivery systems.

For more detailed results of these analyses, refer to Appendix D for additional tables and figures. See the Tools and Resource section of this report for a link to an interactive, online map of behavioral health data in Idaho

Barriers and Assets to Integrating Behavioral Health

Efforts to better integrate care are happening across the nation and across Idaho. The transformation of care delivery to address both physical and behavioral health conditions is supported by a variety of assets and innovations in Idaho, while simultaneously hindered by existing barriers including fragmentation of payment models. The barriers and assets to

integrating behavioral health identified by convening participants are listed below, organized by domain.

Organizing the movement

Barriers: A driving force to hold this stakeholder convening was the identified challenge that although there are multiple entities in the state of Idaho focusing on increased access to behavioral health services, many are currently working in isolation, without a shared understanding of common goals or current work. Influential partners often do not know how to connect and align their efforts, resulting in redundancies and potentially missed opportunities, both at a community and policy level. This convening allowed for some of those communication gaps to be identified and acknowledged, with a commitment to improved collaboration moving forward.

Assets: Idaho's SHIP has provided tremendous opportunity to transform care, including behavioral heath. SHIP has provided recognition of the importance of integrated behavioral health as well as the structure to advance transformation. Additionally, stakeholder engagement and commitment to meeting behavioral health needs through better integrated care is an asset. While there is an issue of efforts and organizations working in isolation in areas, there are also many great community partnerships across disciplines and public and private entities. A complete list of stakeholders identified through the online survey, at the convening, and by the Division of Behavioral Health can be found in Appendix E. Stakeholders include primary care and behavioral health providers and educators, healthcare systems, and agencies and organizations such as the Idaho Department of Health and Welfare and the Idaho Primary Care Association. Participants identified the fact that policy and decision makers are aware of the need to improve behavioral health care, and are poised for change, is an asset.

Workforce, education, and training

Barrier: There is widespread agreement both nationally and in Idaho that the current clinical workforce lacks sufficient diversity, appropriate geographic distribution, and opportunity for inter-professional education and development. There is an immediate need to create and support professional development programs to enable psychologists, social workers, counselors, nurses, physician assistants, physicians, and others to work in integrated settings with a clear understanding of roles and competencies. Stakeholders identified the shortage of behavioral health providers, low pay for primary care and behavioral health providers, and difficulty engaging with primary care providers as challenges to advancing integrated care.

Assets: Academic training programs, like the Family Medicine Residency of Idaho, Boise VA Medical Center primary care psychology postdoctoral program, Boise VA nurse practitioner residency program, and University of Washington-Boise internal medicine residency, provide exposure to and incorporate behavioral health into general medical settings. Local training programs help grow a workforce more likely to stay within the state and prepared to work in integrated settings. A new asset identified by stakeholders is the Idaho Integrated Behavioral Health Network, a newly developed learning collaborative designed to support the growth of

integrated behavioral health programs and to assist in team-based care management of co-morbid medical and behavioral health conditions in primary or specialty care clinics. The learning collaborative develops networking and clinical training opportunities for behavioral health providers and advocates for best practices of integrated care.[7]

Financing

Barriers: Both nationally and locally in Idaho, achieving integration is slowed by financial arrangements that separate out mental and physical health benefits, payments, and services. Fractured payment systems have made it difficult to build and sustain primary care practices with integrated behavioral health providers. There are ongoing efforts with payers in Idaho to better understand the value of behavioral health integration and institute changes in payment models to create an environment where primary care can financially sustain behavioral health services; however, this remains a significant challenge.

Within the current FFS model, there is a lack of sufficient billing codes to support integration. Though convening participants expressed optimism that new codes may become available as soon as 2018, currently participants believe that there are limited billing codes available to support behavioral health services in primary care.

Assets: Although financing was the top barrier identified by convening participants, a few innovations in payment support for integrated behavioral health were highlighted, including new, albeit limited, insurance payment for tele-psychology, Optum's support of newer integrated codes as mentioned above, development of Regional Care Organizations, and Medicaid Healthy Connections tiered payments which include behavioral health integration as an option qualifying for a higher payment tier.

Technology

Barriers: Even in places where technology can enable the exchange of behavioral health data, it is not being used to its full capacity. Extreme privacy practices around behavioral health are often driven by misunderstandings, inconsistent legal interpretations, lack of education of clinical and administrative staff, and conservative legal interpretations by provider organizations, all leading to the inability to coordinate and integrate care.[8] Again, Idaho mirrors these nationally identified challenges. Regulations related to data sharing about behavioral health services have been interpreted in multiple ways, and many providers expressed that they do not have clear guidance on how and with whom it is appropriate to share behavioral health notes, diagnoses, and treatment plans.

Assets: One of the main goals of the SHIP is to improve care coordination through the use of EHRs and health data connections among patient-centered medical homes (PCMHs) and across the medical neighborhood. The Idaho Health Data Exchange (IHDE) provides a platform for data sharing, and together with SHIP, has been connecting more practices across the state. While challenges with behavioral health data sharing remain, IHDE has been requested to provide educational support, and demystify and offer guidance for sharing data.

Care delivery

Barriers: Primary care practices are integrating behavioral health to help overcome barriers due to lack of access and the stigma of seeking and receiving behavioral health care. Some providers acknowledge feeling overwhelmed with the practice transformation necessary for team-based, integrated care. Practices identified the need for technical assistance and resources to help operationalize integrated care. Other challenges include needing support for referrals and transitions of care when integrating within a practice is not feasible.

Assets: There are many efforts across the state to integrate behavioral health into primary care. Stakeholders recognized the work of integration leaders: Family Medicine Residency of Idaho, Terry Reilly and other FQHCs, St. Luke's Health Partnerships, Saint Alphonsus, and Lifeways. Additionally, many endorsed that efforts through SHIP and earlier in the Medical Home Collaborative have spread the PCMH model, laying a foundation of advanced primary care with more capacity for integration. Other efforts to improve behavioral health in Idaho include the work of organizations in the non-profit community such as the Suicide Prevention Action Network of Idaho, Idaho Voices for Children, mental illness intensive care programs, mental health crisis centers, and peer support programs.

Population and community health

Barriers: Integrating behavioral health care is a strategy to meet behavioral health needs and support the health of broad and discrete populations. Coordinating systems for data collection around clear adult and pediatric behavioral health measures and having defined metrics and benchmarks for achieving improved and equitable care are challenges for all states, including Idaho. Disparities in access to care in frontier and rural areas, as well as the lack of Medicaid expansion and the resulting coverage gap were identified as significant barriers.

Assets: Stakeholders recognized the role of agencies and organizations in addressing behavioral heath needs, convening stakeholders, and leading innovative partnerships to advance integrated behavioral health to improve population health. Among those highlighted, the Department of Health and Welfare Divisions of Behavioral Health, Medicaid, and Public Health, Regional Behavioral Health Boards, and the Public Health Districts were named. Additionally, a recent grant awarded to Idaho Voices for Children focuses on consumer advocacy for transformation as a strategy to develop and incorporate a permanent consumer voice and community home for health systems change.

Opportunities to Advance Integration

After indexing current barriers and assets, convening participants identified short term (3-6 months) opportunities to advance integrated care in Idaho. These opportunities were discussed in small groups and reported out to all participants. Each individual then voted on their top two priorities for action from the collated list of reported suggestions. The following synthesis highlights opportunities identified as priority action areas.

Organizing the movement

Having a shared language among all stakeholders is an important precursor for change. Currently, different stakeholders use different definitions and have different understandings of integrated care. Without a shared definition, creating unified strategies for payment reform, workforce, education, and care delivery to achieve and scale integrated care can be challenging.

- Create a shared definition for integrated behavioral health in Idaho. Leverage existing definitions (i.e., AHRQ Lexicon for Integrating Behavioral Health and Primary Care) and expand or adapt to reach consensus on a shared definition for Idaho's efforts to integrate care, including the role of integration in hospitals and primary care working in specialty mental health.
- Use SHIP efforts as a platform to disseminate educational materials to begin using a shared definition.

Achieving and advancing integrated care requires committed stakeholders to champion the cause. Convening participants demonstrated the dedication, passion, and expertise to advance the work of integrating care.

- Build collaboration with this stakeholder group and SHIP Behavioral Health Integration Workgroup to continue multi-stakeholder conversations and act on recommendations.
- Assess stakeholder engagement and recruit missing stakeholder groups to fill any gaps to ensure sufficient representation from primary care, patients and community members, universities, and training programs in addition to local and state public health and government agencies.

Workforce, education, and training

Efforts to train the existing workforce and educate the upcoming workforce are critical to Idaho's integrated care efforts.

Current workforce:

- Educate primary care providers on the value of integrated care and the scope of health conditions behavioral health providers can address, including mental health diagnoses, substance use disorders, and health behavior change.
- Provide assistance to primary care providers to understand the type of behavioral health provider needed to meet their patients' behavioral health needs. Encourage behavioral health providers to follow up with primary care providers on psychiatry referrals to assess whether appropriate for specialty mental health, or if the patients' needs could be met in the primary care office with an integrated behavioral health provider.
- Partner with Optum to train behavioral health providers to understand the broader healthcare continuum and role of integrated services.
- Build learning communities among providers to share best practices and tactics for overcoming challenges. Explore the mentorship program within SHIP and peer-to-peer mentoring with Idaho Integrated Behavioral Health Network as opportunities to grow learning communities.

- Conduct a workforce assessment to describe the current behavioral health workforce. Assess behavioral health needs to understand where workforce distributions (across regions and settings) may be needed as a means to better address the gap between identified behavioral needs and access to services.
- Assess where current integrated care providers are educated and trained to inform opportunities for recruitment and training the future workforce to provide integrated care.

Future workforce

- Within the WWAMI states (Washington, Wyoming, Alaska, Montana, and Idaho), advocate for PCMH training to include behavioral health.
- Support the state legislature's current consideration of increased funding for residencies and training sites for behavioral health professionals. Explore better reimbursement for trainees.
- Assess Idaho's medical and behavioral health training programs and advocate for tracks or education pathways to prepare an integrated care workforce. Learn about current efforts underway to include team-based care in accreditation standards and align support.
- Create partnerships with the VA Center of Excellence and leverage the innovations emerging from the training sites.

Financing

Financing is often identified as the biggest barrier to delivering integrated care. While efforts to fully reform the payment system to support integrated care delivery are needed to scale efforts, participants identified the following actions to achieve iterative, short-term success in financing integrated care.

- Provide opportunities for payer-led education for providers on available billing codes for integrated care, how to better utilize existing funding in the system, and current value-based payment models.
- Convene payers to align incentives and measures for integrated care.
- Inform payers of the business case for integrated care and assist practices in developing their specific case to present to payers.
- Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.

Technology

There is a need for information to be shared across provider types and settings to support integrated care. Although the infrastructure may exist to advance data sharing, efforts to improve understanding of what is allowable is needed.

- Partner with Idaho Health Data Exchange to educate providers on data sharing, including the state statute on psychotherapy versus progress notes.
- Assess how telehealth dollars are being spent and how resources can be maximized.

- Leverage Project ECHO as a platform to spread telehealth.
- Advocate for reimbursement of telehealth provided by non-prescribing behavioral health providers.

Care delivery

There are many practices and health systems across the state restructuring their care delivery to provide integrated care. Building on these innovative practices provides an opportunity to scale efforts.

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care, including on successful business models, how to use data, and competencies for integrated practices and providers.
- Educate providers to use data to understand and assess behavioral health needs within their patient population. If access to the necessary data is lacking, work with state agencies and payers to increase access to current data.
- Explore opportunities to leverage practice efforts to obtain PCMH recognition to focus on behavioral health.
- Develop care compacts between specialty mental health and primary care to establish shared understanding of roles for meeting behavioral health needs, referral standards, and plans for information exchange. Have regular meetings to facilitate collaboration and build a robust bi-directional referral system.

Population and community health

Integrating behavioral health and primary care increases access to behavioral health services at a population level. Additional efforts to integrate across other sectors (such as schools and the justice system), partner with community organizations, and incorporate the patient and community voice in planning can further meet behavioral health needs in the state.

- Educate patients and families to understand the benefits of integrated care.
- Explore opportunities to integrate behavioral health in other settings including schools, correctional facilities, and hospitals.
- Involve patients and families in stakeholder convenings and other planning efforts to advance integrated care.
- Partner with community organizations to understand and meet behavioral health needs. Leverage current opportunities, like Idaho Voices for Children's grant from the Robert Wood Johnson Foundation, to address gaps in behavioral health access and integrate care.

Next Steps

Of the short-term opportunities listed above, the following areas for actions emerged as the top priorities:

Organizing the movement

Create and use a shared definition of integrated care

- Create a shared definition of integrated behavioral health to be used across integration efforts in Idaho.

Workforce, education, and training

Train the current workforce and improve the pipeline for integrated care

- Educate primary care providers on the value of integrated care, the scope of health conditions behavioral health providers can address; and how to identify the type of behavioral health provider needed to meet their patients' behavioral health needs.
- Build learning communities among practices and providers to share best practices and tactics for overcoming challenges.
- Assess Idaho medical and behavioral health training programs and advocate for tracks and education pathway to prepare an integrated care workforce. Learn about current efforts underway to meet accreditations standards and align support.

Financing

Optimize payment for integrated services within the current system

- Provide opportunities for payer-led education for providers on current billable codes for integrated care, how to better utilize existing funding in the system, and understand payers' value-based payment.
- Examine other state strategies to adjust payment policies and reimbursement criteria, such as evolving models of behavioral managed care organizations that differentially cover behavioral health services in primary care and specialty settings.

Care delivery

Support practice transformation with resources and expertise

- Create opportunities to access technical assistance, practice facilitators, integration experts, and resources to operationalize integrated care.

Tools and Resources

Idaho Behavioral Health Mapping Tool

The Farley Center created an interactive mapping tool to better understand behavioral health in Idaho. The map compiles population health outcomes, behavioral health services utilization, and access data from the Divisions of Medicaid, Public Health and Behavioral Health within the Idaho Department of Health and Welfare. Users can map the variables that they would like to compare by region, including the location of providers and services, prevalence of diagnoses, population demographics, and behavioral health outcomes.
Idaho Mapping Tool: https://arcg.is/KuXGi

Eight Core Competencies for Behavioral Health Providers Working in Primary Care

This resource details competencies for onsite behavioral health providers as members of the primary care team in highly integrated practices. Make Health Whole is a communications platform dedicated to advancing whole-person, integrated health. Additional resources will be added to the site in 2018.
https://makehealthwhole.org/

The Integration Playbook

The Playbook is a guide to integrating behavioral health in primary care and other ambulatory care settings. The Playbook's implementation framework is meaningful to organizations at any stage of integration development and of any size. More resources on integrated behavioral health can be found on the AHRQ Academy Portal.
https://integrationacademy.ahrq.gov/playbook/about-playbook

Advancing Care Together by Integrating Behavioral Health and Primary Care

Journal of the American Board of Family Medicine – Supplement
This journal supplement draws lessons and evidence from 19 integrated behavioral health and primary care practices. The articles can be extracted according to a reader's particular interest, but taken together contribute to an emerging picture of complexity, challenge, success, and struggle during the journey to integrate primary care and behavioral health. They are about the "how" of integrated behavioral health and primary care.
http://www.jabfm.org/content/28/Supplement_1
From Our Practice to Yours: Key Messages from the Journey to Integrated Behavioral Health
Innovators integrating behavioral health and primary care share key messages and insight from their practical experiences for use by other practice leaders to accelerate their practice transformation to integrated care.
http://www.jabfm.org/content/30/1/25.full
Outcomes of Integrated Behavioral Health with Primary Care
This article presents quantitative and qualitative data from patients with depression receiving care in integrated primary care practices.
http://www.jabfm.org/content/30/2/130.full

Creating a Culture of Whole Health

This report provides actionable recommendations to begin to scale and spread the integration of behavioral health from more than 70 key informants, focus group participants, and a working meeting of national leaders.
http://farleyhealthpolicycenter.org/cultureofwholehealth/

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Appendix A. Behavioral Health Data Analysis Methods

The Farley Health Policy Center received data from three divisions within the Idaho Department of Health and Welfare: the Division of Medicaid, Division of Public Health, and the Division of Behavioral Health. The following is a list of specific data sources from each department:

- Division of Medicaid
  - Idaho Medicaid FFS claims data, FY16
  - Optum's Idaho Behavioral Health Plan managed care encounter data, FY16
- Division of Public Health
  - Idaho Vital Statistics, Bureau of Vital Records and Health Statistics
    - Birth and Mortality Rates, 2015
    - Pregnancy Risk Assessment Tracking System, 2015
  - Idaho Behavioral Risk Factor Surveillance System 2013, 2015
- Division of Behavioral Health
  - Geographic Data on
    - State Mental Health Hospitals
    - State-Funded Behavioral Health Facilities

For the FFS claims and Idaho Behavioral Health Plan encounter data analyses, the diagnoses, prescription classes and place of service codes used are defined using standard classification methods. The Agency for Healthcare Quality's Healthcare Cost and Utilization Project Clinical Classifications Software (CCS) was used to categorize diagnostic codes from primary or secondary diagnosis listed on the Medicaid claim [9]. The following CCS codes were used to classify behavioral health diagnoses:

HCUP CCS Categories	
'650'	Adjustment disorders
'651'	Anxiety disorders
'652'	Attention-deficit conduct and disruptive behavior disorders
'653'	Delirium dementia and amnestic and other cognitive disorders
'654'	Developmental disorders
'655'	Disorders usually diagnosed in infancy childhood or adolescence
'656'	Impulse control disorders NEC
'657'	Mood disorders
'658'	Personality disorders
'659'	Schizophrenia and other psychotic disorders
'660'	Alcohol-related disorders
'661'	Substance-related disorders
'662'	Suicide and intentional self-inflicted injury
'663'	Screening and history of mental health and substance abuse codes
'670'	Miscellaneous mental health disorders

Prescriptions for Behavioral Health conditions were classified using First Databank's Hierarchical Specific Therapeutic Class Code (HIC-3), which is a component of the National Drug Data File [10]. The treatment setting for claims are classified using the Centers for Medicare and Medicaid's Place of Service Codes for Professional Claims [11].

For the data from the Division of Medicaid, unique member counts were calculated from encounter and claims data and aggregated by Idaho Public Health Districts [12] prior to receipt by FHPC. Descriptive analyses were conducted to describe Medicaid members or the number of services. Fee-for-service claims and Optum's managed care organization (MCO) encounter data were analyzed separately. Because Medicaid beneficiaries can be enrolled in both the fee-for-service and Optum's Idaho Behavioral Health Plan, aggregate-level data cannot differentiate whether an individual was counted in both models; therefore, descriptive statistics are not directly comparable.

While Medicaid utilization and cost data are vital components to understanding behavioral health services, particularly in rural areas where Medicaid is the only payer for behavioral health, our analyses are limited in understanding of trends and distribution of behavioral health in the non-Medicaid population. Although some information can be extrapolated to generalize trends, additional payer data and integrated data collection would provide a more comprehensive picture.

For the Division of Public Health data, descriptive statistics were calculated and aggregated to the Public Health Districts. Geographic data from the Division of Behavioral Health was collected, geocoded and mapped into ArcGIS® software by Esri (Copyright © Esri [13]). These data were used to create the mapping tool for Idaho Behavioral Health data.

Appendix B. Idaho Behavioral Health Stakeholder Convening Agenda

Behavioral Health Integration Stakeholder Convening

Thursday, November 9 | 9:30am-2:30pm | Boise, ID

Convening purpose:
To define a common vision for behavioral health integration in Idaho

Desired outcomes:

- Shared understanding of current practices, efforts and initiatives across the state to integrate behavioral health
- Stakeholder input on the values and priorities that shape an integrated behavioral health system
- Established agreement and variation of the assets and barriers to integrating behavioral health
- Stronger relationships between stakeholders working on these issues across the state
- Delineated next steps that bring stakeholders together

Vision, developed from survey responses**:**
All Idahoans may seek and receive affordable care that recognizes and integrates behavioral health, including substance use, with physical and other health services in their setting of choice without stigma or barriers that limit or fragment their services.

Values, identified from survey responses:

- Every patient should have the right care at the right time with no wrong door for primary care and behavioral health services.
- Payment mechanisms should support provision of behavioral health services to meet patient needs across settings.
- Care should be patient-centered and focus on the needs of each patient and family regardless of ability to pay.
- Clinicians sharing in the care of patients should have mechanisms for seamless communication across teams and organizations.
- Organizations and clinicians should remain open to innovation and collaboration to best meet the needs of patients and families.

Agenda:

9:30am	Welcome and introductions	Gina Westcott
9:45am	What we've learned: Survey results and behavioral health data	Shale Wong, MD, MSPH Lina Brou, MPH
10:45am	Break	
11am	Breakout session: Strengths, gaps, and building relationships	
12pm	Networking lunch	
1pm	Operationalizing integration	Jonathan Muther, PhD Stephanie Kirchner, MSPH, RD
2pm	Integrating together	Shale Wong, MD, MSPH

Appendix C. Stakeholder Convening Participants

Name	Title	Agency
Dr. Rhonda Robinson Beale	SVP-Medical Director	Blue Cross
Sarah Woodley	CEO	Business Psychology Associates
Orla Kennedy	Administrator	Community Catalyst
Jeff Crouch	Regional Director	DHW
Gina Westcott	Hub Administrator	DHW-Behavioral Health
Ross Edmunds	Administrator	DHW-Behavioral Health
Cindy Brock	ACC-Healthy Connections	DHW-Medicaid
David Welsh	Contract Monitor	DHW-Medicaid
Heather Clark	Quality Improvement Specialist	DHW-Medicaid
Mat Wimmer	Administrator	DHW-Medicaid
Burke Jensen	Contract Monitor	DHW-Office of Health Policy
Cynthia York	Administrator	DHW-Office of Health Policy
Kym Schreiber	Contract Manager	DHW-Office of Health Policy
Elke Shaw-Tulloch	Administrator	DHW-Public Health
Dr. John Tanner	Family Advocate	Family Advocate
Dr. Martha Tanner	Family Advocate	Family Advocate
Tori Torgrimson	BH Programs Manager	Family Health Services
Dr. Winslow Gerrish	Chief Psychologist	Family Medicine Residency of Idaho
Dr. Lynn McArthur	Clinical Psychologist	Health West
Lina Brou, MPH	Lead Policy Analyst	Farley Health Policy Center
Emma Gilchrist, MPH	Deputy Director	Farley Health Policy Center
Stephanie Gold, MD	Assistant Professor	Farley Health Policy Center
Stephanie Kirchner, MSPH, RD	Practice Transformation Prgm Manager	Farley Health Policy Center
Jonathan Muther, PhD	Clinical Integration Advisor	Farley Health Policy Center
Shale Wong, MD,MSPH	Director	Farley Health Policy Center
Neva Santos	Executive Director	Idaho Academy of Physicians
Christine Tiddens	Policy Director	Idaho Asset Building Network
Marilyn Sword	Advocate	Idaho Caregiver Alliance
Toni Lawson	Administrator	Idaho Hospital Association
Nicole Pearson	Program Manager	Idaho Primary Care Association
Susan Ault	Director of Care Improvement	Idaho Primary Care Association
Ceci Thunes	Health Policy Specialist	Jannus-Idaho Voices for Children
Claudia Meiwald	Hospital Administrator	Kootnei Behavioral Health
Dennis Baughman	Clinical Director	Lifeways
Ray Millar	COO	Lifeways
Janice Fulkerson	Director of Contracting	Northpoint Recovery
Jennifer Freeman	CFO	Northpoint Recovery
Dr. Tom Young	CEO	Nview Health
Bevin Modrak	Clinical Program Manager	Optum Idaho
Dr. Ronald Larson	Medical Director	Optum Idaho
Georganne Benjamin	Executive Director	Optum Idaho

Jann Stockwell	Sr. Communications Specialist	Optum Idaho
Sara Bartles	Client Relations/Compliance Dir.	Optum Idaho
Sunny Reed	Behavioral Health Case Manager	Pacific Source
Marty Cappe	SHIP PHD3 Support	PHD 3
Rachel Blanton	SHIP Manager	Public Health District 3
Melissa Dilley	PHD 4 SHIP Manager	Public Health District 4
Linda Rowe	Idaho State Director	Qualis Health
Jennifer Yturriondobeitia	BH Programs Manager	St. Lukes Health Partners
Melissa Mezo	Clinical Director	Terry Reilly Health Services
India King	Associate Director	Veterans Administration

Appendix D. Additional Behavioral Health Data Results

In the fee-for-service data, 42% of FFS members had pharmacy claims for BH medications. 19.1% of all pharmacy expenditures go to BH prescriptions, which totals $74.3 million. The following figure describes the distribution of behavioral health prescriptions:

Figure A2. Distribution of BH prescriptions for FFS members

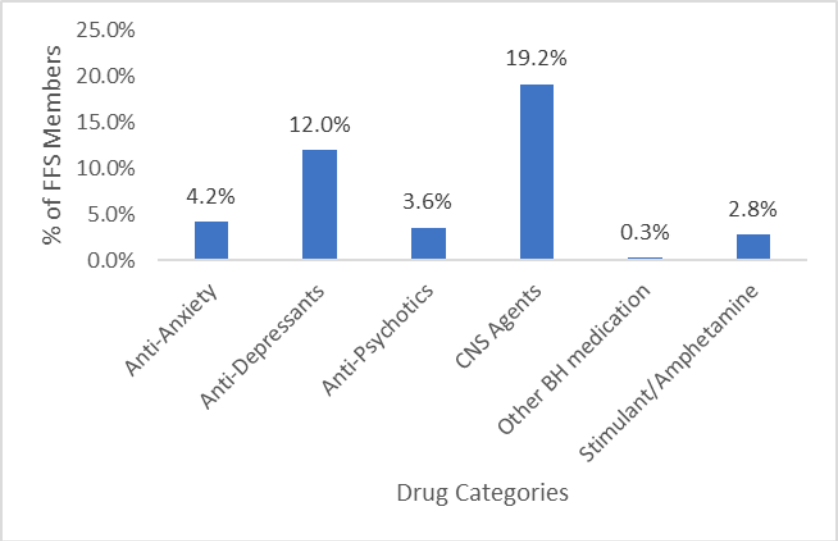
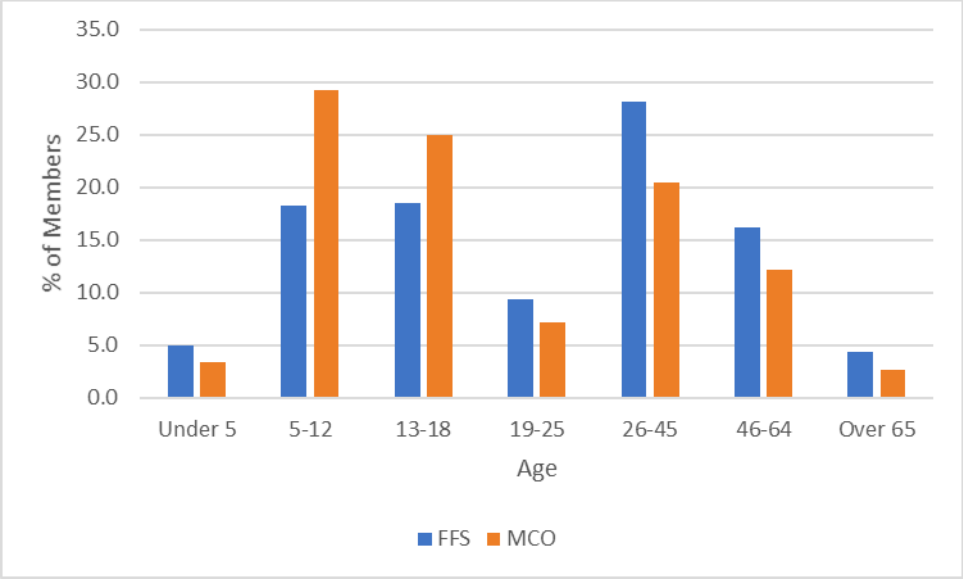


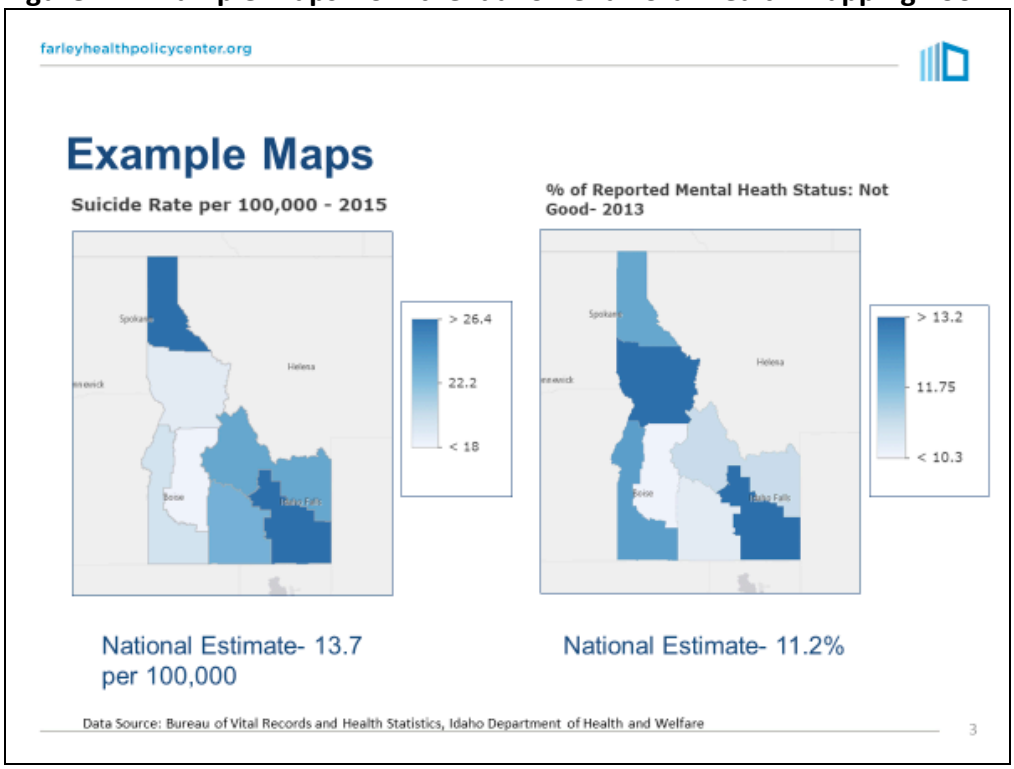
Figure A3 shows the age distribution of the 49,970 members who were enrolled in the Optum Idaho Behavioral Health Plan (MCO) and 108,185 members within FFS in FY16. This figure shows that the MCO members who receive outpatient services under the Idaho Behavioral Health Plan tend to be less than 18 years of age. Given that MCO members may also receive inpatient and pharmacy services within the FFS delivery model, the difference in distributions should be interpreted with caution.

Figure A3. Age Distribution of FFS and Idaho Behavioral Health Plan Members



See the Tools and Resources section for information on an interactive mapping tool that compiles data from three divisions within the Idaho Department of Health and Welfare. Figure A4 displays example maps using the data collected from the Division of Public Health.

Figure A4. Example Maps from the Idaho Behavioral Health Mapping Tool



Appendix E. Behavioral Health Integration Stakeholders

A list of behavioral health integration stakeholders identified by convening participants:

Blue Cross of Idaho
Boise State University
BPA Health
Business Psychology Associates (now known as BPA)
CASA
Clearwater Medical Lewiston
Consortium for Idahoans with Disabilities
Dept of Health and Welfare-Behavioral Health
Dept of Health and Welfare-Medicaid
Dept of Health and Welfare-Office of Health Policy
Dept of Health and Welfare-Office of Suicide Prevention
Dept of Health and Welfare-Public Health
El Centro de Comunidad y Justicia
Empower Idaho
Family Health Services in Twin Falls
Family Medicine Residency of Idaho
Farley Health Policy Center
Head Start
Health Management Associates
Health West Pocatello
Heritage Health
Human Supports of Idaho
Idaho Academy of Family Physicians
Idaho Academy of Physicians
Idaho Association of Counties
Idaho Commission on Aging
Idaho Federation of Families for Children's Mental Health
Idaho Healthcare Coalition
Idaho Hospital Association
Idaho Integrated Behavioral Health Network
Idaho Primary Care Association
Idaho Psychological Association
Idaho Voices for Children
Journey Mental Health
Kootenai Health Network
Kootenai Residency
Kootenai Behavioral Health
Lifeways
Nampa Schools

National Alliance on Mental Illness - Upper Valley Idaho
Northpoint Recovery
Northwest Telehealth Resource Center
Optum Idaho
Pacific Source
Pioneer/Pathways
Public Health Districts
Public Health Executive Directors
Regence
Regional Behavioral Health Boards
Regional Health Collaboratives
SAGE Health Care
Saint Alphonsus Behavioral Health
Shoshone Medical Clinic / Shone Family Medical Center
Suicide Prevention Action Network of Idaho
St. Luke's Health Partners / St. Luke’s Health Systems
Terry Reilly Health Services
University of Idaho
Valley Family Health Care (FQHCs)
Valley Medical Lewiston
Veteran's Administration / VA Medical Center
Warm Springs Counseling
Women’s and Children’s Alliance in Boise

Goal 4

Sustainability Initiatives

Goal 4

1) CHW Curriculum Instruction – Idaho State University will continue to offer the Community Health Worker Curriculum developed through the SHIP initiative.

2) CHEMs Program – Bureau of EMS and EMSAC

Population Health Workgroup

CHEMS Transition Plan

December 5, 2018

Boise, ID

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

CHEMS History

- Nova Scotia, Mexico and Australia
- Community Health Aide/Practitioner, Alaska
- 1995-2000: Red River Project, New Mexico
- 2003-2004: Renewed interest in US
- 2011: Idaho-Ada & Bonner Counties
- 2012: EMSAC Subcommittee
- 2014: Model Test Award

2012 EMSAC Inaugural CP Subcommittee Meeting

Role of the EMSAC Subcommittee

- How do you see your agency/community using Community Paramedicine?
- Ideas for future meetings?
  - Guest speaker from Minnesota or Colorado
  - Medicaid
  - Insurance (Blue Cross/Shield)
  - Hospital/Nursing Associations
- What work needs to be done at the State level (code/rule)?
  - Regulatory roadblocks that need to be removed
  - Regulatory framework that would support programs

Still Relevant Today!

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

SHIP

2016: Community Paramedic Cohort 1
2016: Measures Workgroup
2016: BLS/ILS Workgroup

2017: Community Paramedic Cohort 2
2017: BSU Pilot Study
2017: CHEMS Educational Webinars

2018: Community Paramedic Cohort 3
2018: Learning Collaborative
2018: IHC CHEMS Panel
2018: Peer Mentoring
2018: Statewide Assessment
2018: CEMT Curriculum
2018: CEMT Cohort 1 & 2

IDAHO E·M·S

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

ACCREDITED HEALTH DEPARTMENT · PUBLIC HEALTH ACCREDITATION BOARD · PHAB

Future

- EMS Field Coordinator – CHEMS Coordinator
- Reestablish CHEMS Presence in EMSAC
- Continue to Develop and Pilot CEMT Curriculum
- Designate Standardized Curricula (CP and CEMT)
- Determine Certification Requirement
- Agency Pilot Projects (funding)
- Payment!
- Need for Future Legislation?

Questions?

Wayne Denny
Bureau Chief
Idaho Bureau of EMS & Preparedness
Wayne.Denny@dhw.idaho.gov
(208)334-4000

IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

Goal 4

Telehealth

Sustainability Initiatives

Idaho Department of Health & Welfare

Presentation on Telehealth Needs to the Health Quality Planning Commission

FEBRUARY 06, 2019

IDAHO DEPARTMENT OF
HEALTH & WELFARE

IDAHO State of Idaho Telehealth Council

The Idaho Telehealth Council was created in 2014, under House Concurrent Resolution 46, and was committed to the advancement of telehealth in Idaho by coordinating and developing a comprehensive set of standards, polices, rules, and procedures for the use of telehealth in Idaho.

Telehealth Council Goals

1. Examine reimbursement policies and determine telemedicine payment models
2. Develop roadmap to operationalize and expand telehealth in SHIP PCMH and CHEMS programs
3. Act in advisory capacity to regulatory boards and state agencies
4. Support educational and clinical practice statewide using telemedicine technology

IDAHO State of Idaho Telehealth Council

Representatives to the Council included representatives from Blue Cross of Idaho, the Idaho Hospital Association, the Idaho Medical Association, the Idaho Primary Care Association, Kootenai Health, OptumHealth, Select Health, St. Luke's and various Idaho state departments. The work of the group heavily informed the content and passage of the 2015 Idaho Telehealth Act.

2015 Idaho Telehealth Access Act

- Patient-provider relationships can be established without an in-person visit using 2-way audio and video and maintained using electronic communications
- Prescription drug orders can be issued using telehealth services with some parameters
- Supports multi-disciplinary collaboration
- Decreases healthcare fragmentation; increases continuity of care

Current Telehealth Landscape

Telehealth plays a vital role as Idaho strives to achieve the triple aim to improve: 1) quality of care; 2) population health; and, 3) affordability of healthcare.

Idaho Administrative Code allows Medicaid to cover specific services delivered via telehealth technology, which help ensure all participants receive the best possible care regardless of geographic location.

Idaho does not have any parity laws for private insurance coverage for telemedicine.

ID Medicaid published new rules to allow coverage of primary care, OT, PT, speech therapy, language, and sign language interpretive services via telehealth.

Telemedicine in Idaho: Report Card on Coverage & Reimbursement

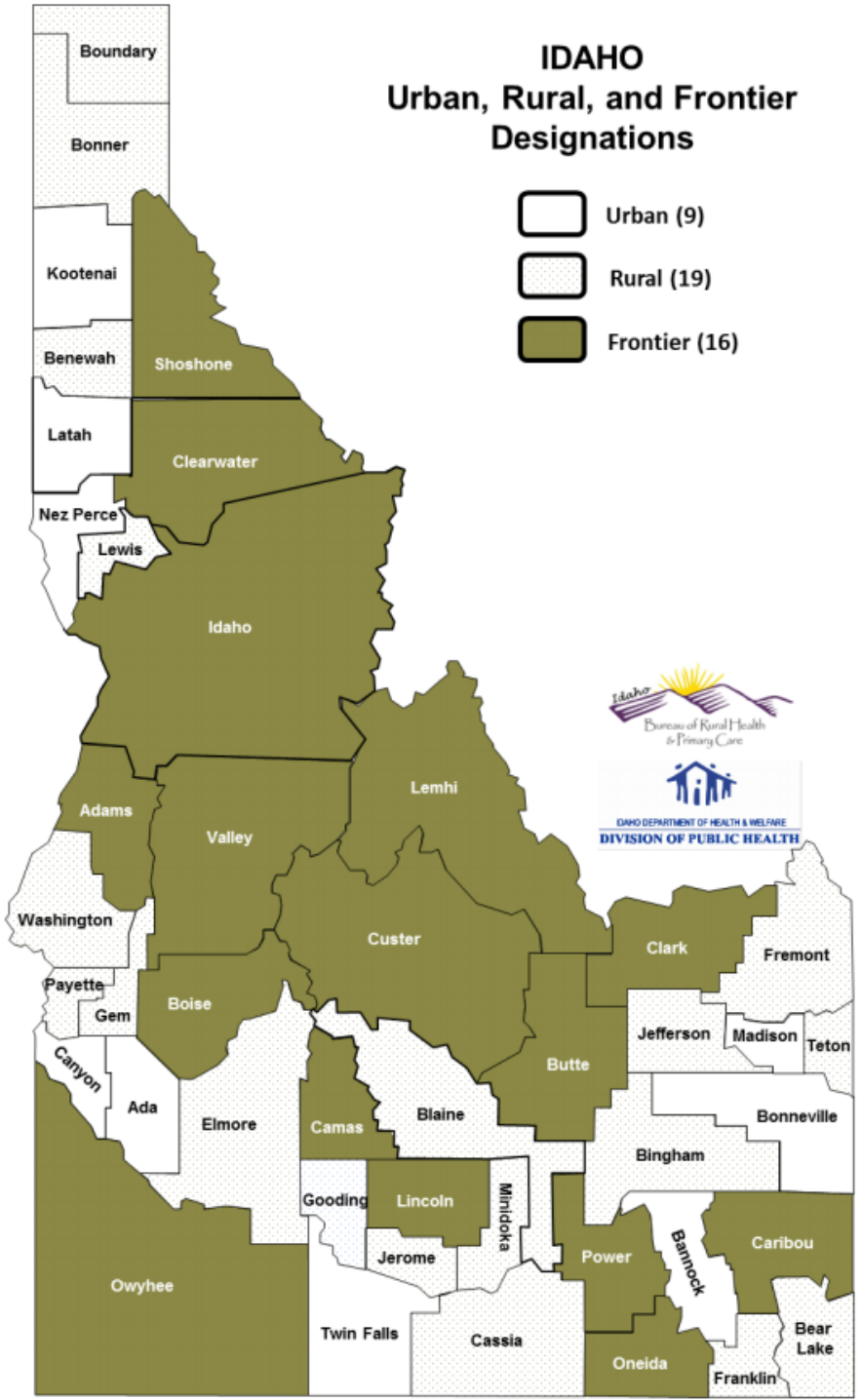
From the American Telemedicine Association, 2017

PARITY:	
Private Insurance	F
Medicaid[91]	B
State Employee Health Plan	F
MEDICAID SERVICE COVERAGE & CONDITIONS OF PAYMENT:	
Patient Setting	A
Eligible Technologies	F
Distance or Geography Restrictions	A
Eligible Providers	C
Physician-provided Services	B
Mental/behavioral Health Services	B
Rehabilitation	A
Home Health	F
Informed Consent	F
Telepresenter	A

Current Telehealth Landscape

35 of Idaho's 44 counties are rural or frontier and many areas have limited access to specialty care.

In addition to the current health care system in place, telehealth holds the potential to increase access for patients and reduce burden on providers.



Idaho Statewide Healthcare Innovation Plan (SHIP)

SHIP is a statewide plan that aims to improve the health of all Idahoans. Private insurers as well as Medicaid and Medicare are meeting together to design healthcare reimbursement methods that pay providers for keeping people healthy. The SHIP was funded through January 31, 2019.

The SHIP was developed to redesign Idaho's healthcare system to improve Idahoan's health by:

1. Strengthening primary and preventive care through the PCMH, and
2. Evolving from a fee-for-service, volume-based payment system of care to a value-based payment system that rewards improved health outcomes.

Timeline of Activities:

Award Year 1	Award Year 2	Award Year 3
• Hiring of project staff and contractors • Selecting the first cohort of 55 primary care clinics to begin their training to transform to PCMHs	• 55 practices were selected for Cohort 2 • Remaining contractors were hired • Communication toolkit was developed to educate and recruit practices to participate in the model test	• Governor Otter reaffirmed the role of the IHC by issuing executive order 2016-02 • Support and incentives for Cohorts 1 and 2 continued • Preparations began to recruit practices for Cohort 3

Idaho Statewide Healthcare Innovation Plan (SHIP) Telehealth

The Idaho Telehealth Council SHIP Subcommittee was charged with developing a telehealth expansion plan to operationalize and expand telehealth services in rural communities as part of the SHIP. SHIP telehealth goals for the 3 years of the model test include establishing rural telehealth capacity across a range of behavioral health and specialty services. As a part of the larger SHIP initiative, significant work has been done to nurture the use of telehealth strategies to increase access to quality healthcare throughout the state.

The efforts have included:

- the development of a telehealth toolkit
- a series of webinars
- two rounds of grantmaking to support new or expanding telehealth programs resulting in twelve sub-grant awards to eight clinics and one CHEMS agency, along with a technical assistance program to all grantees across the state
- A meeting of statewide telehealth stakeholders on May 23, 2018 to set priorities for the future of telehealth

Efforts to Move Forward

On May 23, 2018, the Idaho Department of Health and Welfare hosted a telehealth planning meeting in to convene a diverse set of telehealth subject matter experts to identify and discuss barriers, challenges, and opportunities for advancing telehealth in Idaho.

Barriers and Challenges

- Complex reimbursement landscape with inconsistent and restrictive reimbursement
- Lack of an operational coordinating body
- Lack of training and workflow processes
- Limitations on managing prescriptions
- Addressing technology requirements
- Telehealth Council lacks capacity and resources

Opportunities

- Potential to overcome challenges of provider shortages and rural/frontier isolation
- Improve access to primary care and specialists
- Support patient and provider education
- Share real time actionable data
- Partnership with the IHC and HQPC to help identify resources to support telehealth

Why Telehealth Expansion

By complementing its existing health care system with telehealth capacity, Idaho can better serve patients and better support providers

Telehealth services enhance access to health care, make delivery of health care more cost-effective and distribute limited health care provider resources more efficiently.

Citizens with limited access to traditional health care may be diagnosed and treated sooner through telehealth services than they would be otherwise, resulting in improved health outcomes and less costly treatments due to early detection and prevention.

Telehealth services address an unmet need for health care by persons who have limited access to such care due to provider shortages or geographic barriers.

Telehealth services can provide increased capacity for appropriate care in the appropriate location at the appropriate time to better serve patients, providers and communities.

When practiced safely, telehealth services result in improvement in health outcomes by expanding health care access for the people of Idaho.

Next Steps

Creation of a Business Model for Telehealth

- Find a lasting and effective coordinating body, with the Healthcare Transformation Council of Idaho (HTCI) being the ideal target
- HTCI serves as an advisory body for healthcare delivery issues in Idaho.

Major Decision Makers and Multi-Sector Stakeholders at the Table

- Include CEOs of payers or large employer groups, providers, patients and consumers, and foundations

Coordinated Effort to Plan, Collect, and Leverage Data

- Future SHIP sustainability planning session
- Engaging Multi-Payer Work Group to keep the dialogue on telehealth moving and inclusive of the payers

The Ask: IDHW is seeking support to continue the momentum of telehealth work and address challenges, especially the need for an operational coordinating body.

Goal 4

Project ECHO

Sustainability Initiatives

ECHO Idaho
322 E Front St, Boise, ID 83702
Phone 208-364-4698

PROJECT STATUS REPORT

PROJECT SUMMARY

Reporting PERIOD	Project Name	Prepared By
January 1 - January 31, 2019	ECHO Idaho	Lachelle Smith

STATUS SUMMARY

ECHO Idaho Opioid Addiction and Treatment ECHO program engagement January 1- January 31, 2019:

Sessions: 2
Patient Cases: 2
People: 36
Contact Hours: 48
Participating Organizations: 25
Communities: 12

ECHO Idaho Behavioral Health in Primary Care ECHO program engagement January 1- January 31, 2019:

Sessions: 2
Patient Cases: 2
People: 60
Contact Hours: 76
Participating Organizations: 21
Communities: 15

Five main objectives are detailed in this report: Marketing, Spoke Recruitment, Session Implementation, Evaluation, and Sustainability.

PROJECT OVERVIEW

task	% Done	Due date	driver	notes
Marketing efforts	100%	1/31/2019	Jodi Walker Sara Anderson Lachelle Smith Jeff Seegmiller	Notable outreach efforts this period include: - Six outreach videos were completed this period with a focus on ECHO Idaho Behavioral Health Program and four provider spotlight videos. These videos are used for outreach in presentations, on the ECHO website, and in social media efforts to raise awareness and increase participation in ECHO learning collaboratives. BH long cut: https://www.youtube.com/watch?v=dRU5mz675M8&t=5s BH short cut: https://www.youtube.com/watch?v=q3eHtYns4oI Twin Falls MD: https://www.youtube.com/watch?v=pzbGMIjX3C0 Nampa MD: https://www.youtube.com/watch?v=vrHB8L5XzaY Lewiston CADC: https://www.youtube.com/watch?v=WIP8C698hSI

				Orofino LCSW: https://www.youtube.com/watch?v=s7lQLlccR2c - Print flyer, poster, calendar, and brochures were developed for current and potential learning collaborative participants for a final outreach push at the start of the 2019 new year. - A statewide digital marketing campaign targeting Idaho's rural clinicians to raise awareness and increase participation in ECHO learning collaboratives concluded 1/31/19 with performance above industry standards as outlined in the attached report.
Spoke Recruitment	100%	1/31/2019	Lachelle Smith	430 practitioners across Idaho have enrolled in ECHO trainings with approx. 50% of those enrolled attending. Notable outreach efforts this month include presentations to the following community groups: IDHW Population Health Workgroup, Valley County Opioid Response Planning Consortium, Kootenai Hospital Pain Workgroup, Hindson Foundation Internal Medicine Conference and MAT training, Society for General Internal Medicine NW Society Conference and MAT training, CDHD McCall office, St. Luke's Behavioral Health McCall Clinic, SE Idaho AHEC Board of Directors, St. Luke's Boise Grand Rounds, and CHAS Health Moscow Clinic.
Opioid Program Implementation	100%	1/31/2019	Lachelle Smith Sara Anderson	20/20 Opioid Sessions have been delivered with an average attendance of 22 in the month of January. As of 2/14/18, 45 of 55 waiver seeking providers who attended the 2/10/18 MAT waiver training had completed the online portion of the training.
Behavioral Health Program Implementation	100%	12/12/2018	Lachelle Smith Sara Anderson	8/8 SHIP supported BH sessions were completed in December 2018 with an average attendance of 34 participants per session. The program was notified that it was awarded a SAMHSA grant that will sustain this BH learning collaborative for 3 years past the SHIP grant with sessions beginning 1/16/19.
External Evaluation	100%	1/31/2019	Jeff Seegmiller Lachelle Smith Janet Reis DaNae Snyder	Janet Reis and two BSU Community Health graduate students coded 9 patient transcripts with general codes reviewed by Dr. Coyle. Data was provided directly to IDHW.
Sustainability	100%	1/31/2019	Jeff Seegmiller Lachelle Smith	ECHO Idaho has secured a number of state and federal grants and foundation support to sustain the Opioid and Behavioral Health learning collaboratives past the end of this award through 2019!

BUDGET OVERVIEW

category	spent*	% of total**	on track?	notes
Personnel	$32,326.76		Yes	Staff salaries
Fringe	$9,789.93		Yes	Staff Fringe
Subcontractors	$3,675.88		Yes	ECHO Panelists
Other Expenses	$50,767.22		Yes	Approved Marketing, as outlined in request submitted 9/17/18 and 10/20/18
Travel	$1,629.18		Yes	Approved Travel, as outlined in request submitted 9/17/18
Indirect	$9,818.85		Yes	Overhead
Panel Costs (parking, lunches)	$263.00	WWAMI budget	NA	$2,438.14 for total project per.
CME	$0	WWAMI budget	NA	$1,200 for total project per.
Program Supplies	$0	WWAMI budget	NA	$1,550.66 for total project per.
Promotional	$350	WWAMI budget	NA	$4,070.55 for total project per.
Travel	$0	WWAMI budget	NA	$1,820.94 for total project per.
Misc.	$0	WWAMI budget	NA	$1,732.00 for total project per.
Staff Equipment	$0	WWAMI budget	NA	$8,945.19 for total project per.
ECHO Room Equipment	$0	WWAMI budget	NA	$11,850.77 for project per.

* Spent from IDHW State Innovation Models Grant unless noted otherwise

**Cumulative percentage spent through this reporting period based on total project funding for years one and two.

ADDITIONAL INFORMATION

The following reports are attached:

- ECHO Idaho SHIP Programs Report
- ECHO Idaho Digital Marketing Campaign Analytics Report prepared by Stoltz Marketing Group

It has been a pleasure to work with the IDHW team as part of the CMMI SHIP initiative. This award allowed us to not only build robust learning collaboratives active during the performance period of this award, but to also build a strong foundation for sustainable ECHO programming in the future.

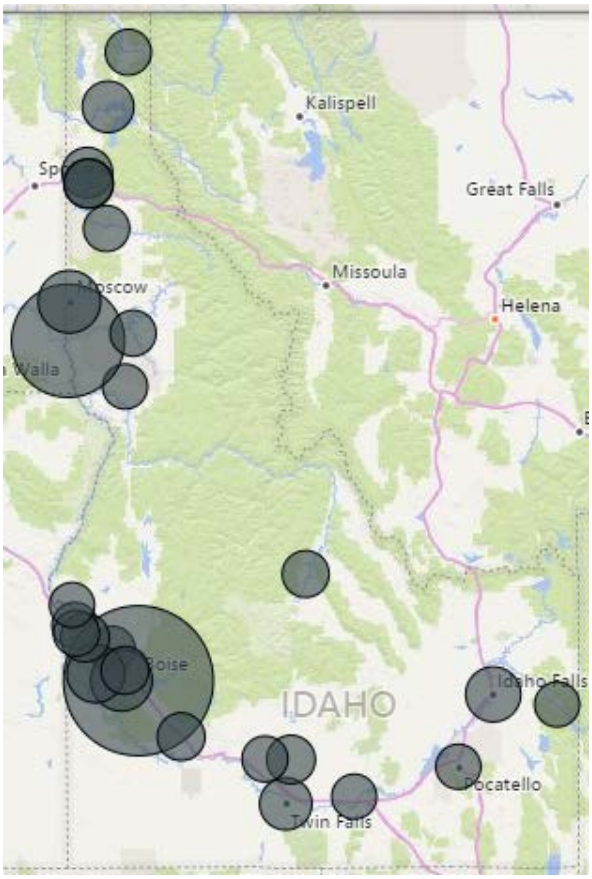
ECHO Idaho SHIP Programs Report

Opioid Addiction and Treatment Program

Time Period: **March 2018 – January 2019**
Number of sessions: **20**
Total Hours: **20**

Attendance

Individual Participants: **144**
Total attendance: **486**
Average attendance: **22** per session
High attendance: **29** (3/15 Intro, 8/2 Cannabis)
Low attendance: **14** (11/8 Acupuncture)
Registered: **234**



By Location
Organizations: **60**
Communities: **29**
Public Health Districts: **7**
Counties**: 22**

By Credential
Physician (MD, DO): **31**
Clinical Pharmacist (PharmD) **10**
Physician Assistant (PA, MHS) **1**
Advanced Practice Nurse (NP, CNM, CNS, etc) **13**
Registered Nurse (RN, BSN) **10**
Medical Assistant (MA, CMA) **1**
Certified Nursing Assistant (CAN) **0**
Registered Dietitian (RD) **0**
Community Health Worker (CHW) **1**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **13**
Certified Health Care Manager (FACHE) **6**
Registered Health Information Technician (RHIT) **0**
Case Manager **0**
Other **56**

Presentations

Patient Case Presentations: **17** (= 16 new + 1 follow-ups) by **18** individuals
Didactics: **20** presentations by **14** individuals

ECHO Idaho is led by the University of Idaho and the WWAMI Medical Education Program and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

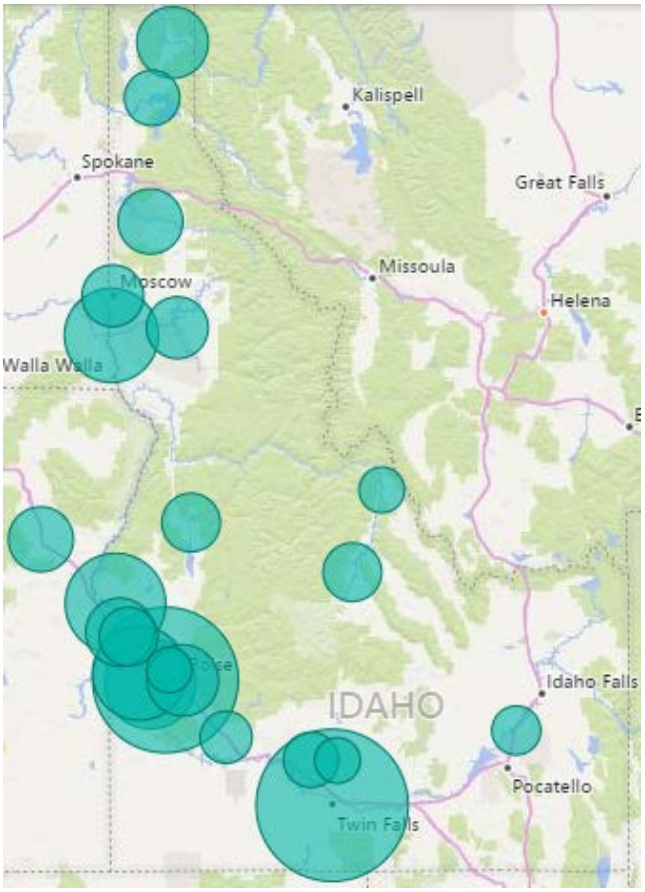
ECHO Idaho 2018 Programs Report

Behavioral Health in Primary Care Program

Time Period: **September 2018 – December 2018**
Number of sessions: **8**
Total Hours: **8 hours**

Attendance

Individual Participants: **59**
Total attendance: **301**
Average attendance: **34 per session**
High attendance: **49** (9/5 Somatic Disorders)
Low attendance: **26** (12/12 Perinatal Mood Disors.)
Registered: **65** in initial pilot, **100** in 2019 cohort



By Location
Organizations: **32**
Communities: **24**
Public Health Districts: **7**
Counties**: 14**

By Credential
Physician (MD, DO): **13**
Clinical Pharmacist (PharmD) **8**
Physician Assistant (PA, MHS) **7**
Advanced Practice Nurse (NP, CRNA, CNM, CNS, etc) **8**
Registered Nurse (RN, BSN) **2**
Licensed Practical Nurse (LPN) **0**
Family Nurse Practitioner (FNP) **0**
Medical Assistant (MA, CMA) **0**
Certified Nursing Assistant (CNA) **1**
Registered Dietitian (RD) **0**
Community Health Worker (CHW) **0**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **11**
Certified Health Care Manager (FACHE) **0**
Registered Health Information Technician (RHIT) **0**
Case Manager **0**
Other **11**

Presentations

Patient Case Presentations: **7** (= 7 new + 0 follow-ups) by **7** individuals
Didactics: **8** presentations by **6** individuals

ECHO Idaho is led by the University of Idaho and the WWAMI Medical Education Program and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

MAT DATA 200 Waiver Half and Half Training

Time Period: **Monday December 10, 2018**
Number of sessions: **1**
Total Hours: **4.5** hours

Attendance

Trainers: **2** (Dr. Todd Palmer and Dr. Magni Hamso)
Individual Participants: **65**
Waiver Seeking: **55**
Auditing: **10**
RSVP'd: **70** waiver seeking / **13** audit

Received Waiver: **TBD**
(As high as 25% increase of waivered providers in ID)

Waiver Completion

45 of 55 providers completed the online module portion of the training to date.

Yet to complete online module by credential: **2** NPs, **2**PAs, **6** MD/DO

PCSS has granted an extension for the 10 remaining clinicians to complete the modules due to the holidays, the complete rate is still pending.

By Location

Organizations: **43**
Communities: **29**
Public Health Districts: **6** (all but PHD 7)
Out of State**: 10** (AZ, CA, CO, IL, NC, NJ, NY, SD, WA)

By Credential

Physician (MD, DO): **38**
Clinical Pharmacist (PharmD) **6**
Physician Assistant (PA) **7**
Advanced Practice Nurse (NP, NA, CNM, CNS, etc.) **4**
Family Nurse Practitioner (FNP) **7**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **1**
Idaho Drug Overdose Prevention Program

KIVI TV media link: https://www.eastidahonews.com/2018/12/idaho-medical-professionals-undergo-training-to-prescribe-suboxone-to-opioid-addicts/

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ECHO Idaho 2018 Programs Report

MAT DATA 200 Waiver Half and Half Training

Attendance and Waiver completion breakout by Public Health District:

Credential	Organization	City	Public Health Dist	Waiver Seeking	Online Modules Status
MD	Shoshone Medical center	CDA	1	x	no response
DO	Shoshone Medical Center	Kingston	1	x	no response
ARNP	idaho pain clinic	Sandpoint	1	x	complete response
FNP	idaho pain clinic	Sandpoint	1	x	complete response
MD	Idaho Pain Clinic	Sandpoint	1	x	complete response
MD	Idaho Pain Clinic	Sandpoint	1	x	complete response
NP	Idaho Pain Clinic	Sandpoint	1	x	complete response
PA	Idaho Pain Clinic	Sandpoint	1	x	complete response
MD	Syringa Hospital and Clinics	Grangeville	2	x	complete response
FNP	Gritman Medical Center	Moscow	2	x	complete response
PA	Clearwater Valley Hospital and Clinics	Orofino	2	x	no response
MD	CVHC	Orofino	2	x	complete response
FNP-C	Southwest District Health	Caldwell	3	x	complete response
DNP, FNP-C	SWDH	Caldwell	3	x	complete response
MD	Emmett Medical Center at Valor Health	Emmett	3	x	complete response
DO	Valor Health	Emmett	3	x	complete response
ARNP	Recovery 4 Life	wilder	3	x	complete response
MD MPH	Boise VAMC/UW	Boise	4	x	complete response
MD	Exodus Pain Clinic	Boise	4	x	no response
MD	IPMR	Boise	4	x	complete response
DO	St. Alphonsus Medical Group	Boise	4	x	complete response
MD	St. Luke's	Boise	4	x	complete response
MD FACP	St. Luke's Health System	Boise	4	x	complete response
MD	TRHS	Boise	4	x	complete response
PAc	TRHS	Boise	4	x	no response
PA-C	Ada County Sheriff's Office	Eagle	4	x	complete response
MD	Boise VA Medical Center	Eagle	4	x	complete response
MD	Vituity	Garden City	4	x	complete response
M.D.	Optum Idaho	Meridian	4	x	complete response
PA-C	Desert Sage Health Center	Mt Home	4	x	complete response
FNP-C	Veteran's Affairs	Mt Home	4	x	no response
MD	Shoshone Family Medical Center	Shoshone	5	x	complete response
NP-C	Intermountain Medical Clinic	Chubbuck	6	x	complete response
PA-C	Shoshone Bannock Com Health Nursing	Chubbuck	6	x	Unknown, pending followup
MD	Not-tsoo Gah-nee Indian Health Center	Fort Hall	6	x	complete response
FNP-C	Shoshone-Bannock Com Health Center	Fort Hall	6	x	no response
MD	Idaho State University	Pocatello	6	x	complete response
M.D.	ISU Family Medicine Residency	Pocatello	6	x	complete response

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MD	ISU Family Medicine Residency	Pocatello	6	x	complete response
D.O.	Intermountain Medical Clinic	Pocatello	6	x	complete response
DO	Intermountain Medical Clinic	Pocatello	6	x	complete response
FNP-C	Intermountain Medical Clinic	Pocatello	6	x	complete response
DO	ISU	Pocatello	6	x	complete response
PA-C	Isu healthwest	Pocatello	6	x	complete response
MD	CEP america	Burr Ridge, Il	N/A	x	no response
MD	Carolinas Healthcare System	Charlotte, NC	N/A	x	complete response
DO	Care on Location	Denver, CO	N/A	x	complete response
DO FACEP	None	Flemington, NJ	N/A	x	complete response
MD	New York-Presbyterian Hospital- Weill Cornell	New York, NY	N/A	x	complete response
MD	Northwest Allied Physicians	Oro Valley, AZ	N/A	x	complete response
MD	Palouse Medical	Pullman, WA	N/A	x	complete response
MD, FACOG	Scottsdale Center for Women's Health	Scottsdale, AZ	N/A	x	no response
MD	Center for Family Medicine	Sioux Falls, SD	N/A	x	no response
MD	Sioux Falls Family Medicine Residency Program	Sioux Falls, SD	N/A	x	complete response
MD	College Medical Center	VICTORVILLE, CA	N/A	x	complete response

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Stoltz

ECHO Idaho

12/24/18 - 1/31/19
Analytics Report

CAMPAIGN OVERVIEW

Geographic Coverage: Idaho statewide

Media: Digital display, IP Targeting, Facebook, LinkedIn

Campaign Goal: Increase awareness of ECHO Idaho across the state

Flight Weeks: 12/24 - 1/31

Overall, the campaign performed very well with all four digital platforms delivering metrics well above industry standards.

CAMPAIGN OVERVIEW: THE DETAILS (FLIGHT WEEKS 12/21 - 1/31)

MARKET/MEDIA	DETAILS	PLANNED IMPRESSIONS	BUDGET
DIGITAL DISPLAY	Location-based mobile reinforces an advertiser's message by seamlessly bridging the gap between the physical and virtual world. Through psychographic, geographic, behavioral and contextual targeting filters, mobile advertising allows us to deliver ECHO Idaho's messaging to a specific demographic with unparalleled relevance.	420,000	$4,200
IP TARGETING	IP targeting is messaging delivered to a user's geographic location as determined by his or her Internet Protocol (IP) address. Our list includes: Doctors, Anasthesiologists, CNAs, Radiologists, Family Medicine, Foot / Ankle, Hand, Military Health, Neurologists, RN, ObGyn, Pediatrician, Physicians, Surgeons, Trauma Surgeon.	185,000	$3,700
FACEBOOK & INSTAGRAM	Facebook and Instagram allow us to deliver ECHO Idaho's messaging to the single largest 'walled garden' on the internet. With more than 1 billion people using Facebook every day, this medium delivers an unparalleled reach.	TBD	$5,000
LINKEDIN	With over 500M active professionals, LinkedIn allows us to deliver personalized ads and target the unique ECHO Idaho audience based on up-to-date professional profile data.	TBD	$2,500
TOTAL		**TBD**	**$15,400**

DIGITAL DISPLAY

DIGITAL DISPLAY: OVERVIEW

Our overall engagement for digital display tracked over double the national average. These strong figures demonstrate that we effectively reached our target audience. We also delivered 58% more impressions than originally projected.

Creative	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
A - ‘Sign Up’	354,939	627	0.18%
B - ‘Learn More’	357,117	578	0.16%
Let’s Fix This’	1,051	27	2.57%
C - ‘Sign Up’	1,041	20	1.92%
D - ‘Learn More’	1,049	23	2.19%
TOTAL:	**715,197**	**1,275**	**0.18%**

CTR: Click through rate, which tells you how many people who’ve seen your ad and end up clicking on it.
Impressions: The number of times your content is displayed.
Link Clicks: The number of clicks on the link included in your post.

Audience: Doctors, Nurses
Geographic Coverage: Idaho Statewide
Industry Benchmark: 0.08% CTR

IP TARGETING

IP TARGETING: OVERVIEW

Our total impressions were well ahead of our original estimates by 52% and engagement was just below double the national average.

Ad Size	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
A - ‘Sign Up’	174,429	237	0.14%
B - ‘Learn More’	175,278	223	0.13%
Let’s Fix This’	462	15	3.25%
C - ‘Sign Up’	466	26	5.58%
D - ‘Learn More’	461	19	4.12%
TOTAL:	**351,096**	**520**	**0.15%**

CTR: Click through rate, which tells you how many people who’ve seen your ad and end up clicking on it.
Impressions: The number of times your content is displayed.
Link Clicks: The number of clicks on the link included in your post.

Audience: Specific health centers sent by ECHO
Geographic Coverage: Hyper Local
Industry Benchmark: 0.08% CTR

FACEBOOK AND INSTAGRAM

FACEBOOK AND INSTAGRAM: OVERVIEW

All ads performed well, with the 'Opioid Number 1 Awareness' creative seeing the highest CTR at 0.28%. This is well over 2x the national average for engagement.

CREATIVE	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
General Message #1	142,189	193	0.14%
General Message #2	176,289	270	0.15%
Opioid Number 1 Awareness	145,847	414	0.28%
General Awareness - Video	158,833	275	0.17%
Opioid Number 2 - Video	103,067	197	0.19%
TOTAL:	**726,225**	**1,349**	**0.19%**

CTR: Click through rate, which tells you how many people who've seen your ad and end up clicking on it.
Impressions: The number of times your content is displayed.
Link Clicks: The number of clicks on the link included in your post.

Audience: Doctors, Nurses
Geographic Coverage: Idaho Statewide
Industry Benchmark: 0.11% CTR

LINKEDIN

LINKEDIN: OVERVIEW

Like all other tactics, overall engagement for LinkedIn was more than double the national average–0.83%. Additional reporting metrics break down company industry and geographic breakdowns.

CREATIVE	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
General Message #1	7,508	59	0.79%
Opioid Number 1 - Awareness	10,210	111	1.09%
General Message #2	10,122	60	0.59%
Opioid Number 2 - Video	9,910	87	0.88%
General Awareness - Video	7,521	61	0.81%
TOTAL:	**45,271**	**378**	**0.83%**

CTR: Click through rate, which tells you how many people who've seen your ad and end up clicking on it.
Impressions: The number of times your content is displayed.
Link Clicks: The number of clicks on the link included in your post.

Audience: Doctors, Nurses
Geographic Coverage: Idaho Statewide
Industry Benchmark: 0.40% CTR

LINKEDIN: METRICS BY INDUSTRY AND LOCATION

By Industry

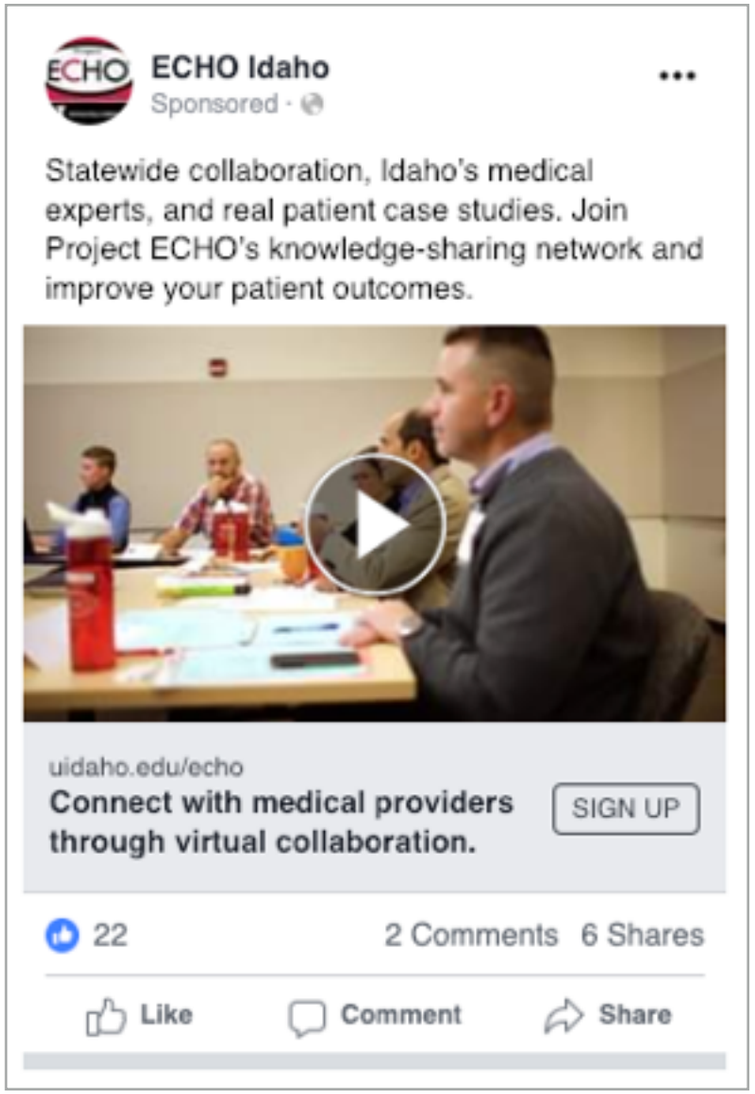
INDUSTRY	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
Hospital & Health Care	6,878	67	0.97%
Medical Practice	830	17	2.05%
Higher Education	3024	22	0.73%
Health, Wellness and Fitness	1634	10	0.61%
Pharmaceuticals	961	14	1.46%
Mental Health Care	719	13	1.81%

By Location

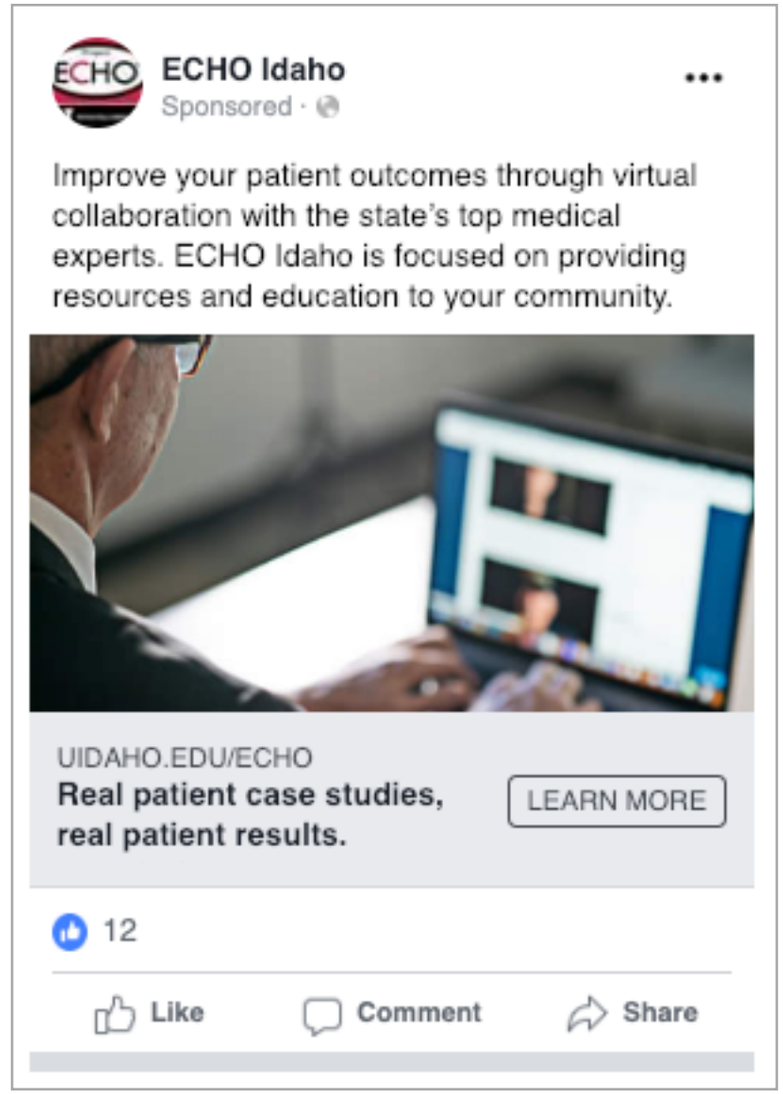
LOCATION	IMPRESSIONS	LINK CLICKS	CLICK THROUGH RATE
Boise, Idaho Area	31,131	266	0.85%
Pocatello, Idaho Area	8,907	62	0.70%
Spokane, Washington Area	5,043	49	0.97%

CREATIVE

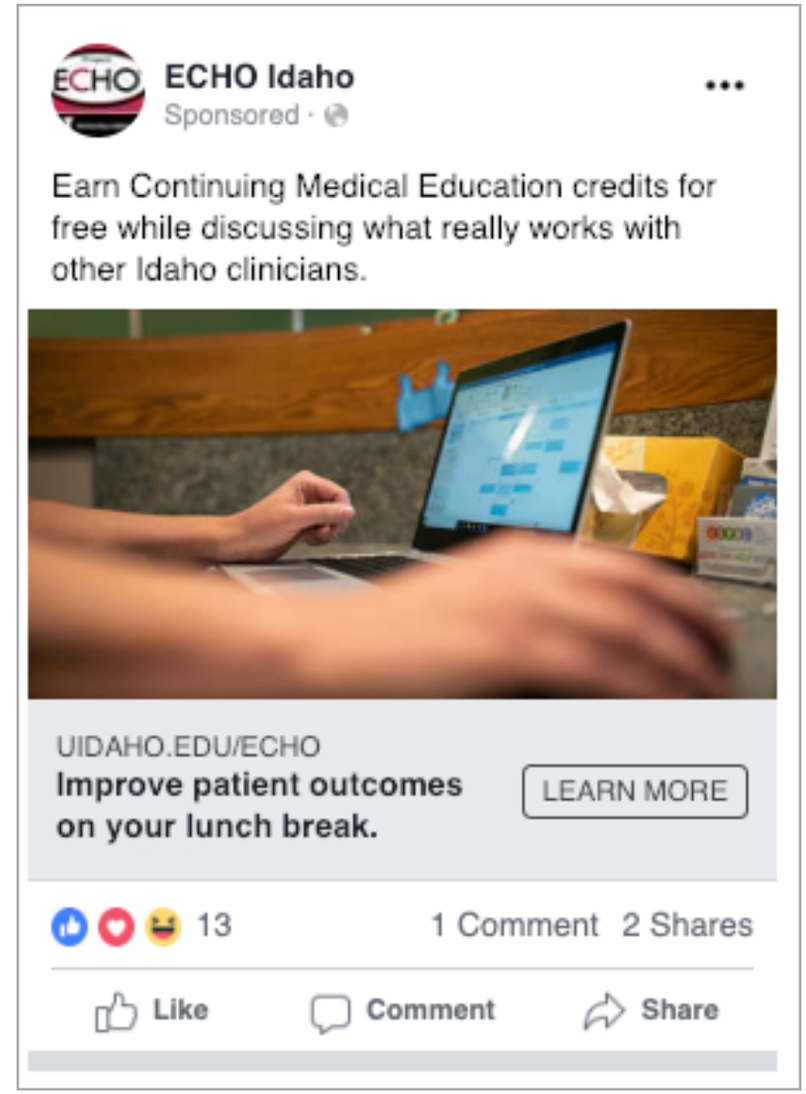
CAMPAIGN OVERVIEW: THE CREATIVE (FACEBOOK & LINKEDIN)



General Awareness Video

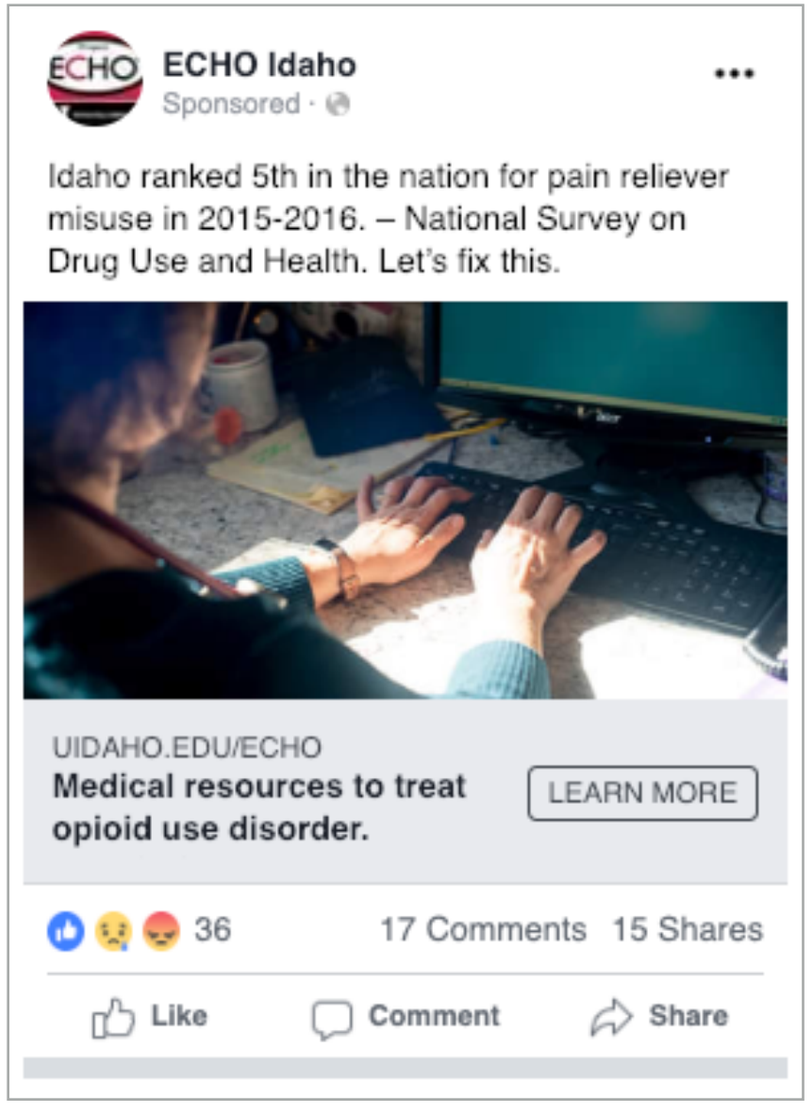


General Message #1

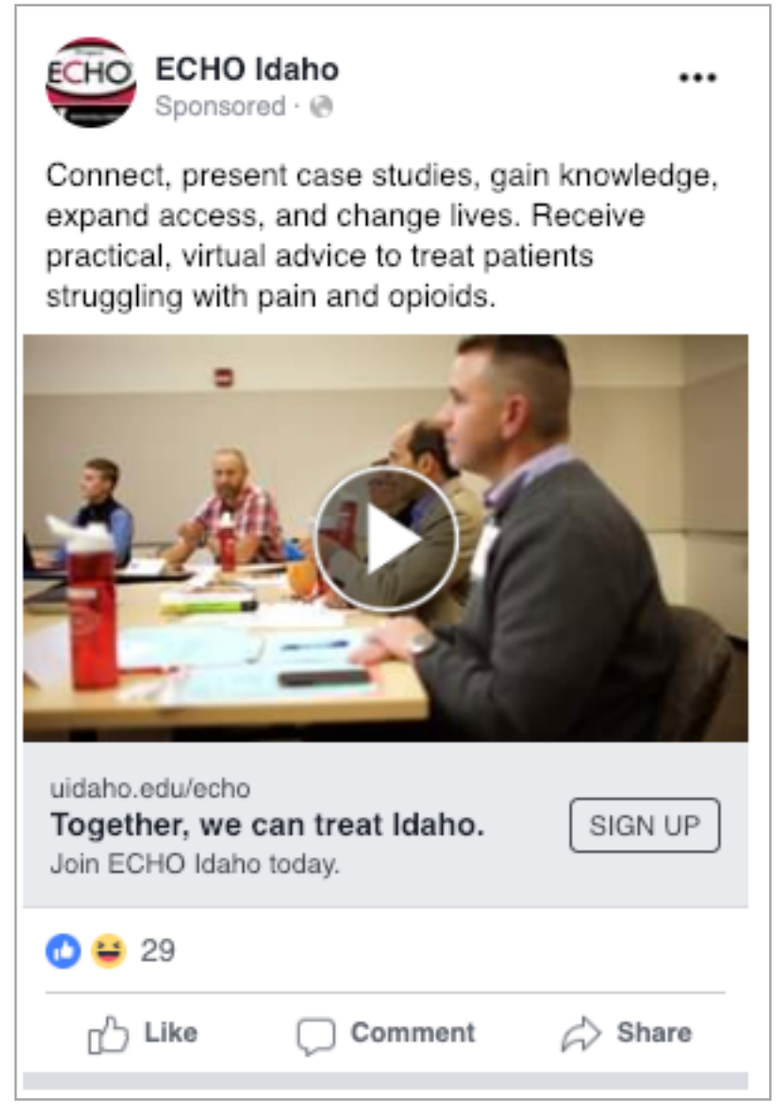


General Message #2

CAMPAIGN OVERVIEW: THE CREATIVE (FACEBOOK & LINKEDIN)



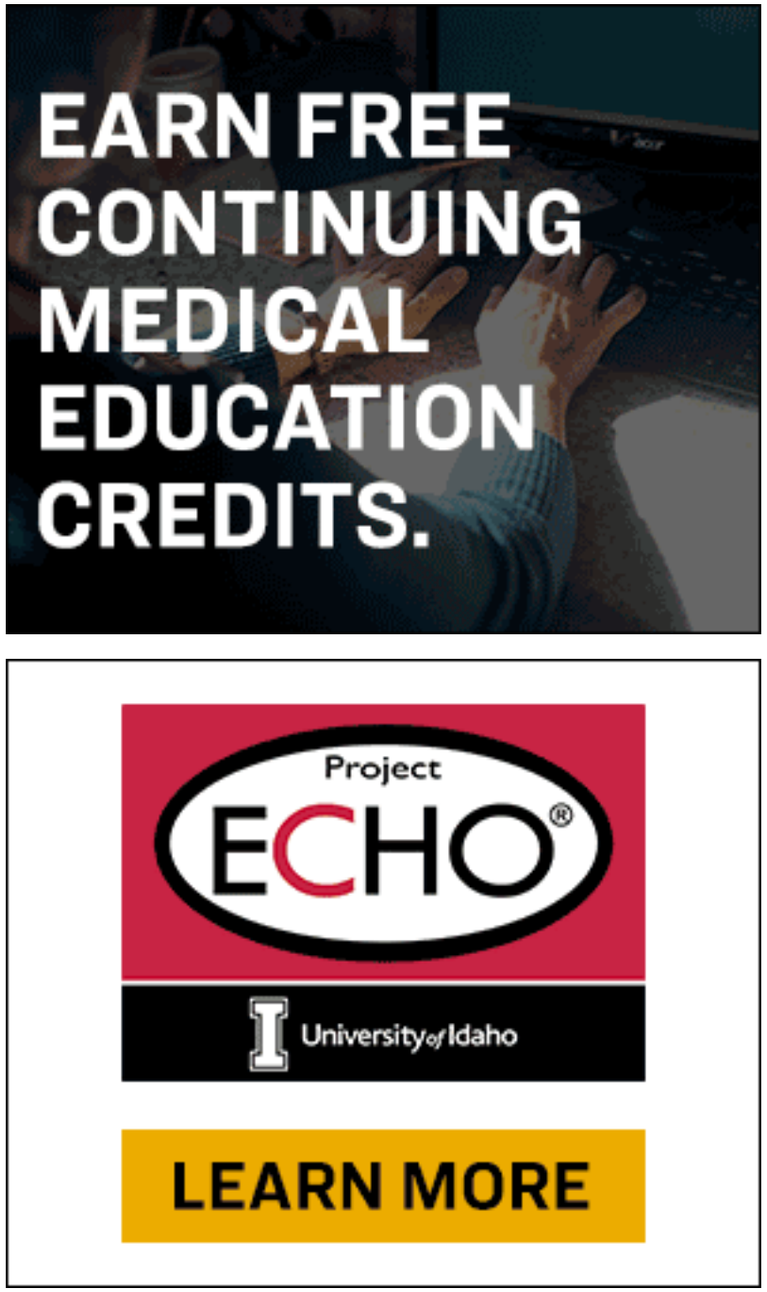
Opioid 1 - Awareness
**Highest CTR for Facebook/LinkedIn*



Opioid 2 - Video

CAMPAIGN OVERVIEW: THE CREATIVE (DIGITAL DISPLAY & IP TARGETING)

A - 'Sign Up'



B - 'Learn More'

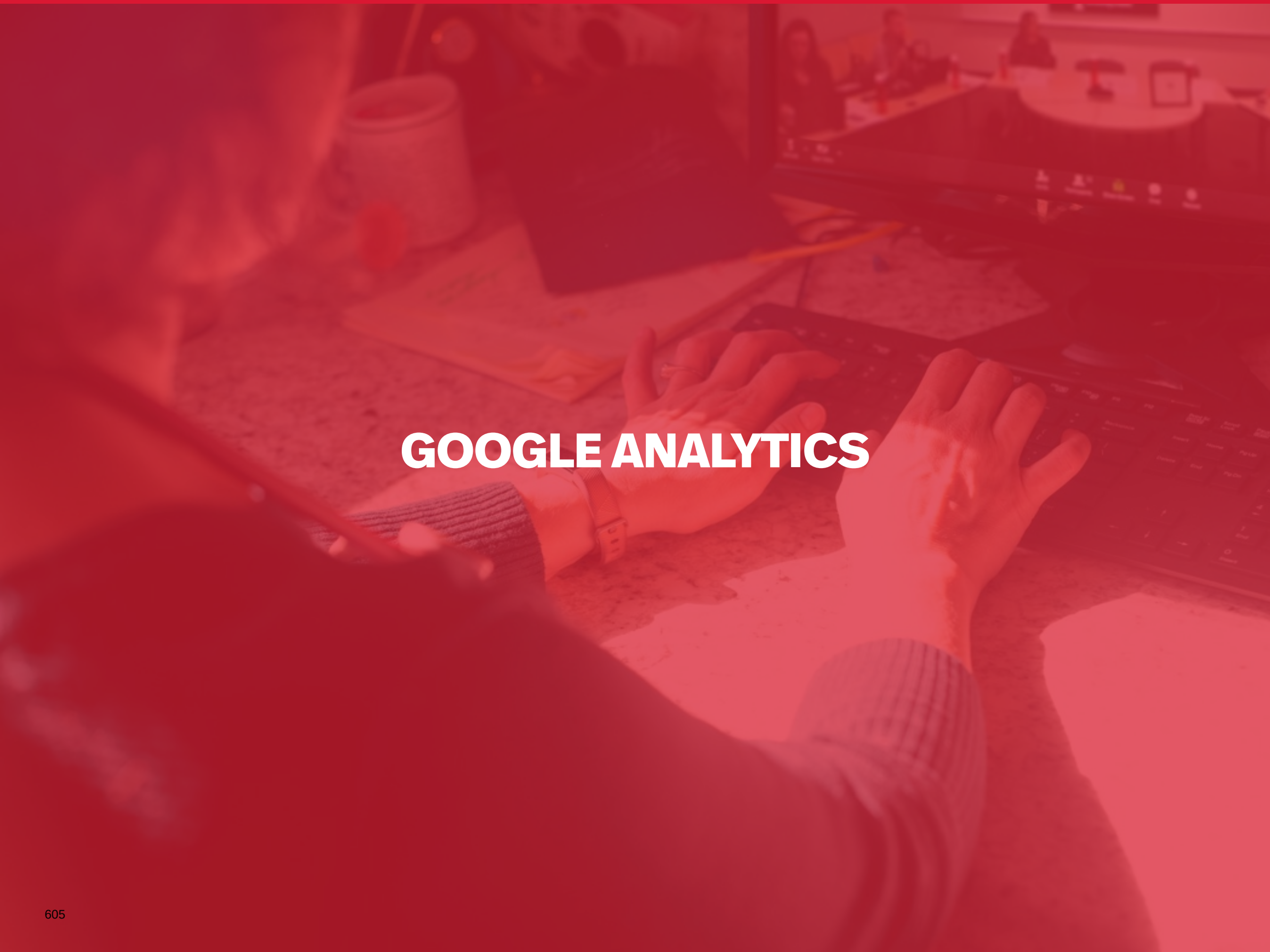
CAMPAIGN OVERVIEW: THE CREATIVE (DIGITAL DISPLAY & IP TARGETING)

'Let's Fix This'
**Highest CTR for Digital Display*

CAMPAIGN OVERVIEW: THE CREATIVE (DIGITAL DISPLAY & IP TARGETING)

C - 'Sign Up'
**Highest CTR for IP Targeting*

D - 'Learn More'



GOOGLE ANALYTICS

CAMPAIGN OVERVIEW: THE CREATIVE

ALL » CAMPAIGN: ECHOWinter18-19

Jan 21, 2019 - Jan 31, 2019

All Users
0.16% Users

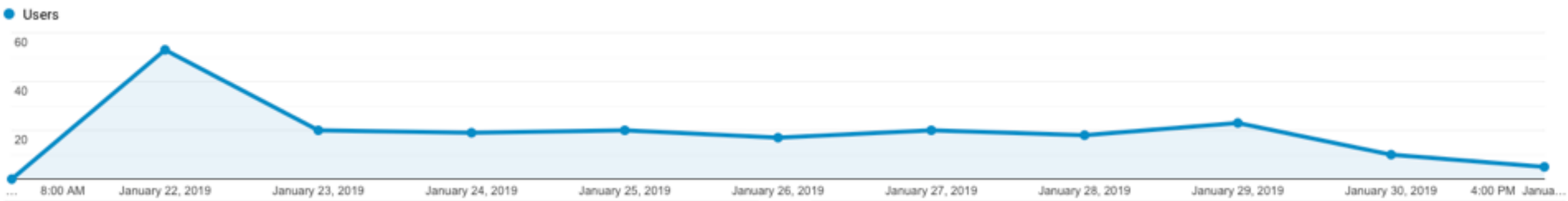
+ Add Segment

Explorer

Summary | Site Usage | Goal Set 1 | Goal Set 2 | Goal Set 3 | Ecommerce

Users vs. Select a metric

Day | Week | Month



Primary Dimension: Source / Medium | Other

Plot Rows | Secondary dimension | Sort Type: Default | advanced

Source / Medium	Acquisition			Behavior			Conversions: Goal 3: Degree Finder - Apply/Learn More		
	Users	New Users	Sessions	Bounce Rate	Pages / Session	Avg. Session Duration	Degree Finder - Apply/Learn More (Goal 3 Conversion Rate)	Degree Finder - Apply/Learn More (Goal 3 Completions)	Degree Finder - Apply/Learn More (Goal 3 Value)
	201 % of Total: 0.16% (126,361)	189 % of Total: 0.20% (93,459)	209 % of Total: 0.10% (217,458)	92.34% Avg for View: 55.34% (66.85%)	1.16 Avg for View: 2.66 (-56.22%)	00:00:13 Avg for View: 00:02:47 (-92.21%)	0.00% Avg for View: 0.00% (0.00%)	0 % of Total: 0.00% (0)	$0.00 % of Total: 0.00% ($0.00)
1. Facebook / web	183 (90.15%)	170 (89.95%)	189 (90.43%)	92.59%	1.13	00:00:13	0.00%	0 (0.00%)	$0.00 (0.00%)
2. LinkedIn / web	19 (9.36%)	19 (10.05%)	19 (9.09%)	89.47%	1.47	00:00:14	0.00%	0 (0.00%)	$0.00 (0.00%)
3. Digital / web	1 (0.49%)	0 (0.00%)	1 (0.48%)	100.00%	1.00	00:00:00	0.00%	0 (0.00%)	$0.00 (0.00%)

CAMPAIGN OVERVIEW: THE CREATIVE

All Users
100.00% Pageviews

+ Add Segment

Dec 24, 2018 - Jan 31, 2019

Explorer | Navigation Summary

Pageviews vs. Select a metric

Day | Week | Month

Primary Dimension: Page | Page Title | Other

Plot Rows | Secondary dimension | Sort Type: Default | /academics/wwami/echo | advanced

	Page	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit	Page Value
		4,174 % of Total: 0.23% (1,782,255)	3,474 % of Total: 0.25% (1,417,561)	00:01:42 Avg for View: 00:01:40 (1.92%)	2,682 % of Total: 0.37% (717,220)	82.33% Avg for View: 60.68% (35.68%)	64.18% Avg for View: 40.24% (59.49%)	$0.00 % of Total: 0.00% ($0.00)
1.	uidaho.edu/academics/wwami/echo	2,612 (62.58%)	2,290 (65.92%)	00:01:58	2,226 (83.00%)	84.64%	80.05%	$0.00 (0.00%)
2.	uidaho.edu/academics/wwami/echo/opioid-program	175 (4.19%)	115 (3.31%)	00:00:34	25 (0.93%)	68.00%	19.43%	$0.00 (0.00%)
3.	uidaho.edu/academics/wwami/echo/how-does-echo-work	148 (3.55%)	101 (2.91%)	00:01:28	17 (0.63%)	52.94%	31.08%	$0.00 (0.00%)
4.	uidaho.edu/academics/wwami/echo/behavioral-health	143 (3.43%)	103 (2.96%)	00:00:36	18 (0.67%)	27.78%	13.99%	$0.00 (0.00%)
5.	uidaho.edu/academics/wwami/echo/opioid-program/schedule	137 (3.28%)	109 (3.14%)	00:01:49	41 (1.53%)	63.41%	35.77%	$0.00 (0.00%)
6.	uidaho.edu/academics/wwami/echo/behavioral-health/schedule	133 (3.19%)	108 (3.11%)	00:02:06	44 (1.64%)	65.91%	42.11%	$0.00 (0.00%)
7.	uidaho.edu/academics/wwami/echo/opioid-program/register	116 (2.78%)	96 (2.76%)	00:02:49	33 (1.23%)	45.45%	37.07%	$0.00 (0.00%)
8.	uidaho.edu/academics/wwami/echo/behavioral-health/register	98 (2.35%)	78 (2.25%)	00:02:11	30 (1.12%)	56.67%	37.76%	$0.00 (0.00%)
9.	uidaho.edu/academics/wwami/echo/opioid-program?uidaho.edu/echo=	68 (1.63%)	65 (1.87%)	00:01:12	65 (2.42%)	92.31%	92.65%	$0.00 (0.00%)
10.	uidaho.edu/academics/wwami/echo?uidaho.edu/echo=	63 (1.51%)	55 (1.58%)	00:02:31	55 (2.05%)	85.45%	82.54%	$0.00 (0.00%)

CAMPAIGN OVERVIEW

Ranking of traffic to ECHO pages

1. ECHO homepage (63% of traffic)
2. Opioid Overview page (4%)
3. How Does ECHO Work page (4%)
4. Behavioral Health Overview page (3%)
5. Opioid Program Schedule page (3%)
6. Behavioral Health Program Schedule page (3%)
7. Opioid Program Register page (3%)
8. Behavioral Health Register page (2%)

Ranking of pages based on average time spent on page (Total average is 1:40)

1. Opioid Program Register page (2:49)
2. Behavioral Health Schedule page (2:06)
3. Behavioral Health Register page (2:11)
4. ECHO homepage (1:58)
5. Opioid Program Schedule page (1:49)
6. How Does ECHO Work page (1:28)
7. Behavioral Health Overview page (:36)
8. Opioid Overview page (:34)

KEY INSIGHTS

- While the homepage bounce rate is high (not uncommon as users often visit a landing page, bounce, then return at a later time) we know that users were moving around the site as 40% of users visited a 2nd page beyond the homepage.
- Pages where users spent the least amount of time have very little content to keep our users engaged. Adding additional content, like the videos and case studies, will help further engage visitors. This will be especially helpful on the Behavioral Health Overview page and Opioid Overview page which users are currently only spending about 30 seconds on.
- Almost 60% of all site traffic is coming from tablets and mobile devices while 40% is from desktops so it's important to continually provide a clear path to crucial information for users as the site content changes.

THANK YOU

Statewide Healthcare Innovation Plan

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

Goal 5 & Goal 6

Sustainability Initiatives

Goal 5

1) Prescription Drug Monitoring Program

Prescription drug monitoring programs (state-implemented programs that contain all patient-specific controlled substance dispensing records from outpatient commercial pharmacies) have been demonstrated as effective tools to identify opioid prescribing patterns that are associated with opioid-related misuse, abuse, overdose, and death (risky prescribing patterns). By analyzing PDMP data, the Idaho Department of Health and Welfare (DHW) is able to identify characteristics of the Idaho PDMP associated with best outcomes and maximizing the utility of PDMP policy and implementation.

2) Get Healthy Idaho Dashboard Design Program

The Idaho Department of Health and Welfare is developing approximately 40 data dashboards to be embedded on the public-facing population health improvement website (gethealthy.dhw.idaho.gov). The dashboards are dynamic in nature and allow for viewers to select various subsets within the data, such as year, sex, age-group, household income, race/ethnicity, etc. The data to be used has already been collected and is maintained by the Division of Public Health.

http://gethealthy.dhw.idaho.gov/index.php/home/health_data

Goal 6

1) Launch of Medicaid Value Based Payment Program

Go to http://www.healthyconnections.idaho.gov/ and click the "+" next to "HC Value Care Program Documents" under 'Provider Information' . The webinar slides give a timeline for their contracts finalization and implementation in regions 3&4.

2) Blue Cross of Idaho Foundation Rural Health Initiative

Blue Cross nationally developed a Community Health Management (CHM) hub tool. This is being endorsed by Blue Cross of Idaho Foundation (BCIF) to visualize population health data across the state and nation. The tool, which can be found at http://app.chmhub.com, provides certain health outcome data down to the geocoded level (smaller geographic level than zip code). BCIF continues to build the hub to be more robust and more searchable by health outcome.

Healthcare Innovation Initiative

Blue Cross of Idaho Foundation for Health

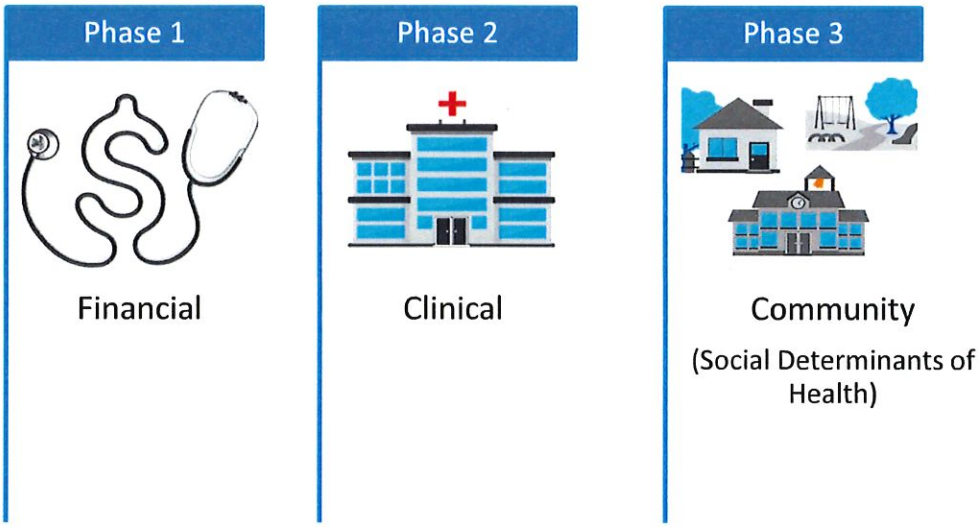
INITIATIVE MISSION/VISION:

In Idaho, the root causes of poor health are addressed to create a healthier Idaho, healthier future.

INITIATIVE PURPOSE:

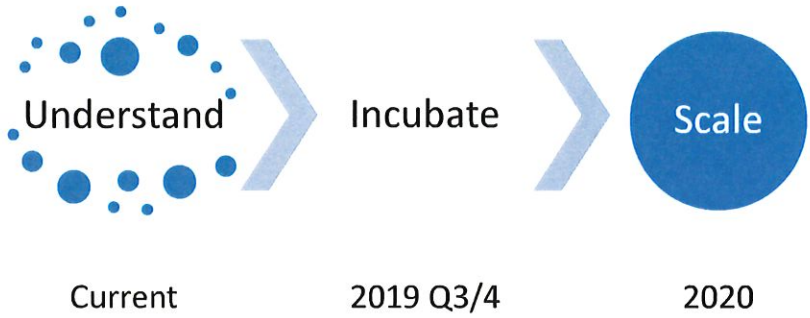
The Blue Cross of Idaho Foundation for Health recognizes health doesn't happen in a doctor's office; and the Healthcare Innovation initiative was created to bridge the gap between clinical and community services to create business solutions to solve for social determinants of health.

The Foundation's Healthcare Innovation initiative will work to uncover and understand the root causes of Idaho's most pressing healthcare issues by collaborating with experts and innovators to proactively identify and prototype solutions to address the social determinants of health and improve outcomes.



Blue Cross of Idaho | Foundation for Health, Inc.

TIMELINE:



If you would like to learn more, please contact Blue Cross of Idaho Foundation for Health Program Officer Connor Sheldon at csheldon@bcidahofoundation.org or 986.224.5077.

Blue Cross of Idaho | Foundation for Health, Inc.

Blue Cross of Idaho Foundation for Health

Practice and Financial Redesign Initiative version3

(3-22-2019

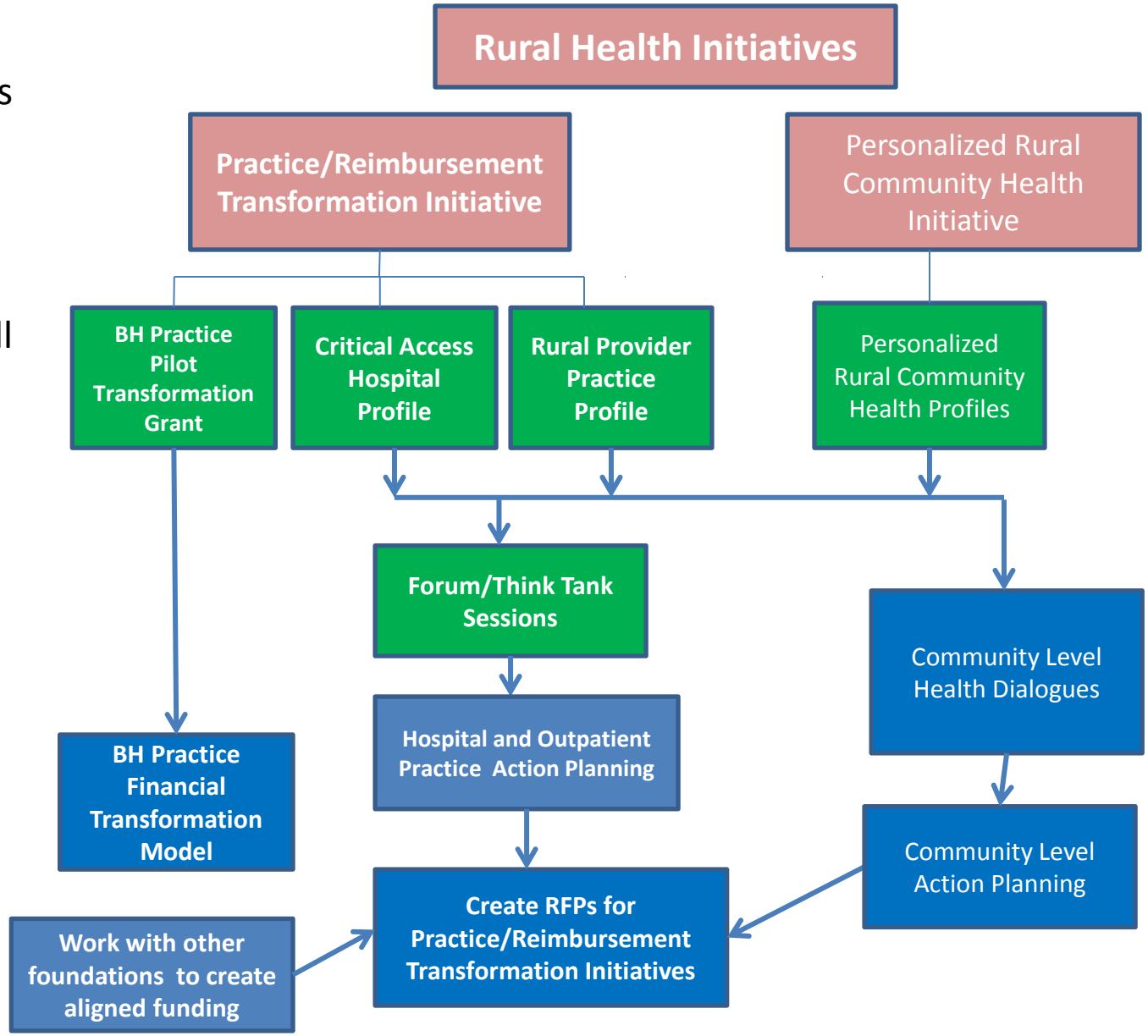
Practice/Financial Redesign Initiative

Strategy

- Gather and communicate data that identifies the key issues and viable models for applying value based population management to rural health community delivery systems.
  - Identify key characteristics of needed practice changes to be in alignment with value based population management.
  - Identify key characteristics of payment models that can be effectively applied to rural health delivery systems.
- Facilitate transformational change through meaningful and "difficult" conversations amongst community stakeholders and SMEs via Forums and/or Think Tanks sessions to begin to identify issues and solutions.
- Create funding opportunities through RFPs and/or technical support contracting for select rural communities to implement community based health system transformations designed specifically for rural communities.

Practice/Reimbursement Transformation Strategy for 2019

This illustrations shows the planned activities, level of activity and where the integration of the activities between initiatives will occur.



Level of Activity Legend

- In process
- Completed
- Not started

Practice/Reimbursement Redesign Health System Profile Mapping

Objectives:

- Use the BCIFH phase 1 profile data and other resources to map out each rural community's health delivery system*.
- Identify findings and questions for reviewing the data.
- Communicate finding to core stakeholders on a county/service delivery level to stimulate interest and action planning.
- Aggregate data to identify statewide special topic for analysis.
- Facilitate forums and think tanks involving stakeholders to engage and have the "difficult conversations" to stimulate transformative thinking.

* Rural community health delivery system includes providers, ancillary providers, community based organizations and services

Basic Tenets

Basic tenets for value based population management

- Value based care is a "team sport" from a provider perspective. Providers need to work together to create a system of care that is efficient, limits duplication and un-necessary competition and is accountable to their community
- Value base contracting for rural areas need to be based on the community's services delivery area and the system of care delivery .
- Not all existing participant in health care delivery today will be a part of the transformed delivery system. They have a choice and must be flexible and be willing to invest in change.
- Cross accountability of the community health status amongst the providers and participants for quality and efficiency of care is essential
- Value base care must focus on balancing quality and cost efficiency of care
- Transparency to providers, community leaders, community resident and funders on quality, efficiency and cost is essential to driving change. The circle of transparency may need to be incremental.
- Practice change is essential and primary to population managed care and must be financially supported fully and early in the process to allow the change.
- Coordination of care services are essential and need to be driven by cross accountability, transparency and appropriate financial support
- Core services need to be identified and made to be universally available for all population segments with financial methodologies that are sustainable, (e.g. emergency triage linked directly to accountable providers for engagement, essential ancillary providers in rural/underserved areas)
- Strongest driver of change is for all payers to participate and drive uniformity around VBC approaches on a community provider system level .
- Electronic medical records are essential for core providers to managing value based population care.
- **Transition facilitated by valued based payments and population accountability for outcomes stimulates new innovative business opportunities**.

Practice/Financial Redesign Initiative Current Activities

Create a Governance Structure

- **Establish Advisory Panel**
  - Give feedback on strategy , receptivity to plan and feasibility of activities.
  - Liaison to your constituents for broad communication
  - Identification of national and local SMEs
  - Feedback on RFPs and major contract statements of work

- **Establish Workgroup Advisory Team**
  - Forum/Think Tank Planning
  - Hospital and Provider Profile Work – “Voice of the Provider”

Practice/Financial Redesign Initiative Current Activities

Action Plan

- Commission activity to enhance the Foundation's community health profiles indicators:
  - To confirm the current status of health system resources, (number of clinics by categories, number of PCMH practices, Number of EMTs, community organizations involved in health system, etc
  - Collect more practice operational info for analysis, (operational hours and days of clinic/practice, has EMR, etc)
  - Use the profile data to visually map out the health delivery system per county in CHM Hub an narrative.
  - Use the profile info to be the bases of the meaningful conversations to drive awareness.
- Create draft criteria and decision tools - core workgroup
  - Ideal community network structure and core services
  - algorithms for classifying/ ranking the rural community health systems as to their VBC readiness
  - algorithms for classifying/ ranking payer VBC readiness.
- Receive feedback and actions from Advisory Panel
  - Receptivity to plan
  - Feasibility of plan
  - Support or actions to support the plan
  - Help select cohort 1 pilot communities

Practice/Financial Redesign Initiative

Forum/Think Tank Plan

Working Definitions

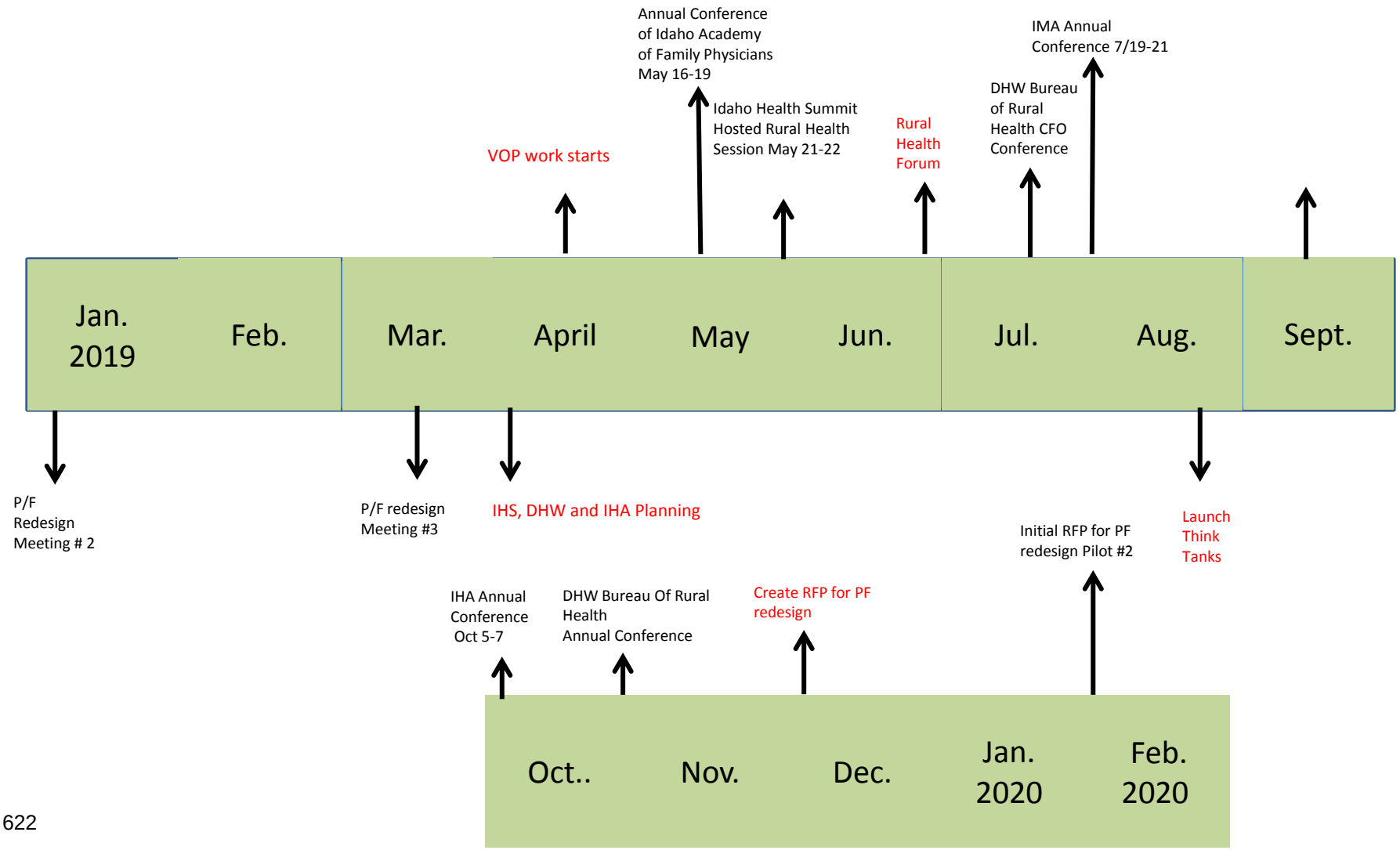
Forum – is a single meeting that introduces the issues with the involvement of SMEs and local stakeholders

Think Tank - a series of sessions that involves local stakeholders with consultation from SMEs to identify the issues, local strategy and actions.

Deliverables

- Inform rural practices of issues and transformation pillars
- Facilitate communities/groups to engage in creating a transformation strategy
- Create RFP for grant funding for starting implementing transformation

2019 Practice Financial Redesign Activities and Timelines



Practice Financial Redesign

Forum/Think Tank Activities

- Identify issues that are the most important changes for Practice Financial Redesign for rural delivery systems
- Prioritization of the issues for in depth analysis, (top 1 per category).
- Establish supported workgroup
- In depth analysis including SME involvement
- Supported forum/think tank sessions
- Bases for future grant support

Practice Financial Redesign

Forum/Think Tank Activities

Background Evidence

- Literature Review
- SME Input
- Hospital Profiles
- Provider Profiles
- Ancillary Provider Profiles
- Community Organization Profiles

Think/Tank Pillars (draft cohort)

- Solvency Issues/ strategies
- System Transformations
- Value Base Contracting Model(s) for Rural Practice?
- ROI Transformative Opportunities
- Data strategy
- CAH changes
- Otpt Practice change
- Service Mapping

Participants

- Payers
- Providers
- Health Community Based Organizations

Practice Financial Redesign Initiative

Voice of the Provider Activities

- Statement of Work contracting to an outside vendor or individual by end of April.
- Project divided into three parts
  - Part 1 -Rural health delivery systems mapping
    - Verify validity of Foundations' health service data for all counties
    - Collect additional practice/service information (e.g. hours of operation)
  - Part 2 - Practice and Financial systems analysis of selected outpatient practices and CAH
    - Patient health system journey, (emergency care, chronic illness, diagnostic complex)
    - Identify typical fee for service payment vs practice gaps
  - Part 3 – Facilitation of focus groups to identify workable issues to address on a community or state wide basis.

Blue Cross of Idaho
Foundation for Health
Rural Health Initiative

Thank You

for your

Participation!

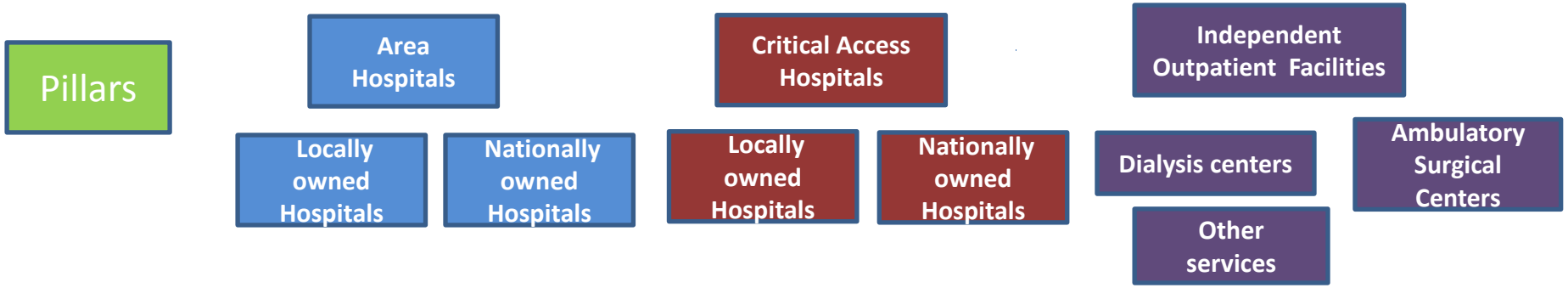
Appendix

Appendix A
Defining the Structure of the Provider Health System

- Defining the grouping of the provider types will be used as a bases for the Practice Finance Redesign approach for initiatives and funding.
- The following slides are being built based on the input from an advisory panel to the Practice Financial Redesign Project.
- The intent is to:
  - Define the provider categories based on similar practice and financial issues
  - Use as a bases for categorizing the local providers into the categories on a county/community level for our mapping of the heath services project, (CHM Hub and Profiles).
  - Use as a bases for identify the segmentation of the needed data elements to be collected that are reflective of the key providers by the various categories.

Practice/Reimbursement Transformation Profile Mapping Project

The goal of the mapping project is to categorize provider types by their business structure (pillars), their service base, (service mapping) and operational parameters, (operational mapping).



Service Mapping Elements

ER, Urgent Care, home visits and treatment capability, Bed flexibility - Swing Beds, Other services

Operational Mapping Elements

Number of beds/slots, operational limitations, electronic medical records, bidirectional data exchange with IHDE, other indicators, clinical hours of operation, Prescriber FTE power,

Practice/Reimbursement Transformation Mapping

Rural Provider Practice Structures

Pillars

- Hospital Owned/ affiliated Practices
  - Facility based services
  - Medical Clinics
- Governmental Sponsored Practices
  - FQHCs
  - Health District Clinics
- Independent Practices
  - Group Practices
  - Solo Practices
  - Rural Clinics
  - Free Medical
  - Facility based services
  - Free Standing Clinics

Service Mapping Elements

Examples = urgent care, home visits and treatment capability, telehealth

Operational Mapping Elements

Examples = Hours of operations, days of operation, service capacity, on-call services

Practice/Reimbursement Transformation Mapping

Rural Health System Components

Pillars

Ancillary Providers

EMTs/First Responders

SNFs

Air Transport

Ground Transport

Dental

Hospice

Home Health

Community Services

Assistant Living

In-home assistance

Meals on wheels

Community Organization(s)

Senior centers

Service Mapping Elements

Operational Mapping Elements

More examples = disability transportation,

Examples = Hours of operations, days of operation, service capacity, insurances accepted, other

Goal 6

Sustainability Initiatives

(Continued)

Goal 6

3) HTCI initiatives to further achievement of value-based payment adoption in Idaho

4) BSU CEH Value Based Curriculum Development

Idaho Health Connect
Learning Resource Site

A New Online Hub for Healthcare Transformation in Idaho

Education and training on healthcare transformation in Idaho is here—and it's all in one place. Idaho Health Connect is home to a free online library for clinics and health professionals who are participating in transformation practices such as the Patient-Centered Medical Home (PCMH) model.

Over 100 open-access resources and training toolkits cover topics such as PCMH mentorship, sustainability, patient engagement, and organizational change management.

In partnership with Boise State University, Idaho Health Connect is launching a Member Portal in spring 2019 that will host new coursework and advanced site features:

- **Earn CEs**
- **Receive badges and certifications**
- **Connect with Communities of Practice**

Explore a wealth of free resources and grow your skills today.

IdahoHealthConnect.org

COURSES COMING IN 2019

VBP 101: VALUE BASED PAYMENTS

VBP 102: QUALITY PAYMENT PROGRAM

VBP 103: CLINICAL QUALITY MEASURES

Statewide Healthcare Innovation Plan

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

Other

Sustainability Initiatives

Other Initiatives

1) DHW Division of Behavioral Health Adolescent Treatment Hospital Development in Nampa projected to be opening by October 2020.

2) Crisis Centers established in Regions 1, 4, 5, 7 (Regions 2 & 3 are negotiating contracts)

3) DHW Center for Drug Overdose and Suicide Prevention

Idaho Department of Health and Welfare

New Center for Drug Overdose and Suicide Prevention to tackle overlapping public health issues

by Forbing-Orr, Niki on 12/21/2018 1:55 PM

The Center for Drug Overdose and Suicide Prevention (CDOSP) in the Division of Public Health officially began work on Nov. 26, 2018.

This new venture, housed in Public Health Administration, combines eight staff members and two previously existing programs: the Drug Overdose and Prevention Program and the Suicide Prevention Program.

The Division of Public Health hired Denise Jensen, program manager, to oversee the center's work and direction. She most recently held a position in the Division of Behavioral Health as the Quality Assurance and Utilization Management Supervisor and has 20 years of experience in the behavioral health field in overseeing and developing statewide programs for Utah and Idaho. Additionally, Denise taught at the University of Utah and provided mental health therapy in trauma and substance use disorders.

"Throughout my career, and in my work with individuals experiencing trauma and substance use disorders, I have seen firsthand the devastating effects that drug overdoses and suicides have on communities and families," Jensen said. "We are at a critical juncture in addressing these issues, and I am excited to work with our staff and stakeholders to improve the health of all Idahoans."

In 2016, the United States lost nearly 45,000 lives to suicide and 42,000 lives to opioid-related overdoses. As a result, the Centers for Disease Control and Prevention recently concluded that life expectancy in the United States has declined over the past few years.

Because there are often clear and/or ambiguous overlaps between suicides and opioid overdoses, the reorganization of these programs into the CDOSP allows the division to combine resources to start addressing suicides and opioid overdoses that impact far too many Idahoans.

The CDOSP's focus is to create healthy and resilient communities through coordinated efforts and innovative approaches to suicide and drug overdose. The CDOSP will work towards achieving these goals by developing and implementing community-driven strategic plans to address opioid overdoses and suicide deaths in Idaho. Within the plans, the CDOSP will detail action items to educate communities, develop statewide infrastructure across agencies and communities, and reduce deaths associated with opioids and suicide.

In addition, the CDOSP will develop its Vision, Mission and Goals, aligning them with the Division's Strategic Plan and supporting the implementation of the department's strategic objectives around the opioid response and suicide prevention. This guiding document will help ensure coordination and communication remain a priority across both programs and the communities they serve.

Statewide Healthcare Innovation Plan

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Other

Sustainability Initiatives

Case Study Saint Alphonsus Hospital and the Treasure Valley Health Care Council - September 2017-October 2018

Implementing Evidence-Based Career Pathways: A Case Study of Saint Alphonsus and the Treasure Valley Health Careers Council.

James W. Guest, Metrics Reporting, Inc.

1. Establishing the Vision

The Treasure Valley region around Boise is the economic center of Idaho and Saint Alphonsus Health System is one of its leading anchor businesses. Saint Alphonsus has the region's only Level II Trauma Center, which recognizes a dedication to providing the highest quality, most optimal care for all critically ill and injured patients.

In September 2017, Saint Alphonsus began to consider some compelling reasons to rethink how they source and hire the talented individuals that serve the Treasure Valley region in roles throughout the hospital.

It is almost a commonplace now that healthcare is among the fastest growing sectors in the American economy. Idaho DOL projects that from 2014–2024 Healthcare Support roles will increase by 2.1% annually, and Healthcare Practitioners and technical jobs will increase at 1.8% annually. When we factor in replacements as well, that translates to a need for more than 14,700 individuals to fill practitioner and support roles and more than 8,300 healthcare support roles through 2024.

Saint Alphonsus therefore saw a need to create a comprehensive approach to sourcing and hiring talent. Currently, too much of the work is done in siloes and there is no traction for the community to meet these needs in a regionally coordinated way. Saint Alphonsus wanted to find a way to invite their separate community partners to be a part of something greater – to work on a regional approach to advancing competency-based sourcing and hiring methods.

Sector Strategies

Saint Alphonsus decided to take a sector strategic approach. Workforce sector strategies organize a group of employers and stakeholders in a specific industry sector in a specific region or labor shed to develop the supply of talent for their industry in their region. The US public workforce system operates through the 50 states that each have a department of labor and a public workforce system of independent workforce agencies as defined by the Workforce Innovation and Opportunity Act (WIOA). Effective sector strategies in a demand-driven workforce system are employer-led, include a broad group of stakeholders, and are facilitated by a “backbone organization” that provides at least one staff member to facilitate the work. This is the framework Saint Alphonsus wanted to adopt.

After internal deliberations, Saint Alphonsus brought together regional stakeholders and presented a vision statement.

Health Career Pathways Vision

> Our goal is to create an innovative and transformative career pathways program designed to connect education and training strategies and support services that enable individuals to secure industry relevant certifications and to obtain employment within an occupational area that enables advancement to higher levels of employment.

Our program will offer an efficient and customer centric approach to training and education by successfully articulating the necessary adult basic education, occupational training, post-secondary education, career/academic advising, and supportive services to enter and progress in a career.

We will collaborate with the leading organizations within our community and work together to create a comprehensive career pathing model for the people we serve. We will leverage Hope Street Group's Health Career Pathways Network to assist us on this journey. Our collaboration and partnership will help us to build a regional talent supply chain that benefits St. Alphonsus and the community we serve.

This vision was accepted by the attendees, and we set to making arrangements for regular monthly meetings, beginning with a stakeholder workshop. We decided to refer to this body of community partners as the Treasure Valley Health Careers Council.

2. Stakeholder Workshop

The Stakeholder Workshop was an all-day affair. From 8am to 5pm, representatives from Saint Alphonsus, Boise State University, College of Western Idaho, Idaho Department of Labor and other state agencies, as well as many other community partners engaged in general conversations about the set of decisions we need to make together in order for our career pathways to function efficiently for the individuals we want to place with Saint Alphonsus. We covered topics such as:

- Who the primary and secondary stakeholders are
- What a collective impact strategy looks like
- The importance of reliable supply-demand calculation and labor market data
- An evidence-based approach to defining job-related competencies
- A seven-step career pathway model
- The role of career coaching
- Career Portfolios and the evidence that identifies a high-quality candidate
- Sustainable funding strategies for the sector initiative

On the basis of these discussions, we began to organize some project teams, very broad work plans, and how to facilitate continuous communication. The major outcomes from the meeting included:

- Identifying Priority Jobs / Projects (two or three job families)
- Identifying lead employer contacts for each project team
- A Draft and Executive Summaries of each project

Over the course of a few additional monthly meetings, department managers and talent acquisition staff from Saint Alphonsus worked with community partners to sort into teams focusing on specific projects. Project Charters that outlined the purposes, goals, and necessary key leadership roles were drafted and then reviewed by the teams. We quickly settled on three projects centering on needs identified by Saint Alphonsus:

Project 1: Environmental Services Job Family (EVS): This team set out to create a robust pipeline of high-quality talent for EVS positions and opportunities for advancement via the Certified Health Environmental Service Technicians (CHEST) program. CHEST is a national development program that offers incumbent environmental service employees the chance to advance their knowledge and skills so that they can better serve patients as well

as earn higher wages. Saint Alphonsus decided to work with IDOL to implement the program as an Registered Apprenticeship – the first of its kind in the country. Sub-steps included:

- Assess supply-demand for business case
- Define occupational competencies and technical skills
- Define foundational competencies
- Identify ideal cohort size and timeline

Project 2: Customer Service Job Family (CS): This team set out to create a robust pipeline of high-quality talent for our CS positions and opportunities for advancement, including call center, patient registration, centralized scheduling, access center and patient service representatives. The project involved working with schools to put together a curriculum that covered a broad set of skills that would make entry into any one of these jobs possible. Sub-steps included:

- Assess supply-demand for business case
- Define occupational competencies and technical skills
- Define foundational competencies
- Define quality credentials
- Identify schools to deliver program

Project 3: Internship and Externships: This team is seeking to implement highly effective internship and externship opportunities so that we build relationships, provide an adequate number of clinical placements, and attract top graduates from community partners. Saint Alphonsus wanted to connect with Saint Luke's so that these two largest systems work together to assess opportunities within our community for student placement and explore an option for an electronic clinical scheduling program that was multi-disciplinary and bi-directional.

- Identify programs today that have a waiting list for jobs in area
- Identify best tools and practices – National trends
- Identify how to get an earlier offer for top candidates
- Work with schools on software program for scheduling that is bi-directional instead of uni-directional

Career Navigation Meeting

In regions across the country, career pathways are emerging as a leading workforce strategy. A career pathway is an integrated collection of programs and services intended to develop individuals' core academic, technical, and employability skills and to provide them with continuous education, training, and placement in high-demand, high-opportunity jobs. Three departments of the federal government signed a joint letter on career pathways in 2012 and over a dozen departments signed and reissued the joint letter in 2016. This letter is aligned with the major Workforce Investment and Opportunity Act (WIOA) legislation. Metrics Reporting and Hope Street Group brought a lot of experience developing career pathways with them to the Treasure Valley.[1]

[1] CareerSTAT and RFUMS case studies links.

Through previous work with Trinity Health in West Michigan and with the Manufacturing and Health Career Pathways Networks funded by Hope Street Group, Metrics Reporting has framed processes, tools, technology, and data frameworks into a participant-focused, seven–step model.

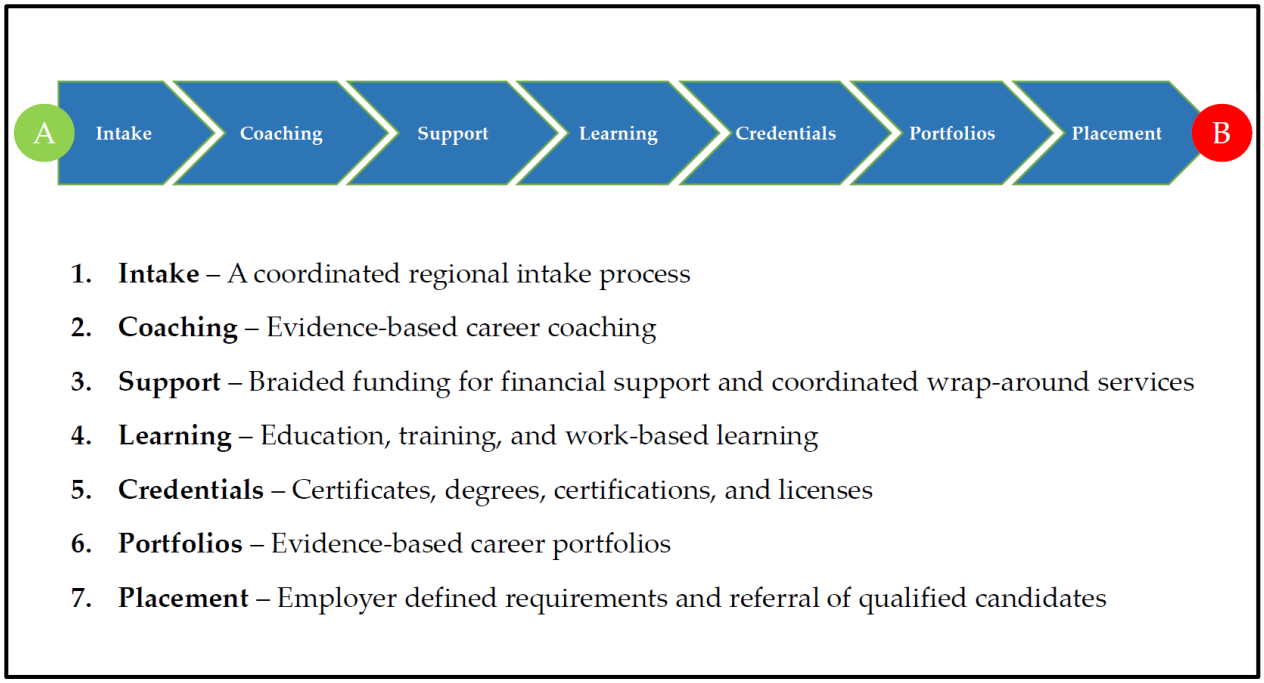

Figure: Diagram of the Seven Step Career Pathway Process

With some preparation and follow-up activities built around it, this seven-step model tracks the participant progress through an evidence-based career pathway and helps community partners locate their own work and services in relation to it.

We held another all-day workshop to discuss the model step-by-step. The model helped facilitate conversations and agreements among regional stakeholders as they developed and revised their project plans in light of it.

Addressing the Need for a Pre-Apprenticeship program for Environmental Services

While discussing the model, it quickly came to light, for example, that immigrant populations are a major talent pool for entry-level jobs, especially in Environmental Services. One of the barriers in a hospital setting, however, is the importance of English language skills. Aside from language skills needed to perform specialized job duties, Environmental Services professionals are often the face of the healthcare organization not only for patients but for visiting family members as well.

Our partners at College of Western Idaho saw an opportunity to draw on their English as a Second Language program and Basic Skills Education program to design a pre-Apprenticeship that prepares these individuals to enter Saint Alphonsus CHEST Apprenticeship program. And our partners at the International Rescue Commission serve a large population of refugees eager for the opportunity.

We decided to split the Environmental Services project into two distinct pieces – a Pre-Apprenticeship program and the CHEST Apprenticeship program:

(1) Pre-Apprenticeship Specific Activities

- Identify Basic Skills Assessments
- Design pre-apprenticeship curriculum
- Identify career coaches that will be trained by Easter Seals Goodwill
- Align with employer defined requirements for placement in EVS

(2) CHEST Apprenticeship Program Specific Activities

- Saint Alphonsus aligns internal training and development for EVS to the Certified Health Environmental Services Technician (CHEST) certification program from the American Hospital Association (AHA).
- Train CHEST certified instructors
- The CHEST certification is not a hiring requirement, but the outcome of the program for incumbent employees.

The Environmental Services Pre-apprenticeship class, held twice a week at Saint Alphonsus, focuses on language and career development. Students in the class receive 80 hours of instruction and training including English language acquisition and literacy, job task and soft-skill training, and career navigation skills.

Evidence-Based Selection

We've focused so far on establishing connections between Saint Alphonsus and their regional partners. But within the organization, selecting the right candidate is one of the most important decisions an employer makes. Saint Alphonsus wanted to adopt procedures that promote consistency in hiring by ensuring that employees in the same role use similar methods to seek information, integrate it into a view of the candidate, and translate that view into a hiring decision.

An evidence-based selection process leverages quantitative data in order to reduce bias (conscious or unconscious prejudice) and noise (factors unrelated to job performance) in the process. This involves several considerations:

- Everyone involved in the selection process should have the same understanding of the job groups
- There should be valid selection criteria for each job group
- There should be a rigorous process with valid and reliable selection tools
- Everyone involved in a hiring decision should be looking at the candidate holistically and scoring using a compensatory model
- The organization should be collecting outcome data to improve the valid selection criteria, scoring model, and selection tools over time
- The organization should be providing training, support, and tools to reduce bias

A process like this has been developed and implemented at Mercy Health in west Michigan. Mercy Health, like Saint Alphonsus, is a ministry of Trinity Health, and Boise's Chief Human Resource Officer CHRO (Saint Alphonsus) Heather Sprague was a part of the design team in west Michigan at the beginning. As implemented at Mercy Health, evidence-based selection is a fair, objective, data-driven selection strategy that has been proven to improve the quality of hires, reduce first-year turnover, and increase workforce diversity. [Note: In October 2018, Sprague was appointed by Governor Otter to serve a three-year term on the Idaho Workforce Development Council.} The process uses job grouping, job analysis and validation, and established practices from Industrial Psychology to develop valid selection criteria. Results over several years include:

- 23% reduction in turnover
- 16% reduction in time to fill
- Diversity of the workforce doubled

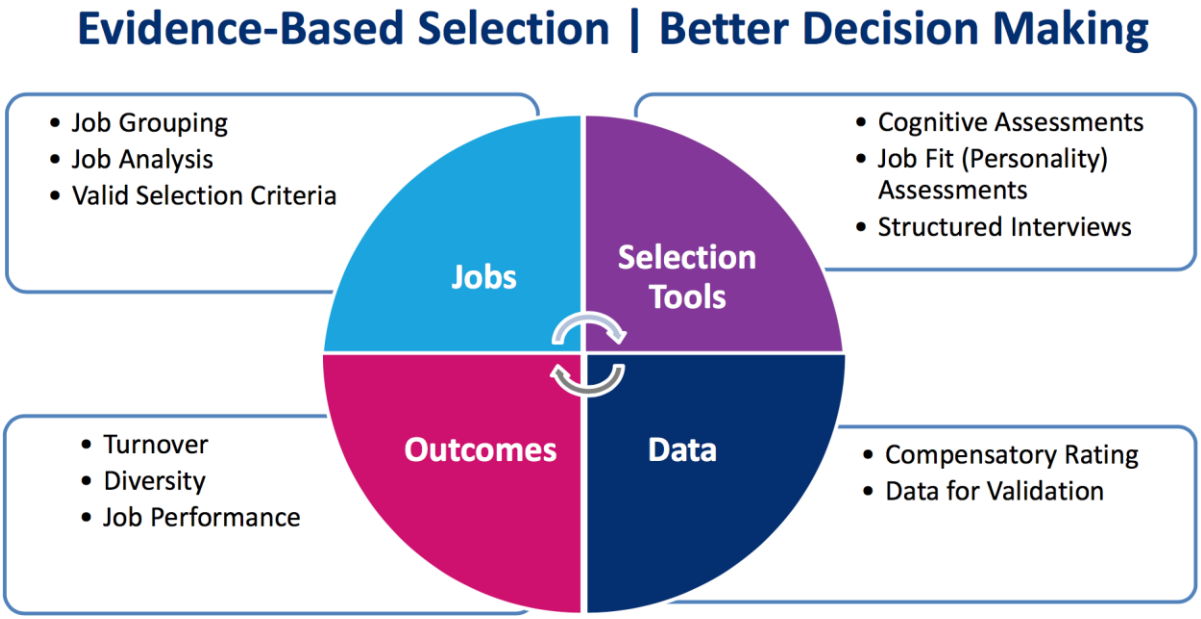

Figure: Matrix of mutually reinforcing elements of Evidence-Based Selection.

Confirmatory Job Analysis and Process Mapping

Job analysis played an important role in defining competencies related to job performance for the purposes of evidence-based selection at Saint Alphonsus and for developing curriculum and training among education and community partners. At Saint Alphonsus, Metrics Reporting (MRI) used a Confirmatory Job Analysis process to define job related competencies for the Environmental Services and Customer Services job families.

Job analysis (sometimes also known as work analysis) is a family of procedures used to identify the content of a job in terms of the activities involved in the work, the competencies or attributes of the individuals that do the job, or the job requirements needed to perform the work activities. Job analysis provides detailed information to organizations that helps them determine which potential or incumbent employees are the best fit for specific jobs.

In Confirmatory Job Analysis, we use O*NET data gathered and organized by MRI tools to clarify occupational and foundational competencies that define the things individuals need to know and be able to do at work. The O*NET is a project of the U.S. Department of Labor and the nation's largest database for job related information. While open and easy to access, the O*NET model contains hundreds of competency elements of knowledge, skills, abilities, work styles, and more that are difficult to take in at a glance. MRI tools and processes simplify and present the data in a way that is useful for job analysts.

The purpose of job analysis is to take a general view of a family of jobs. The Environmental Services job family simply combined two job codes, and the Customer Services job family combined ___ codes. We sought to identify the essential core competencies of each job family.

This model has two main parts: occupational competencies and foundational competencies.

- Occupational competencies are mainly represented by nationally portable occupational credentials that are developed and maintained by credentialing organizations in the sector. Credentialing organizations may be professional associations, industry organizations, or others. Occupational competencies can be sub-divided into job-specific and industry-wide competencies.
- Foundational competencies refer to cognitive, character and physical abilities and are sometimes referred to as “soft skills” or “professional behaviors.” To qualify as “evidence-based,” they should be determined by job analysis and confirmed by rigorous validation studies, not simply by discussion and consensus.

SME Sessions

Once MRI did the background prep-work using the O*NET, we held separate Subject Matter Expert (SME) sessions for each job family at Saint Alphonsus. We presented three key pieces of information that we wished to be confirmed by the SMEs – a group of incumbent employees with relevant experience in the jobs assess, alter as necessary, and confirm that the competencies we have identified are an accurate description of the work they do. Various community partners were invited to observe the sessions, but we requested that that only the SMEs comment on the materials. The three documents we reviewed were:

- A detailed list of occupational competencies (task list), which were confirmed or edited as necessary
- A list of foundational competencies, which were rated according to importance on a five-point scale
- A list of tools and technology used by incumbents in ordinary course of their work, edited as necessary

Each SME session typically took about three hours from start to finish. We see the job analysis process as collective work that is inclusive of employers, education & training providers, and community partners. The job analysis report is the result and documentation of that effort. The results of the job analyses were used in a couple of different ways:

> *Employers:* Saint Alphonsus used the information gathered to revise job descriptions. Job descriptions are frequently under- or over-specified. Job analysis provides an accurate picture of job relevant competencies. In a more complex way, the job analysis also supports the development of an evidence-based selection process (EBSP) by defining job-related competencies that can be measured with assessments or structured interview techniques. Finally, job analysis provides the information that can help Human Resources draw new connections between job families and develop internal career pathways from entry-level to middle-skills jobs and beyond.
>
> *Education and Training:* There are two main ways that education and training providers benefitted from the job analysis: (1) by participating in the job analysis process, and (2) reviewing the contents of the job analysis reports and incorporating the confirmed competencies into existing education and training. Documenting and clearly communicating the competencies that are job-related enables education & training providers to improve programs by appropriately focusing competency development and occupational training on areas that are related to job performance. Our partners at College of Western Idaho, for example, used the occupational competency or task list generated by the Environmental Services job analysis to inform skills-based learning exercises in their Pre-Apprenticeship program.

Boise - Customer Service - Occupational Competencies Based on O*NET Generalized Work Activities (GWAs)						
KEY:	Major Groups	Minor Groups	Generalized Work Activities (GWAs)	Intermediate Work Activities (IWAs)	Detailed Work Activities (DWAs)	O*NET Tasks (Supporting Details)

Information input: Where and how are the information and data gained that are needed to perform this job?

Looking for and Receiving Job related Information: How is information obtained to perform this job?

Getting information

Gather information from physical or electronic sources

1. Search files, database or reference material to obtain needed information.

Conduct searches to find needed information using sources as the internet.

Consult sources such as rate books, manuals, or insurance company representatives to determine specific charges or information such as rules, regulations, or government tax and tariff information.

Review files, records, and other documents to obtain information to respond to requests.

2. Interview employees, customers, or others to collect information.

Interview patients or their representatives to identify problems relating to care.

Interview patients to complete documents, case histories, or forms such as intake or insurance forms.

Monitor Processes, Materials, or Surroundings: Monitoring and reviewing information from materials, events, or the environment to detect or assess problems.

3. Monitor medical facility activities to ensure adherence to standards or regulations.

Review records for completeness, accuracy, and compliance with regulations.

Identify and Evaluate Job-Relevant Information: How is information interpreted to perform this job?

Identifying Objects, Actions, and Events: Identifying information by categorizing estimating, recognizing differences or similarities, and detecting charges in circumstances or events.

Inspecting Equipment, Structures, or Material: Inspecting equipment, structure, or materials to identify the cause of errors or other problems and/or defects.

Estimating the Quantifiable Characteristics of Products, Events, or information: Estimating sizes, distances, and qualities; or determine time, costs, resources, or materials needed to perform a work activity.

Mental Processes: What processing, planning, problem-solving, decision-making, and innovating activities are performed with job-relevant information?

Information and Data Processing: How is information processed to perform this job?

Judging the Qualities of things, services, or people: Assessing the value, importance, or quality of things or people.

Processing information: compiling, coding, categorizing, calculating, tabulating, auditing, or verifying information or data.

Evaluate the quality or accuracy of data

4. Check data for recording errors.

Compute, record, and proofread data and other information such as records and reports.

5. Verify accuracy of financial or transactional data.

Verify accuracy of billing data and revise any errors.

6. Sort mail.

Collect, sort, distribute, or prepare mail, messages, or courier deliveries.

Open, sort, and route incoming mail, answer correspondence, and prepare outgoing mail.

7. Compile data or documentation.

Compile and record medical charts, reports, or correspondence.

Compile reports of cost factors; such as labor, production, storage, or equipment.

Compile, copy, sort, and file records of office activities, business transactions, and other activities.

8. Reconcile records of sales or other financial transactions.

Resolve discrepancies in accounting records.

9. Prepare cash for deposit or disbursement.

Revised: 2018-05-11 Boise - Customer Service - Occuptional Competencies List Page 1 of 8

Figure: Partial task list for the customer services job family developed for a healthcare employer. The list is organized according to the O*NET taxonomy. Numbered items are Detailed Work Activities (DWAs), which are usually common to all job codes in our job family; and white items are example tasks that are often specific to one or another of the particular job codes in the job family. For that reason, MRI's process defines occupational competencies at the DWA level.

Evidence-Based Career Coaching

A typical career coaching process has four steps:

1. Self-Awareness – Participants complete assessments, resumes, career histories, and investigate interests
2. Career Exploration – Participants utilize career interests assessments and explore O*NET online
3. Decision Making – Participants, using evidence, make informed decisions to select a target job
4. Action Planning – Participants develop an action plan focused on education, training, and work readiness

Similar tools and processes used to improve selection systems can also be used to improve career coaching. In fact, TVHCC partners are already doing so in other projects. Easter Seals-Goodwill was one of eight Goodwill's selected to participate in the GoodPaths pilot (2017-

present), a project of Goodwill Industries International. GoodPaths is a career navigation initiative aimed at the broader retail industry where workers are more likely to leave a job if they are unclear about expectations, if training and advancement opportunities are lacking, and if they don't get positive recognition for their work. GoodPaths is addressing these issues by providing ongoing training and coaching opportunities and additional resources to support advancement and workplace growth. ESGW had 87 retail employees complete CiR with 82% retaining employment for six months upon completion. As of September 30, 2018, 160 ESGW retail employees have received GoodPaths career navigation services of which 81% have retained employment with ESGW.

Evidence-based career coaching leverages similar kinds of quantitative applicant data used in evidence-based selection in order to inform and plan individuals' career choices and development decisions. Instead of using this data to select the best candidate, we use it to train and coach individuals, building the supply of talent in the region. Skills addressed in coaching sessions include: interpersonal skills, team work, motivation, communication, problem solving, professionalism, planning & organization, human resources, observation & coaching, performance management & professional development, and business communication.

Conclusions

Four Stages of Regional Progress – System change takes time, but there is a step-by-step path to regional transformation.

Stage One: Organizing the Sector.

In this stage, regions align stakeholders in the sector around a specific set of job families, agree to a *Collective Impact* plan, and designate a backbone organization to guide the work. The primary outcomes of Stage One for HCPN regions are participation in a Stakeholder Workshop and a written plan for the region based on that workshop.

Stage Two: Developing Career Pathways.

Regions design and work to implement demand-driven career pathways in their target job families. Early in this stage, regions hold a Career Navigation System Workshop and agree to a regional approach to some or all of the following elements: intake processes, career coaching, support services, learning, credentials, or career portfolios. At the end of this stage, regions have implemented functioning career pathway pilots that incorporate career coaching and portfolios.

Stage Three: Improving the Pathway with Evidence-Based Competencies

Regions with operational pilots advance individuals through demand-driven, evidence-based career pathways with elements of evidence-based career coaching and/or career portfolios. They may be exploring job analysis and competency validation.

Stage Four: Expanding Evidence-based Career Pathways.

Regions at this stage have implemented multiple demand-driven, evidence-based career pathways that deliver substantial quantities of high quality, diverse talent to employers using evidence-based career coaching and evidence-based career portfolios. Job analysis and data collection for validation studies are used to identify and validate competencies across the sector or multiple sectors.

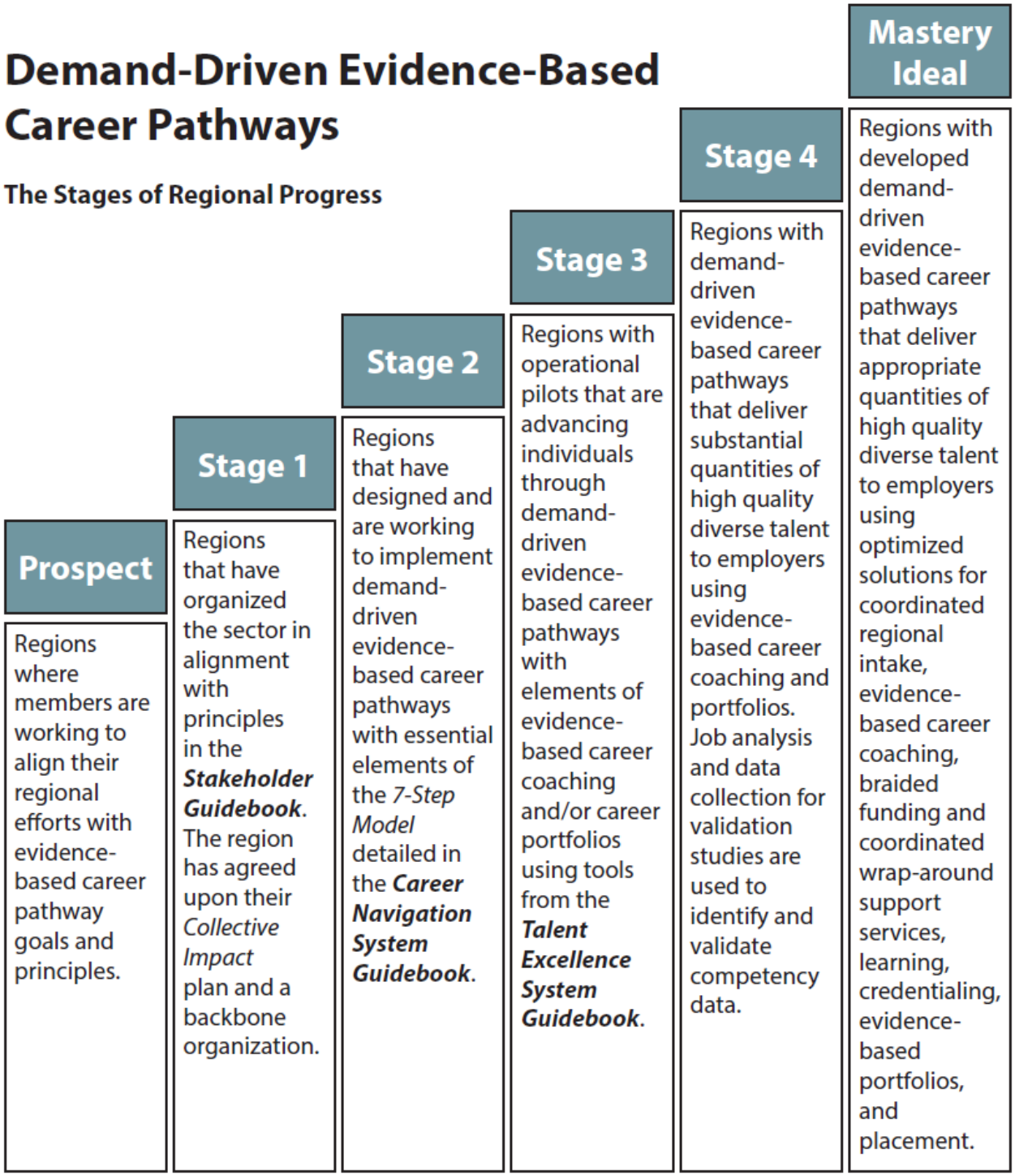

Figure: Four Stages of Regional Progress. With Saint Alphonsus as a lead employer, Boise moved from stage one to stage three in 18 months.

In our vision, a region that has transformed its talent supply systems will exhibit nine characteristics.

1. **Key Stakeholders Engaged** – The right organizations and the right people with the right skills and resources are actively engaged in the work.

2. **Collective Impact Plan** – A documented Collective Impact plan guides the work. For each career pathway project, an executive summary and team charters provide supporting communication and guidance.
3. **Seven Step Model** – The 7-step career pathway model has been applied to career pathways that lead to jobs known to be in demand on the basis of labor market analysis and employer input.
4. **Evidence-Based Career Coaching** – The evidence-based career coaching model is used to help individuals identify the optimal path forward for them. Multiple organizations (K-12, community colleges, workforce agencies, employers) have trained career coaches and are using the same coaching process.
5. **Job Analysis** – Job analysis and validation studies are used to identify competencies that are measurably related to job performance.
6. **Evidence-Based Career Portfolios** – Evidence-based career portfolios have been defined by employers and are commonly used by individuals to illustrate their job qualifications.
7. **Integrated Technology Platform** – The region uses a common technology platform that brings together common intake systems, rigorous job analysis, career coaching, job seeker skills portfolios and employer talent acquisition in one seamless, integrated technology platform that can be deployed at a regional level.
8. **Funding** – The region has the ability to plan, pursue and secure the funding required for the administration and improvement of the sector initiative.
9. **Benchmarking and Networking** – The region actively participates in national networks to benchmark regional programs against other high-performing sector initiatives in the nation.

Lead Partners

Saint Alphonsus Health System has the region's only Level II Trauma Center, which recognizes a dedication to providing the highest quality, most optimal care for all critically ill and injured patients. Saint Alphonsus is the lead employer in the Treasure Valley Health Careers Council, and CHRO Heather Sprague holds the chair for healthcare sector in the Governor's Workforce Development Commission.

Hope Street Group (HSG) is a non-profit whose mission is to increase economic opportunity for all Americans. In March 2016, Hope Street Group convened healthcare systems and leaders from the learning and workforce community at the White House to identify solutions to critical workforce issues in the healthcare industry. In April 2016, HSG launched the Health Careers Pathways Network (HCPN), a nationwide initiative designed to support individuals by advancing demand-driven, competency-based career pathways, with seven founding regions. HCPN promotes tools and practices to reduce job vacancies, increase diversity, decrease first-year turnover, and increase advancement of entry level employees for health care providers by adopting a competency-based approach.

Metrics Reporting, Inc. (MRI) develops processes and tools for evidence-based career pathways and employer-driven talent supply chain management systems. MRI has been working for the last decade on the design of regional evidence-base talent supply chains. MRI has been actively involved in developing career pathways into healthcare jobs for a decade in

west Michigan. For the last four years, MRI has partnered with the Hope Street Group on the development of their Sync Our Signals initiative.

Boise State University (BSU) is designated as a doctoral research institution by the Carnegie Classification of Institutions of Higher Education and offers about 200 programs of study. The Department of Community and Environmental Health (CEH) represents Boise State University's College of Health Sciences in the Customer Services group in the Treasure Valley Health Career Council (TVHCC). With 1600 students, CEH has the largest number of undergraduates at Boise State University. Majors within the Department earn degrees in health studies, health informatics and information management, public health, environmental and occupational health, and health education and promotion. CEH brings expertise in workforce development and Boise State's commitment to relevant educational programs and seamless transfer from community colleges.

College of Western Idaho (CWI) expands learning and life opportunities, encourages individual advancement, contributes to Idaho's economic growth, strengthens community prosperity, and develops leaders. CWI is a comprehensive community college providing higher education programs to residents of Western Idaho. They offer a full range of academic and career-technical courses leading to an Associate of Arts or Science degree, Associate of Applied Science degrees, continuing education, and certificates. CWI also offers Basic Skills Education to help prepare for a GED, Dual Credit for high school students, and fast-track career training for working professionals.

BSU and the CWI represent nearly 60,000 students in the Treasure Valley. The two institutions are close collaborators and have established mechanisms to partner, including articulation agreements and Bronco Connect, a gateway for students transferring from CWI to BSU.

International Rescue Committee (IRC) helps people whose lives and livelihoods are shattered by conflict and disaster to survive, recover and gain control of their future. IRC puts in place high-impact, cost-effective solutions that help people affected by crisis. They also use their learning and experience to shape humanitarian policy and practice in ways that improve the lives of more people worldwide.

Idaho Workforce Development Council (IWDC) is an independent office under the Governor and was established in October 2017 by Executive Order 2017-13. IWDC is setting the direction for Idaho's state departments and is a critical partner to organize WIOA funded support services and sustainable, braided funding. Via IWDC, we coordinate with Idaho Department of Labor, Health and Human Services, and other state workforce agencies.

Statewide Healthcare Innovation Plan

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

Other

Sustainability Initiatives

Other Initiatives

5) Future Event - Critical Access Hospital Symposium Initiative through the Blue Cross of Idaho Foundation - 2019

6) Future Event - Idaho Healthcare Summit – Focus on SHIP Initiatives – May 2019

Appendices:

Final Progress Report

Appendices

Prepared for
CMMI

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Celebrating Transformation in Idaho Healthcare

When Idaho's Statewide Healthcare Innovation Plan (SHIP) wrapped up on January 31st, an infrastructure ensuring a future of better health, better healthcare, and lower costs of care had been built.

The Office of Healthcare Policy Initiatives (OHPI) led this 4 year $39.6 million, federally funded effort—a cooperative agreement with the Centers for Medicare and Medicaid Innovation (CMMI) involving multiple public and private entities and stakeholders across the state. Over 38 contracts and sub grants were executed to achieve the seven goals and related deliverables for SHIP. 254 Stakeholders participated in this collective impact initiative involving the 50-member Idaho Healthcare Coalition, ten workgroups/advisory groups as well as seven regional collaboratives.

As a result of strong stakeholder engagement and commitment:

1. Idaho adopted the patient-centered medical home (PCMH) model of care. This team-based, coordinated care approach allows the patient to work collaboratively with their providers and be proactive in their healthcare decisions. The progress is encouraging.
   - 164 primary care clinics have participated in the SHIP technical assistance and training PCMH initiatives, providing better healthcare to more than 700,000 Idahoans. When SHIP launched, 31 primary care practices were PCMH accredited. As of January 31, 2019, 95 practices in Idaho were nationally accredited as PCMHs. Expect these numbers to increase.
   - A growing workforce of more than 100 trained Community Health Workers (CHWs) have been integrated into healthcare teams, helping them to address the social determinants of health, increase patient engagement, and achieve better health outcomes. Watch for this workforce to develop.
   - Nine medically-underserved communities across Idaho are now able to provide valuable healthcare services, screenings, referrals and support through different models of Community Health EMS (CHEMS). A Community EMT curriculum was developed and two live-online training courses were offered in the fall 2018. A total of 20 students were trained as CEMTs. See this momentum build.
   - Healthcare providers in some rural and frontier communities have been supported through telehealth programs as well as Project ECHO, which connects them to healthcare specialists via technology. Twice monthly sessions include clinical training, patient case studies and treatment suggestions on *Opioid Addiction and Treatment*, *Behavioral Health in Primary Care*, and *Medication-Assisted Treatment (MAT) Training*. Expect telehealth and Project ECHO to continue to grow and thrive.
2. Idaho is moving toward a value-based payment system which emphasizes health outcomes rather than services. Public and commercial payers have worked with healthcare providers to identify necessary changes and ways to track health outcomes. Everybody wins.
3. Idaho has enhanced an electronic health data exchange (IHDE). Already more than 150 primary care clinics, nine hospitals systems, and 19 individual hospitals can use it to improve care coordination. As IHDE expands, the sharing of data will prevent unnecessary expenses and improve health outcomes.

Federal evaluators with CMMI consistently recognized progress in Idaho throughout the SHIP period. This reflects the hard work of individuals dedicated to improving access, quality, and the health of all Idahoans. Furthermore, Idaho is well positioned for the next level of healthcare transformation. The Healthcare Transformation Council of Idaho (HTCI) is a recently established body charged with working with OHPI to facilitate ongoing transformation initiatives

Idaho Lifespan Family Caregiver Action Plan

Idaho Caregiver Alliance

To advance the well-being of family caregivers by promoting collaboration that improves access to quality support and resources, including respite, for caregivers across the lifespan.

Idaho Caregiver Alliance

History of Alliance

- 2012 Idaho Lifespan Respite Coalition established
- 2013 Idaho Commission on Aging receives $200,000 3-yr planning grant
  - Partnered with Boise State Center for the Study of Aging
  - Goals:
    - Enhance access to respite across the lifespan
    - Build sustainable coalition
    - Develop long range plan
- 2014 Statewide Respite Needs and Capacity Assessment
- 2015 Passage of HCR 24 recognizing value of family caregivers
- 2016 Presentation of Caregiving in Idaho report to Senate and House Health and Welfare Committees
- 2016 Created Idaho Lifespan Family Caregiver Action Plan and fostered steps for implementation

Why Now?

Why this attention now?

- Demographic changes
  - More aging baby boomers and fewer caregivers
  - More families caring for young and adult children with disabilities at home
- Caregiving more complex
- Supports are fragmented and difficult to access
- Family caregiving is not free
  - Lost income to employed caregiver
  - Lost productivity to employers
- Caregiving impacts the whole family
- It's the right thing to do and it makes cents
  - Delays need for institutional care
  - Caregivers are a key asset in the medical neighborhood

Action Plan Goal 1:

Family Caregiver Supports

Goal 1: Ensure a streamlined, coordinated system of supports for caregivers across the lifespan, recognizing the unique needs of Idaho's diverse population.

Objective 1 – Develop statewide respite resources.

Objective 2 – Ensure culturally appropriate information and resources are available to caregivers across the lifespan.

Objective 3 – Establish training resources for family caregivers on caregiving responsibilities, techniques, and strategies for self-care.

Objective 4 – Establish a statewide network of experts equipped to serve as information and support navigators or guides for family caregivers across the lifespan.

Caregiver Support:

Evidenced-based Powerful Tools for Caregivers

Idaho Caregiver Alliance

Powerful Tools FOR Caregivers

Boise
Legacy Corps
Kelle Sweeney
(208) 336-5533, ext 243
ksweeney@jannus.org

Coeur d'Alene
Strengthening Villages
Rebekah Forster-Casey
(208) 771-0628
strengtheningvillages@gmail.com

Grangeville
Syringa Hospital and Clinics
Maja Ledgerwood
(208) 315-2797
mledgerwood@syringahospital.org

Idaho Falls
Area Agency on Aging – Area VI
Heather Croft
(208) 522-5370
hcroft@eicap.org

Lewiston
Area Agency on Aging – Area II
Community Action Partnerships
Julie Christianson
(208) 791-0015
j.christianson@cap4action.org

Nampa
Terry Reilly Health System
Laramie Holtman
(208) 318-1326
lholtman@trhs.org

Pocatello
Area Agency on Aging – Area V
Southeast Idaho Council of Governments
Mike Hirschi
(208) 399-3077
mike@sicog.org

Action Plan Goal 2:

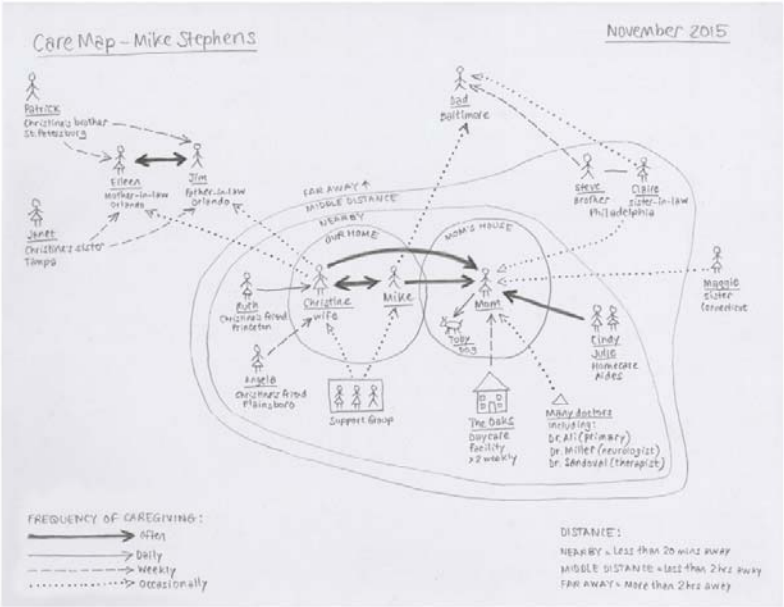
Awareness

Goal 2: Increase public awareness about unpaid family caregiving and help people within our communities identify as caregivers.

Objective 5 – Family members recognize themselves as caregivers and the general public is aware of the needs and contributions of family caregivers across the lifespan.

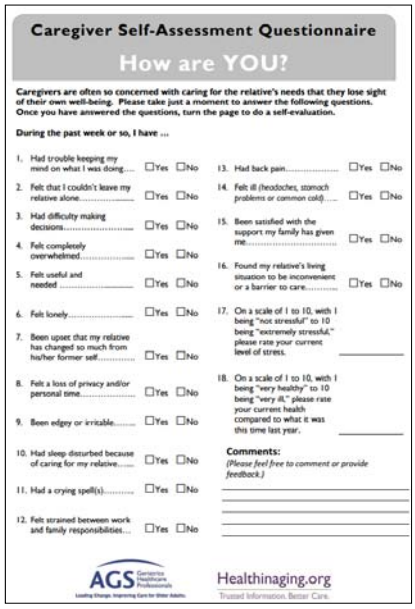
Awareness:

Complexity of Caregiving



Awareness

Caregiver Assessment Tool (devised by AMA)



Caregiver Self-Assessment Questionnaire

How are YOU?

Caregivers are often so concerned with caring for the relative's needs that they lose sight of their own well-being. Please take just a moment to answer the following questions. Once you have answered the questions, turn the page to do a self-evaluation.

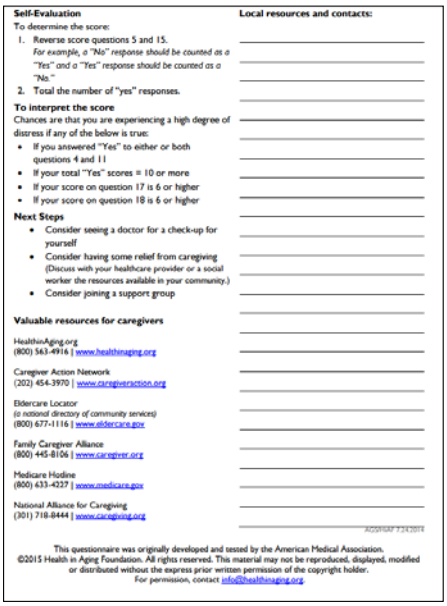
During the past week or so, I have ...

1. Had trouble keeping my mind on what I was doing..... ☐Yes ☐No
2. Felt that I couldn't leave my relative alone..... ☐Yes ☐No
3. Had difficulty making decisions..... ☐Yes ☐No
4. Felt completely overwhelmed..... ☐Yes ☐No
5. Felt useful and needed ..... ☐Yes ☐No
6. Felt lonely..... ☐Yes ☐No
7. Been upset that my relative has changed so much from his/her former self..... ☐Yes ☐No
8. Felt a loss of privacy and/or personal time..... ☐Yes ☐No
9. Been edgey or irritable..... ☐Yes ☐No
10. Had sleep disturbed because of caring for my relative..... ☐Yes ☐No
11. Had a crying spell(s)..... ☐Yes ☐No
12. Felt strained between work and family responsibilities.... ☐Yes ☐No
13. Had back pain..... ☐Yes ☐No
14. Felt ill (headaches, stomach problems or common cold)..... ☐Yes ☐No
15. Been satisfied with the support my family has given me..... ☐Yes ☐No
16. Found my relative's living situation to be inconvenient or a barrier to care..... ☐Yes ☐No
17. On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress. _____
18. On a scale of 1 to 10, with 1 being "very healthy" to 10 being "very ill," please rate your current health compared to what it was this time last year. _____

Comments:
(Please feel free to comment or provide feedback.)

AGS Geriatrics Healthcare Professionals — Leading Change, Improving Care for Older Adults.

Healthinaging.org — Trusted Information. Better Care.



Self-Evaluation

To determine the score:

1. Reverse score questions 5 and 15.
   For example, a "No" response should be counted as a "Yes" and a "Yes" response should be counted as a "No."
2. Total the number of "yes" responses.

To interpret the score

Chances are that you are experiencing a high degree of distress if any of the below is true:

- If you answered "Yes" to either or both questions 4 and 11
- If your total "Yes" scores = 10 or more
- If your score on question 17 is 6 or higher
- If your score on question 18 is 6 or higher

Next Steps

- Consider seeing a doctor for a check-up for yourself
- Consider having some relief from caregiving (Discuss with your healthcare provider or a social worker the resources available in your community.)
- Consider joining a support group

Valuable resources for caregivers

HealthinAging.org
(800) 563-4916 | www.healthinaging.org

Caregiver Action Network
(202) 454-3970 | www.caregiveraction.org

Eldercare Locator
(a national directory of community services)
(800) 677-1116 | www.eldercare.gov

Family Caregiver Alliance
(800) 445-8106 | www.caregiver.org

Medicare Hotline
(800) 633-4227 | www.medicare.gov

National Alliance for Caregiving
(301) 718-8444 | www.caregiving.org

Local resources and contacts:

AGSHIAF 7.24.2014

This questionnaire was originally developed and tested by the American Medical Association.
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For permission, contact info@healthinaging.org

Action Plan Goal 3:

Systems Change

Goal 3: Recognize the importance of family caregiving and embed the voice of family caregivers in policy and system change.

Objective 6 – Recognize family caregivers as part of their family members' health care and social support team.

Objective 7 – Embed family caregiver perspective and involvement in Idaho's efforts to transform its primary care, long-term care, and behavioral health systems.

Objective 8 – Include family caregivers in Idaho's efforts to enhance employment opportunities and tax policies that support families and the state's economic vitality.

Action Plan Goal 4:

Infrastructure

Goal 4: Ensure a coordinated voice for family caregivers in Idaho through the development of a sustainable structure for the Idaho Caregiver Alliance.

Objective 9 – Build on the established foundation of the Idaho Caregiver Alliance and ensure that the Idaho caregivers across the lifespan have a coordinated voice.

Objective 10 – Assure data are available to inform decision-making related to family caregiver supports and services.

Sustainability

What is needed?

- Resources to implement Action Plan.
- Institutional home and funding for ICA.

A voice, convener, and catalyst for support of unpaid family caregivers across the lifespan.

Idaho Caregiver Alliance

Resources to sustain ICA

$100,000 a year

- $55,000 Project Coordinator
- $25,000 Quality Improvement/Data Manager
- $20,000 Operating budget

Sponsoring agency

- State-wide reach
- Capacity to work across sectors

Next Steps

Your voice and leadership are key to sustainability.

Your support is essential as we establish a network of public/private partnerships.

Thank you

Idaho Caregiver Alliance

Pam Oliason, Pam.Catt-Oliason@aging.idaho.gov

Kelle Sweeney, ksweeney@jannus.org

Marilyn Sword, frontiergroupidaho@gmail.com

Tiffeny Stees, tiffenykiiha@u.boisestate.edu

Sarah Toevs, stoevs@boisestate.edu

Statewide Healthcare Innovation Plan

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

Goal 1

Appendices

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVID J. JEPPESEN – Director

CASEY MOYER – Administrator
OFFICE OF HEALTHCARE POLICY INITIATIVES
450 West State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-6997

MEMO:

The purpose of this memo is to remind you of the Learning Resource Site that Boise State presented during the SHIP closeout webinar in January – the Idaho Health Connect at IdahoHealthConnect.org. The site offers free and direct access to an online resource library that features:

- **Six toolkits offering interactive training on key subjects** (PCMH 101, Mentoring, Patient Engagement, Employee Training, Sustainability and Change Management)
- **SHIP PCMH Transformation Portal materials** (SHIP cohort educational webinars, SHIP mentorship presentations and SHIP learning collaborative documents)

Soon, the site will feature additional coursework for health and wellness professionals. The new courses will be available through a member portal system, which will require registration. Key aspects of the PCMH model will be covered, with an initial focus on value-based payment models for physicians. Examples of the coursework coming out in spring of 2019 include, but are not limited to:

- VBP 101: Value-Based Payments
- VBP 102: Quality Payment Program
- VBP 103: Clinical Quality Measures

As a member of a SHIP cohort, your clinic and public health district will have access to Idaho Health Connect and any new courses developed this year with *a one-year free trial subscription*. Please submit the Member Portal Interest Form to request that your clinic be contacted with instructions for enrolling this spring. The form can be found at the Idaho Health Connect website, under the Resource Library tab.

The Learning Resource Site facilitates the legacy of SHIP by serving the training needs of health professionals in Idaho. We greatly appreciate whatever you can do to help spread the word about the site to your professional networks.

A flyer is provided to assist you in sharing information on Idaho Health Connect with your colleagues, professional associations and clinics.

If you have questions about Idaho Health Connect or would like to sign up for their mailing list to receive additional information as it is updated, please contact ihc@boisestate.edu.

Idaho Health Connect
Learning Resource Site

A New Online Hub for Healthcare Transformation in Idaho

Education and training on healthcare transformation in Idaho is here—and it's all in one place. Idaho Health Connect is home to a free online library for clinics and health professionals who are participating in transformation practices such as the Patient-Centered Medical Home (PCMH) model.

Over 100 open-access resources and training toolkits cover topics such as PCMH mentorship, sustainability, patient engagement, and organizational change management.

In partnership with Boise State University, Idaho Health Connect is launching a Member Portal in spring 2019 that will host new coursework and advanced site features:

- **Earn CEs**
- **Receive badges and certifications**
- **Connect with Communities of Practice**

Explore a wealth of free resources and grow your skills today.

IdahoHealthConnect.org

COURSES COMING IN 2019

VBP 101: VALUE BASED PAYMENTS

VBP 102: QUALITY PAYMENT PROGRAM

VBP 103: CLINICAL QUALITY MEASURES

Patient Engagement Snapshot from Clinic Interviews

Clinic	How do you define patient engagement?	Do you think PCMH transformation has helped your patients engage with their own health?
Kaniksu	They defined patient engagement as patients who actively work to involve themselves in their care and actively work to prevent illness.	PCMH has absolutely helped patients engage with their own health. There has been more outreach from clinic to patients, more identification and follow-through on gaps. Care management services have worked well for patients, teaching them how to self-manage their chronic conditions. The patient portal has been very helpful in keeping patients engaged and participating in active communication with their providers. Shared decision making helps patients and their families engage in decision making for the most effective treatment options. Introduction of group visits for particular needs has helped patients begin to participate actively in improving disease.
CHAS	Transitioned mindset to coaching patients and empowering them rather than providing them with directions. It is their life and their healthcare.	PCMH has helped on all ends of the spectrum. The clinic has moved beyond meeting PCMH requirements and towards continued growth. BH specialists meet with patients to help them develop SMART goals.
Tueller	They allow space for patients to play a part in planning their healthcare. They coordinate, facilitate, and educate them. This concept is new for some patients. Some people are really reluctant to use the patient portal but they strive to keep communication lines open by using texting, messaging, etc.	Helping other people understand health—not assuming patient knows something—is a big part of patient engagement. They've found that presenting something to a patient 8 different ways helps. The more you educate patients and the more people they have telling them something, the more likely they are to start to catch on, which increases patient engagement.
Seasons	Patient engagement is the involvement of the patient in the development of their individual care plan.	PCMH has stressed the importance of involving the patient in decision making which helps make the care plan more effective.

Statewide Healthcare Innovation Plan

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

Goal 3

Appendices

The Southwest Region Community Health Assessment-2016

A collaborative effort between agencies that serve our six county community in Southwest Idaho.

SOUTHWEST HEALTH
COLLABORATIVE

Adams, Canyon, Gem, Owyhee, Payette and Washington Counties

Acknowledgements

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Andy Bourne	Research Analyst	Idaho Department of Health & Welfare
Angela Wickham MPA, HCC	Quality Improvement Consultant	Qualis Health
Angie Bailey RDH-EA, MSDH	Oral Health Program Manager	Idaho Department of Health & Welfare
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Carol Julius RD, LD, CPM	Division Director	Southwest District Health
Cheryl Craig MPH	Epidemiologist	Southwest District Health
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Juanita Aguilar RD, CDE	Diabetes Education Coordinator	Southwest District Health
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Adams County Health Center
Council Chamber of Commerce
Gem County Community Health Connection
Nampa Chamber of Commerce
Payette Library
Southwest Diabetes & Hypertension Coalition
Weiser Senior Center
Wilder City Council

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Summary

Demographics

- The Southwest Region of Idaho has the second largest population in the state. It is a region with extreme variability in population density, ranging from frontier to urban.
- The majority of residents identify as white. The Hispanic identifying population has grown at a significantly higher rate than the non-Hispanic population.
- Much of the population is resource constrained, classified as either living in poverty or part of the Asset Limited Income Constrained Employed (ALICE) population. Approximately one-fourth of the all residents in the area fall into one of these two categories. In some communities this number is as high as 79%.
- More than one-fifth of all children in the area live with food insecurity.

Mortality

- Chronic diseases rank in the top four positions in the most common causes of death in the Southwest Region while accidents and suicide rank in the top ten.

Environmental Health

- Approximately one-third of houses in the Southwest Region have at least one substandard condition.
- The area has significantly less grocery stores per capita than the state average.
- Every community reported significant transportation concerns.
- Communities reported significant community health benefit from nature paths, pools, and recreation centers.

Access to Healthcare and Services

- Approximately 22% of residents in the Southwest Region lack health insurance. Community reports indicated that this lack of coverage as well as high deductible plans were a significant concern.
- The area has a significant lack of physicians, behavioral health providers, and oral health professionals. Feedback from outreach events suggested that this impacted access to care and choice of providers.
- Breast cancer and colon cancer screenings in the Southwest Region are lower than both the state and national average. However, diabetes screening rates are comparable to national averages.
- Communities throughout the region share concerns regarding access to services related to language barriers.

Health Behaviors

- Families with lower incomes are less likely to eat the recommended servings of fruits and vegetables and are also less likely to participate in leisure time physical activity. In addition, families who identify as Hispanic are significantly less likely to engage in leisure time physical activity.

- Almost every community expressed concern over the lack of incentives for healthy eating in the Supplemental Nutrition Assistance Program (SNAP).
- All communities that provided feedback for the assessment indicated that residents valued nature and outdoor recreation.

Chronic Disease

- Diabetes represents a significant health concern in the Southwest Region. Approximately 9.6% of adults self-report that they have been diagnosed with the condition. The prevalence of diabetes increases with poverty and age.
- The area reports the highest rate of overweight and obese adults in the state. Across Idaho, 65.7% of adults are overweight or obese but in the Southwest Region that number jumps to 73%. All communities reported obesity as a significant concern.
- Cardiovascular diseases are quite common in the Medicare population in the area: 44% of beneficiaries have high blood pressure, 20% have heart disease, and 34% have high cholesterol.

Communicable Disease

- Whooping cough rates are lower than the state average but above national averages.
- The Southwest Region has the highest rate of STDs in the state. There is currently a syphilis outbreak in one of the areas.

Maternal and Infant Health

- Nearly one-quarter of mothers in the area have annual incomes of less than $15,000.
- The rate of teen pregnancy is higher in the Southwest Region (34.2 births per 1,000 female teens) than across the state as a whole (27.5 births per 1,000 female teens).
- Approximately one-quarter of new mothers in the area report significant stress in the 12 months prior to giving birth. This rate is higher for younger mothers and unmarried mothers.
- Half of women in the area rely on Medicaid for prenatal care and delivery.
- Community feedback identified a primary value of supporting families regardless of community size and composition.

Child and Adolescent Health

- Over 23,000 children in the Southwest Region are on SNAP. Communities reported significant concern over the lack of incentives to use benefits for healthy foods.
- Over 20% of children in PHD3 are considered obese while approximately 15% are considered overweight.
- Primary series immunization rate is 61%.
- Communities report significant interest in investing in the health of children.

Oral Health

- Just over 43% of adults in the Southwest Region report that they have not seen their dentist in the past 12 months.
- Just under 30% of adults with incomes of $15,000 or below have lost six or more teeth from decay.

Mental Health

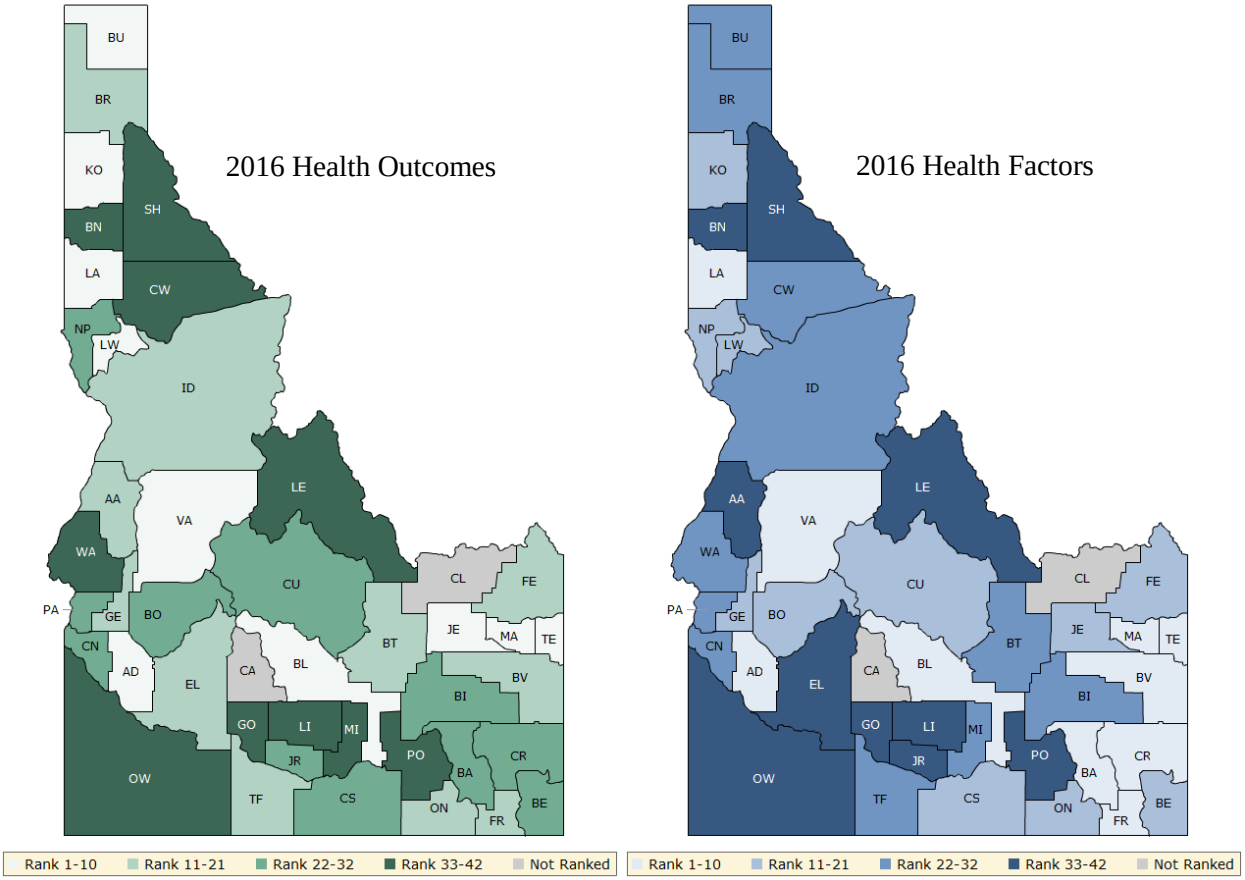
- The Southwest Region has a significant shortage of behavioral health providers.
- The suicide rate per 100,000 residents is 13.1.
- Several communities reported decreasing stigma around mental health.

Alcohol, Tobacco, and Drug Use

- The Southwest Region reports less binge drinking and heavy drinking than the state average.
- Just over 1 in 5 adults smoke tobacco.
- Illicit drug use and prescription drug abuse is just under the national average.

Introduction

This document was created by the Southwest Health Collaborative to represent the six county (Adams, Washington, Payette, Gem, Canyon, and Owyhee) region of Southwest Idaho. The purpose is to describe social, health, economic, and demographic conditions in the area served by Southwest District Health, multiple health systems, community organizations, and local governments. Our aim is to highlight both qualitative and quantitative data that paint a picture of strengths and areas for improvement at the regional and community level. It will serve as a starting point for the development of strategies to leverage new and existing resources to enhance the lives of those in our communities.



(County Health Rankings and Roadmaps, 2016)

The above figure displays health outcomes and health factors across the state. The Community Health Assessment reports various conditions and related influences on health and wellbeing.

Methods and Limitations

The Southwest Health Collaborative (SWHC) Community Health Assessment (CHA) represents a novel combination of quantitative and qualitative data to describe the six county (Adams, Washington, Payette, Gem, Canyon, and Owyhee Counties) Southwest Region, also referred to as PHD3. It is modeled on the Regional Health Assessment conducted by the Central Oregon Health Council and meets accreditation standards. Data from a variety of existing sources were combined to highlight specific focus areas at the regional level and county level where appropriate and available. These resources are listed in the References section. This data report was reviewed for relevancy, accuracy, and completeness by a variety of professionals in healthcare, public health, local government, quality improvement, and social services.

Next, community outreach events were conducted to assess congruency between the quantitative report and the experiences and perceptions of community groups. These groups consisted of local government bodies, civic organizations, and coalitions. The facilitation guide can be found in the Appendix. In addition, SWHC members provided brief narratives to highlight their experiences in the communities captured in the report.

The CHA is not intended to be an exhaustive list of all regional data but instead a summary of salient features to help guide the development of health improvement activities. We list the resources utilized for the development of this tool in the appendix if readers would like more information. It should also be noted that the CHA utilizes the most current data available at the time of the report but for certain metrics this may not be very timely. In addition, much of the publicly available data is based on self-report. Finally, data may not be reported in certain counties if sample size was too small. In this case, regional data is provided if available.

Demographics

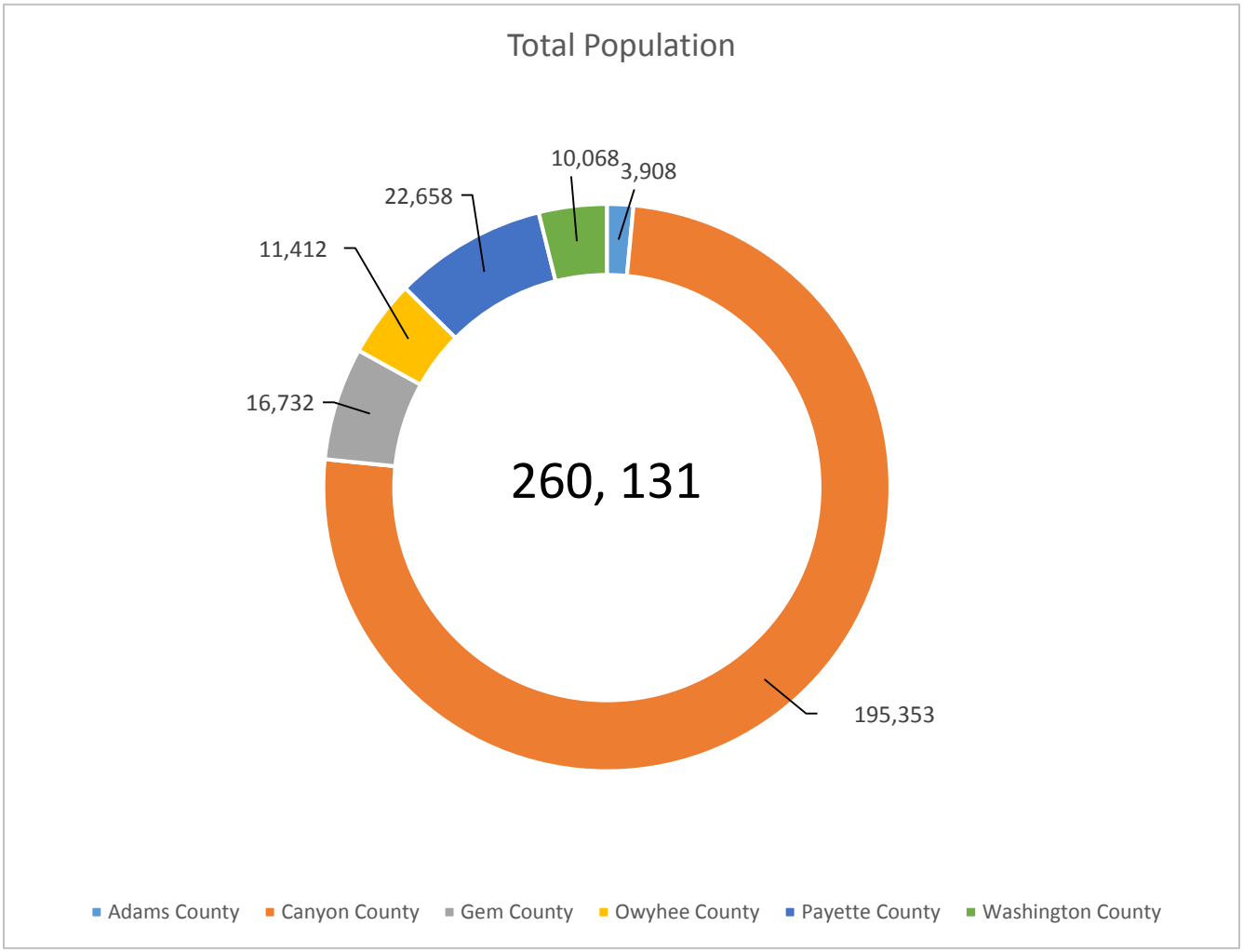
Introduction

The social determinants of health are increasingly considered as key factors in the overall wellbeing of individuals and communities. Features such as poverty, education, age, and race are closely correlated with some health outcomes.

Population

There is significant various in total population and population density across the Southwest Region.

Figure 1. Total population by county



(American Community Survey, 2010-2014)

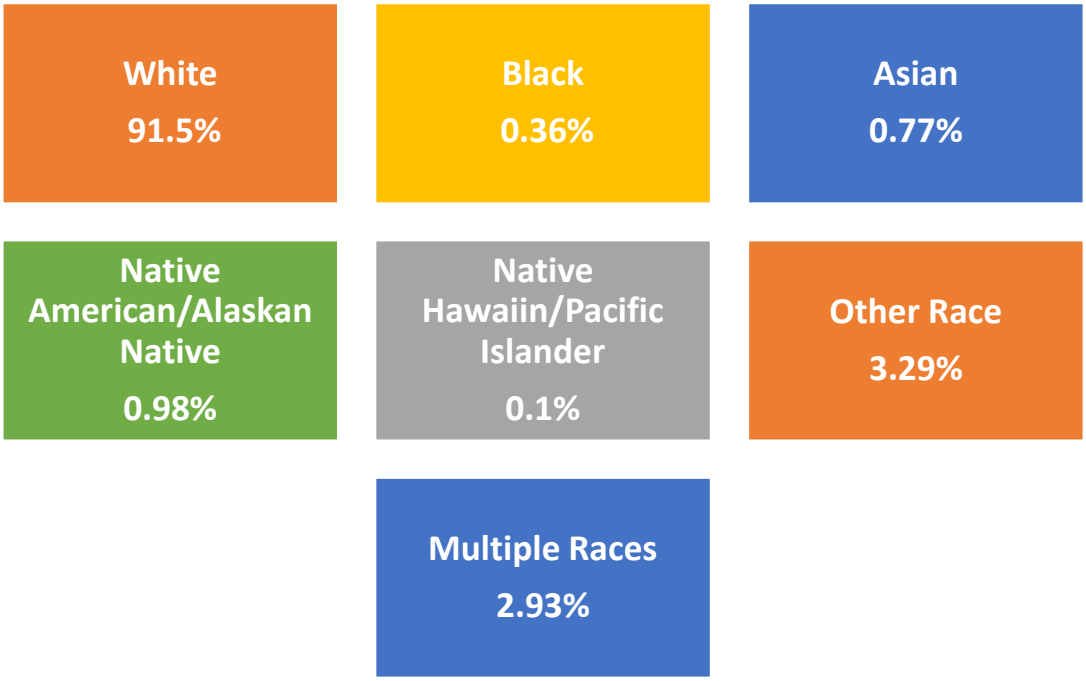
- It is also worth noting that each of the six counties contained within the Southwest Region have markedly different population densities based on both total population and land area (American Community Survey, 2010-2014).

Figure 2. Population density

Area	Total Land Area (square miles)	Population Density (per square mile)
PHD3	12,036.68	21.61
Adams County	1,363.06	2.87
Canyon County	587.37	332.59
Gem County	560.9	29.83
Owyhee County	7,665.54	1.49
Payette County	406.87	55.69
Washington County	1,452.94	6.93

- Clearly, Canyon County has the largest and most densely populated communities while Adams County has the smallest population and Owyhee County has the most dispersed.

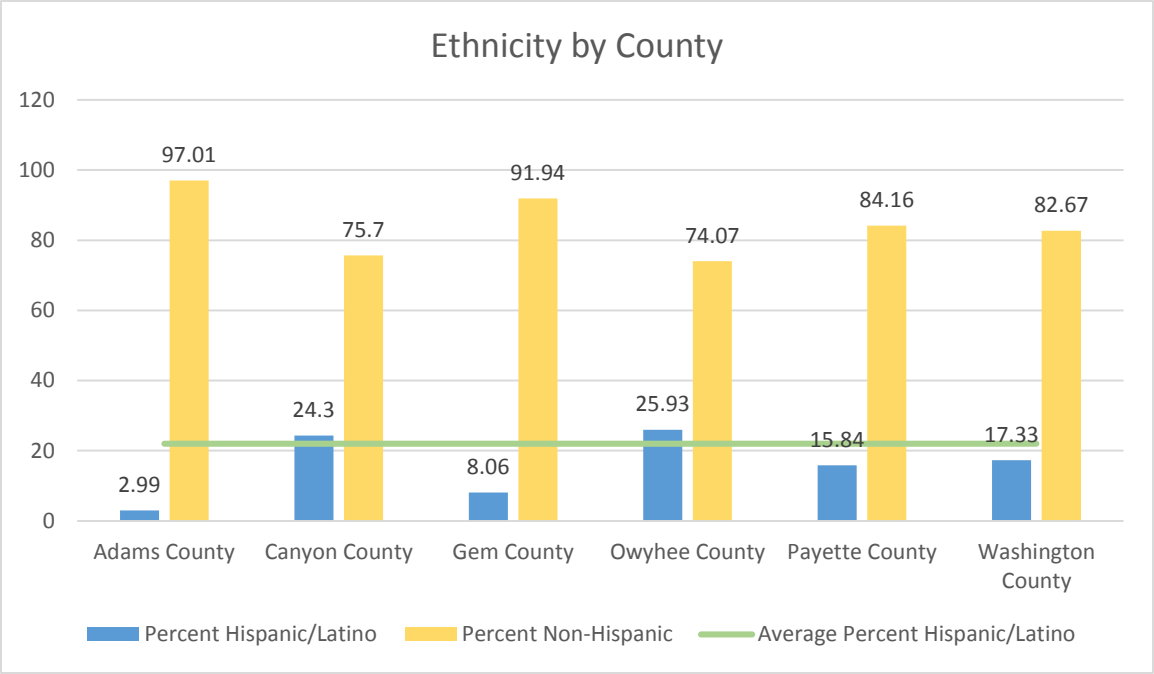
Figure 3. Racial composition



(American Community Survey, 2010-2014)

- Ethnicity varies significantly between counties. Cities reported as much as 80% of their communities identifying as Hispanic/Latino. It is worth noting that while the region overall grew by 32.76% from 2000-2010, the Hispanic/Latino community grew by 71.33% (U.S. Census Bureau, 2000-2010).

Figure 4. Ethnicity by county



(U.S. Census Bureau, 2010-2014)

- In the Southwest Region, 17.2% of the population age five and older speaks a language other than English at home (U.S. Census Bureau, 2010-2014). The majority of those who speak a language other than English at home speak Spanish (U.S. Census Bureau, 2010-2014).

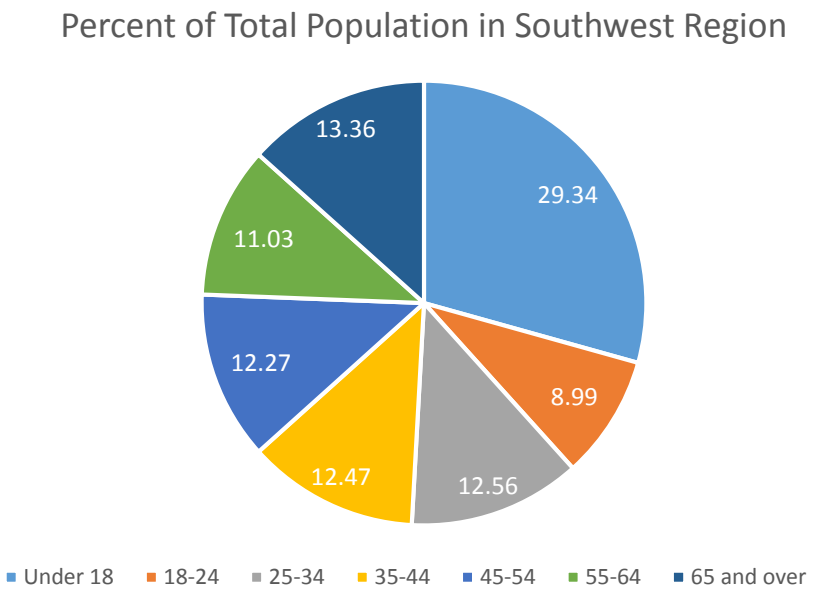
Figure 5. Language spoken at home for population age five and over, by county

Area	Speak English Only at Home	Speak Language Other Than English at Home
PHD3	82.8%	17.2%
Adams County	97.3%	2.7%
Canyon County	81.4%	18.6%
Gem County	91.2%	8.8%
Owyhee County	77.1%	22.9%
Payette County	88.2%	11.8%
Washington County	85.7%	14.3%

(U.S. Census Bureau, 2010-2014)

- Finally, as populations age, their healthcare needs change. Therefore, it is important to understand the composition of a region by age (U.S. Census Bureau, 2010-2014).

Figure 6. Population by age



(U.S. Census Bureau, 2010-2014)

- The two largest populations also tend to be the most vulnerable, those that are older and those that are younger.
- Canyon County has a much younger population than other counties (30.62% of population under 18) while Adams County and Washington County have older populations (23.06% and 21.48% over the age of 65, respectively).

Socioeconomic Status

Socioeconomic status includes such features as income, education and employment. These measures are crucial determinants of health as they dictate access to resources. A new measure has been developed by our partners at United Way called "ALICE". This metric captures the working poor or those that fall in the gap between public assistance and sufficiently resourced. Asset Limited, Income Constrained, Employed (ALICE) and poverty households (United Ways of the Pacific Northwest, 2015).

Figure 7. ALICE and poverty households

Area	Total Households	Percent ALICE & Poverty	Percent Poverty	Percent ALICE
PHD3	89,770	42%	18%	24%
Adams County	1,707	39%	19%	20%
Canyon County	65,923	41%	18%	23%
Gem County	6,323	38%	16%	22%
Owyhee County	3,911	62%	23%	39%
Payette County	7,968	40%	20%	20%
Washington County	3,938	46%	17%	29%

- Certain towns within the region report even higher levels of ALICE & Poverty including Homedale (79%), Wilder (69%), & Cambridge (62%).

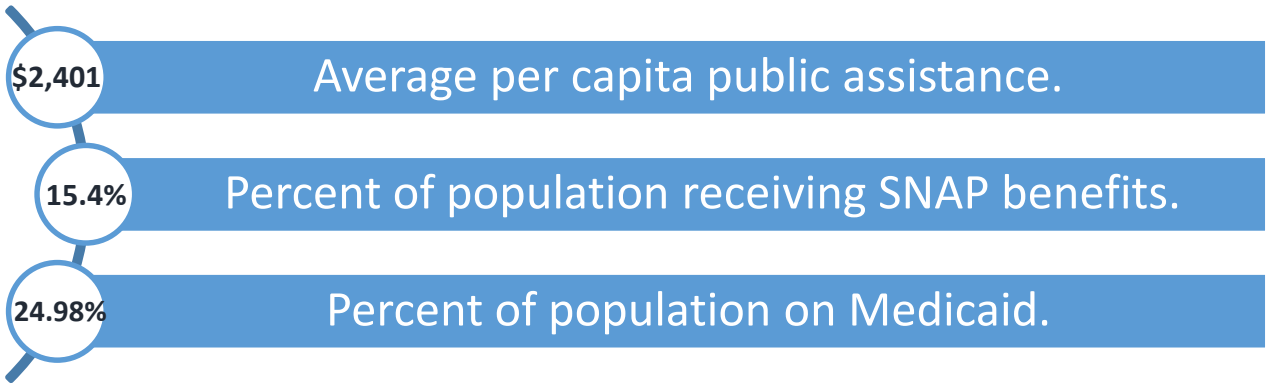
- It is also worth noting that Owyhee County has not only the highest percent of population in the ALICE & Poverty category but also falls low on the economic viability dashboard.
- Unemployment in the Southwest Region is on average 5.2% but is as high as 9.0% in Adams County (U.S. Department of Labor, 2016).
- Region 3 has a high percent of population age 25 and older without a high school diploma, 16.9% versus 10.9% across the state (U.S. Census Bureau, 2010-2014).
- Graduation rates range from a low of 71% to 100% (Idaho State Department of Education, 2014-2015).

Figure 8. Economic Viability Dashboard form the ALICE Report

County	Housing Affordability	Job Opportunities	Community Resources
Adams	good	poor	poor
Canyon	fair	fair	poor
Gem	good	poor	fair
Owyhee	fair	fair	poor
Payette	good	poor	poor
Washington	fair	poor	fair

(United Ways of the Pacific Northwest, 2015)

Figure 9. Public assistance



(U.S. Census Bureau, 2010-2014; Idaho Department of Health and Welfare [IDHW], June 2016).

- Community outreach events suggested that there is significant concern regarding SNAP fraud and the ability of individuals to purchase unhealthy food with SNAP benefits.
- Overall food stamp utilization has been declining across all counties from 2011-2015 (Annie E. Casey Foundation).
- 14.4% of the region reports a disability (U.S. Census Bureau, 2010-2014).

Food Insecurity

Food insecurity and access issues are a key driver of disease. Community outreach revealed concerns over cost of food in frontier communities and food deserts in economically depressed neighborhoods.

- Children are particularly vulnerable to food insecurity in the region. The adult food insecurity rate is 14.9% but for children it jumps to 22.7% (Feeding America, 2013).

- The rate of free/reduced lunch is 61.7% across the region (National Center for Education Statistics, 2013-2014).

Safety and Violence

Overall crime rates are relatively low across the Southwest region when compared to national averages. However, it is worth noting that some crimes may be underreported.

Figure 10. Crime

Crime	Arrest Rate (per 100,000 people)
Aggravated assault	8.74
Murder	0.11
Rape	0.22
Drug violations	43.08
DUI	41.23
Runaway	8.26

(Idaho State Police, 2014)

- Some communities, particularly those in more densely populated areas, reported concerns over gang violence. It was noted that certain communities may have a reputation for gang-related crime and violence.

Housing

Housing is a significant burden to many families in the Southwest Region as the population increases. Some communities in Southwest Idaho face housing shortages and experience rising rents as a result.

Figure 11. Housing assistance

Area	Total Housing Units (2010)	Total HUD-Assisted Housing Units	HUD-Assisted Units, Rate per 10,000 Housing Units
PHD3	97,399	1,474	151.34
Adams County	2,636	4	15.17
Canyon County	69,409	1,190	171.45
Gem County	7,099	59	83.11
Owyhee County	4,781	18	37.65
Payette County	8,945	116	129.68
Washington County	4,529	87	192.1
U.S.	133,341,676	5,038,578	377.87

(U.S. Department of Housing and Urban Development, 2015)

- Areas in the Treasure Valley may face more significant housing shortages as rents and prices rise in Boise.
- Approximately 33% of families in the area have housing costs that are 30% or more of their total income (U.S. Census Bureau, 2010-2014).

Location is no longer just the realtor's mantra. There is a growing body of research which suggests that where you live affects your health (Feldscher, 2011). In fact, a person's zip code can predict how long they will live (Roeder, 2014). How is this so? It's simple, really. Communities with smoke-free air laws, access to healthy foods, quality affordable housing, good schools and safe places to recreate are healthier than those that do not. These community factors play a larger role in a person's health status than how often they go to the doctor (Robert Wood Johnson Foundation, 2011). Social and economic features of neighborhoods have been linked with mortality, general health status, disability, birth outcomes, chronic conditions, health behaviors and other risk factors for chronic disease (Commission to Build a Healthier America, 2008). These environmental factors are also associated with mental health status, injuries, violence and other important health indicators (Commission to Build a Healthier America, 2008).

Southwest District Health works with food banks, religious groups, housing authorities, employers, community organizations, local governments and others to identify and address the environmental conditions that negatively affect the health of our citizens.

Nikole Zogg, PhD, MPH, Director, Southwest District Health

Mortality

Introduction

Causes of death and mortality data can reveal important information about the social and environmental conditions in which a community lives. Some conditions are more closely tied to resource constraints and access to preventative services.

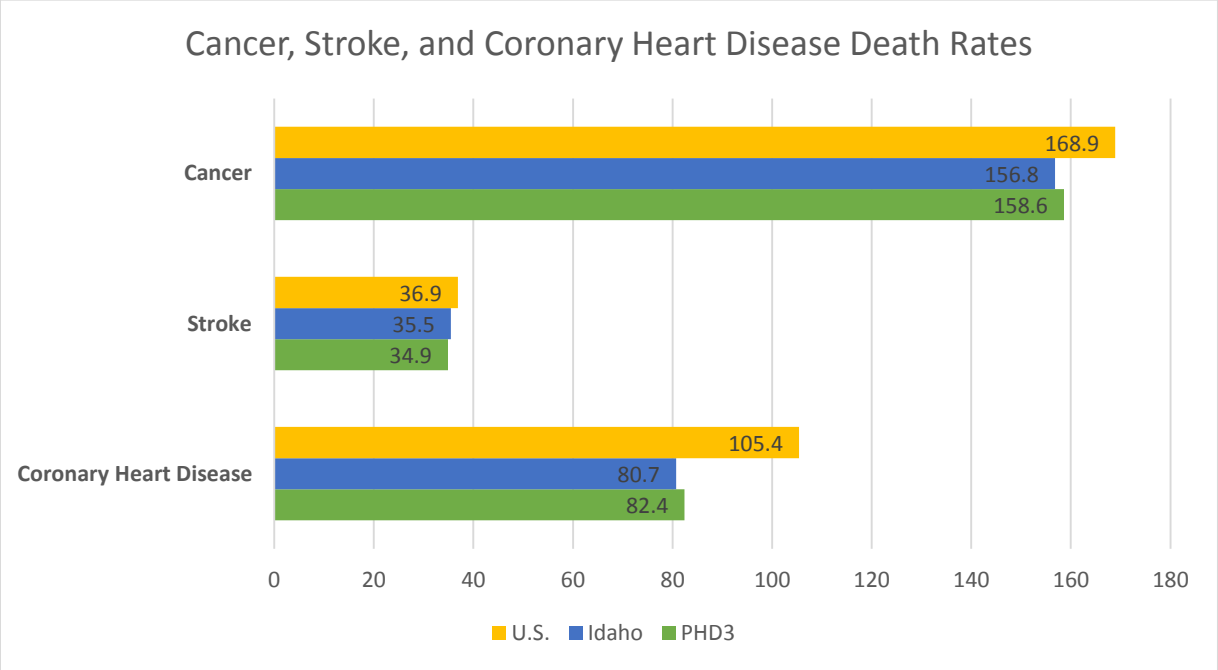
Figure 12. Causes of death

Cause	Number	Rate per 100,000
All causes	1,977	737.5
Diseases of heart	452	168.6
Malignant neoplasm (cancer)	434	161.9
Chronic lower respiratory diseases	143	53.3
Cerebrovascular diseases	113	42.2
Accidents (unintentional injury)	97	36.2
Alzheimer's disease	66	24.6
Diabetes mellitus	57	21.3
Suicide (intentional self-harm)	35	13.1
Chronic liver disease and cirrhosis	31	11.6
Influenza and pneumonia	21	7.8
All other causes	528	NA

(IDHW, Division of Public Health, 2016b)

- Chronic diseases rank in the top four positions of leading causes of death in the Southwest Region.
- Accidents and suicide also rank in the top 10 causes of death.

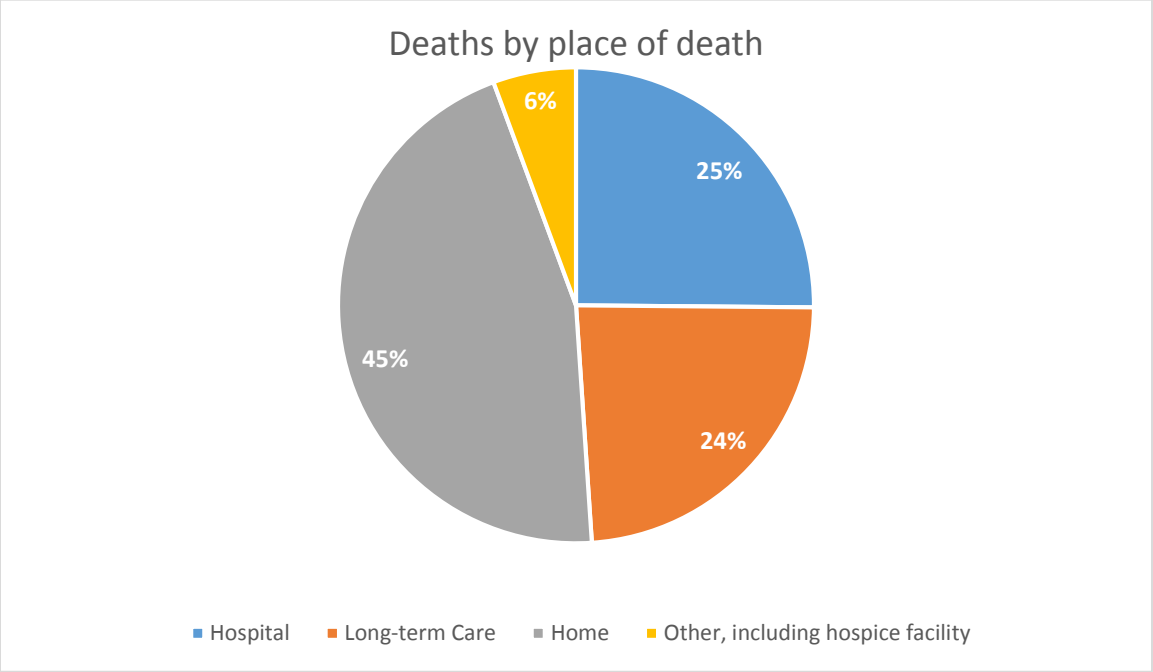
Figure 13. Cancer, stroke, and coronary heart disease death rates in 2013



(IDHW, 2015b)

- Clearly, the Southwest Region has lower rates of mortality by certain diseases than the U.S. average. However, it is important to note that some vulnerable populations may be more at risk.
- Certain communities reported high concern over cancer rates.

Figure 14. Deaths by place of death, 2015



(IDHW, Division of Public Health, July 2016)

- Place of death is an important consideration as approximately 80% of Idahoans report wanting to die at home, yet in the Southwest Region only 45% do (Boise State University, 2006).

Environmental Health

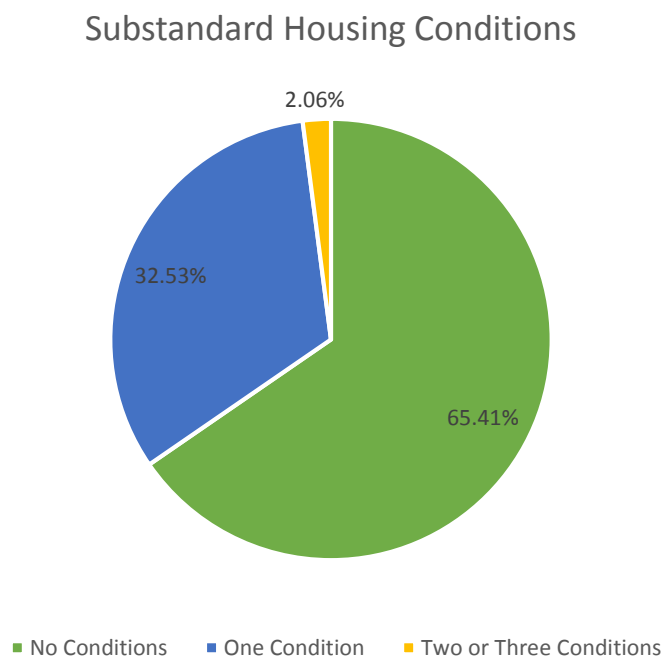
Introduction

Health is not just related to genetics and individual behavior but also largely to the environments in which we live, work, and play. Communities can promote wellness by developing and supporting infrastructure that makes the healthy choice the easy choice.

Living Conditions

Public health and other sectors play an important collaborative role in the promotion of housing that keeps people healthy. When conditions are substandard, the health and wellbeing of families may be at risk.

Figure 15. Number of substandard conditions present in housing 2010-2014



(U.S. Census Bureau, 2010-2014)

- More than one-third of houses in the region have at least one substandard condition.
- Overcrowding can also be an issue in the region. On average, 4.5% of houses are considered overcrowded compared to the state and national averages of 3.1% and 4.3%, respectively. The issue is particularly serious in Canyon County (4.9%) and Owyhee County (8.7%). (U.S. Census Bureau, 2010-2014).

Water and Air Quality

Access to clean water and air are crucial to health. Pollution and water contamination can cause certain diseases, spread infectious disease, and exacerbate chronic conditions.

- Average days (population adjusted) exceeding air quality standards is 0.48% compared with the U.S. average of 0.10%. Gem County (0.55%) and Canyon County (0.53%) have the most diminished air quality days by this measure (Centers for Disease Control and Prevention [CDC], 2012).

Figure 16. Common water contaminants by county 2016

County	Contaminants
Adams County	Arsenic, fluoride
Canyon County	Nitrate, arsenic, fluoride, uranium
Gem County	Nitrate, arsenic, fluoride
Owyhee County	Nitrate, arsenic, fluoride, uranium
Payette County	Nitrate, arsenic
Washington County	Nitrate, arsenic, fluoride

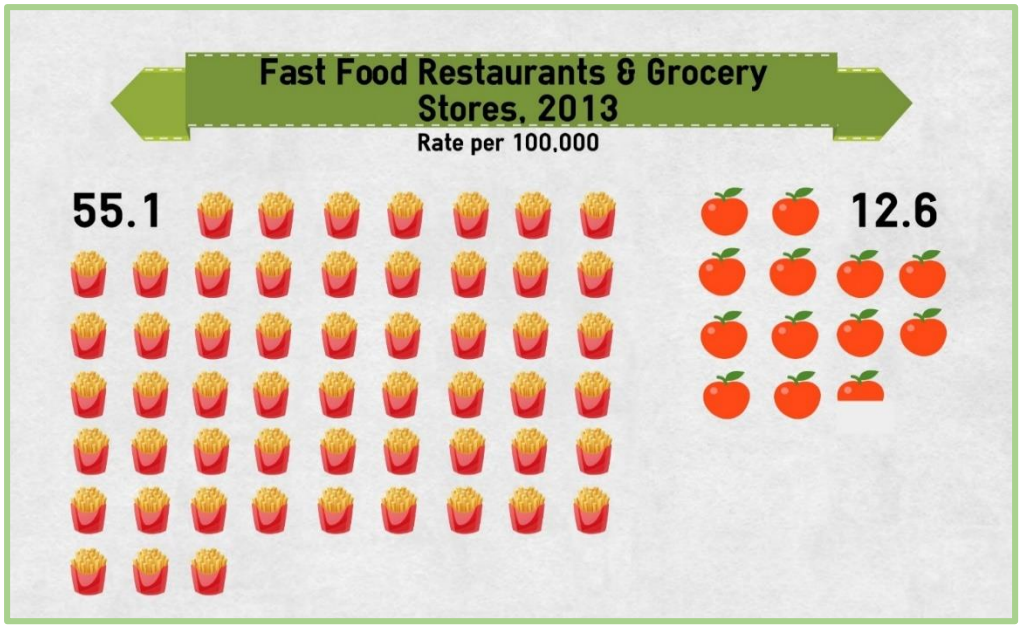
(Southwest District Health, Environmental Health Division, 2016)

- Many communities in the region are on wells and water systems that potentially contain contaminants. Private wells are not required to be inspected for water quality (Southwest District Health, 2016).
- In the Southwest Region there were seven reports of blood lead levels greater than 10mg/dL in 2014 (IDHW, Bureau of Communicable Disease Prevention, n.d.). Elevated blood lead levels have been linked to developmental disabilities and other serious illnesses in children.

Service Access

Community design can dictate access to healthy options (recreation centers, farmer's markets, libraries) or unhealthy spaces (fast food, liquor stores).

Figure 17. Fast food restaurants and grocery stores in PHD3, rate per 100,000



(U.S. Census Bureau, 2013)

I had been working with a member who lived in a very small rural community. He had multiple chronic conditions including respiratory failure, obesity, congestive heart failure, chronic kidney failure, and diabetes. He had been in the hospital three times in as many months. He lived alone and his family members were caring for his 91-year-old mother. He was the youngest sibling and did not wish to burden his family by asking for help when his mother needed it as well. His family lived in Boise and while he knew that there were better resources for medical care in the larger area, he did not wish to relocate as he was homebound and one of his joys was watching local wildlife from his home. Over the course of many phone calls, I helped him arrange transportation to and from his many doctors' appointments, helped him to empower himself by learning to contact resources on his own, and encouraged him to resubmit a prior authorization for a motorized scooter to maintain his independence. He was hesitant to do so because he had previously been denied when he was still able to ambulate more than 10 feet. His request was soon approved, and he was able to enjoy some increased independence before he eventually passed away in the hospital.

Elaina Donohoe, Member Support Specialist, PacificSource

- Community feedback suggested that neighborhood access to spaces such as libraries, parks, and healthy eating options had the potential to greatly enhance local health. Strong assets included community pools, child friendly parks, and senior centers.
- There are 20 liquor stores in PHD3 (T. Barnes, Idaho State Liquor Division, personal communication, July 29, 2016).
- The Southwest Region has less grocery stores per 100,000 people than the national average of 21.21. In addition, it also has less fast food establishments (55.1 per 100,000 in PHD3 compared to 72.7 per 100,000 as a national average) (U.S. Census Bureau, 2013).

Transportation

Transportation can be a major concern for families, especially in low SES and rural areas. A city or town center may be resource rich but if community members do not have a mode of transportation to access these resources it will not benefit them.

- Even in more densely populated areas, it can take up to three hours by public transportation to go to the local grocery store.
- Only 0.34% of the population utilizes public transit to get to work (U.S. Census Bureau, 2010-2014).
- This was a strong community feedback theme, especially for seniors and low income adults. Participants shared stories of community members who had gone without prescriptions, food, and medical care to the detriment of their health simply because they could not find a way to get there.

Access to Healthcare

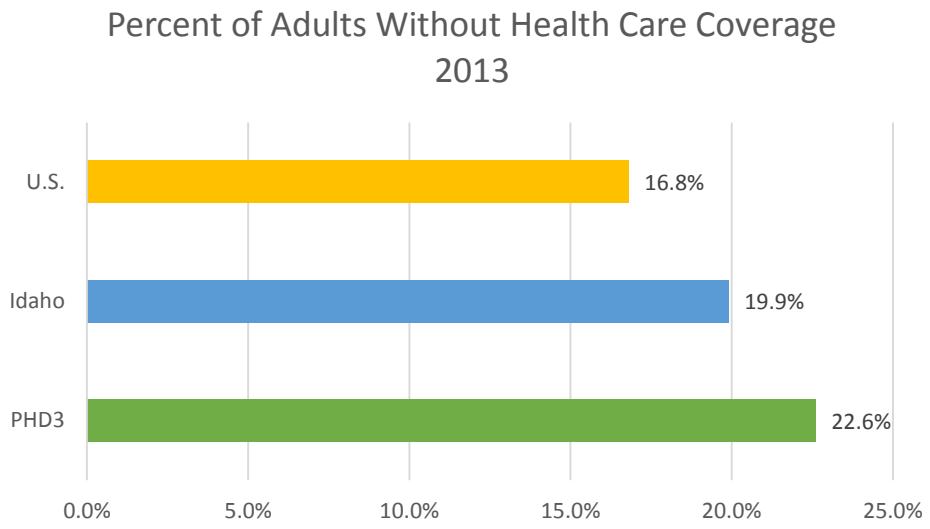
Introduction

Health and healthcare are not synonymous but are related. Healthcare is a component of health and can help individuals and communities maintain and improve health as a navigator, advocate, expert, and provider. Getting an appointment with a physician, dentist, or counselor can be challenging due to a multitude of factors including insurance status and availability of providers. One crucial mechanism of action by which access to healthcare can influence long term health is through screening and preventative services. This allows conditions to be caught and addressed before they intensify.

Insurance Status

As the cost of healthcare continues to rise, paying out of pocket for any service can be prohibitively expensive. Therefore, health insurance is a crucial component of access to care.

Figure 18. Health care coverage



(IDHW, 2015b)

- Community feedback emphasized concern over the uninsured population and their access to both preventative and acute care. In addition, many community members highlighted the experiences of the working poor who could only afford high-deductible plans but could not afford to use them and access care.
- The data shows that the Southwest Region has a high percentage of uninsured adults compared with both state and national averages. In Owyhee County the rate of uninsured adults is 28.2%, significantly higher than the national average (U.S. Census Bureau, 2014).

Providers

While access to clinical providers is only a part of what contributes to a person's health status, it is an important aspect of prevention and intervention. Availability of primary care providers, dentists, and behavioral health specialists is particularly significant.

Figure 19. Number of providers per 100,000 residents by provider type for most recent count

Area	Dentists (2013)	Mental Health Providers (2014)	Primary Care Physicians (2012)
PHD3	41.8	51	35.6
Idaho	63.9	118.5	61.8
U.S.	63.2	134.1	74.5

(U.S. Department of Health and Human Services, 2012 & 2013; County Health Rankings, 2014)

- Clearly, the Southwest Region has relatively few providers across disciplines. This is not only reflected in the quantitative data but also the community report. Rural and frontier communities reported significant challenges in accessing care due to lack of providers. Of note, shortage of children's providers was highlighted including the need for more pediatric mental and oral health services.
- Feedback from community outreach events also highlighted concerns over a lack of choice in providers due to low density of service.
- Many communities expressed concerns over a lack of language sensitive services and the barrier this represents for many community members in accessing healthcare and other services.
- Access to a regular source of care is a clear issue for communities in the Southwest Region. Nationwide, approximately 22% of individuals report not having a regular provider compared with 29.8% locally (IDHW, 2015b).

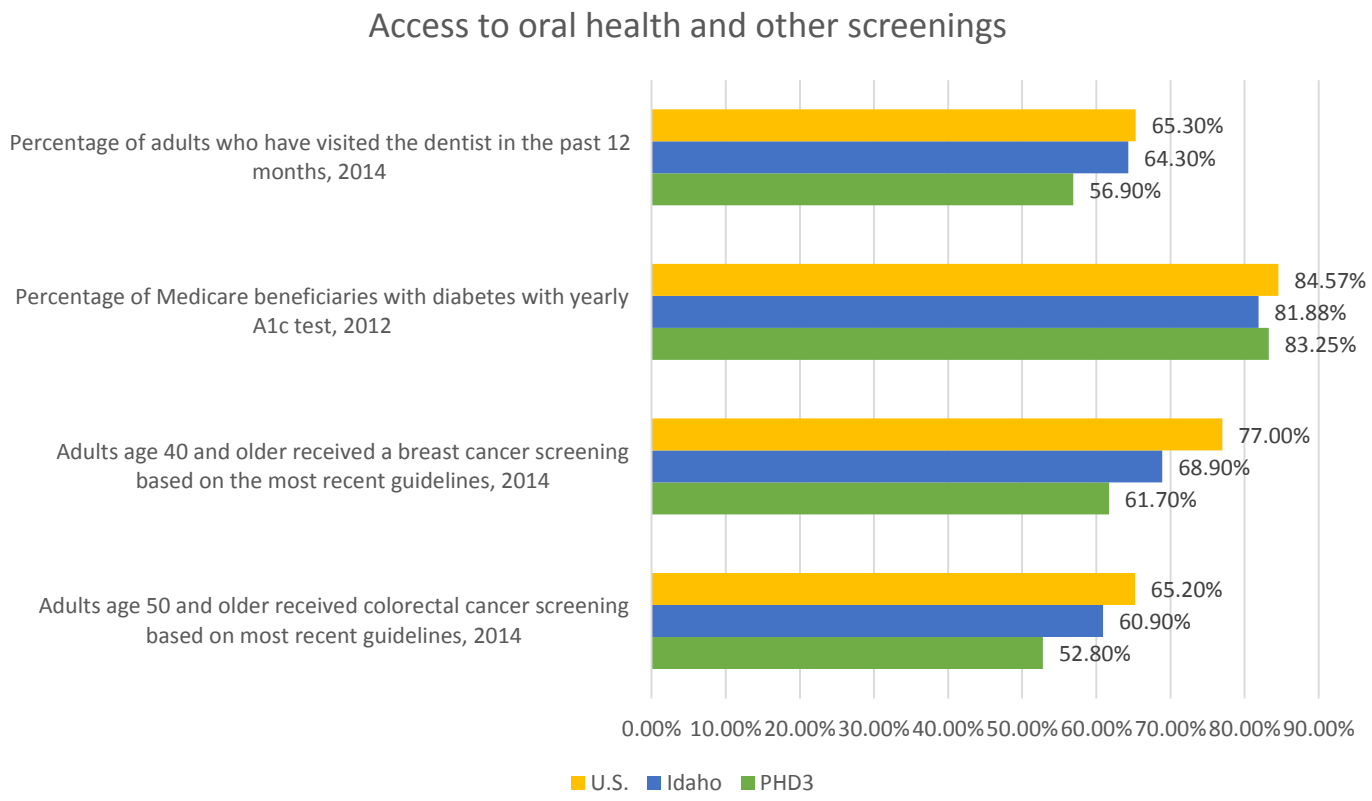
One of the great things about Idaho is the opportunity to live in rural communities, places like Marsing, Parma, Cambridge and Council. Places where the entire community turns out for the high school football game and for the county fair. Individuals and families that choose to live in these rural communities understand that they are making a trade-off. They are trading easy access to a movie theatre for easy access to the outdoors. That said, individuals and families that choose to live in rural areas should not have to give up access to high quality health care as one of these trade-offs. Far too often families that reside in these areas are unable to access health care because of access and travel issues. Individuals and families often have to drive an hour or more, each way, in order to access health services. Which makes accessing care very difficult if not impossible. They are unable to participate in smoking cessation, access physical therapy or engage in prenatal care. This lack of access then drives up the cost to the health system. This is unacceptable. Individuals and families that choose to live in our beautiful rural and frontier areas should not have to give up access to health care.

Dennis Baughman, LCPC, Project Director, Lifeways Inc.

Screening

Screenings for health conditions are a critical component of a well-functioning health neighborhood. It allows providers to catch conditions before they end up causing more harm and suffering to the patient and before they become quite costly to treat.

Figure 20. Access to oral health and other screenings for adults



(Percentage of Medicare beneficiaries with A1c test obtained from Dartmouth College Institute for Health Policy and Clinical Practice, 2012. For other indicators PHD3 and Idaho data obtained from IDHW, 2016a, U.S. data from CDC, 2016.)

- The data shows that cancer screenings and dentists visits are relatively low.
- The qualitative data did not indicate that this was a significant concern but did suggest that negative outcomes related to the screened conditions were major issues including cancer rates and diabetes.

Health Behaviors

Introduction

One of the most critical factors in a person's health is their behaviors. This is influenced by their access to resources such as safe places to be active, stress, and availability of affordable and healthy food.

Nutrition

Many of the major health issues in the U.S. are related to nutrition. Obesity, diabetes, and heart disease have clear connections to dietary behaviors while the connections to other conditions are just being established.

Figure 21. Percentage of adults in PHD 3 who consume fewer than five servings of fruits and vegetables a day, by income, reported in 2013

Income	Percent
Less than $15,000	96.6%
$15,000-$24,999	79.3%
$25,000-$34,999	81.6%
$35,000-$49,999	81.6%
$50,000-$74,999	84.8%
$75,000+	77.4%

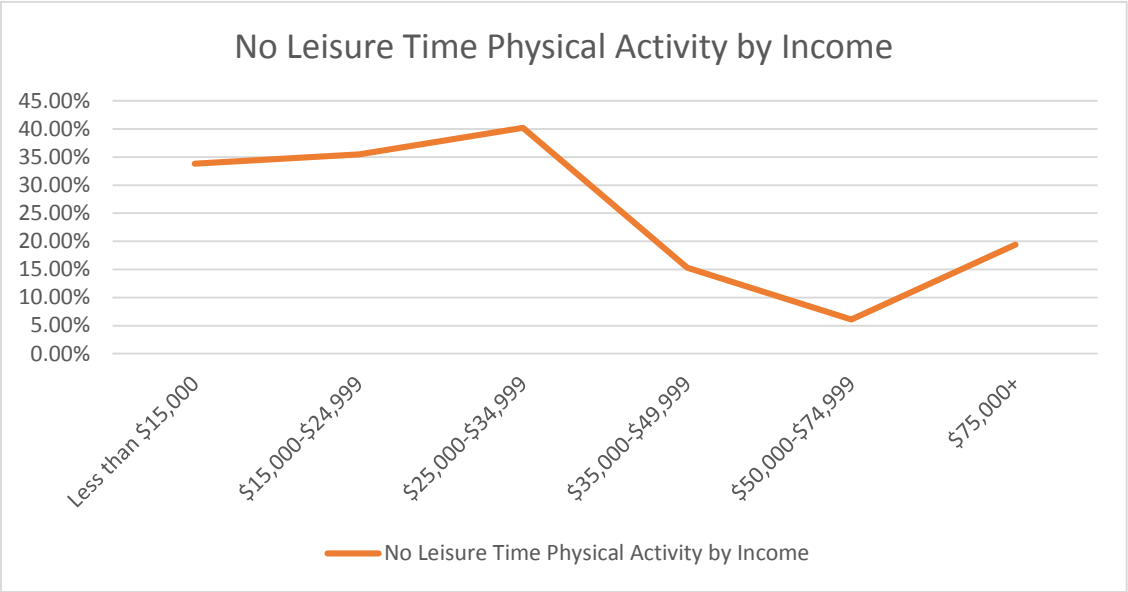
(IDHW, 2015a)

- Only 15.8% of the Southwest Region's population consumed five or more servings of fruits and vegetables a day.
- Families with low incomes are much more likely to consume less than the recommended servings of fruits and vegetables.
- Isolated communities noted the lack of options and the expense of healthier food options. In addition, almost every group indicated that there were issues with lack of incentives for healthy eating for SNAP recipients and perceived excessive SNAP fraud. On average, 4.47% of Southwest Idahoan's incomes are spent on soda. This more than both the national (4.04%) and state (4.39%) averages (Nielsen, 2014).

Physical Activity

Movement, exercise, and time outside are all positive health behaviors. Unfortunately, many adults and kids have predominantly sedentary lives.

Figure 22. Percentage of adults in PHD3 with no leisure time physical activity, by income, reported in 2014



(IDHW, 2016a)

- Physical activity follows a similar trend as fruit and vegetable consumption. As incomes increase, so does the likelihood that families are active.
- Hispanic families in particular are at risk for no physical activity (23.9% reporting no leisure time physical activity versus 31.7% for non-Hispanic adults) (IDHW, 2016a).
- The qualitative report tied physical activity to environment. Many communities reported lack of safe places to be active as a major concern. However, many groups indicated that time outside and nature were important values to their residents.

Chronic Disease

Introduction

While the threat of communicable disease endures, chronic disease has become the predominant concern in most healthcare settings. People are living longer with more conditions that can be treated but require more contact with providers and care.

Diabetes, Type 2

Based on Behavioral Risk Factor Surveillance System (BRFSS) data, 9.6% of adults in the Southwest Region have been told that they have diabetes (IDHW, Division of Public Health, 2016a). The burden of disease falls particularly heavily on populations that are considered more vulnerable such as those with lower levels of educational attainment and income. Diabetes is significantly correlated with socioeconomic status and costs, on average, $7,900 per person per year to treat (American Diabetes Association, 2013).

Figure 23. Adults who self-reported they had ever been told they had diabetes, reported in 2014

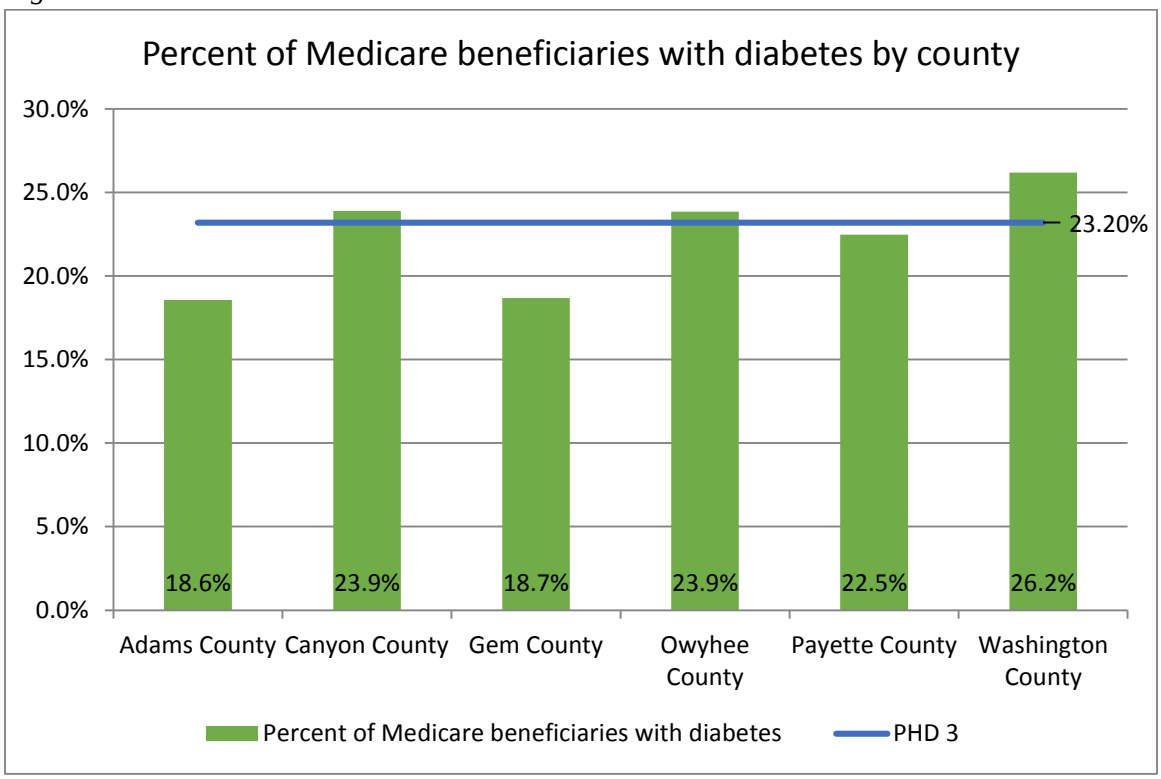
	PHD3	Idaho
Total	9.6%	7.6%
By Age		**PHD3**
25-34		1.6%
35-44		2.9%
45-54		12.0%
55-64		16.4%
65+		20.2%
By Income		**PHD3**
Less than $15,000		20.3%
$15,000-$24,999		7.1%
$25,000-$34,999		12.3%
$35,000-$49,999		12.5%
$50,000-$74,999		5.7%
$75,000+		2.4%
By Education		**PHD3**
K-11th Grade		13.7%
12th Grade or GED		11.0%
Some College		7.3%
College Graduate+		7.7%

(IDHW, 2016a)

At Terry Reilly Health Services, we recognize the huge impact that diabetes has on our community. However, we also know that we can do so much as a health clinic and as a part of the bigger community to prevent and manage this condition. Take, for example, Susie. She came to me with an A1C of 13.1%. This means that her blood sugar was completely out of range and chronically, dangerously high. I counseled her on the importance of monitoring her blood sugar regularly to manage her diabetes. She made the connection and returned weekly to work with me to manage her condition. At first, she had to take a lot of medications and really spend time to learn how to keep herself from getting sicker. However, within four months of consistently working together to control her diabetes we were able to drop her A1C to 7% and better manage her meds as well. Susie was a partner in improving her health. We worked together to help her get healthy and see her as a part of the bigger picture of access to healthy foods, education about health, and access to services.

Dr. Andrew Baron, Medical Director, Terry Reilly Health Services

Figure 24. Medicare beneficiaries with diabetes 2012



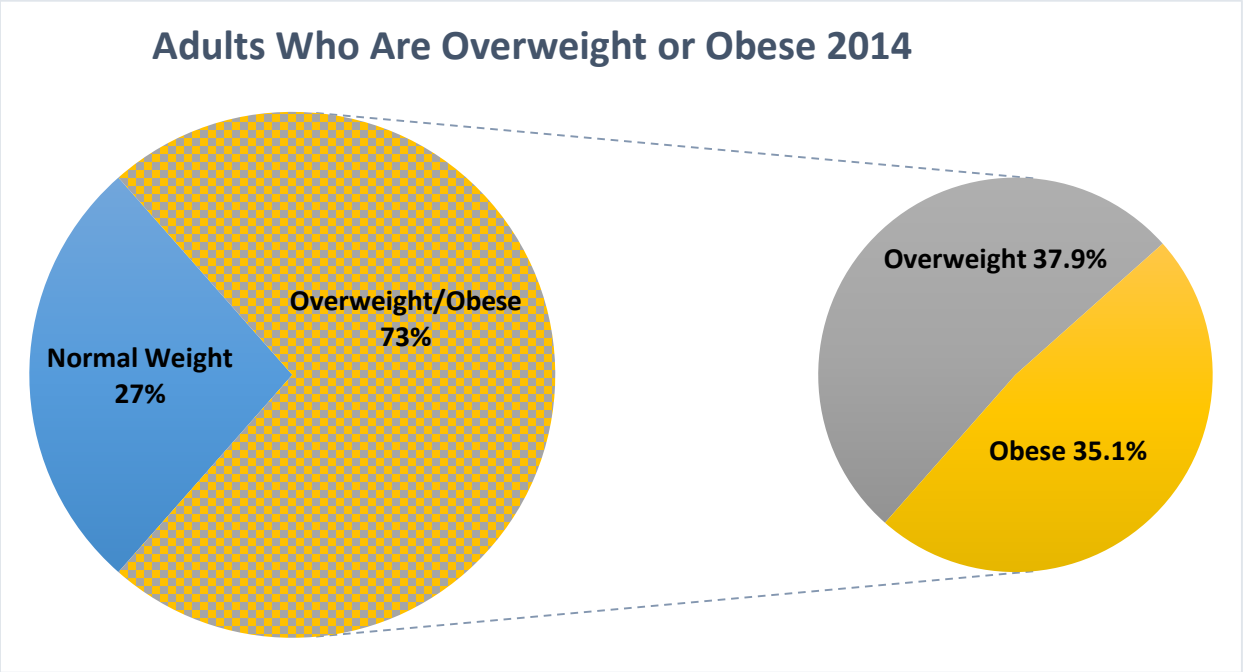
(Centers for Medicare and Medicaid Services [CMS], 2012)

- Qualitative and quantitative data reveals that diabetes is a significant concern in the Southwest Region. Every community cited diabetes as a major health issue.
- Diabetes is tied to income. As income increases, rates of diabetes decrease. This is particularly concerning as diabetes is an expensive illness to treat and can deplete financial resources or be left out of control if a budget is tight.
- We can also see that as age increases, so does the risk of diabetes. With an aging population we can anticipate that disease burden to remain a concern.

Overweight and Obese

The dramatic rise in obesity has been described as an "epidemic". The U.S. and other developing countries have seen a rapid increase in the average BMI of their populations. This collective weight gain has been associated with a rise in disease burden related to obesity.

Figure 25. Adults who are overweight or obese, reported in 2014



(IDHW, 2016a)

- In the Southwest Region, 73.0% of residents are considered overweight or obese, compared with 65.7% across the state. This is the highest percentage in the state with the next closest being 67.6% in PHD 6 (IDHW, 2016a).
- Outreach event participants reported that weight issues were one of the primary health concerns in their communities.
- Obesity is quite prevalent in the Southwest Region with 35.1% of the population exhibiting a BMI over 30.
- There appears to be a relationship between obesity and income (IDHW, Division of Public Health, 2016a).
- Excess weight is also more prevalent in the Hispanic-identifying population (81.2%) compared with the non-Hispanic population (70.8%) (IDHW, Division of Public Health, 2016a).

Figure 26. Adults who were overweight and/or obese by income, reported in 2014

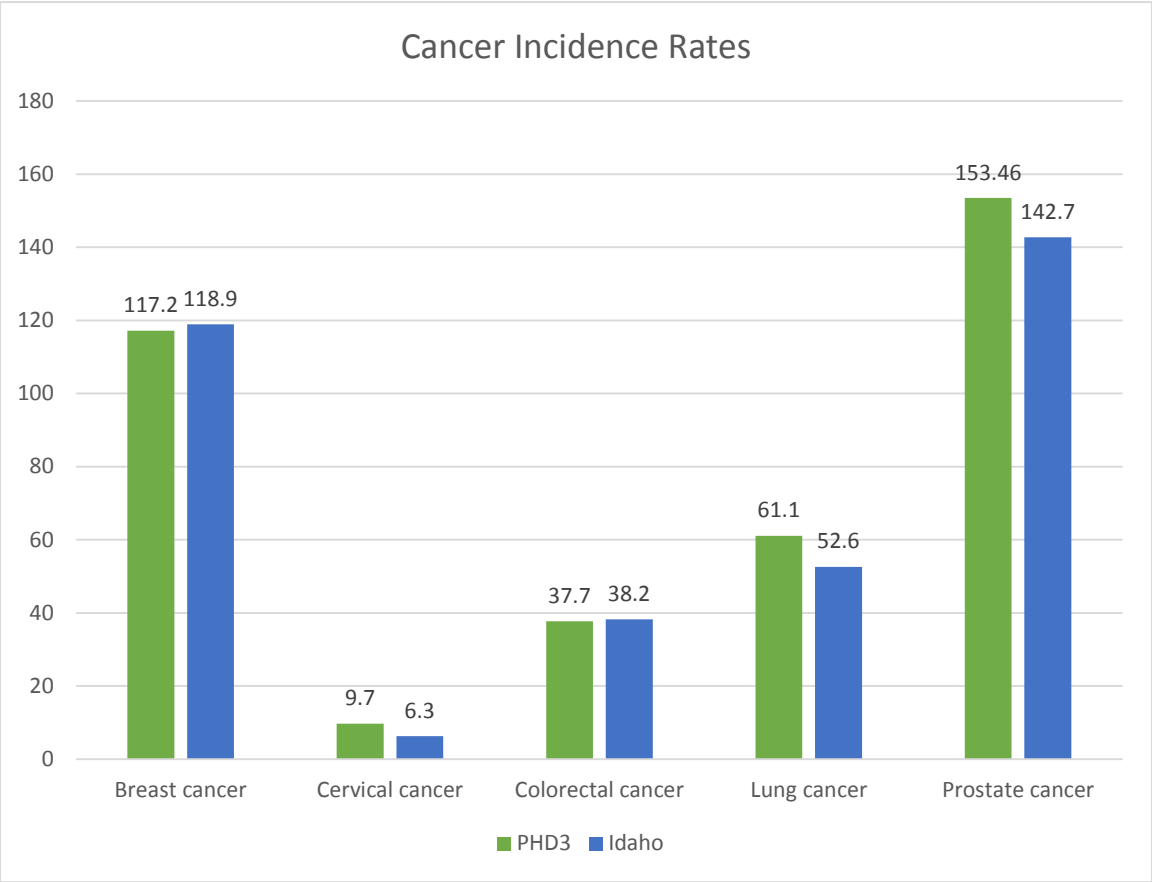
Overweight/Obese		Obese	
Income	Percent	Income	Percent
Less than $15,000	70.7%	Less than $15,000	49.5%
$15,000-$24,999	80.7%	$15,000-$24,999	46.9%
$$25,000-$34,999	72.2%	$$25,000-$34,999	25.3%
$35,000-$49,999	74.1%	$35,000-$49,999	47.1%
$50,000-$74,999	74.0%	$50,000-$74,999	23.5%
$75,000+	64.4%	$75,000+	27.6%

(IDHW, 2016a)

Cancer

Cancer rates represent the complex interplay between access to care, screenings, environmental exposures, and genetics. These rates can tell us where we can do more as a community to intervene in order to prevent cancer or catch it early when it is treatable.

Figure 27. Incidence rates of selected cancers, rate per 100,000 residents



(National Institutes of Health [NIH], 2008-2012)

- The Southwest Region has rates of breast cancer and colorectal cancer similar to the state average. However, it appears that cervical cancer, lung cancer, and prostate cancer are elevated.
- Some communities indicated that cancer was a significant health concern for them. This was especially true in older populations where rates increase for many types of cancer.

Cardiovascular Disease

Heart disease refers to a constellation of conditions (heart attack, stroke, coronary artery disease, etc.) that result from narrowed or blocked blood vessels. Diet, exercise, age, and genetics all play a role in the development of these conditions.

Figure 28. Cardiovascular disease risks

Area	Adults With High Blood Pressure (CDC, 2011-2012)	Medicare Beneficiaries With High Blood Pressure (CMS, 2012)	Medicare Beneficiaries With Heart Disease (CMS, 2012)	Medicare Beneficiaries With High Cholesterol (CMS, 2012)
PHD3	27.83%	44.43%	20.27%	33.75%
Adams County	21.7%	38.52%	21.58%	29.74%
Canyon County	28.7%	45.48%	20.54%	34.36%
Gem County	27.5%	36.2%	19.31%	28.08%
Owyhee County	24.5%	42.8%	21.26%	31.11%
Payette County	24.7%	45.55%	19.18%	33.19%
Washington County	26.5%	48.53%	19.65%	40.55%

- High blood pressure impacts over one-quarter of the adult population in PHD3 and nearly half of the Medicare beneficiaries.
- There is not significant variation in the percentage of Medicare beneficiaries with heart disease across the six counties but it does impact approximately 20% of the population on average.
- The regional average percentage of adult population who has ever been told that they have high cholesterol is nearly identical to the state average, 38.77% vs. 38.65% (CDC, 2011-2012). However, there appears to be significant variation among counties.
- While heart disease was not a common theme in the community feedback it can be tied to other conditions such as obesity, stress, smoking, and diabetes that were noted in outreach events.

Communicable Disease

Introduction

While chronic diseases have begun to take center stage, public health is still charged with the prevention and management of communicable diseases. Many of the more common communicable diseases are no longer deadly but they can cause significant illness and impairment.

Figure 29. Number of selected reportable disease cases, 2014

Reportable Disease	Number Reported
Hepatitis C, Acute	1
Whooping Cough	101
Syphilis, All Stages	3
West Nile Virus	7

(IDHW, Bureau of Communicable Disease Prevention, n.d.)

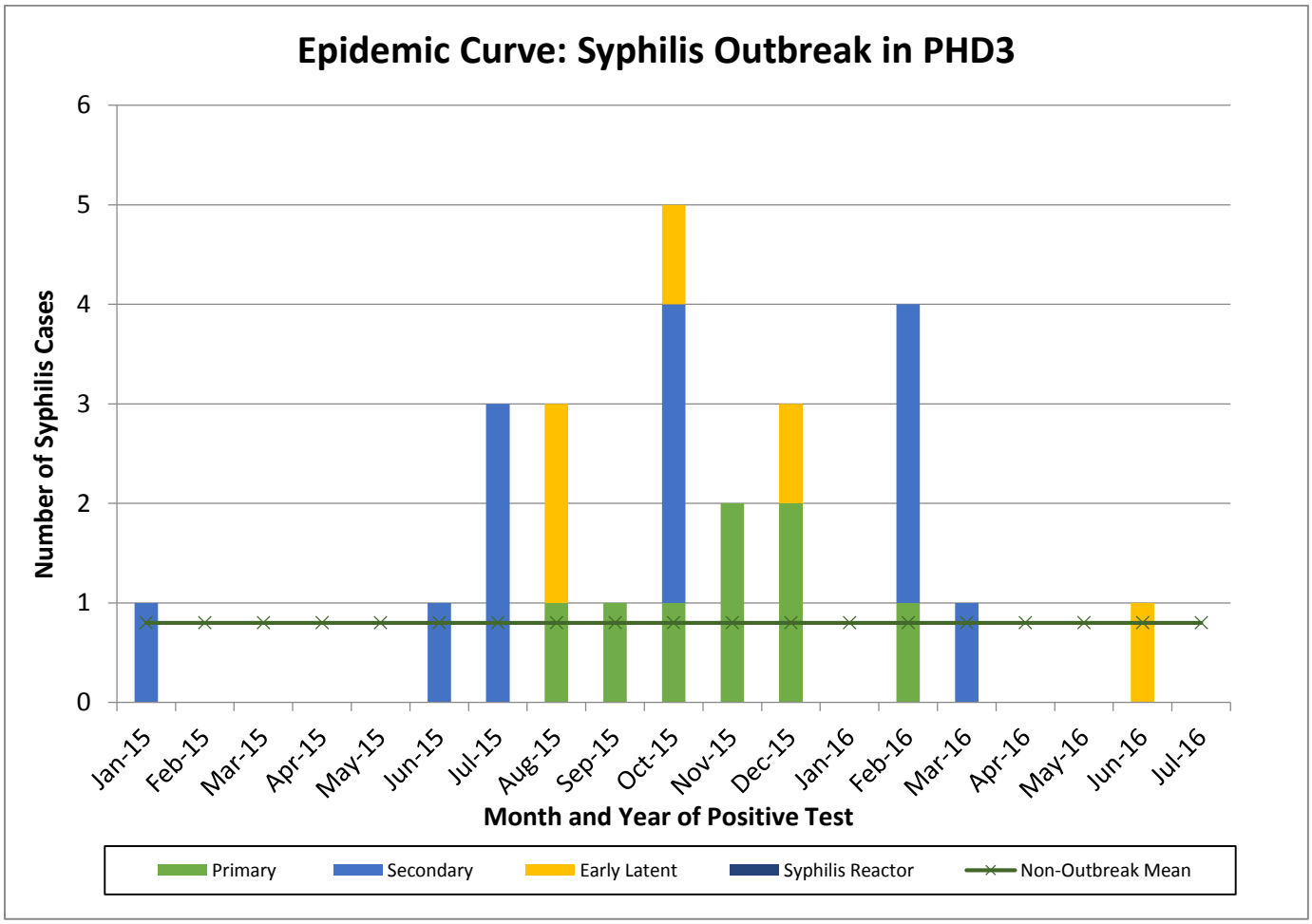
- While the Southwest Region has a lower incidence rate (9.9 cases per 100,000) of whooping cough, a condition that can prove fatal in infants, than the state (14.7 cases per 100,000), it is still well above the national average (7.7 cases per 100,000) (IDHW, Division of Public Health, 2015b).
- The rate of enteric disease in the area is comparable to the state (IDHW, Division of Public Health, 2015b).

Around 40% of infants born to Hepatitis B virus-infected mothers will develop chronic Hepatitis B infection if not given medication to prevent them from getting the virus (CDC, 2016b). In the Perinatal Hepatitis B Program at Southwest District Health, we help break the cycle of Hepatitis B virus transmission from mother to baby. We receive notification of Hepatitis B positive pregnant women in the region and contact them to offer education, case management support, and no-cost preventative shots for their baby. We also work with their medical providers and the hospital to provide the shots; the first dose must be given to their baby within 12 hours of birth. Our program is optional, and some women decline to participate. For those that opt to participate, we keep in contact with them throughout their pregnancy and up until their baby is around 9 months old. In many cases, we help out the mothers in other ways as well. For example, by arranging for transportation, coordinating specialist referrals, and arranging for interpreters. The women we serve in this program are often foreign-born and non-English speaking, or have other social challenges affecting their access to healthcare such as poverty, domestic abuse, and substance use disorders. One family we have worked with has a generation of adult siblings who all have Hepatitis B. They are now having their own children who, from getting preventative shots through this program, are able to live free from Hepatitis B virus infection.

Randi Pedersen, MPH, Epidemiologist, Southwest District Health

- There are just over 200 HIV and AIDS positive individuals in the Southwest Region (IDHW, Bureau of Communicable Disease Prevention, 2016).
- The area has a very high rate of STDs: 433.5 per 100,000 compared to the statewide rate of 351.2 per 100,000 (IDHW, Division of Public Health, 2015b). It should also be noted that there is a long term outbreak of syphilis in one of the communities.

Figure 30. Syphilis outbreak 2015



(Southwest District Health, Epidemiology Program, 2016)

Maternal & Infant Health

Introduction

Maternal and child health reveals quite a lot about the health of a community. Not only does it demonstrate the manner in which a vulnerable segment of the population is treated but it also represents a point far upstream in a person's life: gestation and birth.

Maternal Characteristics

The social and economic vulnerability of a mother impacts the life of her children. Communities and families have an important role to play in creating positive environments for the start of life.

Figure 31. Demographic characteristics of adult mothers in PHD3, reported in 2014

Age	
18-19	2.9%
20-24	24.6%
25-29	36.4%
30-34	20.55%
35+	15.75%
Income	
Less than $15,000	24.1%
$15,000-$24,999	15.8%
$25,000-$34,999	15.6%
$35,000-$49,999	15.3%
$50,000+	29.2%
Education	
K-11th Grade	15.3%
High School or GED	22.1%
Some College	35.8%
College Graduate +	26.7%
Ethnicity	
Non-Hispanic	79.4%
Hispanic	20.6%
Marital Status	
Not Married	32.8%
Married	67.2%

(IDHW, Division of Public Health, 2016c)

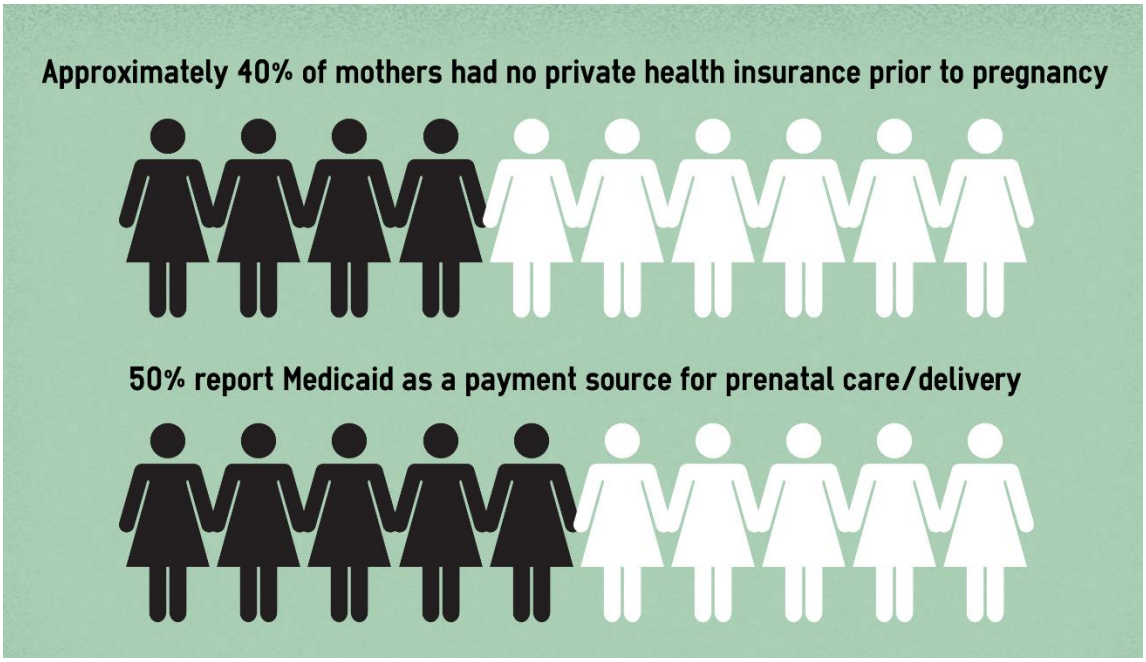
- The average age of first birth in PHD3 for 2014 was 25.5 years compared with the Idaho average of 26.2 years (IDHW, Division of Public Health, 2016f).
- Nearly one quarter of mothers in the Southwest Region have household incomes of less than $15,000.
- Mothers in the area have less formal education than the average among mothers across the state.
- The rate of teen pregnancy in PHD3 is higher (34.2 births per 1,000 female teens) than across the state as a whole (27.5 births per 1,000 female teens) (IDHW, Division of Public Health, 2016b).

- Outreach feedback suggested significant value of mothers, children, and families across communities.

Insurance Status

Access to healthcare prior to and during pregnancy is crucial for managing the health of mothers and babies.

Figure 32. Health insurance and Medicaid enrollment of mothers in PHD3, reported in 2014



(IDHW, Division of Public Health, 2016c)

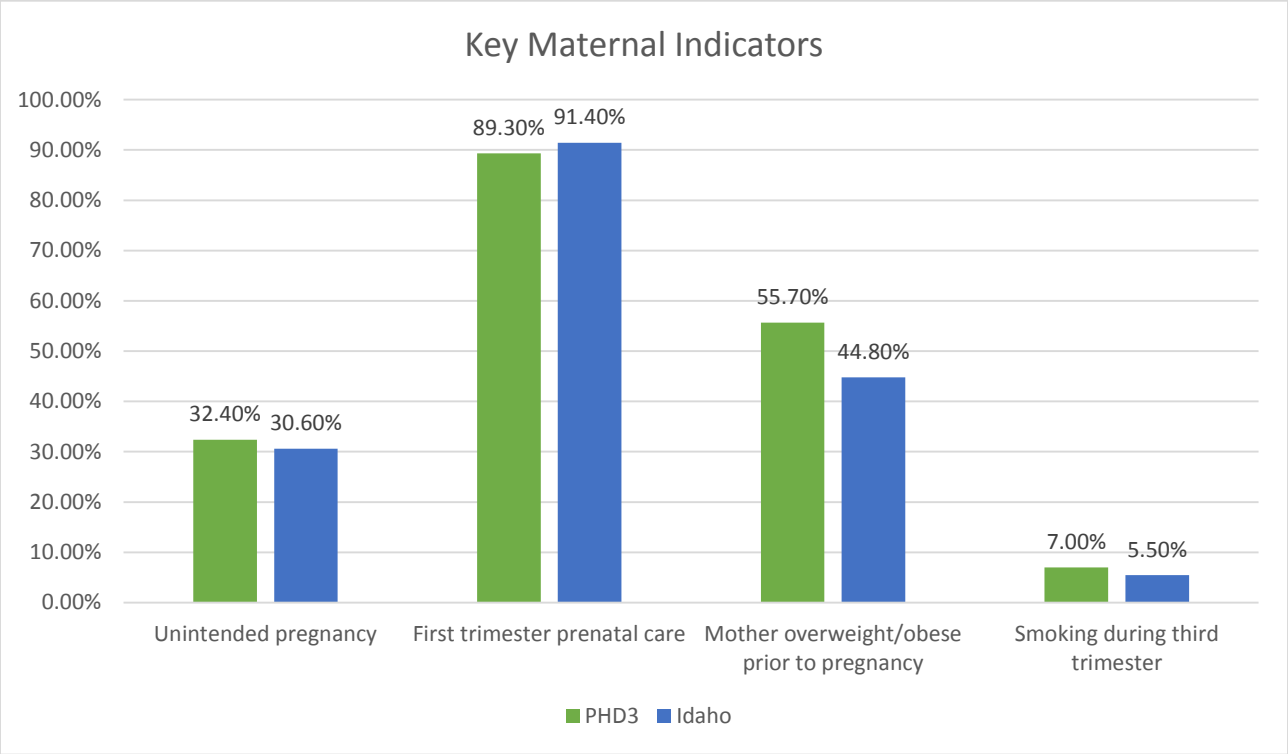
- As a percentage of total population, Hispanic mothers report not having access to private insurance prior to pregnancy at a much higher rate (70.8%) compared to non-Hispanic mothers (36.9%) (IDHW, Division of Public Health, 2016c).
- Mothers in the Southwest Region report Medicaid as their primary source of healthcare payment (50%) at a higher rate than all of Idaho (41.2%).

Pregnancy and Prenatal Care

Before a baby is born, he or she relies on a mother and her health behaviors and healthcare to manage the fetus's exposures to the world.

- Nearly one third of women in the Southwest Region report that their pregnancy was unintended.

Figure 33. Key maternal indicators, reported in 2014



(IDHW, Division of Public Health, 2016c)

- Slightly more than one quarter of women in PHD3 who deliver a baby report high stress (three or more highly stressful life events) in the 12 months prior to giving birth. Younger mothers, 20-24 years of age, report elevated stress at a higher rate (35.2%). Unmarried mothers also reported stress at a higher rate (45.7%) than married mothers (15.8%) (IDHW, Division of Public Health, 2016c).
- In PHD3 51% of mothers report not receiving dental care during their pregnancies as compared to 44% across Idaho (IDHW, Division of Public Health, 2016c).
- Pregnant women in the area are obese or overweight at a higher rate than women across the state.
- Mothers in the Southwest Region report depression post-delivery at a lower rate (12.7%) than all mothers across Idaho (15.2%) (IDHW, Division of Public Health, 2016c).
- Women in PHD3 report that their baby's shots are up to date at a similar rate (87.7%) to women across Idaho (89.7%) (IDHW, Division of Public Health, 2016c)
- In 2016, 9,275 women were enrolled in WIC in the Southwest Region (IDHW, WIC Program, 2016).
- Among WIC enrollees in the area, approximately 20% of children are overweight or obese.

Figure 34. Prevalence of nutrition risks for WIC participants in PHD3, July 2014 – June 2015

Nutrition Risks for Women	Hispanic/ Latino	Non-Hispanic/ Latino	Migrant	Total
Underweight woman	3%	4%	0%	4%
Overweight woman	66%	59%	100%	62%
Low maternal weight gain	22%	19%	50%	21%
Maternal weight loss in pregnancy	12%	11%	0%	11%
High maternal weight gain	47%	50%	50%	49%
Pregnancy at young age	6%	5%	0%	5%
Closely spaced pregnancy	22%	26%	0%	25%
Lack of or inadequate prenatal care	6%	4%	0%	5%

Nutrition Risks for Children	Hispanic/ Latino	Non-Hispanic/ Latino	Migrant	Total
Underweight/At risk of underweight	4%	6%	0%	5%
Obese children (2-5)	11%	6%	0%	9%
Overweight children (2-5, >=85%)	12%	9%	33%	11%
High weight-for-length	8%	6%	0%	7%
Low birth weight	4%	4%	0%	4%
Oral health conditions	3%	2%	0%	2%
Inappropriate nutrition practices - infant	1%	1%	0%	1%
Inappropriate nutrition practices - child	9%	9%	0%	9%
Primary milk source inappropriate	9%	8%	17%	8%
Sugar-containing beverages replacing other nutrient rich beverages	15%	10%	33%	12%
Inappropriate bottle, cup, or pacifier use	12%	10%	0%	11%
Disregarding development	1%	1%	0%	1%

(IDHW, WIC Program, 2014-2015)

A few years ago I was asked to help a mother who was having trouble breastfeeding her 3-day old baby. It was a Friday afternoon and 15 minutes before closing when this client walked in crying. After introducing myself and offering her my help, which she immediately accepted, I took her into an exam room. Upon examination I could see what the difficulty was. The baby was having trouble latching and consequently the client's pain continued to increase. With the client's consent I helped fix the cause of the problem. The mom was so grateful for the help and her ability to breastfeed without pain that her tears of pain turned to tears of joy. I gave her instructions on what she should do throughout the weekend and she agreed to follow them. I also gave her an appointment for Monday afternoon and I told her that if she needed to she could come in at any time on Monday.

On Monday when the participant came into the office the participant asked for me. I was greeted with a big hug from her and her tears of joy once again began to flow. From that day on anytime I saw this participant I was greeted with a friendly smile and a big hug.

Southwest District Health WIC Program

Child & Adolescent Health

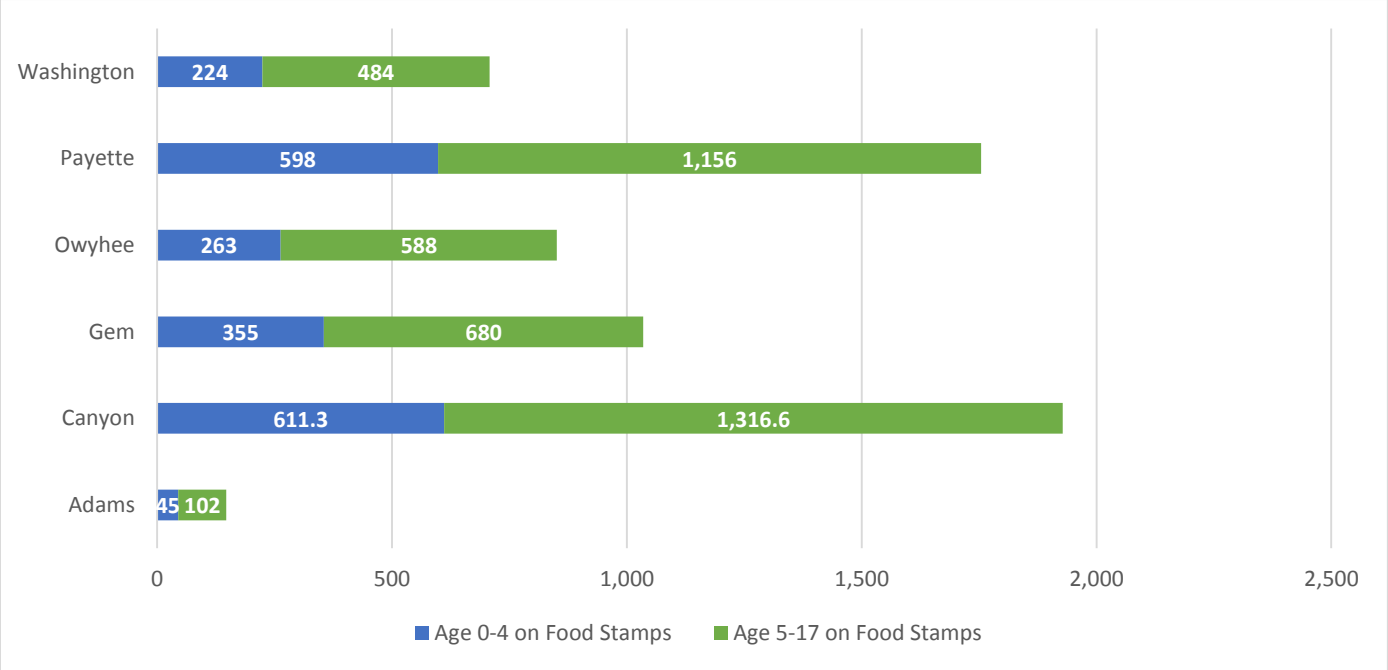
Introduction

Children are significantly impacted by health experiences and exposures with consequences that can endure into adulthood. Unfortunately, many children, who should be most protected from harm continue to be at risk in a variety of ways.

Nutrition & Food Insecurity

As children grow adequate nutrition is particularly important to development and performance, however man children in the Southwest Region experience nutrition deficits and food insecurity.

Figure 35. Children on food stamps 2015



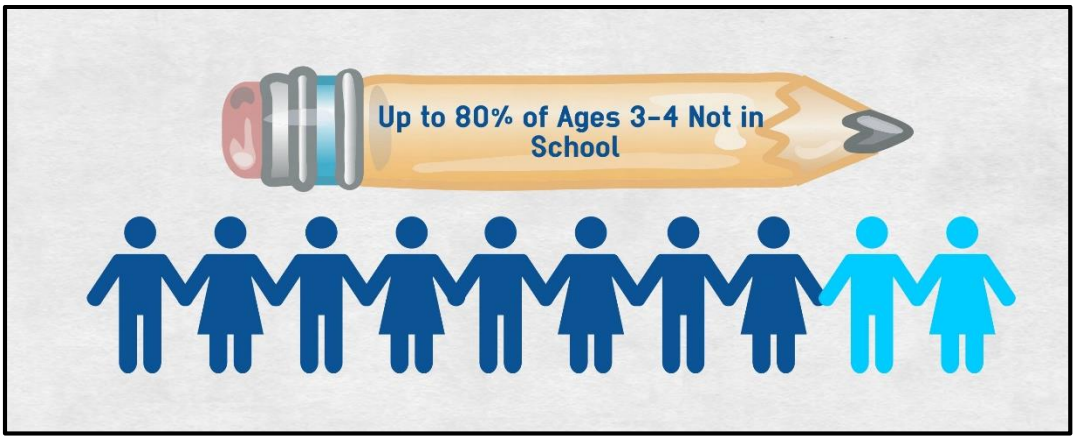
**Canyon County 1 unit = 10 children
(Annie E. Casey Foundation, 2015)

- A significant number of children in the Southwest Region are on food stamps. Canyon County has a total of 19,279 children on food stamps, and of that 6,113 are age four or under.
- Several communities reported that they are concerned with the inability to incentivize healthier eating behaviors for food stamp beneficiaries.
- Only slightly over 60% of children in the Southwest Region are considered to be at a healthy weight based on measurements of third-graders. Over 20% are considered obese and approximately 15% are considered overweight (IDHW, 2012).
- Communities report significant interest in investing in the health of children.

Access to Resources

Children rely on a variety of supportive services to help them mature into successful community members. When there are deficits in these supports, children can fall behind.

Figure 36. Children ages three to four not enrolled in any type of school, reported 2006-2010



- In counties where there is data available, up to 80% of children ages 3-4 do not attend any type of school (Annie E. Casey Foundation, 2015).
- 2,423 youth in schools in the Southwest Region were homeless during the 2014-2015 school year (Idaho State Department of Education, n.d.).
- In PHD3, 9.4% of children are medically uninsured (Annie E. Casey Foundation, 2015).
- Community feedback indicated that food insecurity for children is a significant concern.

Immunizations

Immunizations help keep children free from the burden of severe and debilitating illnesses such as polio, measles, and diphtheria.

- The average primary series immunization rate in the PHD3 is 61% for ages 19-35 months based on data from organizations participating in the Idaho Immunization Program (2015).
- The school immunization exemption rate ranges from 4.8% to 11.6% in the Southwest Region. The majority of children in Idaho with exemptions have received some vaccines, potentially indicating that parents declare an exemption in order to avoid delaying school registration (DHW Blog, 2015).

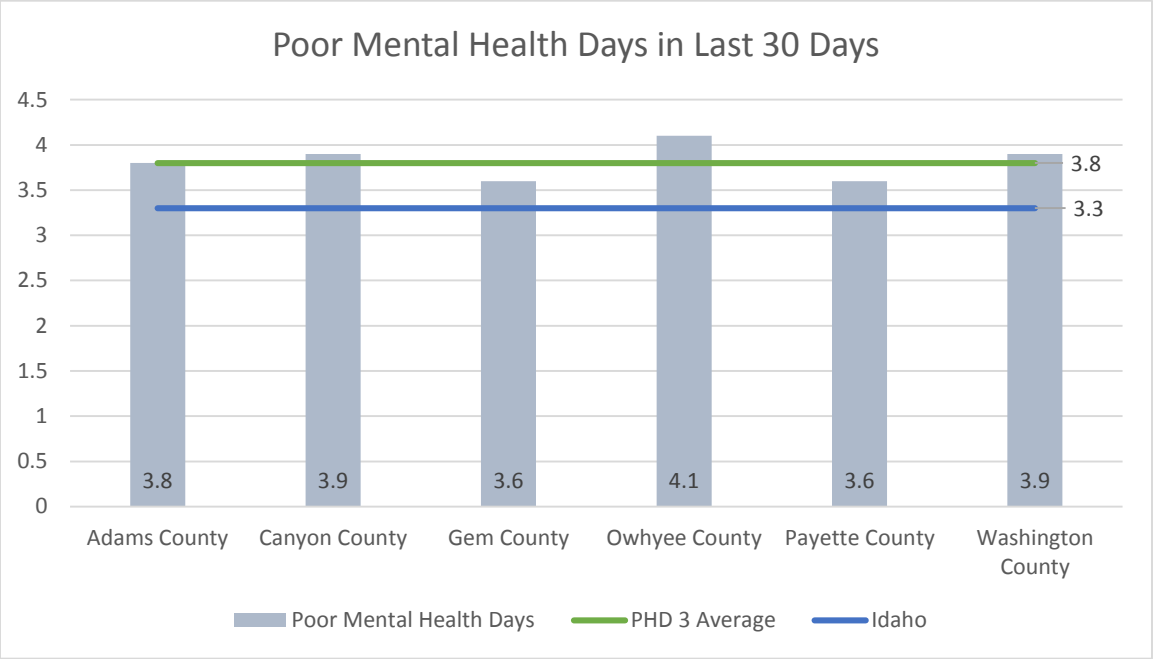
Substance Use in Adolescents and Teens

Alcohol and drug use in teens and children is a common concern among parents and communities in general. The long-term effects of substance use can be medically, socially, and criminally significant in the trajectory of a young person's life.

- Alcohol use in the past month among individuals aged 12 to 20 in the area was below the national rate and trended down from 19.3% to 18.4% between 2010 and 2014 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014).

- The estimated number of current cigarette smokers aged 13 to 18 in the Southwest Region is 2,465 (IDHW, 2015c).
- Though the numbers are not available for PHD3, current e-cigarette use among youth is estimated at 25% in Idaho. E-cigarette use is significantly associated with poor academic achievement (Idaho State Department of Education, 2015).

Figure 40. Average poor mental health days in the last 30 days, reported in 2014



(County Health Rankings and Roadmaps, 2016)

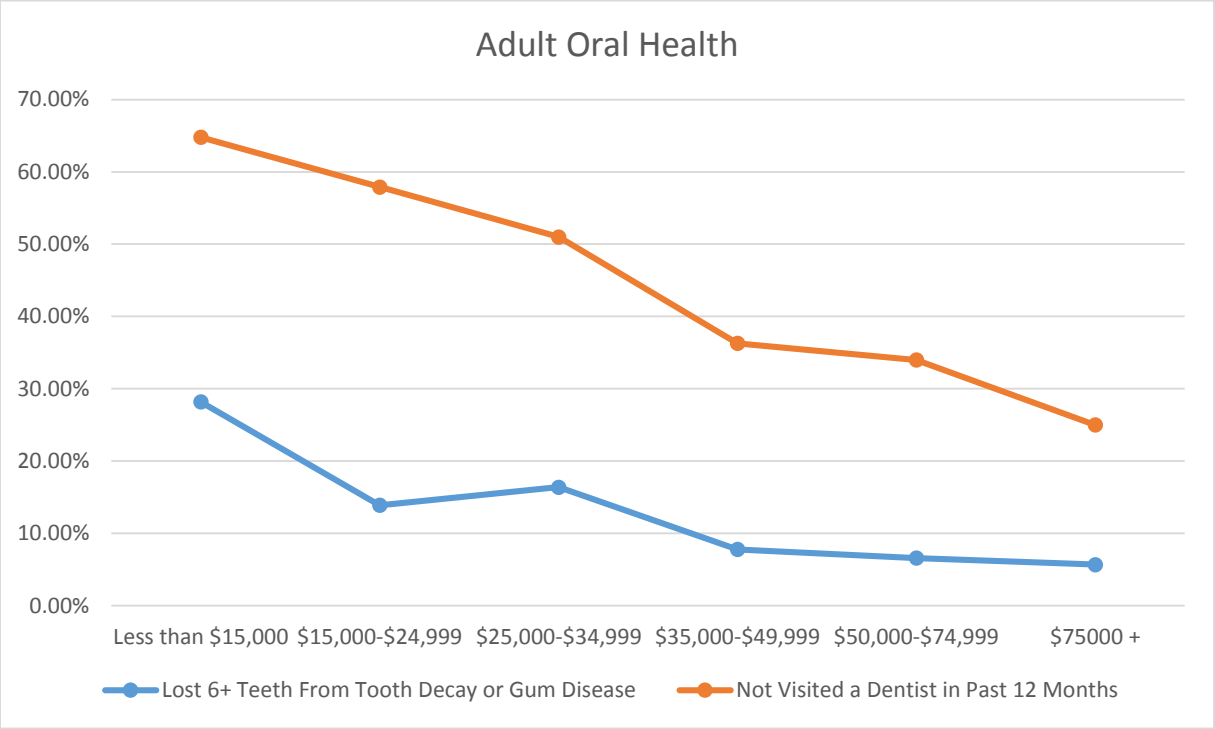
- Concerns over access to mental health providers and treatment was one of the most consistent and strongest themes from community outreach. Stigma, particularly in older and Hispanic communities, was reported. However, several communities report a reduction in the overall perception of stigma around mental health.

Oral Health

Introduction

Oral health is often considered entirely separate of general physical health and wellbeing. However, the health of one's mouth can have significant implications for conditions that garner much attention including diabetes and heart disease.

Figure 37. Lost teeth and no dental visits for adults by income, reported in 2014



(Lost 6+ teeth from decay or gum disease – IDHW, Division of Public Health, 2016d; No dental visits – IDHW, Division of Public Health, 2016a)

- Clearly, access to dental services is closely tied to income.
- When adults are queried regarding their dental visits, those in the Southwest Region respond that they have not seen a dentist in the past 12 months at a higher rate (43.1%) compared to the state as a whole (35.7%) (IDHW, Division of Public Health, 2016a).
- More than half of adults in PHD3 do not have dental insurance (Mispireta, Fore, Piland, and Kelchner, 2014).

In many integration models, behavioral health is only being integrated into the primary care clinic setting. The dental clinics at Terry Reilly Health Services have taken behavioral health integration to a new level; it has a place in the dental clinic setting as well. At Terry Reilly Dental Clinics, patients are receiving a depression screening in addition to their dental services. Some may question how oral health and behavioral health are related, but it is honestly very simple. When someone is experiencing poor mental health, this takes precedence over them caring for their oral health. Identifying patients in need of behavioral health services helps put them in touch with the care they need.

One example of this is a patient who recently came to the dental clinic for an urgent visit for pain from a toothache. After completing the depression screening, it was quite evident that the patient had other things causing significant stress in their life. Upon further questioning, the patient explained how they had suffered a traumatic loss recently and this was ultimately causing them stress in addition to the painful toothache they were suffering. Thankfully, the dentist was able to connect this patient with a behavioral health consultant to help address the patient's needs.

In cases more extreme than this, such as possible threats of suicide, the dentists at Terry Reilly are able to connect their patients to either on-site social workers or to triage nurses available by phone, which ultimately results in these patients receiving the mental health intervention they need.

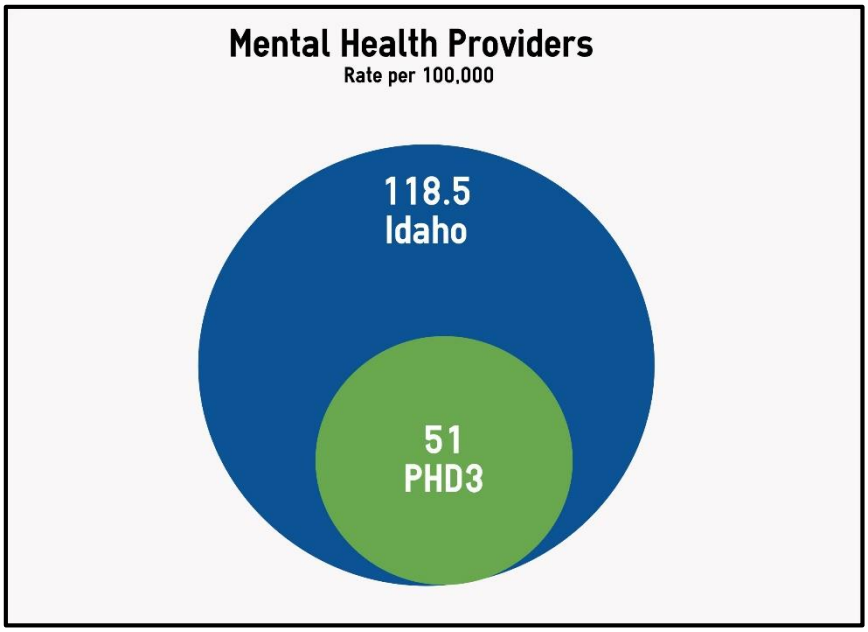
Ernest Meschack-Hart, DDS, Terry Reilly Health Services

Mental Health

Introduction

Mental health is an issue that is gaining increased recognition as a significant problem in the U.S. While there is still a significant lack of quantitative data available to highlight mental health in communities, available data and community concerns are reported.

Figure 38. Mental health provider* rate per 100,000 residents, 2014



*Includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care.
(County Health Rankings and Roadmaps, 2014)

- Clearly, there is a significant shortage of behavioral health providers in the Southwest Region. The entire state is considered a shortage area but PHD3 does not have even half as many providers as the Idaho average.
- The suicide rate per 100,000 people in the area is 13.1 (IDHW, Division of Public Health, 2016e).
- Approximately 16.6% of Medicare beneficiaries in the region have been diagnosed with depression (CDC, 2011-2012).

Figure 39. Mental health in Southwest Idaho, reported in 2012-2014

	PHD3	Idaho	U.S.
Serious Mental Illness in the Past Year	5.16	4.79	4.13
Any Mental Illness in the Past Year	21.56	20.77	18.39
Serious Thoughts of Suicide in the Past Year	4.66	4.29	3.91
Major Depressive Episode in the Past Year	7.25	7.38	6.71

(SAMHSA, n.d.)

Alcohol, Tobacco, & Drug Use

Introduction

Substance use impacts many communities in different ways from legal substances like tobacco and alcohol to illegal drugs and the consequent crime to which they are tied.

Alcohol

Alcohol misuse can result in outcomes from dependency to motor vehicle accidents.

- Residents of Southwest Idaho report binge drinking (14.1%) at the same rate as the state as a whole (14.1%) (IDHW, Division of Public Health, 2016h). Interestingly, more binge drinkers reported higher incomes (IDHW, Division of Public Health, 2016a).
- In addition, local residents report slightly less heavy drinking (5.2%) than the state as a whole (5.3%) (IDHW, Division of Public Health, 2016h).

When it comes to improving the health of a population, access to and coordination of resources (often times from multiple organizations) is paramount in achieving positive outcomes. Take for example a patient who was seen in the last year at one of our rural facilities. This individual had been suffering from undiagnosed post-traumatic stress disorder, had reported a high level of alcohol use, was in trouble with the law, had a strained relationship with their family, and had frequented the Emergency Department. All of these factors had led to complex health issues that were potentially leading to a tragic outcome. Upon getting connected with a team of nurse care coordinators and a patient navigator through their primary care provider, this patient was able to sign up for health insurance, have the necessary appointments and outside resources coordinated, and ultimately was able to reverse their health trajectory toward many years of positive health, personal enjoyment and overall purpose of life. Through the support of the healthcare team, this individual was able to quit drinking, had joint replacement surgery, had major dental work completed at a reduced cost, and was able to continue working while rebuilding relationships with their family. This type of an effort and showing of compassion is indicative of the passion these individuals bring to their work each day. However, ultimately these are outcomes that are only possible through the coordination of many people, services and organizations, and is a level of access and coordination only possible through the collaboration of entire communities.

Matthew Kaiserman, Director of Rural Primary Care Operations, St. Luke's Health System

Tobacco

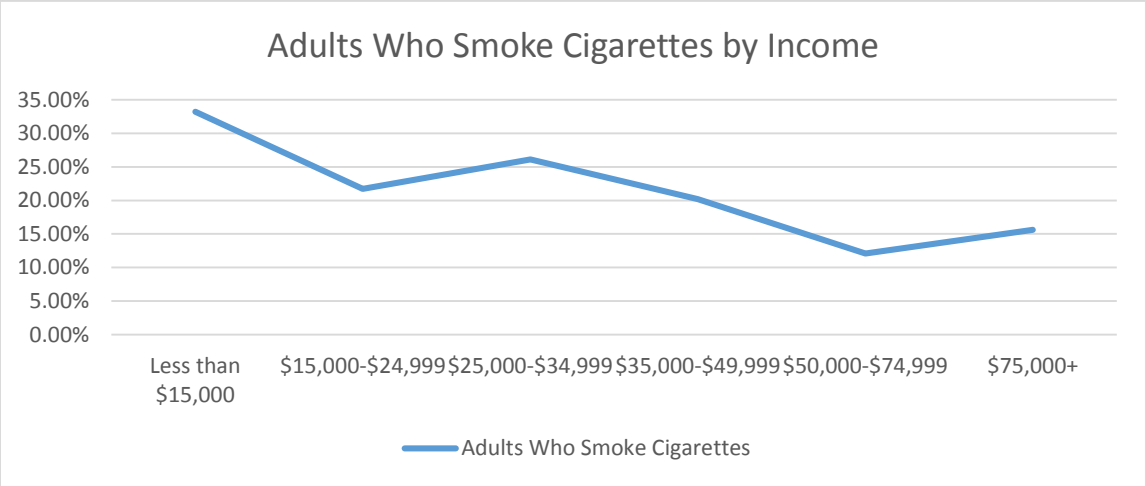
While long established as harmful to health, tobacco use is still prevalent among Idahoans.

Figure 41. Adults who smoke, reported in 2014

(IDHW, Division of Public Health, 2016a)

- Slightly over 20% of adults in the Southwest Region report smoking. This is greater than the state average of 15.9% (IDHW, Division of Public Health, 2016a).
- Smoking is more common in adults with lower incomes.
- Smokeless tobacco use is reported at approximately 5.7% of the adult population (IDHW, Division of Public Health, 2016a).

Figure 42. Cigarette smoking by income, reported in 2014



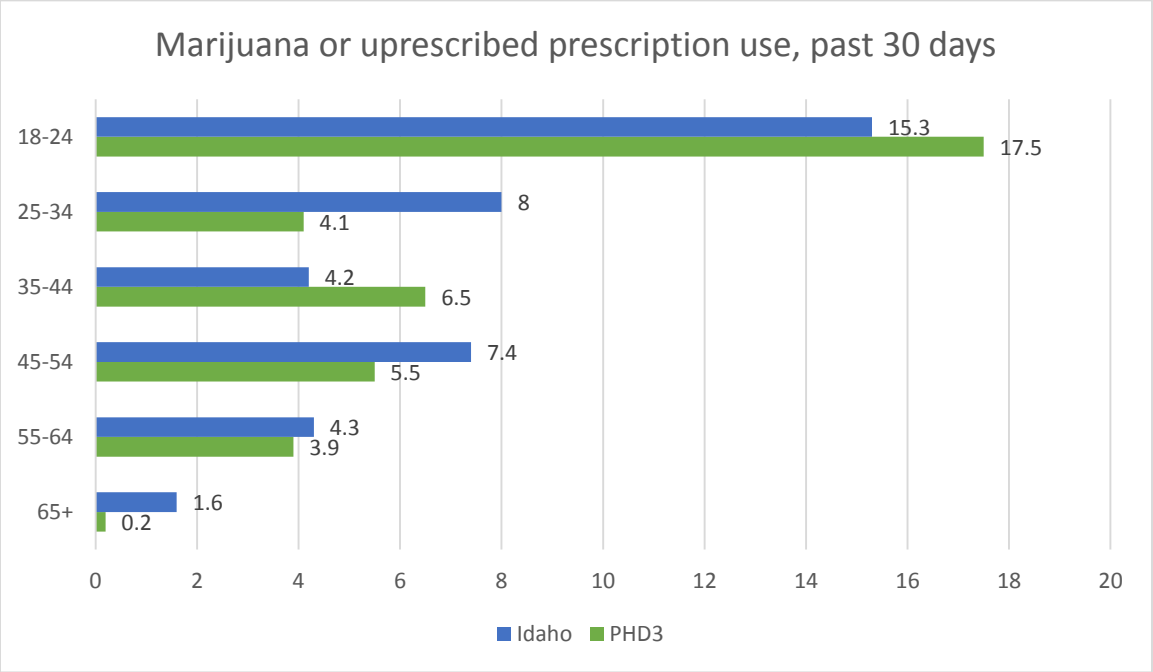
(IDHW, Division of Public Health, 2016a)

Illegal Drug Use

Drug use has long been considered a law enforcement and crime issue but is increasingly considered a health problem as well.

- Illicit drug use in the past month among those aged 12 or older had previously been on par with the national average but in recent years has decreased to below national average (SAMHSA, 2014).
- Dependence or abuse of illicit drugs or alcohol in the past year decreased slightly from 8.17% to 7.28% between 2010 and 2014 (SAMHSA, 2014).

Figure 43. Adults who have used marijuana or unprescribed prescription drugs in the past 30 days by age, reported in 2015



(IDHW, Division of Public Health, 2016g)

- The rate of drug-induced deaths in the Southwest Region was 14.2 per 100,000 for 2014 (IDHW, Division of Public Health, 2016b).
- In PHD3, nonmedical use of pain relievers in that past year among individuals aged 12 or older has decreased from 5.25% (2010-2012) to 4.05% (2012-2014). Though initially above the national average, the most recent numbers are below it (SAMHSA, 2014). To clarify, nonmedical use does not cover overutilization or overprescribing of opioid pain medications to treat an underlying pain condition.
- The overuse of opioid pain medications was a strong theme in community feedback.

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Appendix A Program & Data Set Listing

Data Set/Program	Acronym	Year of Data
Behavioral Risk Factor Surveillance System	BRFSS	2013, 2014, 2015
American Community Survey	ACS	2010-2014
County Business Patterns	CBP	2013
County Health Rankings		2014, 2016
Decennial Census		2000, 2010
Idaho State Police Statistical Analysis Center	ISP	2014
Idaho's Immunization Reminder Information System	IRIS	2015
Kids Count Data Center		2015
National Center for Education Statistics	NCES	2013-2014
National Survey of Drug Use and Health (SAMHSA)	NSDUH	2010-2012, 2012-2014
Pregnancy Risk Assessment Tracking System	PRATS	2014
School Report Card/Idaho State Department of Education		2014-2015
Small Area Health Insurance Estimates	SAHIE	2014
WIC Information Systems Program	WISPr	2015-2016
Youth Risk Behavior Survey	YRBS	2015

Appendix B Acronyms

Acronym	Full Text
BRFSS	Behavioral Risk Factor Surveillance System
ACS	American Community Survey
CBP	County Business Patterns
CDC	Centers for Disease Control and Prevention
HUD	Housing and Urban Development
IDHW	Idaho Department of Health and Welfare
IRIS	Idaho's Immunization Reminder Information System
ISP	Idaho State Police
NCES	National Center for Education Statistics
NSDUH	National Survey of Drug Use and Health
PHD3	Public Health District 3, Southwest District Health
PRATS	Pregnancy Risk Assessment Tracking System
SAHIE	Small Area Health Insurance Estimates
SAMHSA	Substance Abuse and Mental Health Services Administration
WISPr	WIC Information Systems Program
YRBS	Youth Risk Behavior Survey

Appendix C Community Input

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 11:00am
Date: 6/16/16
Location: Southwest District Health
Community Partner/ Group Name: Southwest Idaho Diabetes & Hypertension Coalition

What assets and resources do we have that can be used to improve community health?	
❖ Faith-based communities ❖ Manageable size of communities ❖ Increasing diversity and openness to culturally relevant solutions ❖ Community health workers and care coordinators (increased emphasis on a holistic focus) ❖ Population management focus in healthcare ❖ Recognition of behavioral health (BH) needs and diminishing taboo about mental health (MH) ❖ Growing health workforce ❖ More open dialogue about health and equity	❖ Community outreach programs (hospitals, PHD, YMCA, SAMG) ❖ Community health vision ❖ Coalitions/partnerships/networks ❖ Parks/rec environment ❖ Physically active population ❖ HEAL network ❖ Infrastructure for outdoor living ❖ State and federal partners ❖ Increasing emphasis on the built environment and intentionally healthy design
What are the major health concerns in the community?	
❖ Aging community ❖ Poverty/ALICE ❖ Thinking in silos (lack of collaboration and coordination between providers/agencies) ❖ Oral health ❖ Resilience stretched (stresses of financial constraints) ❖ Health literacy ❖ Obesity/chronic conditions	❖ Prescription abuse and substance use disorders (SUDs) ❖ Transportation ❖ Cost of medication ❖ Environmental health/justice (contaminants) ❖ Social determinants of health ❖ Food access ❖ Lack of health insurance coverage ❖ Management of MH & capacity to treat MH/BH

What do you consider barriers to health?	
❖ Resistance to healthcare ❖ Failure to access preventative care ❖ Financial stability ❖ Cost of healthy food ❖ Lack of education (people can't access higher education due to tuition cost to get better jobs to enhance socioeconomic status)	❖ Lack of understanding/long-term thinking about expense of food versus expense of healthcare ❖ Families are overwhelmed (it takes time to eat healthy and exercise and it just isn't a priority) ❖ Families don't know how to eat well
What do you consider barriers to accessing health care?	
❖ High deductible ❖ People don't understand "right time, right place" ❖ Getting into providers ❖ Bad experiences with healthcare providers	❖ Language barriers ❖ Understanding health insurance ❖ Sustainability of funding for future projects
What does our community value?	
❖ Community mentality/framework ❖ Safety ❖ Partnerships ❖ Follow-through ❖ Diversity ❖ Resources ❖ Family ❖ Open communication	❖ Independence ❖ Local foods/resources ❖ Local ideas ❖ Considering the customer first ❖ Tradition ❖ ❖

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 6:00pm

Date: 7/12/2016

Location: Wilder City Hall

Community Partner/ Group Name: Wilder City Council

What assets and resources do we have that can be used to improve community health?	
❖ Clinics (Southwest District Health and West Valley Medical Center) ❖ Fresh air ❖ Fire departments	❖ Biking and greenbelt (more momentum to develop) ❖ Church services (note the need to do more to get the word out) ❖ Senior dinners
What are the major health concerns in the community?	
❖ Environmental (safety of homes and vacant buildings) ❖ Aging (social isolation and access to healthcare)	❖ Mental health ❖ Chronic pain
What do you consider barriers to health?	
❖ Safe places for activity ❖ Limited income ❖ Language (excluded from many resources). Many families have children that speak English but parents only speak Spanish.	❖ Healthy foods (lack of, note utilization of SNAP for unhealthy foods) ❖ Transportation issues (isolated from resources) ❖ Literacy
What do you consider barriers to accessing health care?	
❖ Insurance coverage→ working poor with limited or no coverage and students (parents don't enroll kids in CHIP and university students can't afford coverage) ❖ Language barriers	❖ Schedule of provider and lack of providers (only 1) ❖ Healthy foods (lack of, no grocery store) ❖ Lack of health literacy ❖ Transportation (long distance to pharmacy and specialists

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 5:00pm

Date: 7/14/2016

Location: Payette Library

Community Partner/ Group Name: Payette Library Board

What assets and resources do we have that can be used to improve community health?	
❖ Pool ❖ Library ❖ Active Senior Center ❖ University of Idaho Extension Office (HEAL curriculum) ❖ Walking path ❖ Meals on wheels	❖ New farmer's market ❖ WICAP ❖ AA meetings ❖ Faith-based social support ❖ Prison program to refurbish bikes for kids ❖ St. Alphonsus Medical Group health resource (Diabetes and general support)
What are the major health concerns in the community?	
❖ Aging community & poverty (pride as a barrier to accessing resources) ❖ Affordability of health insurance ❖ Poverty (hungry kids) ❖ Slow response from system to get resources (disability applications) ❖ Lack of exercise (poor infrastructure)	❖ Nutrition (lack of quality) ❖ Transportation (resources that go out of the community but lack of options to move within community) ❖ Lack of health education ❖ Mental health care for kids (no counseling services) ❖ Lack of health insurance coverage
What do you consider barriers to health?	
❖ Not enough education and clear incentives for youth to be healthy ❖ Community knowledge (regarding resources and how to be healthy) ❖ Drug use (alcohol, minor in possession, smoking). Proximity to Oregon and legal marijuana were described as issues as well as heroin/opiate abuse.	❖ Providers are driven by money ❖ Lack of patient engagement (the group noted difficulties for low socioeconomic status groups and those with mental health constraints) ❖ The quick win (people selling SNAP for cash) ❖ No youth activities ❖ Too much emphasis on a "pill" and the pharmacy fix

What do you consider barriers to accessing health care?	
❖ "Booked solid"→ not enough providers ❖ Difficult to get appointments with specialists	❖ Language barriers
What does our community value?	
❖ Education/youth ❖ Family unity ❖ Cohesiveness and community	❖ Future (-oriented) ❖ Story time (Library event) ❖ Opportunities
How is quality of life perceived in our community?	
❖ "I would live nowhere else" ❖ Good weather ❖ Safe ❖ Good opportunities to be outside	❖ Close to Boise ❖ Secure ❖ Rich in opportunities ❖ Good activities

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 3:00pm

Date: 7/21/2016

Location: Adams County Health Center

Community Partner/ Group Name: Council Chamber of Commerce

What assets and resources do we have that can be used to improve community health?	
❖ New bike path (to be completed next year) ❖ Food pantry ❖ Community garden ❖ University of Idaho Extension Office ❖ More families moving back to town (invigorated/vision) ❖ Meals on Wheels ❖ Growing school class sizes ❖ Community pond/baseball diamond/horseshoes/basketball courts ❖ Community-minded churches ❖ Adams County Patient Assistance Fund (independent of clinic)	❖ Gym ❖ Adams County Health Center (ACHC) (**sliding scale) ❖ Outdoor activities (noted that they aren't used at full capacity) ❖ After school program (noted that only for grade-school kids) ❖ Pool ❖ Yoga classes and walking club (not very well utilized) ❖ Senior Center ❖ 4H/Future Farmers of America ❖ Skating rink ❖ Noted needs: space for exercise in the winter and community center/gathering space
What are the major health concerns in the community?	
❖ Obesity ❖ Diabetes ❖ Bullying (in the high school) ❖ Mental health (suicide and depression) ❖ Lack of education about nutrition (particularly for low income families)	❖ Cycle of poor health for families (particularly low income where cheap food is consumed more than good food) ❖ Heart disease and hypertension ❖ Alcohol ❖ Drugs ❖ High cancer rates
What do you consider barriers to health?	
❖ School lunch restrictions (regulatory) vs. affordability of food ❖ Youth are not engaged ("you can provide resources but you can't make them use it") ❖ Produce: little variety and high prices	❖ No sidewalks and kids don't know how to walk on the roads safely ❖ No PE

❖ The healthy choice isn't always the easy choice ❖ Aging facilities and infrastructure (environmental health concerns and EPA sewage citation)	❖ No mental health education and stigma over behavioral health concerns ("your brain is an organ", "it is a small community and people will find out"). Noted that this has lessened for PTSD and veterans.
What do you consider barriers to accessing health care?	
❖ Remote/difficult to access specialists ("bouncing around from provider to provider") ❖ Health literacy and understanding healthcare ❖ Lack of navigation support for patients and clients (resources are available but no dedicated personnel to help access) ❖ Transportation (regular visits, urgent visits, and life-threatening) ❖ Lack of communications between providers (Boise/VA) ❖ Lack of on-site pharmacy	❖ No assisted living (splits up families because they have to move) ❖ Lack of mental health and physical health integration ❖ Inefficient commitment resources for patients in crisis ❖ No occupational therapist ❖ Care dictated to seniors and vulnerable populations instead of working together ❖ No urgent care
What does our community value?	
❖ Independence ❖ Clean air, clean water ❖ Self-sufficiency balanced with relationships and care for others ❖ History	❖ Recreation ❖ Livestock/farming ❖ Tradition ("change is very painful") ❖ "Make your own entertainment"
How is quality of life perceived in our community?	
❖ "You can actually see the sky" ❖ Slower pace ❖ Good neighbors ("people look out for each other") ❖ Good connection to nature ("we live in it") ❖ Safe	❖ Some resources are spread a little thin ❖ You have everything that you need ("Simpler way of life […] there's no 'keeping up with the Joneses") ❖ No traffic ❖ Quiet

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 10:30am

Date: 8/8/2016

Location: Nampa Library

Community Partner/ Group Name: Nampa Chamber of Commerce

What assets and resources do we have that can be used to improve community health?	
❖ Parish nurses and the faith community ❖ Hands of Hope (medical equipment) ❖ Paths for physical activity ❖ Large parks and rec center ❖ More than two dozen schools with green spaces ❖ Immunization Coalition ❖ Farmers markets and community garden ❖ Many major health systems ❖ World of Nutrition (innovative education and community outreach) ❖ Library ❖ Spirit of collaboration and growing coalitions ❖ Access to higher education and workforce development ❖ Nursing students (**need more projects) ❖ Tolerance for cyclists ❖ Strong volunteer base (maybe lacking coordination) ❖ Strong Chamber of Commerce	❖ Senior Center ❖ Terry Reilly Health Services ❖ Big community spaces (Ford Center, Nampa Event Center) ❖ Growing community health worker workforce ❖ Opportunities to communicate/coordinate volunteers (justserve.org) ❖ Service Clubs ❖ Mobile health services ❖ United Way/Boys and Girls Club/Salvation Army ❖ Grant funding ❖ Rescue Mission ❖ Meals on Wheels ❖ CATCH ❖ Schools with strong communication channels (peach jar) ❖ Hispanic Cultural Center ❖ Southwest District Health and the Medical Reserve Corps ❖ New nurse practitioner program at NNU

What are the major health concerns in the community?	
❖ Lack of immunizations (a lot of kids on the waiver) ❖ Obese adults and children ❖ Medicaid Gap ❖ Compliance/adherence to chronic disease treatment (challenges with lower income and access) ❖ Mental health issues (limited access to treatment resources and overutilization of the ER) ❖ Education about availability of resources ❖ Poverty ❖ Air quality/allergens ❖ Homelessness ❖ Diabetes	❖ Low screening rates ❖ Poor housing quality ❖ Number of poor health days reported ❖ Disabled adults with very poor access to management services ❖ Food insecurity (11/13 schools are free/reduced lunch) ❖ Litter and pollution (poor water quality) ❖ High blood pressure, cholesterol, and diabetes in the Latino population (*noted highest immunization rate) ❖ Lack of prenatal care ❖ Lack of early childhood education (waiting list for Head Start)
What do you consider barriers to health?	
❖ Lack of affordable, low-cost housing (people are afraid to speak up if quality of housing is poor) ❖ Closing grocery stores and food deserts ❖ Illiteracy ❖ “Sidewalks are stamped with 1910”, old and failing infrastructure ❖ Food insecurity ❖ Lack of communication about existing resources (difficult to access the population that needs the resources) ❖ Language (barriers to accessing support) and culture (different values for prevention) ❖ Pathways and roads that don’t go where the community needs to go ❖ Transportation (community has sprawled and it is difficult to access work, play, food, and health sites). ❖ Low incomes	❖ Health literacy (parents don’t know how to keep their kids healthy) ❖ Security (lack of safe places to play and false perceptions about stranger danger) ❖ Cultural sensitivity (not meeting people where they are) ❖ Time (too many competing priorities) ❖ Cost of a healthy meal (long term thinking vs. short term need) ❖ Food insecurity in families ❖ Pride (don’t want to ask for help) ❖ Lack of sensitivity to poverty at the local government level ❖ Children interpreting for parents ❖ Lack of understanding/representation of vulnerable populations in decision making ❖ Balance between improving infrastructure and leaving people behind

❖ High property tax rates that limit building and investment ❖ Hours of employment and access to resources (fields and shift work) ❖ Educational level of population ❖ Literacy	❖ Health is not a priority with local leadership (it is a silo→ Health Department and hospitals) ❖ Negative feedback to language sensitive resources
What do you consider barriers to accessing health care?	
❖ Hours of employment and access to providers (fields and shift work) ❖ Different understanding of healthcare systems (international students) ❖ Language sensitive services ❖ Documentation and affordability for the Latino community ❖ Lack of health insurance (may be business owners or part-time workers) ❖ High deductible plans (can't use insurance) ❖ Using the ER as primary care	❖ Migrant and seasonal workers only accessing care episodically ❖ Schedules and employer sensitivity to healthcare needs ❖ Access to care in schools ❖ Lack of internet ❖ Low numbers of providers (long wait times and limited acceptance of certain types of payment) ❖ Distance to specialists ❖ Transportation ❖ Income level
What does our community value?	
❖ Independence/limited government (2) ❖ Choice ❖ Good schools ❖ Faith (3) ❖ Morals ❖ Children and families (10) ❖ Deception of others ❖ Safety (6) ❖ Agriculture	❖ Altruism/helping others (3) ❖ Living wage to support family ❖ Big trucks ❖ Community (6) ❖ Outdoors (3) ❖ Collaboration ❖ Cultural diversity (2) ❖ Healthy environment

How is quality of life perceived in our community?	
❖ Businesses work hard to stay in business and face a challenge with keeping people working, shopping, and playing in town ❖ Some neighborhoods have high crime and gang activity. Respondents reported gun sounds. ❖ Safer than some big cities ❖ Affordable (housing and utilities) ❖ Poor food access ❖ A lot of poverty and stereotypes about those living in poverty ❖ Commuter town (people are taking their shopping to Boise) ❖ It is great to see the mountains ❖ There are many homeless children	❖ Quality of life is very dependent on what part of the community you belong to (income level) ❖ Varied, depends on the family ❖ Less shared resources than other areas ❖ Schools get a bad reputation ❖ Good free activities (hiking/camping/fishing) ❖ Gathering places are well-utilized ❖ Easy access to healthcare ❖ Good faith communities ❖ No public transportation ❖ Good progress on emphasizing outside activities

Community Themes and Strengths: Issues, Perceptions, and Assets worksheet

Time: 9:00am

Date: 8/16/2016

Location: Weiser Senior Center

Community Partner/ Group Name: Weiser Senior Center Board

What assets and resources do we have that can be used to improve community health?	
❖ Hospital ❖ Clinics ❖ Police departments ❖ Therapists ❖ Parks, track, fish pond, pool, river trail ❖ Dentists ❖ Chiropractors ❖ Southwest District Health, WACHAT ❖ Lion's Club (eye exams and glasses)	❖ Elks ❖ Angel Wings and Rose Advocates ❖ WICAP ❖ Senior Center ❖ Faith Communities (Love INC) ❖ Community garden ❖ USDA ❖ Schools
What are the major health concerns in the community?	
❖ Water quality (is it safe?) ❖ Insurance gaps (high deductible and uninsured) ❖ Air quality	❖ Cancer ❖ MS (in young adults) ❖ Oral health
What do you consider barriers to health?	
❖ Education (the resources are here but people aren't coordinating) ❖ Communication (health education; "you can tell them but they may not understand")	❖ Money ❖ Lifestyle cycles and passing on bad habits ❖ Transportation to doctor appointments (specialists)
What do you consider barriers to accessing health care?	
❖ Money ❖ Transportation ❖ Insurance (carriers dropping out of rural coverage and increasing cost)	❖ Bad communication between providers (have to go back to the office to get results) ❖ It is helpful to have walk-ins

What does our community value?	
❖ Heritage ❖ Kids/family ❖ Being a small town	❖ Preservation ❖ Conservatism
How is quality of life perceived in our community?	
❖ Average ❖ 1950s era/older way of living ❖ Depends on the person ❖ Conservative ❖ Happy (until a big challenge comes up and it is hard to cope) ❖ Accepting ❖ Clean town	❖ Close community ❖ Good schools ❖ Good people ❖ Professionals that help as much as possible ❖ Good seasons and weather ❖ Everyone gets along

Community Themes and Strengths: Issues, Perceptions, and Assets Worksheet

Time: 12:00pm

Date: 08/30/2016

Location: Valor Health

Community Partner/ Group Name: Gem County Community Health Connection

What assets and resources do we have that can be used to improve community health?	
❖ Rec district ❖ Fitness facilities ❖ Walking paths ❖ Island ❖ Hospital ❖ Classes ❖ Head Start ❖ Newspaper ❖ Recovery Center ❖ Gem County Community Health Connection	❖ Worksite wellness ❖ Drug and needle drop off ❖ Public officials and their focus on embedding health issues in goals ❖ School district ❖ Senior Center ❖ Community events ❖ Biking ❖ Health care providers ❖ Farmers market
What are the major health concerns in the community?	
❖ Diabetes ❖ Obesity ❖ Cancer (environmental exposure/ “Downwinders”) ❖ Substance use ❖ Inactivity ❖ Smoking percentage ❖ Mental health	❖ Nutrition ❖ Education and health literacy ❖ Teen pregnancy ❖ Senior care ❖ Homebound ❖ Transportation ❖ Money

What do you consider barriers to health?	
❖ Anti-vaccination movement ❖ Education and continuation rate ❖ Mental health and substance use stigma ❖ Generational poverty and social determinants of health ❖ Commuting population ❖ Tobacco use ❖ Multiple health conditions	❖ ALICE/working poor ❖ Access to insurance ❖ Affordable, available, and quality housing ❖ Transportation ❖ Fast food (lack of access to grocery stores) ❖ Unhealthy culture (especially the portrayal in the media) ❖ Cultural barriers to accessing care and services in Hispanic community
What do you consider barriers to accessing health care?	
❖ Transportation ❖ Insurance (both uninsured and underinsured) ❖ Money (families cannot afford care) ❖ Knowledge about where to go for care and how to use providers ❖ Disconnect between providers and patients (what resources patients can access, what options patients have, etc)	❖ Number of providers and variety of providers ❖ Time of appointments (large commuter population) ❖ Stereotype and stigma for seeking services (especially mental health; may be bigger problem for veterans) ❖ Education and health literacy
What does our community value?	
❖ Family ❖ Military pride ❖ Schools ❖ Hospitals ❖ Small town feel ❖ The balance of rural culture and access to Boise ❖ Parks/rec/youth supports and the whole town support they receive	❖ Independence ❖ Visible leadership ❖ Safety ❖ Landscape ❖ Freedom of worship ❖ Interaction and events

How is quality of life perceived in our community?	
❖ "Thumbs up" ❖ "It is like going back in time", slower, Mayberry ❖ Safe and less violent crime (year 3 without a homicide) ❖ Healthy (going in the right direction with health) ❖ High quality of life ❖ Affordable and cheap (note that this can amplify some of the resource needs due to the population)	❖ Good school systems ❖ Collaborative ❖ Caring teachers and volunteers ❖ Helping neighbors ❖ Open and friendly

Goal 3

Appendices

Care Coordination Website

https://www.idcarenetwork.com

Goal 3

Appendices

Primary Care Coordinator
Summer 2018 Pilot

Brought to you in partnership by Nampa Smiles, Delta Dental of Idaho, the Southwest Health Collaborative, and the Central Health Collaborative.

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

Background

The Southwest Health Collaborative, Central Health Collaborative, Nampa Smiles, Idaho Oral Health Program, Delta Dental of Idaho, Idaho State Dental Association, and Idaho Oral Health Alliance have partnered together to support enhanced connections between dental services and medical services. During the summer of 2018, the group collected data on dental patients in four practice sites across the Treasure Valley, including private dental offices and embedded Federally Qualified Health Center Sites. These data demonstrated that approximately 40% of patients seen at the dental office did not have a primary care provider and 15% of total patients surveyed had unmanaged elevated blood pressure. Blood pressure was assessed once at the time of service based on clinic operating procedures. These results indicate a need to connect patients to a primary care provider and continue to develop the relationship between physicians and dentists.

As a result of these findings, the group decided to pilot a care coordinator position in a local clinic, to connect dental patients who identified a care access challenge to a primary care provider. The PCC was required to work with an extensive network of primary care coordinators to match patients based on insurance status, transportation, distance and other relevant factors. This document highlights the pilot program design, observations from implementation, and key conclusions.

Design

The group spent several months designing the system for deploying the PCC in a local dental office. The following plan was initially presented to the dental clinic and the care coordinator in June 2018, prior to staffing the PCC role.

Primary Care Coordinator Job Description

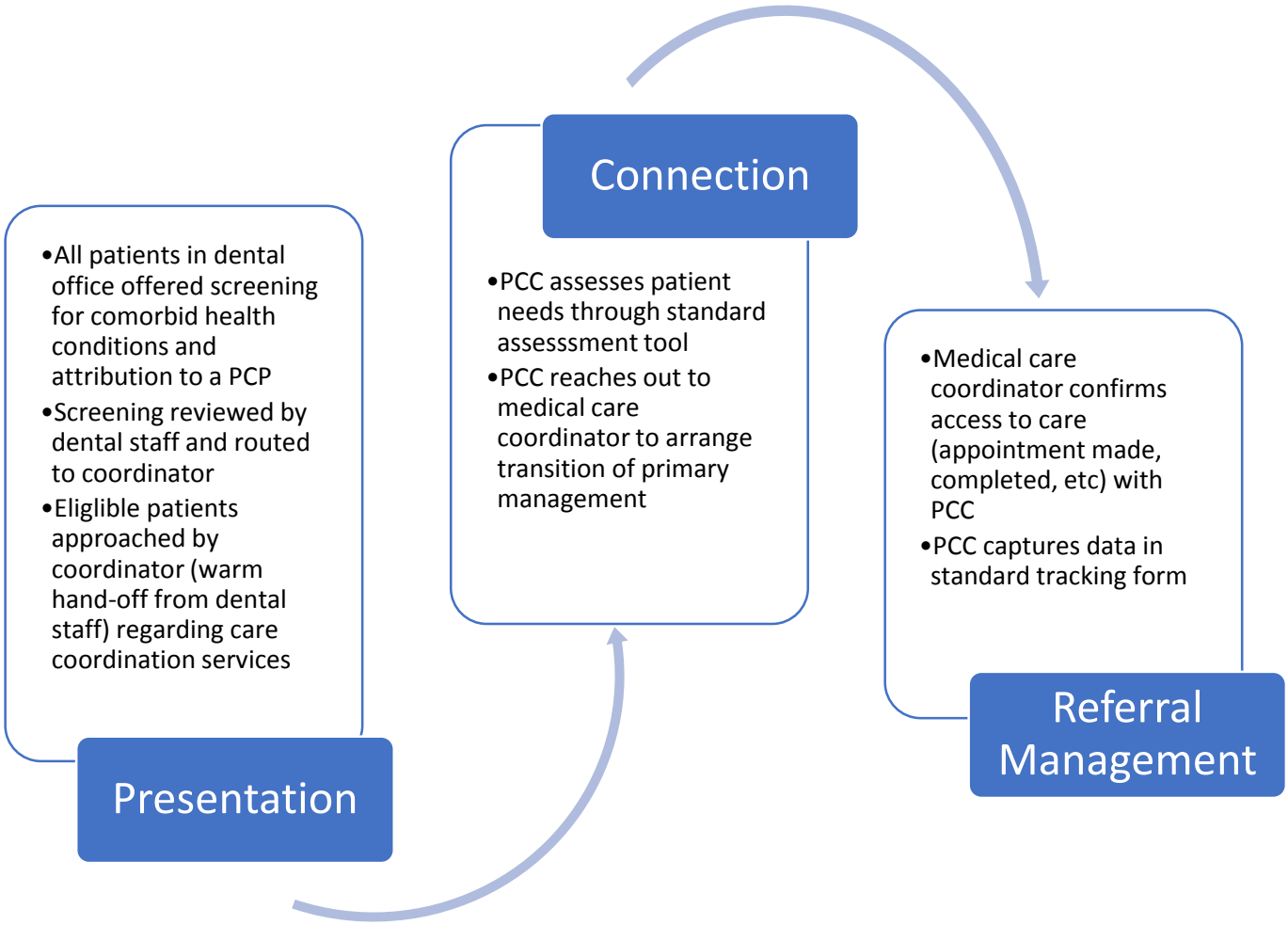
The Primary Care Coordinator (PCC) is responsible for working collaboratively with the dental staff to identify patients for care coordination and connecting those patients with appropriate primary care services, based on patient needs.

Responsibilities

- Review screening forms for patient contact information and reach out to interested patients
- Assess patient needs and features (insurance status, location, schedule, etc.) to connect them with a medical office
- Call medical offices to coordinate patient scheduling as needed
- Respond to phone call referrals from the dental office in a timely manner
- Maintain appropriate confidentiality in handling patient information in accordance with HIPAA
- Follow up with patients regarding scheduling primary care appointments as needed
- Track screening/assessment form data
- Report back to the project team on any challenges in implementation
- Meet regularly with front office staff at dental offices to identify opportunities for coordination

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

Workflow Summary



Continuous Quality Improvement

It should be noted that the plan described above was introduced as the initial design but that participants, including the PCC and the dental staff, were encouraged to make changes as needed to generate successful identification of patients with needs and subsequent connections to care resources. The project manager met weekly with the PCC who was asked to keep detailed notes on experiences with the process. The process was continuously developed and refined based on these observations and shifts. The observations of the team and subsequent adjustments to implementation are detailed below.

Observations

Various iterations of approach and scope were trialed through the summer of 2018. These versions of the plan and observation of efficacy and fit are described below.

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Approach

Strategy	Observations	Changes made
All dental patients handed screener at intake to complete	• The dental staff felt like it would be more appropriate to have the PCC individually approach patients	• PCC approaches patients individually
PCC approaches patients who have checked in at the waiting room	• PCC felt that formal dress may have been unapproachable • Patients may be uncomfortable discussing challenges accessing care in front of others	• PCC dresses in Delta Dental polo • PCC reintroduces screener with expanded scope • PCC approaches patients in treatment area • PCC sign posted at check-in
Warm handoff from dental hygienists and dental assistants in treatment area to introduce PCC	• Better response rate and engagement from patients	• Maintained for the duration of the project

Scope

Strategy	Observations	Changes made
Ask patients about access to primary care and insurance status	• Much higher level of "no assistance needed" response than in pilot	• Start screening for other social determinants of health needs
Screen patients for social determinants of health	• More responses on assistance needed	• Maintained social determinants screening for duration

Recommendations

The following recommendations are made based on observations during the pilot.

- Use internal staff for care coordination when able. This will allow teams to work more easily with existing workflows and for patients to feel more comfortable with the coordinator being a part of the care team.
- Consider whether you want the coordinator to support broader connections to health-related resources or provide more clinical support. A community health worker (CHW) may be more appropriate for managing broader resource needs (transportation, food insecurity, etc). A CHW can be a dental assistant, front office staff, or other staff member. It may be more appropriate to have a dental hygienist coordinating more clinical needs as these staff have more training and background in general healthcare issues.

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- Standardize your screening workflow to make consistency easier for all staff. There are many opportunities to connect with patients in a dental encounter but if responsibilities for screening and follow-up are clear, they are more likely to be followed for all patients.

Conclusions and Discussion

While the original intent of the project was maintained throughout the pilot, the implementation shifted significantly. The screening became broader in scope and was modified in workflow. It is also worth noting that significantly fewer patients indicated that they had a need to connect to a primary care provider when there were on-site resources being offered as compared to the original data collection pilot.

Future efforts to connect dental patients to care resources may look to embed screening and follow-up within existing staffing models as yield was somewhat low in positive screens for assistance. In addition, groups looking to do this work may consider utilizing clinically-trained staff to screen and connect patients to a PCP because they have an established, trusted relationship with their patients. Finally, clinics may consider screening for resource needs beyond primary care, as it was noted that many patients indicated that they required support services in the areas of education, transportation, insurance, and food security.

Screening patients in multiple care settings for opportunities to close gaps in care will enhance the treatment environment for all patients and providers. As patients come into dental settings with more of their care needs met, they will be more empowered to engage in dental health activities and more able to receive dental intervention (due to controlled blood pressure, transportation to appointments, etc.). This pilot shows that with a well-documented plan and strong support from the dental clinic, a system for screening and resource connection can be developed to assist patients in accessing the care and services they need to achieve improved health.

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

Nampa/Caldwell Local Resource Guide

HOUSING

Utilities

Area 3 Senior Services Agency	208-898-7060
WICAP	208-459-1851

Repairs and Weatherization

Metro Comm. Services	208-459-0065

Hoarding

International OCD Foundation	https://hoarding.iocdf.org/about-hoarding
CTR – Cleanup and Total Restoration	208-377-1877 http://www.ctridaho.com/

ADULT PROTECTION

Area 3 Senior Services Agency	208-898-7060

MEDICATION

Prescription Assistance

Metro Comm. Services	208-459-1334
Needy Med	Drug discount program 1-888-602-2978 http://www.drugdiscountcardinfo.com/
Idaho Commission on Aging	208-334-3833 Https://aging.idaho.gov/adrc/

LEGAL AID

Idaho Legal Aid Services	208-454-2591

MEDICARE ASSIST

SHIBA Helpline	1-800-247-4422
Metro Community Services	208-459-0063 www.metrocommunityservices.net/

TRANSPORTATION

Metro Community Services Canyon county	208-459-0063 www.metrocommunityservices.net/
VEYO Statewide	1-877-503-1261 https://idahotransport.com/schedule-a-ride/

TECHNOLOGY ASSISTANCE

Idaho Assistive Technology Project	208-885-6102 Idahoat.org/consult-train/adults

FALLS

Fit and Fall Proof Southwest District Health	208-455-5321 www.swdh.org

RESPITE *(Planned or emergency temporary care provided to caregivers of a child or adult).*

Legacy Corps	208-336-5533
Metro Community Services/Area on Aging In-Home Services Adopt-a-Senior	208-459-0063

NUTRITION

Meals on Wheels (Nampa)	208-463-5720
Meals on Wheels (Caldwell)	208-454-8142
Salvation Army (Nampa)	208-467-6586
Oasis Food Center (Caldwell)	208-459-6000
Metro Meals on Wheels	208-321-0030

CANYON COUNTY PRIMARY CARE PROVIDERS

- ✓ Primary care providers help you manage all our health conditions and can help you get the right care at the right time. Specialists are important, but you should have a primary care provider to help you with all your health needs.
- ✓ Please have your insurance card available when calling to schedule an appointment.
- ✓ This list is not meant to be exhaustive. Please contact Marty Cappe at 208-455-5313 if you believe we have missed a clinic.

Clinic Name	Address	Phone
Caldwell Immediate Care	2523 S. 10th Ave, Ste 103, Caldwell, ID 82605	208-459-7788
Clinica Santa Maria, Inc	524 Cleveland Blvd. Ste 110, Caldwell, ID 83605	208-459-3630
Family Care Clinic	1007 W Orchard, Nampa, ID 83651	208-461-2838
Primary Health Medical Group Caldwell	4815 Cleveland Blvd., Caldwell, ID 83605	208-455-3545
Primary Health Medical Group South Nampa	1115 12th Ave. Road, Nampa, ID 83686	208-498-1080
Primary Health Medical Group-Nampa	700 Caldwell Blvd, Nampa, ID 83651	208-466-6567
Saint Alphonsus Medical Group Family Practice Resource Center		208-367-3627
Saltzer-Nampa Main Clinic	215 E Hawaii Ave, Nampa, ID 83686	208-463-3000
St. Luke's Clinic Nampa Family Medicine Resource Center		208-381-9000
Terry Reilly - Melba Clinic	150 2nd Ave., Melba, ID 83641	208-495-1011
Terry Reilly Health Services- Caldwell	2005 Arlington Ave., Caldwell, ID 83605	208-459-1025
Terry Reilly Health Services- Middleton	201 S 1st Ave East, Middleton, ID 83644	208-585-0048
Terry Reilly Health Services Nampa 1st Street	207 1st St. South, Nampa, ID 83651	208-466-7869
Terry Reilly Health Services Nampa 16th Street	223 16th Ave. North, Nampa, ID 83687	208-467-7869
West Valley Medical Group, Caldwell	1906 Fairview Ave, Ste 230, Caldwell, ID 83605	208-459-4667
West Valley Medical Group, Middleton	381 S. Middleton Rd, Ste B, Middleton, ID 83644	208-585-6311
West Valley Medical Group, Nampa	16459 N Midland Blvd, Nampa, ID 83687	208-795-5075
West Valley Medical Group, Parma	307 Grove St., Parma, ID 83660	208-722-5147

West Valley Medical Group, Wilder	124 5th St, Ste A, Wilder, ID 83676	208-482-7430

Idaho Integrated Behavioral Health Network Strategic Plan

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Leadership from the Idaho Integrated Behavioral Health Network (IIBHN), met on July 10, 2017 and August 30, 2017 to participate in a strategic planning session. Convened by Southwest District Health and Central District Health, the discussion allowed the group to further define key goals and action items which are captured in this document. The strategic plan is meant to be a living document and will be updated as goals and strategies are refined and as progress is made.

Vision

Local networks of BHCs across the state of Idaho that facilitate sharing of best practices, promotion of integrated behavioral health, and are connected to a larger state guiding body that supports this vital healthcare role through technical assistance and advocacy.

Leadership

The current IIBHN leadership represents multiple organizations from across the state of Idaho who are committed to developing and sustaining a network of talented behavioral health consultants across the state, supported by local and state leadership. The group was formed as an outgrowth of the Behavioral Health Integration Workgroup, a sub-committee of the Idaho Health Coalition. We are confident that additional members will be added as additional regions and clinics become active in integrated behavioral health.

Name	Organization
Dr. Winslow Gerrish	Family Medicine Residency of Idaho
Gina Westcott, LCSW	Idaho Department of Health and Welfare
Tori Torgrimson, LCSW	Family Health Services
Lyn McArthur, PhD	Healthwest
Melissa Mezo, LCSW	Terry Reilly Health Services
Amy Walters, PhD	St. Luke's Health Partners
Jen Yturriondobieta, LCSW	St. Luke's Health Partners
Sarah Ludovic-Young, LCSW	Valley Family Health Care
Bevin Modrack, LCPC	Optum
Melissa Dilley, MHS	Central District Health Department
Rachel Blanton, MHA	Southwest District Health

The Public Health Districts (PHDs), Southwest District Health and Central District Health Department, have assumed the role of convener to provide a neutral space to pursue the group's vision across the state. Roles and responsibilities as conveners include:

- Planning meetings (scheduling and space)
- Facilitating meetings
- Providing administrative support (notes, document updates, etc)

Goal 1: Provide education on different integration models regarding value, implementation, best practices, and resources.

Strategy: Plan an annual state convening (Sept 2018) for BHCs (1.5-2 days)

Not Started Deferred On Target Off Target Waiting on Someone Critical Achieved

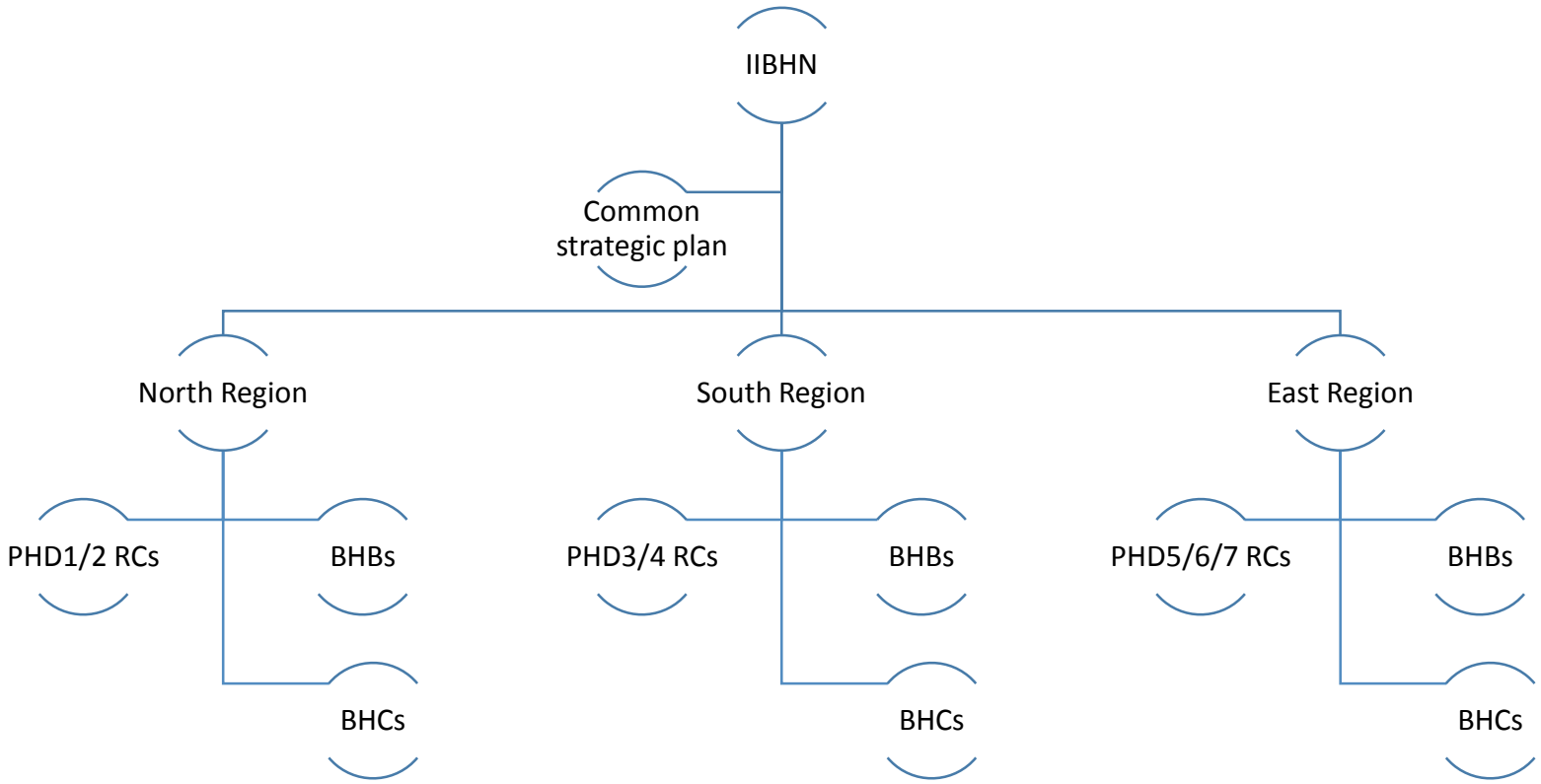
Activity	Target Date	Status	Notes	Action item
Identify target audience and topics	Dec 1, 2017		Will continue discussion at next meeting. It was noted that the PIP tool should be covered.	N/A
Develop agenda	Sept 30, 2017		Will complete once target audience and topics are identified at the 8/30 meeting	◻ Gina will begin drafting the agenda after the 8/30 meeting
Develop budget	Oct 1, 2017			◻ Rachel will start a draft budget based on *Let's Talk* event ◻ Melissa D will review and edit draft budget
Request funding support	Oct 1, 2017		Potential partners/funding sources include: SHIP/IDHW, R3BHB, PacificSource CHE, SLHS Foundation, Optum, BCI Foundation, IPCA, Bureau of Rural Health and Primary Care	◻ Gina to present request at BCI meeting ◻ Rachel to report back on PacificSource funding ◻ Bevin to send Optum event sponsorship application to Rachel
Identify speakers	TBD		Pending determination of target audience and topics	◻ Jen will reach out to Drs. Kesler and O'Donnell re interest in presenting at Spring 2018 meeting

Parking lot:

Develop standard presentation for all Behavioral Health Boards

Goal 2: Facilitate opportunities for statewide and local professional network development among BHCs and administrators on a regular basis.

Strategy: Three core regional networks will be developed across the state. These groups will be convened by the PHDS, led by regional champions, and participants will include local stakeholders. The structure is illustrated below:



Not Started Deferred On Target Off Target Waiting on Someone Critical Achieved

Activity	Target Date	Status	Notes	Action item
Establish the PHDs as conveners.	Sept 15, 2017	North:	Gina facilitated meeting with PHD1 on 8/25. First convening date set for 10/4. Need commitment to get CE to attend meeting with Gina (Melissa M, Kendra, or Winslow).	
		South:	PHD3 and PHD4 currently established as conveners.	N/A
		East:	Meeting with PHD5/PHD6 on 8/16 with next steps to plan convening.	
Convene key stakeholders.		North:		◻ Melissa M, Kendra, or Winslow to attend first convening to present on South's efforts
		South:	Next BHC meeting on 9/7 with current participants including GFHC, FMRI, and TRHS	◻ Melissa M. will build a regional listserve ◻ Jen to begin developing state roster of engaged clinics
		East:	Meeting with Tori, Lynn, Rob Petroch (D5), Melissa D, and Rachel on 8/16 and will convene stakeholders after meeting.	◻ Rob, Lyn, and Tori to meet to discuss initial convening.
Identify regional champions.		North:	Need representation on leadership group from North regions.	
		South:	No current action needed but need to consider primary care representation	N/A
		East:	No current action needed	N/A

Goal 3: Identify a common readiness tool and promote utilization of the NCQA guidelines for integrated behavioral health.

Strategy: The Idaho Integrated Behavioral Health Network will not select a model to promote but will instead aim to identify a common readiness tool and quality guidelines. This will allow practices in the network the flexibility to implement a model that is appropriate for their practice setting. By selecting common readiness tools and guidelines, it will allow the IIBHN to appropriately assign technical assistance resources and track progress throughout the state.

Activity	Target Date	Status	Notes	Action item
Identify common readiness tool.	Nov 1, 2017		Group to review the PIP tool and practices actively utilizing the tool to provide feedback at next meeting.	◻ Jen to send out the PIP tool ◻ Practice representatives to provide feedback on utility of PIP
Train clinics on utilization of readiness tool.				
Promote utilization of the NCQA guidelines for integrated behavioral health.				

Goal 4: Position the IIBHN as a key policy, advocacy, and technical assistance resource in the state of Idaho.

Strategy: The Idaho Integrated Behavioral Health Network will work to identify key policy, compliance, payer, etc issues in the state of Idaho and will pursue strategies to elevate issues as appropriate.

Activity	Target Date	Status	Notes	Action item
Obtain list of key policy issues from each hub.	Nov 1, 2017	North:	To be discussed at first convening on 10/4.	
		South:	To be discussed at BHC meeting in Sept and at leadership meeting.	◻ Winslow to query BHCs at Sept meeting.
		East:	To be discussed at first convening.	
Discuss list at Nov meeting.	Dec 1, 2017		Identify key policy issues to elevate to state/payer level and provide TA as appropriate.	
Identify policy agenda.				

Goal 5: Educate specialty behavioral health providers on integrated care and provide resources to improve co-management environment.

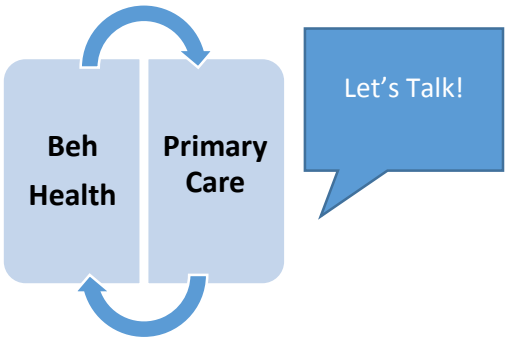
Strategy: The Idaho Integrated Behavioral Health Network with intentionally outreach specialty behavioral health to provide education on the integrated model and opportunities to collaborate with the integrated patient-centered medical home.

Activity	Target Date	Status	Notes	Action item
Develop slide deck for outreach.	Nov 1, 2017		Group to develop slide deck for outreach in each region highlighting basics of integration, myths about integration (emphasizing that this will not 'steal' patients), co-management strategies, PCMH background, and allowable information sharing.	☐ Gina to draft slide deck and send to group to review.
Present at all seven Optum provider network meetings.	Sept 1, 2018	Region 1 Region 2 Region 3 Region 4 Region 5 Region 6/7	Champions and subject matter experts from across the state with present the content in the aforementioned slide deck (45min presentation with time for questions). High performing co-management partners may be invited to participate.	☐ Bevin to send dates to IIBHN group members for scheduling purposes.

Let's Talk

Dos and Don'ts: Information Sharing Between Agencies

Co-Management in Behavioral Health and Primary Care



Frequently Asked Questions:

1. **What information can be disclosed between treatment providers without a patient/legal guardian's written authorization under HIPAA?**

   Any pertinent clinical care information, including mental health treatment information, can be disclosed and discussed between a patient's current treatment providers without written disclosure authorization except for the following two types of information: A) the content of written psychotherapy notes (see below), and B) substance abuse treatment records that are maintained by a licensed substance abuse program (42 USC § 290dd–2; 42 CFR 2.11). Substance abuse information obtained in other treatment settings may be communicated among a patient's treating providers without written consent.

2. **What constitutes psychotherapy note information that cannot be disclosed under HIPAA without a patient's explicit consent?**

   The HIPAA definition of a "psychotherapy note" is quite restrictive. A psychotherapy note per HIPAA can only consist of a mental health professional's written analysis of a conversation that occurred during a private counseling session that is maintained separately from the medical record. These written analyses serve as working process notes about sessions to

Dos and Don'ts

Do…

- Collaborate to provide good patient/client care
- Know the Privacy Rule
- Know the Minimum Necessary Rule
- Find out which other providers your patient/client is seeing

Don't…

- Assume that you cannot share information – Find Out
- Use non secured methods of communication (talk to your Privacy/Security Officer for more details)
- Confuse a psychotherapy note with a progress note

[INSERT YOUR LOGO HERE]

HIPAA References:
www.ama-assn.org
www.aap.org
www.hhs.gov

SOUTHWEST HEALTH COLLABORATIVE
Adams, Canyon, Gem, Owyhee, Payette and Washington Counties

Steps to Collaboration

1. Identify key partners:
    - *Who do you refer to most often?*
    - *Where can your patients consistently access good quality care?*
2. Gather data.
    - *How many patients do you send to this office?*
    - *How often is there a communication breakdown?*
3. Reach out.
    - *Contact the office manager and leadership to schedule a time to discuss co-management of patients. Come prepared to discuss what can be improved and the value add for staff and clients.*
4. Establish shared expectations for communication.
    - *Create MOUs or consistent workflows (who to contact, what information to share and when, etc).*

assist the therapist, and are not put into the medical record billing document. Anything which appears in the patient's medical record cannot be categorized as a psychotherapy note under the HIPAA rule. Specific content that has been listed as not falling under the "psychotherapy note" protections include medication management information, counseling session start and stop times, the type and frequency of treatment delivered, the results of clinical tests, diagnosis summaries, functional status, treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501.

3. Can treatment providers who work in separate care systems communicate with each other about a shared patient?

Yes. Treatment providers do not have to share the same employer or share the same electronic health record in order to disclose pertinent protected health information about a mutual patient without consent from the patient or parent. The key component for this HIPAA allowance is that both providers have a treatment or consultative role with that patient. (See also http://www.hhs.gov/ocr/hipaa). Whenever PHI is transmitted electronically (eg, telephone voice response, text messaging, faxback, or email, etc) it is covered by the Security Rule and must be made secure by measures such as encryption, secure platforms, or closed systems. Voice mail messages, telephone conversations, and paper-to-paper faxes are not subject to the Security Rule. All PHI (eg, in oral, electronic and written forms) fall under the Privacy Rule.

4. Does HIPAA allow for sharing treatment information via an electronic health record without written consent?

Yes, but there are additional regulations around the security standards needed for protecting electronic health records. Essentially, rules and procedures are required in the maintenance of an electronic health record to prevent their unauthorized access, alteration, deletion, and transmission. These security regulations for electronic records are outlined in the HIPAA security rule of 2005, and the HITECH act of 2009.

5. Are there any other regulations that conflict with HIPAA communication allowances?

Yes. Providers need to be aware that any state regulations that are more restrictive than the HIPAA rules will take precedence in those states, and so providers need to be aware of their own state's information regulations. If you are unfamiliar with your state's regulations, it will be important to specifically seek out your state department of health's privacy rules. To obtain information on current state laws, you may also contact the AAP Division of State Government Affairs at stgov@aap.org.

Also, clinical information obtained at a certified substance abuse treatment center is subject to additional federal privacy rules, which at this time do not allow provider to provider communication without formal consent.

This is an excerpt from the full AHRQ Health Literacy Universal Precautions Toolkit, Second Edition, available at http://www.ahrq.gov/literacy.

Make Action Plans — Tool 15

Overview

An action plan, created together by the patient and clinician, outlines one or more easy steps a patient can take to attain a health goal such as losing weight or improving self-management of a chronic condition. This tool will guide clinicians through the process of creating and using action plans in collaboration with their patients.

TIPS

Use action plans to help patients:

- Implement dietary changes
- Stop smoking
- Increase physical activity
- Reduce stress
- Improve sleep habits
- Take medicines correctly

Actions

Watch an action plan video.

- This 6-minute American College of Physicians Foundation Video shows three examples of patients and clinicians creating action plans for management of diabetes.

Create action plans with patients.

- **Ask permission to talk about health behaviors.** For example,
  - "Would it be OK if we talked about improving your blood sugar level?
  - "Would it be OK to talk a bit about your weight?"
- **Determine motivation.** Does the patient express the motivation to change? If patients do not show interest in making changes (i.e., a score of 5 or less), explore what barriers might stand in their way and what they see as possible benefits of changing their lifestyle.
- Have patients choose the goals. In order for the plan to be successful, the goal must be important to the patient, and he or she must be motivated to change. Ask patients, "What matters to you?" Have a list of goals to give patients ideas on what they could work on and help them decide on changes they are motivated to make.

- **Help patients break down goals into manageable steps.** Have patients pick one specific step they are likely to do. Steps should be small and realistic to do over a short time (e.g., 1 week).
- **Fill out an action plan form.** Use a form to outline exactly what the patient will do. The simple Action Plan Form in the Appendix can be modified to fit your needs. This visually appealing Action Plan Form from the University of California at San Francisco Center for Excellence in Primary Care is available in English and Spanish.

MY ACTION PLAN

DATE: _____

I_____and _____
have agreed that to improve my health I will:

1. Choose ONE of the activities below:

____Work on something that's bothering me:
_____

____Stay more physically active!

____Take my medications.

____Improve my food choices.

____Reduce my stress.

____Cut down on smoking.

2. Choose your confidence level:
How sure are you that you can do the action plan? (if < 7, then change plan)

10 VERY SURE
7 SURE
5 SOMEWHAT SURE
0 NOT SURE AT ALL

3. Fill in the details of your activity:

What:_____
_____
How much:_____
When:_____
How often:_____
Where:_____
With whom:_____
Start Date:_____
Follow-Up Date:_____
Best Way to Follow-Up: _____

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- **Assess confidence.** Assess the patient's confidence by asking, "On a scale of 1 to 10, how sure are you that you can follow this action plan?" Research shows that a confidence level of 7 or above increases the likelihood that the patient will carry out the plan. If they are not, the clinician and patient should explore ways to revise the plan so the patient feels more confident.
- **Identify barriers.** Ask the patient "What might stop you from following this action plan?" Problem solve about how to overcome barriers.
- **Make a copy of the action plan.** Give a copy to the patient and place a copy in the patient's medical record. If your practice has an EHR, determine how to standardize documentation, since there may be more than one place to capture action planning.

- **Follow up after the visit.** Followup lets patients know that you are interested in helping them achieve behavior change. Ideally, set up a time to follow up a week or two after the patient's visit. See Tool 6: Follow Up with Patients for more guidance.
  - If the goal wasn't met, help patients develop a plan that can be achieved.
  - If the goal was achieved, celebration and praise are in order. Work with patients to plan the next step. Each small step gets patients closer to the ultimate goal of improving their health-related behaviors.
  - Update the medical record to reflect the current plan the patient is following.

Track Your Progress

Have clinicians record in the medical record whether an action plan was created. After 1 or 2 weeks, identify the percentage of patients for whom an action plan was created. You may be able to look at all patients if you have EHRs. Otherwise, choose a sample of 20 patients seen in the last week. Check again in 2 months, 6 months, and 12 months to see if there has been an increase in that percentage.

Look at the records of 20 patients with action plans. See how many have notes on whether initial steps have been completed, additional steps have been added, and goals have been achieved. Repeat in 2 months, 6 months, and 12 months to see if there has been an increase in the percentage of patients with updated action plans.

Resources

Find more details about how to conduct action planning during a primary care visit in the following document: "Brief Action Planning to Facilitate Behavior Change and Support Patient Self-Management."

TIPS

- It can be tempting to make suggestions, but action plans need to come from the patients. Try having a menu of options (e.g., lists of exercises, foods to cut down on) that can give patients ideas for specific steps they can take. Healthfinder.gov has lots of suggestions for making healthy changes.
- Ask patients when they want to start. Having a concrete date sets patients in motion.
- Ask patients whose help they can enlist in completing their action plan. Support at home is an important determinant of success.

Terry Reilly Caldwell Clinic
Health Literacy Action Plan

This Action Plan to Improve Health Literacy is a set of health literacy priorities to be addressed by Terry Reilly Health Services (TRHS) Caldwell during calendar year 2018. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. As one of Southwest Idaho's principle organizations for protecting the health of its citizens, TRHS is a critical agent for improving health literacy.

Statement of the Problem:

Nine out of 10 adults may lack the skills needed to manage their health and prevent disease, according to the National Assessment of Adult Literacy. Limited health literacy has negative implications for health outcomes, health care quality, and health care costs. Additionally, limited English proficiency may contribute to and intensify the consequences of limited health literacy. At the Caldwell clinic, 26% of patients are best served in a language other than English.

TRHS Caldwell Clinic's Response:

The Caldwell clinic has begun efforts to assess the health literacy of its patient population and adjust individual care delivery for patients with basic and below basic health literacy. In addition to these interventions, the clinic will work to address the five following health literacy priorities in order to provide high quality, health literate care to all patients:

Priority 1: Raise Awareness of Staff

Objectives:

1. Educate all staff on the meaning of health literacy, its impact on health, and their role in providing health literate care to all patients.

Action Steps:

1. All staff complete Health Literacy Brief Assessment Quiz (see Appendix) at a care team meeting.
2. Provide health literacy tips/educational activities at all care team meetings in 2018, then quarterly. See resources in Appendices.
3. Post health literacy information and action prompts in locations visible to all staff quarterly.
4. Update Action Plan and check for new tools annually.
    a. Monica (office manager) and Terry (BHC) will work together to update. Bethany can assist with identifying new tools.

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Priority 2: Obtain Patient Feedback

Objectives:

1. Collect and review patient feedback on the spoken and written communication patients receive at the practice.
2. Use feedback to drive further action in improving health literate care.

Action Steps:

1. Collect patient feedback through surveys, shadowing, and interviews.
    a. Consider using AHRQ Brief Patient/Parent Feedback Forms (in Appendix).
    b. See Tool 17 in Appendix.
2. Share with practice staff at care team meeting.
3. Use to identify specific projects needed in priority areas as well as new priority areas if needed.
4. Develop ongoing system for monitoring patient feedback:
    a. Who will champion?
    b. When/how frequently will we get feedback?
    c. How will we get feedback?

Priority 3: Use Health Education Tools Effectively

Objectives:

1. Effectively use health education tools to improve the capability of patients to manage their health and chronic conditions.

Action Steps:

1. Incorporate hands-on teaching and practice tools (e.g. infant acetaminophen/ibuprofen oral syringe practice sets) into visits.
2. Use additional techniques when providing handouts and brochures (e.g. Circle/highlight info, use teach-back, refer to material during follow up visits and calls).
    a. See Tool 12 for suggestions and resources (in Appendix).
    b. All staff will receive training on improving usability of handouts.
        i. Who will provide the training?
        ii. How often will this be repeated?
3. Continue teaching patients how to use the portal.
    a. Ricardo, Terry, and the outreach team currently do this.

Priority 4: Connect Patients with Literacy and Math Resources

Objectives:

1. Connect interested patients with resources for enhancing literacy and math skills.

Action Steps:

1. Develop/update list of classes for literacy, math and English for speakers of other languages.
    a. Terry (BHC) will update the list at least annually, or more frequently if new resources identified.

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2. Develop process for referring patients (this priority will be addressed later in the year).
    a. See Tool 20 for suggestions and resources (in Appendix).

Priority 5: Health Literacy Assessment

Objectives:

1. Assess and document the health literacy level of all patients seen in medical.

Action Steps:

1. Expand OB health literacy assessment to parents of pediatric patients.
2. Implement assessment process for all adult patients in medical
    a. Determine preferred assessment tool or process in partnership with organization-level Health Literacy Workgroup.
3. Consider other patient populations (future focus):
    a. Behavioral health clients
    b. Adolescents
        i. Areas of special consideration: Medications, when to call the doctor, health behaviors, provider support.

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Appendix A – Links to Resources

Links to items referenced throughout the plan are provided below. Full text of some of the resources here as well as other resources without Internet links are in Appendix B.

Priority 1: Raise Awareness of Staff

Health Literacy Brief Assessment Quiz

Tool 3: Raise Awareness (Videos, slideshows, other resources)

TED talk (Video) – Are you confused about health information? You're not alone. ~Dr. Lisa

Video – Best of Dr. Lisa on the Street

MN Health Literacy Jargon Alerts (File of pictures to use, some examples included in Appendix B)

MN Crossword Puzzles (highlighting medical and insurance terminology and jargon, and their alternatives)

AHRQ Health Literacy Resources (expand Professional Education and Training section)

Priority 2: Obtain Patient Feedback

Tool 17: Get Patient Feedback

AHRQ Health Literacy Patient Survey

Priority 3: Use Health Education Tools Effectively

Tool 12: Use Health Education Material Effectively

Priority 4: Connect Patients with Literacy and Math Resources

Tool 20: Connect Patients with Literacy and Math Resources

Priority 5: Health Literacy Assessment

Boston University Health Literacy Tool Shed: A Database of Health Literacy Measures

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Appendix B – Resources (full text)

Priority 1: Raise Awareness of Staff

Plain Language Examples

Instead of…	Say…
Hypertension	High blood pressure
Modify	Change
Oral	By mouth
Contraception	Birth control
Mammogram	Breast x-ray
Optimal	Best way
Diet	What you eat
Bacteria	Germ
Benign	Not cancer
Bronchodilator	Medicine to help open up your lungs
Cardiologist	Heart doctor
Echocardiogram	Picture of your heart
MRI	Picture without the radiation of an x-ray
Stool	Poop

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Health Literacy Brief Assessment Quiz

We would like to get a sense of the knowledge and understanding you have about health literacy. Please complete this brief quiz that assesses some key facts about health literacy.

---

1. Limited health literacy is associated with:
   - ☐ A. Higher mortality rates
   - ☐ B. Lower levels of health knowledge
   - ☐ C. Greater use of inpatient and emergency department care
   - ☐ D. Poor medicine adherence
   - ☐ E. B and D
   - ☐ F. All of the above

2. You can tell how health literate a person is by knowing what grade he or she completed in school.
   - ☐ A. True
   - ☐ B. False

3. Which of the following skills are considered to be components of health literacy?
   - ☐ A. Ability to understand and use numbers
   - ☐ B. Reading skills
   - ☐ C. Speaking skills
   - ☐ D. Ability to understand what is said
   - ☐ E. Writing skills
   - ☐ F. All the above

4. Being anxious affects a person's ability to absorb, recall, and use health information effectively.
   - ☐ A. True
   - ☐ B. False

5. What is the average reading level of U.S. adults?
   - ☐ A. 4th-5th grade
   - ☐ B. 6th-7th grade
   - ☐ C. 8th-9th grade
   - ☐ D. 10th-11th grade
   - ☐ E. 12th grade

6. What is the grade level at which health-related information (like a diabetes brochure) is typically written?

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- ☐ A. 4th-5th grade
- ☐ B. 6th-7th grade
- ☐ C. 8th-9th grade
- ☐ D. 10th grade or higher
- ☐ E. 11th grade or higher
- ☐ F. 12th grade or higher
- ☐ G. college level

7. What is the best reading level for written materials used with patients?
   - ☐ A. 3rd-4th grade
   - ☐ B. 5th-6th grade
   - ☐ C. 7th-8th grade
   - ☐ D. 9th-10th grade
   - ☐ E. 11th-12th grade

8. To use good health literacy practices, staff and clinicians should use which of the following words/phrases when talking to or writing instructions for a patient or family member?

Circle the word/phase in either Option 1 or 2 in each row			
	Option 1	**OR**	**Option 2**
a.	Bad	OR	Adverse
b.	Hypertension	OR	High Blood Pressure
c.	Blood Glucose	OR	Blood Sugar
d.	You have the flu.	OR	Your flu test was positive.
e.	The cardiologist is Dr. Brown.	OR	The heart doctor is Dr. Brown.
f.	Your appointment is at 11:00 AM. Check in 20 minutes early.	OR	Arrive at 10:40 AM to check in.

9. It is a good health literacy practice to assume that each patient you communicate with has limited health literacy.
   - ☐ A. True
   - ☐ B. False

10. What strategies could all of us adopt to minimize barriers and misunderstanding for patients?

_____

_____

_____

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Health Literacy Brief Assessment Quiz

Answer Key

Question Number and Answers

1. F
2. B
3. F
4. A
5. C
6. D
7. B
8. a. Option 1 – Bad
   b. Option 2 – High Blood Pressure
   c. Option 2 – Blood Sugar
   d. Option 1 – You have the flu.
   e. Option 2 – The heart doctor is Dr. Brown.
   f. Option 2 – Arrive at 10:40 AM to check in.
9. A
10. Open-ended answer

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Health Literacy Bingo

Used a plain language word or phrase	Asked "What questions do you have?"	Used Teach Back
Used materials with pictures (or drew one), visual aids, etc.	Highlighted or circled important info on papers	Instead of an acronym or abbreviation, used a full word/phrase
Used Teach Back	Used a plain language word or phrase	Completed a communication self - assessment

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MN Health Literacy Jargon Alert
(see web link for more)

JARGON ALERT
Coinsurance

Say this instead...

amount you pay (a percentage) for health care services when you go to the doctor, clinic or hospital

JARGON ALERT
"Your test is positive"

Say this instead...

Your test shows you have...

JARGON ALERT
Formulary

Say this instead...

drug list

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Priority 2: Obtain Patient Feedback

Forms can also be found on O: drive in folder with Health Literacy Action Plan for better printing/copying quality.

Health Literacy Patient Visit Form

Information in shaded area are not entered into data system	
Patient Name:	Date of Birth (MM/DD/YYYY) ____/____/_____
Name of Provider for today's visit:	Date of Visit (MM/DD/YYYY) ____/____/_____

We would like your honest feedback. Please answer these questions about today's visit.

1. Did this provider seem to know the important information about your medical history?	Yes	No	
2. Did this provider explain things in a way that was easy to understand?	Yes	No	
3. Did this provider use medical words you did not understand?	Yes	No	
4. Did this provider show respect for what you had to say?	Yes	No	
5. Did this provider listen carefully to you?	Yes	No	
6. Did this provider encourage you to ask questions?	Yes	No	
7. Did you talk with this provider about any health problems or concerns? *If YES, please answer these two questions; if NO, answer N/A to Questions 7a and 7b and go to Question 8.*	Yes	No	
a. Did this provider give you easy to understand instructions about taking care of these health problems or concerns?	Yes	No	N/A
b. Did this provider ask you to describe how you are going to follow these instructions?	Yes	No	N/A
8. Do you take medicine regularly? *If YES, please answer these two questions; if NO, answer N/A to Questions 8a and 8b and go to Question 9.*	Yes	No	
a. Did you bring to this office all of your prescription medicines?	Yes	No	N/A
b. Did anyone in this office look at your medicine bottles AND talk with you about these medicines?	Yes	No	N/A
9. Were you given any written information today? *If YES, please answer Question 9a; if NO, go to Question 10.*	Yes	No	
a. Was the written information you were given easy to understand?	Yes	No	N/A
10. Did this provider help you set a personal goal to improve your health? *If YES, please answer Question 10a; if NO, go to Question 11.*	Yes	No	
a. Did you and your provider agree today on at least one action that you plan to take to meet one of your health goals?	Yes	No	N/A
11. Did this provider spend enough time with you?	Yes	No	

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Formulario de visita del paciente de conocimientos sobre salud **PATIENT FORM**

Información en el área sombreada es para uso de oficina solamente.	
Patient name:	Date of Birth (MM/DD/YYYY) ____/____/_____
Name of provider for today's visit:	Date of Visit (MM/DD/YYYY) ____/____/_____

Nos gustaría obtener sus sinceras opiniones. Por favor, conteste estas preguntas sobre la visita de hoy.

1. ¿Parecía que este profesional médico sabía la información importante acerca de su historia clínica?	Sí	No	
2. ¿Explicó este profesional médico las cosas de una manera fácil de entender?	Sí	No	
3. ¿Usó este profesional médico palabras médicas que usted no entendió?	Sí	No	
4. ¿Mostró este profesional médico respeto por lo que usted tenía que decir?	Sí	No	
5. ¿Le escuchó este profesional médico con atención a usted?	Sí	No	
6. ¿Le animó este profesional médico a hacer preguntas?	Sí	No	
7. ¿Habló usted con este profesional médico acerca de sus preocupaciones o problemas de salud? *Si la respuesta es sí, conteste estas preguntas. Si la respuesta es no, conteste N/A a preguntas 7a y 7b y pase al número 8.*	Sí	No	
a) ¿Le dio este profesional médico instrucciones fáciles de entender sobre cómo atender estos problemas o preocupaciones de salud?	Sí	No	N/A
b) ¿Le pidió este profesional médico que describa cómo va usted a seguir estas instrucciones?	Sí	No	N/A
8. ¿Toma usted medicina regularmente? *Si la respuesta es sí, conteste estas preguntas. Si la respuesta es no, pase al número 9.*	Sí	No	
a) ¿Trajo usted a esta oficina todos sus medicinas recetados?	Sí	No	N/A
b) ¿Revisó alguien de esta oficina los envases de las medicinas Y habló con usted acerca de sus medicinas?	Sí	No	N/A
9. ¿Le dieron información por escrito hoy? *Si la respuesta es sí, conteste esta pregunta. Si la respuesta es no, pase al número 10.*	Sí	No	
a) ¿Era fácil de entender la información escrita que le dieron?	Sí	No	N/A
10. ¿Este profesional médico lo ayudo con una meta personal para mejorar su salud? *Si la respuesta es sí, conteste esta pregunta. Si la respuesta es no, pase al número 11.*	Sí	No	
a) ¿Se pusieron de acuerdo hoy usted y su profesional médico por lo menos en una acción que usted planea tomar para alcanzar una de sus metas de salud?	Sí	No	N/A
11. ¿Pasó este profesional médico suficiente tiempo con usted?	Sí	No	

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Health Literacy Parent Visit Form

Information in shaded area are not entered into data system	
Patient Name:	Date of Birth (MM/DD/YYYY) ____/____/_____
Name of Provider for today's visit:	Date of Visit (MM/DD/YYYY) ____/____/_____

We would like your honest feedback. Please answer these questions about today's visit.

1. Did this provider seem to know the important information about your child's medical history?	Yes	No	
2. Did this provider explain things in a way that was easy to understand?	Yes	No	
3. Did this provider use medical words you did not understand?	Yes	No	
4. Did this provider show respect for what you had to say?	Yes	No	
5. Did this provider listen carefully to you?	Yes	No	
6. Did this provider encourage you to ask questions?	Yes	No	
7. Did you talk with this provider about any of your child's health problems or concerns? *If YES, please answer these two questions; if NO, answer N/A to Questions 7a and 7b and go to Question 8.*	Yes	No	
a. Did this provider give you easy to understand instructions about taking care of these health problems or concerns?	Yes	No	N/A
b. Did this provider ask you to describe how you are going to follow these instructions?	Yes	No	N/A
8. Does your child take medicine regularly? *If YES, please answer these two questions; if NO, answer N/A to Questions 8a and 8b and go to Question 9.*	Yes	No	
a. Did you bring to this office all of your child's prescription medicines?	Yes	No	N/A
b. Did anyone in this office look at your child's medicine bottles AND talk with you about these medicines?	Yes	No	N/A
9. Were you given any written information today? *If YES, please answer Question 9a; if NO, go to Question 10.*	Yes	No	
a. Was the written information you were given easy to understand?	Yes	No	N/A
10. Did this provider help you set a personal goal to improve your child's health? *If YES, please answer Question 10a; if NO, go to Question 11.*	Yes	No	
a. Did you and your provider agree today on at least one action that you or your child plan to take to meet one of your child's health goals?	Yes	No	N/A
11. Did this provider spend enough time with you?	Yes	No	

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Formulario de visita para padres sobre conocimientos acerca de la salud **PARENT FORM**

Información en el área sombreada es para uso de oficina solamente.	
Patient name::	Date of Birth (MM/DD/YYYY) ____/____/_____
Name of provider for today's visit:	Date of Visit (MM/DD/YYYY) ____/____/_____

Nos gustaría obtener sus sinceras opiniones. Por favor, conteste estas preguntas sobre la visita de hoy.

1. ¿Parecía que este profesional médico sabía la información importante acerca de la historia clínica de su hijo?	Sí	No	
2. ¿Explicó este profesional médico las cosas de una manera fácil de entender?	Sí	No	
3. ¿Usó este profesional médico palabras médicas que usted no entendió?	Sí	No	
4. ¿Mostró este profesional médico respeto por lo que usted tenía que decir?	Sí	No	
5. ¿Le escuchó este profesional médico con atención a usted?	Sí	No	
6. ¿Le animó este profesional médico a hacer preguntas?	Sí	No	
7. ¿Habló usted con este profesional médico acerca de problemas o dudas que usted tenía con respecto a la salud de su hijo? *Si la respuesta es sí, conteste estas preguntas. Si la respuesta es no, conteste N/A a preguntas 7a y 7b y pase al número 8.*	Sí	No	
a) ¿Le dio este profesional médico instrucciones fáciles de entender sobre cómo atender estos problemas o preocupaciones de salud?	Sí	No	N/A
b) ¿Le pidió este profesional médico que describa cómo va usted a seguir estas instrucciones?	Sí	No	N/A
8. ¿Toma su hijo medicina regularmente? *Si la respuesta es sí, conteste estas preguntas. Si la respuesta es no, pase al número 9.*	Sí	No	
a) ¿Trajo usted a esta oficina todos sus medicinas recetados?	Sí	No	N/A
b) ¿Revisó alguien de esta oficina los envases de las medicinas de su hijo Y habló con usted acerca de las medicinas?	Sí	No	N/A
9. ¿Le dieron información por escrito hoy? *Si la respuesta es sí, conteste esta pregunta. Si la respuesta es no, pase al número 10.*	Sí	No	
a) ¿Era fácil de entender la información escrita que le dieron?	Sí	No	N/A
10. ¿Este profesional médico lo ayudo con una meta personal para mejorar la salud de su hijo? *Si la respuesta es sí, conteste esta pregunta. Si la respuesta es no, pase al número 11.*	Sí	No	
a) ¿Se pusieron de acuerdo hoy usted y su profesional médico por lo menos en una acción que usted o su hijo planean tomar para alcanzar una de las metas de salud de su hijo?	Sí	No	N/A
11. ¿Pasó este profesional médico suficiente tiempo con usted?	Sí	No	

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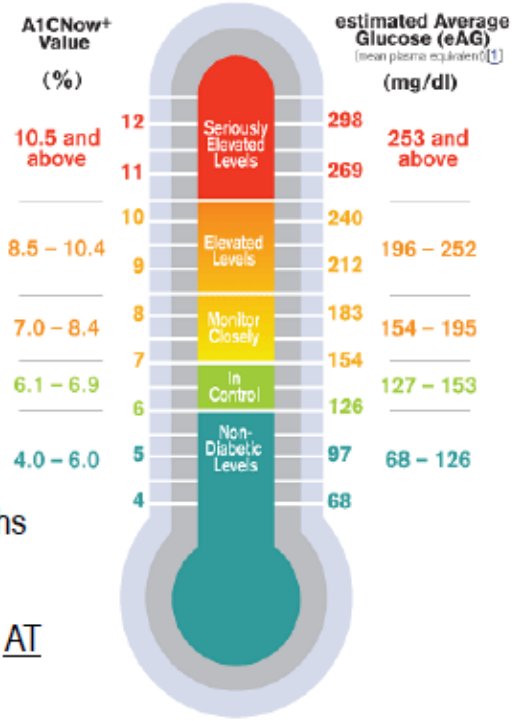
My Diabetes Goals

GOALS	
My Current HbA1c:_____	My Goal HbA1c:_____
My Current Blood Pressure:_____	My Goal Blood Pressure:_____
TWO Diet/Exercise changes I am willing to make: 1._____ 2._____	



- ❑ I need to have an appointment EVERY 3 months with my primary care provider
  - ❑ My Next Appointment is on_____ @ _____
- ❑ I must have my diabetes blood work completed AT LEAST 3 times per year
- ❑ I need a Diabetes eye exam 1 time per year
  - ❑ My next appointment is on _____@_____
- ❑ My next foot exam is _____

Important Diabetes Medicines I *NEED* to Take

	Helps Reduce my blood sugar
❑Aspirin ❑Statin	Helps prevent heart Disease
	Helps to lower blood pressure
	Helps Prevent Kidney disease
	When I miss my medicines it is because. . .

MetaQual
Change in Practice.

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Literacy, Math, and Language Resources

Organization	Education Offered	Cost	City	How to Get Started	Notes
College of Western Idaho Basic Skills Education	Math, Reading, Writing, Computer Skills	Free	Nampa	Go in person to CWI Community Learning Center 2407 Caldwell Blvd Nampa, ID 83651 Hours: Mon-Thur: 9a-7p, Fri: 9a-2p Phone: 208-562-2068	Day and evening classes.
College of Western Idaho ESL	English as a Second Language	Free	Nampa	Call to register: 208-562-2014	Day and evening classes.
Treasure Valley Community College	GED Prep	$25		Call to register: English- 541-881-5865 Spanish - 541-881-5866	Must attend an orientation first. Daytime classes (generally 9a-2:30pm).
Caldwell School District	English as a Second Language	Free	Caldwell	Contact Dalila Martinez at Caldwell School District. 208-455-3300 ext. 2288 dmartinez@caldwellschools.org	Classes run during the school year. For parents.
Karcher Church of the Nazarene	English as a Second Language	$25 Scholarships Available	Nampa	E-mail or call Pastor Oscar Diaz. Odiaz@nnu.edu (208) 918-9319	Childcare provided.
Literacy Learning Lab	GED, English, Reading, Writing, Math, ELL,	Sliding scale and scholarships	Garden City	Call to register: 208-344-1335, ext 110 or	Classes are held in various locations

	Citizenship, Adult Literacy			www.learninglabinc.org	
Nampa Library	Citizenship classes	Free	Nampa	Call to pre-register: 208-466-9926 or https://ccidaho.org/	Paid for by Catholic Charities 10 week series of classes
International Rescue Committee	Citizenship classes			Contact: Gabriela.Nix@Rescue.net	

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HEALTHY MINDS
PARTNERSHIP ROADMAP

A guide for schools looking to increase access to specialty behavioral health services for students and families.

THANK YOU

Thank you to the following agencies for helping develop this report:

LIFEWAYS HELPING PEOPLE

NAMPA SCHOOL DISTRICT

Pathways℠

St Luke's®

SOUTHWEST HEALTH COLLABORATIVE

TERRY REILLY
Your Health. Our Mission.

Support for this report provided by:

Blue Cross of Idaho
Foundation for Health, Inc.

EXECUTIVE SUMMARY

Purpose

The purpose of this document and supporting materials is to help communities across Idaho jump start partnerships between schools and specialty behavioral health providers to increase access to services. We have taken lessons learned from several school partnerships in the Treasure Valley and have done our best to share candid observations, tips/tricks, and helpful resources from our work. Our hope is that your community can take this information to meet the needs of your students and families.

Partnership

This guide is designed to highlight opportunities to partner between schools and specialty behavioral health providers. We recognize that there are many other types of partnerships that can help address provider shortage and access issues in behavioral health. We have decided to shine a spotlight on this approach as we push further upstream to give people the tools to cope with mental health and substance use issues earlier in their lives.

We cannot emphasize the value of partnership and collaboration enough. As you read and work through this roadmap, please consider your partners and how we can all do better in serving the needs of students and families by working together.

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BACKGROUND

The Need

You probably don't have to go much further than a school administrator or counselor's office to understand that there is an access issue for youth behavioral health clinical services. We know that so many schools are stretched too thin by trying to manage the crisis and ongoing support needs of students, not to mention the related impact on performance, behavioral disruptions, and family life. It is also clear that the entire state of Idaho struggles to meet the mental health and substance use treatment needs of communities. In fact, the entire state is considered a shortage area for behavioral health providers. With the stress on schools, the lack of appointments for external agencies, and transportation issues for students, it is no wonder that many children and young adults go without the specialty behavioral health services that they desperately need.

On the other hand, students who do access specialty behavioral health services may have to be pulled out of school for a half-day each week while their parents must miss work or other obligations to take them to appointments. Neither situation is ideal and points to the need for new and innovative solutions.

The Process

In the Fall of 2016, the Behavioral Health Integration Workgroup of the Southwest Health Collaborative began exploring opportunities to increase access to behavioral health services for children and youth. Inspired by innovative partnerships in the area, with an emphasis on a novel program developed by Terry Reilly Health Services for the Caldwell School District, the group sought to assist additional local schools in program development and evaluation to document the process for other schools across the state. This included everything from interviews with key program personnel to meeting observations to review of documents generated through the partnership.

The Result

The information captured from this work has been distilled into the **Healthy Minds Partnership Roadmap.**

It is a roadmap for you and your community to work together to address the needs of students. Please note that this will not replace your obligation for services identified in an IEP, but based on our work with various schools, this option can be a crucial tool in your work to enhance the lives of students and staff by supporting their intellectual and behavioral growth and health.

QUICK REFERENCE GUIDE

We know that health does not just happen in a doctor's office and that one of today's biggest concerns is youth behavioral health. In fact, many teachers, counselors and school staff report that today's students display symptoms of mental, behavioral, and developmental disorders. To provide better care for students and improve health outcomes, the **Healthy Minds Partnership Roadmap** provides details to help schools/school districts build partnerships with specialty behavioral health providers to meet students where they are and not just in a doctor's office.

KEY COMPONENTS OF A SUCCESSFUL SCHOOL – SPECIALTY BEHAVIORAL HEALTH PROVIDER PARTNERSHIP:

- Commit school leadership time to develop the partnership
- Pick the right specialty behavioral health provider/agency as a partner
- Talk through details early and often (space, resources, technology, referrals, communication flow, consent to treat, etc.)
- Set clear expectations for the specialty behavioral health provider about their role as a service provider in a school setting
- Schedule regular meetings between leadership and specialty behavioral health provider to coordinate care of students

The table on the following page acts as a quick reference to help your school/ school district develop key partnerships to improve the health outcomes of students.

***Refer to the complete HEALTHY MINDS PARTNERSHIP ROADMAP for more information on each step.**

TIMELINE	ACTIVITY	KEY STAKEHOLDERS	ACTION ITEMS
6 months before services are to be implemented	**READINESS** Determining where to begin: • Asking key questions • Establishing a time frame	• **School lead**	• **Complete "Readiness Worksheet for School Teams"** to review availability and support of key staff at the school and district level
4 months before services are to be implemented	**PLANNING** • Picking your specialty behavioral health provider partner	• **School lead** • **School counselors** • **School administration** • **Specialty behavioral health provider**	• **Review the differences** between various types of providers • **Conduct interviews** with specialty behavioral health providers • **Plan to meet monthly** with the specialty behavioral health provider team to co-design the program
3 months before services are to be implemented	**WORKING TOGETHER FOR STUDENTS** • Developing agreements • Establishing workflows • Working through logistics such as summer coverage, staffing, and communication	• **School lead** • **School counselors** • **School administration** • **Specialty behavioral health provider**	• **Develop Memorandum of Understanding** • **Create clear workflows** for successful partnership • **Determine youth behavioral health provider access** to school space and resources • **Set expectations** for crisis situations • **Create schedule** for students to see provider • **Develop a consent packet/paperwork** • **Discuss how students are identified** for services • **Plan a weekly "huddle"** • **Discuss how to access and leverage data** • **Develop and share a communication guide**
2 months before services are to be implemented	**SPECIALTY BEHAVIORAL HEALTH CONSIDERATIONS** • Reimbursement • Collaboration • Documentation • Staffing	• **School lead** • **School counselors** • **School administration** • **Specialty behavioral health provider**	• **Determine billing flow** at the beginning • **Establish expectations** regarding consent and referral routing • **Refine details** around space, technology, office equipment, and referrals • **Consider saving 5-10% of youth behavioral health provider time** to deliver pro-bono services
Meet **2-3 times per semester** in the first year	**EVALUATION** • Tracking your data	• **School lead** • **Specialty behavioral health provider**	• **Review metrics** for program evaluation regularly • **Communicate** about what is going well and what can be improved at regular intervals

READINESS

Key Questions

We know that youth behavioral health is a priority for many schools and communities across Idaho. However, before embarking on a journey to create a partnership with behavioral health, there are several key questions that you must address with your leadership and staff. Please take time to think about the questions/issues below. The appendix includes a worksheet to aid in the initial planning discussions *(Appendix A: Readiness Worksheet).*

"One of our students had avoided school regardless of the supports that were put into place. This year [with specialty behavioral health services], his attendance has improved significantly. The referrals for behavior are of a different nature also. In the past, the issues were of disrespect and outward behavior toward other students. Now they are about work avoidance. Increased attendance and more appropriate behavior are steps in the right direction."

— LOCAL MIDDLE SCHOOL PRINCIPAL

DO YOU HAVE SUPPORT FROM YOUR SCHOOL DISTRICT LEADERSHIP, SCHOOL LEADERSHIP, AND COUNSELING PROGRAMS?

Before introducing behavioral health services in a school setting, carefully consider the impact on the schools and have several conversations about roles, responsibilities, and any potential feelings of being displaced. This allows school counselors to be part of the planning process and consider the support needed to better serve students. In addition, establishing a partnership requires close coordination and collaboration between both district administrators and school leadership (deans, principals, etc). Consequently, it is crucial that school counselors, district administration, and school leadership are "on board."

DO YOU HAVE THE SPACE TO HOST A PROVIDER?

This may seem like it is too much detail early in the process, but it can be a major stumbling block later. A provider needs a private space to see students and clients that is quiet but also not completely isolated from other staff for safety and liability issues. This means that administrative offices, repurposed classrooms, or converted library offices may be good fits. Stand-alone mobiles or outbuildings without regular traffic from the school are not good options.

WHAT IS THE ANTICIPATED SERVICE VOLUME?

When you start working with your behavioral health partners, you want to have a sense of how many hours/staff you'll need from them. In our experience, services tend to fill up quickly. We've detailed examples for full caseloads/staffing below:

- Elementary school (Spring 2017): 1 FTE social worker took one month to get to full caseload in a school of 500
- High school (Fall 2018): 1 FTE social worker took about three weeks to get to a full caseload in a school of 1,400

WHO ON YOUR TEAM WILL BE THE LEAD? WHO ELSE NEEDS TO BE ON YOUR CORE PLANNING TEAM?

It is important to identify a primary contact who will help manage logistics, scheduling, and be the "point person" as questions arise. This lead will interface with the program manager from the behavioral health agency. If you are looking to pilot and then expand to other schools, it may be ideal to identify someone with a district level position (counseling director, executive director, etc). However, a principal or school counselor may be a good option if they have the bandwidth to assist in transition to other schools.

DO YOU WANT TO FOCUS ON STUDENTS OR THE BROADER COMMUNITY?

You can consider adding on-site services for students exclusively or expanding specialty behavioral health services access to families or community members. Communities where there may be limited behavioral health services in general may benefit from expanding access, but you will then need to consider student safety and security.

Time Frames

You can implement any time. Some schools have chosen to use the start of the school year as their service start, while others have started mid-year. Regardless of when you choose to start, if your school district is new to this work, give yourself **4-6 months** to plan. That may seem like a lot of time, but we know that you have many other responsibilities and navigating this new terrain can take some time.

FALL START	MID-YEAR START
+ More time over the summer to meet/test workflows	+ Ability to test/see space while school is in session
+ Good access to parents and students at registration	+ School staff are not off for the summer during planning
− Busy start of the school year means referrals may not pick up as fast	− More difficult to plan/make time during normal school operations
− Not all relevant project staff may be available over the summer to provide assistance	− Potentially less access to parents

PLANNING

Picking Your Behavioral Health Partner

Depending on the size of your community, there may be many local specialty behavioral health providers... or just a handful. It is possible that you have an individual or agency in mind that you would like to work with, however we recommend interviewing several providers and/or agencies if at all possible. An example of a request for applications is included in the appendix *(Appendix B: "Request for Applications" Announcement).* You can customize these based on your school district's needs. The announcement requesting a specialty behavioral health provider at school can be distributed through your local behavioral health boards or counselor referral channels.

THE INTERVIEWS

At minimum, a practice administrator (program manager, clinic manager, etc.) should attend the interview. They will be able to answer questions about logistics, billing, agreements, timeline, etc. If the behavioral health agency has someone in mind for the clinician role, it is ideal to have that person attend the interview as well. However, many agencies will need to hire someone to fill the position. If you have a staff member or someone else that you think would be a good fit, please make recommendations. One school that we worked with made a hiring recommendation to their partnering agency and it has been a perfect match.

Consider who you would like to have from your team at your interviews. Plan to include the program lead and at least one representative from the school(s) where the services will be introduced. This may be a counselor, dean, or principal.

Ask questions about capacity to add services, timelines, and performance expectations. To streamline the process, make sure that this is a good fit up front. You may also want to have a discussion about the provider's capacity to provide pro-bono or reduced fee services. Sample interview questions are included in the appendix *(Appendix C: Interview Questions).*

DIFFERENT TYPES OF PROVIDERS

Federally Qualified Health Centers

Key Features FQHCs are comprehensive clinics that have special state and federal recognition. FQHCs have a unique role in their local neighborhoods. They are tasked with serving underserved populations.

This is most evidently reflected in their reimbursement model and their staffing models. The reimbursement model makes it easier to have increased availability while a program is building. The staffing model makes it easier to provide culturally appropriate services to

diverse populations. They are eligible for grants and other awards which can provide alternative funding options.

Private Specialty Behavioral Health Agencies

Private specialty behavioral health agencies, including both non-profit and for-profit organizations, typically deliver mental health and substance use services in a community. These may be large agencies with a regional or statewide presence or smaller, more local companies.

Key Features Private for-profit or non-profit agencies are businesses that provide various amounts of specialty behavioral health services. They can be very large with lots of locations and staff or small with one office and just a few staff.

For-Profit Agencies can often more quickly staff up or respond to opportunities as their owner(s) can quickly make decisions. They have reimbursement arrangements that pay when a service is provided. This can allow for a quick increase in staff when needed but can reduce their availability when a service program is just starting.

Not-for-Profit Agencies operate from a community mission perspective. They are eligible for grants and other awards, which can provide alternative funding options. They have reimbursement arrangements that pay when a service is provided. This can allow for a quick increase in staff when needed but can reduce their availability when a service program is just starting.

Yes... Another Meeting

We would recommend meeting at least once a month for four months before implementing the services. A monthly in-person meeting is in addition to site visits to the schools, interviews, and frequent email communication. The monthly meeting will allow you and your behavioral health partner to co-design your program, develop rapport and comfort between school staff (administrators and counselors) and the behavioral health provider, and address issues that may arise. Also, depending on your district or your partner agency's process for routing and review of business agreements, it may take nearly that long to put something in place.

WHO TO INCLUDE

For the most part, include the same people in your meetings as you did in your initial planning:

- School counselors
- School administrators
- District administrators (as needed)
  **Some district level staff want to be involved in planning meetings and others may not. Do what feels comfortable to you and your group.*

From the behavioral health agency, plan to include:

- The behavioral health provider that will be working at the school
- An administrator or program manager that will be supervising program implementation

Ensure that someone in leadership from both agencies — with the ability to make decisions — joins for the first few meetings. This will allow you to be more active and flexible instead of waiting to check with supervisors to make changes.

Lastly, if there is anyone in neighboring communities that has done similar work before, try to have them join you for the first meeting or two. You will likely save yourself some time with their direction and experience.

WORKING TOGETHER FOR STUDENTS

Agreements

Both the school and the behavioral health agency rely on each other for close coordination and collaboration. An agreement will help you better understand expectations for your relationship as you move forward. An example of a memorandum of understanding is provided in the appendix *(Appendix D: Memorandum of Understanding).* These agreements should cover the following areas:

- Information exchange
- Space agreement
- Performance measures (if any)
- Crisis services for students
- Responsibilities for obtaining consent and completing necessary paperwork
- Any pro-bono or in-kind services
- Technology or security requirements
- Review timelines

Workflows

The school team and the behavioral health team will be working together very closely. This is especially true for the school counselor, the specialty behavioral health provider, and any school administrators who manage behavioral issues. Being clear about how you want workflows to go will make the partnership much better. A workflow example is provided in the appendix *(Appendix E: Workflow).*

Don't just form the partnership and expect services to fall into place. While building these workflows should be intentional, be flexible and communicate about what needs to change to better serve students. It may be worth developing a procedure manual as the services expand to more schools in your community or as your site is established to make sure that there is consistency and continuity.

ACCESS TO BUILDING AND SERVICES

It is important to work together to identify what type of access the behavioral health provider will have to the school space. This will dictate service hours and ability of the clinician to manage contact hours. It should also be clear whether the clinician will be treated as a part of the school team. Does he or she have a school badge? Is he or she on the school email distribution list for important announcements? Is he or she included in staff trainings or school events like pep rallies? Who does the provider notify when they are sick and will not be coming in?

CRISIS SITUATIONS

Be clear on what you expect the specialty behavioral health provider, the school counselor, and the administration to do in the case of a crisis. This includes suicidal ideation, violence, and abuse (both on campus and off campus, outside of school day, etc). We know that these can be incredibly high stress situations for everyone involved. Talking about them ahead of time will help everyone know their role. Understand that a specialty behavioral health provider from an outside agency may have different expectations of what they should do in these situations. This may or may not work for your team. Talk about it and work together to maximize your resources to better assist the student in need.

INCLUDING GUARDIANS AND FAMILY

Schools and behavioral health agencies understand that while working with children and young adults, you also must engage guardians and family. However, not being clear on who manages communication, outreach, and engagement with a student's support system could cause confusion due to over or under communication. Make sure you talk about who calls home in what situations, and what information gets shared when families are involved in student treatment and support.

PULLING STUDENTS OUT OF CLASS

You will want to talk about your staff's preference for scheduling student specialty behavioral health services. Should appointment times be shifted so that students are not missing the same class in middle and high schools? Should you schedule the same appointment time each week for consistency for the student? You may want to include teachers in this discussion as well as any support staff that may be running hall passes. They may have important insights into the logistics of pulling a student out of class and instructional needs for the students you serve.

"We have made a decision that services make such a significant difference for our students that they take priority. Our clinician works to vary which classes students are pulled from weekly. The intent is not to pull from the same classes routinely."

— LOCAL MIDDLE SCHOOL PRINCIPAL

GETTING CONSENT TO TREAT

When you do identify a student who needs services, it is important to discuss what documentation your specialty behavioral health provider may need to begin treatment. Releases for treatment and consents will need to be signed by the guardian. Be clear about who is primarily responsible for getting this paperwork to the guardian and following up. An example consent packet and referral workflow are included in the appendix *(Appendix F: Consent Packet and Appendix E: Workflow).*

REFERRALS

Talk with your team about how students are identified for specialty behavioral health services. Who should be making referrals from the school team? Will you accept outside referrals (e.g. from a primary care provider)?

Talk to the specialty behavioral health provider/agency about what they need from your team to appropriately engage the student to start. What about other students who are already seen by the provider or will be in the future? Review the list of different types of referrals below and discuss how you will manage each:

1. **Medical Providers:** One community has started distributing a contact list for partnerships in their area to local pediatric and family practice clinics. This way, if they see a child who needs behavioral health support, they can call the right person at the agency to get them connected to services. An example contact list is included in the appendix *(Appendix G: Pediatric Referral Sheet).*
2. **School Referrals:** Administrators, school counselors and school social workers identify students who would likely benefit from specialty behavioral health services. Oftentimes, that referral starts with teacher concerns. Once identified, the school administrator, school counselor or social worker talks with the student to determine if they are interested in the services. Parent contact is made prior to sending an information packet home with the student so the parent is not caught off-guard by the paperwork.

3. **Self-referrals:** As the word gets out, you may receive emails from students or notes asking if they can be seen by the specialty behavioral health provider. Some students are 18 years old and able to sign the consent for treatment on their own, so the school counselor or social worker can help them complete the paperwork. If the student is a minor and seeking self-referral, the need for consent from guardians is discussed.

Be sure to discuss the best way to communicate with the student when a referral is made so that they understand the connection.

ASSESSING NEEDS

Student support needs may shift over time, whether that is week-to-week or month-to-month. Think about how you will provide opportunities for your school counselor and the specialty behavioral health provider to coordinate around students who may need to be seen right away, those who are doing better, or when families may need to get involved. One successful model has been to plan a weekly "huddle" between the school counselor and specialty behavioral health provider to review the caseload and look for any opportunities to enhance appropriate access to services for students.

SCHOOL DATA FOR TREATMENT

Think about how you can work with a specialty behavioral health provider to get permission to share disciplinary, attendance and academic performance data to help better understand students' goals and needs. You could generate a release for guardians to voluntarily sign or allow the students to voluntarily share their progress. Engagement with the school may be one of the targets for specialty behavioral health providers to indicate how students are doing. With this information, the behavioral health provider may be better able to align goals for the school, student, and family.

Summertime

Come up with a plan for summer as early as possible. Just because students are on break it does not mean that their behavioral health needs are also on break. Whether it is working in a summer school site, setting up transportation, or designing other creative solutions to connect students to the specialty behavioral health services, make sure you talk about how to work together over the summer. This will likely mean different solutions for elementary, middle, and high school levels. Don't just think about resources with the school or behavioral health provider, look to community resources to come up with a plan.

For example, some schools may work with the summer school program to host group therapy sessions or accommodate individual therapy. Other schools may opt to work with specialty behavioral health providers to schedule transportation through Medicaid or another funding source. In Idaho, Medicaid provides non-emergency medical transport to help patients get to their appointments. Finally, this may be the perfect time to engage with parents by hosting family sessions or group parenting classes while students are also receiving services. This helps overcome the transportation barrier and helps connect with the family as a whole.

"Through this partnership, we have seen a young lady establish a positive relationship with an adult on our campus. This has allowed her a voice that she had not had prior. Her grades have gone from all failing to passing. She is utilizing the clinician to work with administration to support her. The turnaround has been significant."

— LOCAL MIDDLE SCHOOL PRINCIPAL

Staffing Coverage

Your team and students will hopefully develop a very close relationship with the behavioral health provider. This is the goal of fostering this partnership, but it can mean that there is a vacuum when the specialty behavioral health provider is not there either short-term or long-term. Come up with an agreement with the specialty behavioral health provider for coverage and communication to students when the provider is out. This includes sick time and vacation as well as vacancies in the position. Continuity of services is essential for students, so make a plan that ensures support of the specialty youth behavioral health provider.

Communication

We recommend developing a communication guide for everyone's reference. In the partnership between schools and specialty behavioral health providers, it may be challenging to know who to contact if an issue arises or if you have a question, especially if you have multiple contacts for administrative issues, clinical issues, and referrals.

Example:

FOR QUESTIONS ABOUT...	CONTACT
School facility issues	Name, phone number, e-mail & work hours
Coordinating the provider's schedules	Name, phone number, e-mail & work hours
New referrals	Name, phone number, e-mail & work hours
Behavioral health program administration	Name, phone number, e-mail & work hours
School program administration	Name, phone number, e-mail & work hours
School counselor contact	Name, phone number, e-mail & work hours
Behavioral health provider contact	Name, phone number, e-mail & work hours

INFORMATION FOR SPECIALTY BEHAVIORAL HEALTH PROVIDERS

Reimbursement

At new service locations, it is difficult — even impossible — to deliver sustainable services if you can't get paid. The good news is that most payers are reimbursing for the specialty behavioral health services provided to students just like they would any other treatment for which you would expect to be paid. Consider reaching out to Optum, Blue Cross of Idaho, Select Health and others to let them know what you are doing. Thus far in the pilot, specialty behavioral health providers have had success in getting paid. It is important to note these services are not school based, but a partnership between schools and external providers to enhance access to care.

Collaboration

It is important to think about the partnership between the specialty behavioral health provider and school as not just another satellite site, but a daily coordination and collaboration between agencies. This means that you and your staff will need to dedicate time and energy to working together with the school. In early planning, allocate at least 10 hours a month to develop the partnership and work out logistics (more time if hiring a new clinician). Soon, you should be able to scale back program administration time (unless your service sites are rapidly expanding) to about 4-5 hours per month per school. Also note that the provider on your team will need time to coordinate with the school as he or she works to navigate school schedules, new referrals, crisis services, and communication with families. Remember that you can use collateral contact opportunities to help support this work. Finally, our school partners have told us that it is important to have the specialty behavioral health provider be a true part of the school team, whether that is dressing up on spirit days or being on the school-wide email list. Budget time for your staff member to attend staff trainings at the school, presentations, and other school events. This will help the provider to become a part of the school team.

Documentation

Your specialty behavioral health providers and agencies are savvy to documentation and rules and regulations, so we won't go through every piece of paper that needs to be signed. However, we will highlight two components that are slightly different than the typical work you do.

CONSENT TO TREAT

Parents or guardians will typically be present for the first appointment when you see students. However, in the schools setting, this may not be true. Think through how you will involve the parents or guardians.

You will need to develop a consent packet for the school to give to guardians or students to complete. In our experience, the school has managed following up on this and has tracked completion. However, it is crucial that you still have the appropriate consents on file to provide services *(Appendix F: Consent Packet).*

UNACCOMPANIED YOUTH

One significant challenge we have faced in getting students who are most vulnerable into specialty behavioral health services at the school is that of managing consent for unaccompanied youth. Children and adolescents who are unaccompanied may be among those who most need support, but there are clear laws and provisions that dictate the conditions necessary for the treatment of youth. Refer to the resources below and to your organization's HIPAA officer for more details. Talk with your payers and local policy makers about how to solve this problem.

Communicating with a Patient's Friends, Family, or Others Involved in a Patient's Care
(www.hhs.gov/sites/default/files/provider_ffg.pdf)

Consent for Treatment of Minors in Idaho
(www.hollandhart.com/consent-for-treatment-of-minors-in-idaho)

HIPAA and Disclosure to Family Members and Others Involved in the Patient's Care
(www.hollandhart.com/hipaa-and-disclosure-to-family-members)

Key Questions for Your School Partner

SPACE

Specialty behavioral health providers are accustomed to having quiet, comfortable office spaces that are conducive to a treatment environment. Make sure that you are clear with your school partner about the type of space your team needs. Many schools may be tight on space and it is important that you work together to identify a good option for everyone. Some districts rely on mobile units to expand capacity. Be clear if you do consider this option available, your specialty behavioral health provider should not be the only one in the mobile.

To consider: Noise during passing periods, if parents/guardians are coming to appointments and how to accommodate, privacy for student in accessing the space, safety and support if there is a crisis.

TECHNOLOGY

Work closely with the IT manager for the school district to discuss network access and technology needs. The specialty behavioral health provider will need to have good access to documentation and billing systems, especially if the specialty behavioral health provider is on-site more than 0.5 FTE. Make sure that the network security requirements meet the standards of your organization.

To consider: Mobile technology, landlines versus mobile phones for contact, secure printing if needed.

OFFICE EQUIPMENT/SUPPLIES

The specialty behavioral health provider will be working out of another site's space and may need to use their supplies and resources, from paper to furniture. Talk about this ahead of time to avoid conflicts over resources. Be clear about which organization is responsible for providing what.

To consider: Desks and chairs, printing, office supplies.

REFERRALS (INTERNAL AND EXTERNAL)

Your organization is accustomed to seeing clients from a variety of referral sources. However, the school may want to limit on-site clients to only

the students that they send to you. Talk about who you will see and how they will be referred. We have found that local pediatricians have been interested in referring directly to on-site specialty behavioral health providers (see Appendix G for an example of a contact page distributed to local primary care providers). Talk about who you will see and where referrals will be coming from.

To consider: Who else in the community may refer? Do you want to advertise or otherwise promote the services?

The Right Fit for Clinicians

In our experience, specialty behavioral health providers who like to work with children and families are very excited about the opportunity to fill this position. However, behavioral health organizations have also said that fit is absolutely crucial.

Some of the features that make clinicians a good fit in this program:

- **Highly independent:** Instead of working in your offices with colleagues and a supervisor, this clinician will be off-site for the majority of their work time.
- **Self-driven:** Again, this clinician will be working off-site with major demands being made on them to collaborate, innovate, and deliver high quality services for students and their families. The clinician in this position should be very motivated and driven to serve children and young adults.
- **Good problem solvers:** This is a highly dynamic practice environment involving more moving pieces (school rules, peer dynamics, school resource officers, changing schedules) than a typical office.
- **Collaborative:** Because there are multiple partners working together to get students to the right place, coordinating with teachers, administrators, school counselors and social workers, parents, and school resource officers is crucial.

If your agency is considering hiring a new provider, ask the school if they have anyone they would recommend. They might have someone in mind who is interested in transitioning into this work.

Pro-Bono or Sliding Scale

Many students and families struggle to pay for specialty behavioral health services whether or not they have coverage. It is important to communicate how you can accommodate families of various means, as well as to be clear with the school regarding how you can help students who do not have a very high deductible plan or may be age 18 without Medicaid. Do not count on all students being able to pay through insurance coverage — many are in situations that make cost a barrier. Consider saving 5-10% of slots for pro-bono services or developing a special fee schedule to support students and families.

EVALUATION

Tracking Your Data

For the purposes of this work, this data set has been compiled to help better understand the impact of provisioning behavioral health services in school settings.

DATA ELEMENT	DESCRIPTION	PARTY RESPONSIBLE
Behavioral disruptions	Reports of behavioral issues tracked by school (disciplinary actions, suspensions, etc.)	School
Academic performance	Academic performance measure for student in year prior to treatment (if available) and for year during treatment	School
Staff satisfaction	Qualitative and quantitative report of staff satisfaction (counselors, administrators, teachers, specialty behavioral health providers) should be obtained and reviewed regularly	School & specialty behavioral health agency
Clinical outcome data	Aggregate reports of student functioning on a standard measure (PH-9, GAD7, etc.) can be tracked over time to monitor improvements	Specialty behavioral health agency
Requests for appointments and capacity	Ability of students to access appointments should be tracked and monitored by both the school and the specialty behavioral health provider	School & specialty behavioral health agency

You may choose to track this data as you work to implement and maintain your program. It is not required and can certainly be modified. However, we highly encourage you to monitor impact on students, access to services, and staff satisfaction in one way or another. This will help your team make adjustments as needed to better serve students, staff, and families. Finally, the data may be used in the future to identify funding sources and grant opportunities.

READINESS WORKSHEET

Who is on our support team? Is there anyone not involved who should be?

Who is our team lead?

Do we want to provide services focused on students or the broader community?

How many students/clients do we think will need services?

Do we have space to host a specialty behavioral health provider?

What is our goal for implementation of services (time)?

How frequently should we meet as we plan?

"REQUEST FOR APPLICATIONS" ANNOUNCEMENT

Nampa School District Behavioral Health Partnership

The Nampa School District is working with the Southwest Health Collaborative, St. Luke's Foundation, and the Blue Cross of Idaho Foundation to enhance access to behavioral health services for students. We are in the process of identifying potential partner agencies in the community to help us provide services to our students.

Required Capabilities

Cultural Competence and Bilingual

The Nampa School District serves a diverse community of families and children. It is crucial that clinicians possess appropriate cultural competence and language abilities to serve Hispanic students and families.

Service Requirements

Clinicians will be expected to provide mental health and substance use services in both individual and group settings. Services will be open to students and families.

Service Location

Organizations will be expected to accommodate the provision of services both at the school and in the community/home.

Staffing

Approximately 1-2 FTEs are anticipated in the first year of activity.

Billing

Organizations will be expected to bill for services. The Southwest Health Collaborative will provide technical assistance as appropriate.

Schedule

Clinicians should anticipate working a flexible schedule to accommodate family services after work hours.

Important Information

The purpose of this project is to establish durable partnerships that are not tied to limited grant funds. Organizations should expect to be responsible for their own billing and staffing. The Nampa School District will assist by providing space and scheduling support.

Interviews

Interviews will be conducted by the Nampa School District 5/24-6/7. Contact NAME to schedule. We request that both the clinician and an operations director attend to help us assess fit and feasibility.

EMAIL

PHONE

INTERVIEW QUESTIONS

TOPIC	QUESTIONS
Capacity	• Will you be hiring on a new provider or shifting responsibilities for an existing provider? • How much provider time can you commit for our start date? • If we see an increased need for provider time, how much and how quickly could you scale up services in our school(s)? • If we decided to add additional schools, would you be able to add providers to meet their needs?
Timeline	• How quickly could you begin seeing students at our school(s)? • Would you be able to meet for at least one hour per month and be available by email to coordinate in advance of implementing services?
Billing	• Do you feel comfortable billing for services in this partnership?
Provider Match	• Do you anticipate that your provider would be full-time working with students? • What qualities would you look for to place a provider in this role? • (Conditional) Would the provider for this partnership speak Spanish?
Logistics	• What resources/supplies would your specialty behavioral health provider need to see students at the school(s)? • How do you envision partnering to manage referrals and obtaining consents to treat? • Could you dedicate staff time (not billing hours) to attending school events (registration, rallies, teacher work days)? • Who would be our lead contact in your organization? • Would you be willing to sign an MOU if you were selected as our partner agency?
Services	• Do you offer family services and CBRS? • How would you connect families to services through your partnership with our school?

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding

School District and Behavioral Health Agency

This Memorandum of Understanding is entered into on this day, July 31, 2017, by and between the following two entities:

1. SCHOOL DISTRICT
   ADDRESSS

2. BEHAVIORAL HEALTH AGENCY
   ADDRESSS

WHEREAS, SCHOOL DISTRICT and BEHAVIORAL HEALTH AGENCY are in agreement about the need to increase access to behavioral health services for at-risk youth.

NOW, THEREFORE, SCHOOL DISTRICT and BEHAVIORAL HEALTH AGENCY agree to the following:

This MOU is to serve as the operating agreement between both parties for the purpose of providing and coordinating behavioral health and prevention services to students.

BEHAVIORAL HEALTH AGENCY will follow all policy and regulatory requirements for SCHOOL DISTRICT in working with the school and with students. SCHOOL DISTRICT will provide written documentation of such requirements upon completion of this agreement.

BEHAVIORAL HEALTH AGENCY offers these services to students at schools selected by SCHOOL DISTRICT as a part of their community provider services.

INTENDED RESULTS

BEHAVIORAL HEALTH AGENCY and SCHOOL DISTRICT share a commitment to building a delivery system that increases youth access to behavioral health services and prevention collaboration and formal partnership. Intended outcomes of this partnership include:

1. Quicker and easier access for students identified for behavioral health counseling;
2. More efficient use of resources;
3. Stronger linkages to community partners;

GENERAL TERMS AND CONDITIONS

The purpose of this MOU is to formalize terms and conditions under which the parties shall work together to support the provision of behavioral health and prevention services responsive to the needs of youth and families within the SCHOOL DISTRICT. The MOU sets the framework for coordinated practices in the following areas:

1. Separate responsibilities of BEHAVIORAL HEALTH AGENCY and SCHOOL DISTRICT;
2. Integrated roles and responsibilities at schools served;
3. Space and facilities;
4. Management of life-threatening emergencies, including privacy considerations; and

5. Exchange and disclosure of student information, subject to constraints of privacy considerations and safeguards.

RESPONSIBILITIES OF THE PARTIES

BEHAVIORAL HEALTH AGENCY and SCHOOL DISTRICT agree upon the following general framework for separate responsibilities and contributions to the partnership.

Responsibilities of BEHAVIORAL HEALTH AGENCY

BEHAVIORAL HEALTH AGENCY agrees to:

1. Provide administrative oversight of their employees providing services at school locations, managing the scope of services and performance expectations as identified in the above goals.
2. Obtain written permission from parents prior to meeting with students, including a signed release of information between SCHOOL DISTRICT and BEHAVIORAL HEALTH AGENCY.
3. Communicate regularly with building level administration regarding scheduling and services being provided to students on SCHOOL DISTRICT campuses.
4. Provide the following scope of services: outpatient individual and family psychotherapy, in addition to assessment and referral for additional services if necessary.
5. Meet with SCHOOL DISTRICT Administration quarterly to evaluate services, MOU and to make adjustments based on needs and priorities.
6. Will retain, keep current and provide a copy of professional liability insurance in the amount of $1,000,000.
7. BEHAVIORAL HEALTH AGENCY will be responsible for working with parents/guardians of clients to determine insurance eligibility, bill all sessions to the appropriate insurance, collect payment, and in some cases, determine eligibility for a sliding scale program, which can reduce or eliminate payment on the part of the parent/guardian.

Responsibilities of SCHOOL DISTRICT

SCHOOL DISTRICT agrees to:

1. Identify students for behavioral health services and refer to BEHAVIORAL HEALTH AGENCY for individual/family/group therapy as appropriate and with multiple options offered to families.
2. Provide space and facilities support for mental health clinicians in agreed upon schools, during agreed upon times.
3. Meet with BEHAVIORAL HEALTH AGENCY Administration quarterly to evaluate services, MOU and to make adjustments based on needs and priorities.
4. Train BEHAVIORAL HEALTH AGENCY clinicians to be providing services within the school with appropriate site specific training regarding facilities, emergency procedures, and reporting structure.

OUTREACH, SCREENING AND REFERRAL

The process for outreach, screening, and referral will be outlined below:

1. Teacher identifies student who may be eligible for psychotherapy services, and contacts a SCHOOL DISTRICT School Counselor or Social Worker.
2. Social Worker or School Counselor meets with student, confirms need for services, fills out SCHOOL DISTRICT referral sheet, and makes attempts to obtain new client paperwork packet from parent/guardian.
3. Once new client packet is received by BEHAVIORAL HEALTH Clinician, student will be placed on

Clinician's schedule.

4. Student will first receive a Comprehensive Diagnostic Assessment, to confirm student's suitability for psychotherapy, to determine appropriate treatment goals, and to assess for any additional services student may benefit from.
    a. If it is determined that student could benefit from additional services, student parent/guardian will receive communication from BEHAVIORAL HEALTH AGENCY informing them.
    b. Parent/Guardian will then receive information about at least three (3) agencies in the area that can meet these needs.
5. Student receives psychotherapy for the prescribed period of time deemed necessary by the Clinician
6. Students can be discharged from care for the following reasons:
    a. Student has three consecutive (3) no shows to psychotherapy appointments.
        i. No student will be discharged for this reason without first collaborating with a School Counselor or Social Worker.
    b. Student has met all treatment goals determined by Clinician and student at the beginning of treatment.
        i. No student will be discharged for this reason without first collaborating with a School Counselor or Social Worker.
    c. Student is unsuitable for treatment due to non-cooperation with Clinician and/or treatment.
        i. No student will be discharged for this reason without first collaborating with a School Counselor or Social Worker.
    d. Student presents as a danger to the safety of Clinician.
        i. No student will be discharged for this reason without first collaborating with a School Counselor or Social Worker.

EXCHANGE OF STUDENT INFORMATION AND PRIVACY CONSIDERATIONS

Responsibilities of both parties

BEHAVIORAL HEALTH AGENCY and SCHOOL DISTRICT will not use or disclose students' personal behavioral health information in a manner that would violate the requirements of the HIPAA privacy rule. Additionally, SCHOOL DISTRICT will not use or disclose students' personal and/or educational information in a manner that would violate the requirements of The Family Educational Rights and Privacy Act (FERPA).

The parties agree that personal behavioral health information in records maintained at school will not be released to school personnel without required minor or parental consent.

EXECUTION OF MEMORANDUM OF UNDERSTANDING

The parties agree that:

1. The parties to this Agreement are not partners or joint venturers with each other and nothing herein shall be construed to make them partners or joint venturers or impose any liability as such on either of them. Neither party shall receive any compensation from the other party for services related to this agreement. This Agreement shall not be construed to be an exclusive Agreement between BEHAVIORAL HEALTH AGENCY and SCHOOL DISTRICT, nor shall it be deemed to be an Agreement requiring SCHOOL DISTRICT to refer students to Provider for health care services.
2. Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.
3. This MOU is expressly subject to and shall not become effective or binding on any party hereto until it has been fully executed by all parties.
4. The MOU shall be binding on all parties, their successors and assigns.
5. All parties shall review terms and conditions of the MOU during the spring quarter of each academic school year. Amendments to the MOU negotiated during the spring quarter affect terms, conditions and binding agreements for the following school year.
6. The term of this MOU shall commence on August 16, 2017 and shall continue for a period of 10 months. Thereafter, this MOU shall continue unless otherwise terminated pursuant to this paragraph. This MOU may be terminated without cause by BEHAVIORAL HEALTH AGENCY or SCHOOL DISTRICT upon 30 calendar day's written notice.

IN **WITNESS WHEREOF,** the parties have caused this Memorandum of Understanding to be executed.

FOR SCHOOL DISTRICT:

_____ _____

Superintendent Date

FOR BEHAVIORAL HEALTH AGENCY:

_____ _____

State Director Date

Addendum #1 to Memorandum of Understanding (MOU) Between SCHOOL DISTRICT and BEHAVIORAL HEALTH AGENCY

1. Student in Crisis Protocol

If a student is already a client with BEHAVIORAL HEALTH AGENCY, the school counselor/social worker/administrator agrees to contact the BEHAVIORAL HEALTH AGENCY Clinician to let him/her know the student is in crisis. The school counselor/social worker/administrator agrees to provide the immediate mental health supports necessary for the student. The BEHAVIORAL HEALTH AGENCY clinician agrees to meet with the student and/or family at the soonest available appointment.
If a student is not a current BEHAVIORAL HEALTH AGENCY client, and in a mental health crisis, a signed parental consent form is required before a referral can be made. The school counselor/social worker/administrator agrees to provide the immediate mental health supports necessary for the student. The school counselor/social worker/administrator can contact parents on an emergent basis and receive consent. The BEHAVIORAL HEALTH AGENCY clinician will meet with the student and/or family at the soonest available appointment.

2. Pro Bono Student Psychotherapy Process: SCHOOL DISTRICT

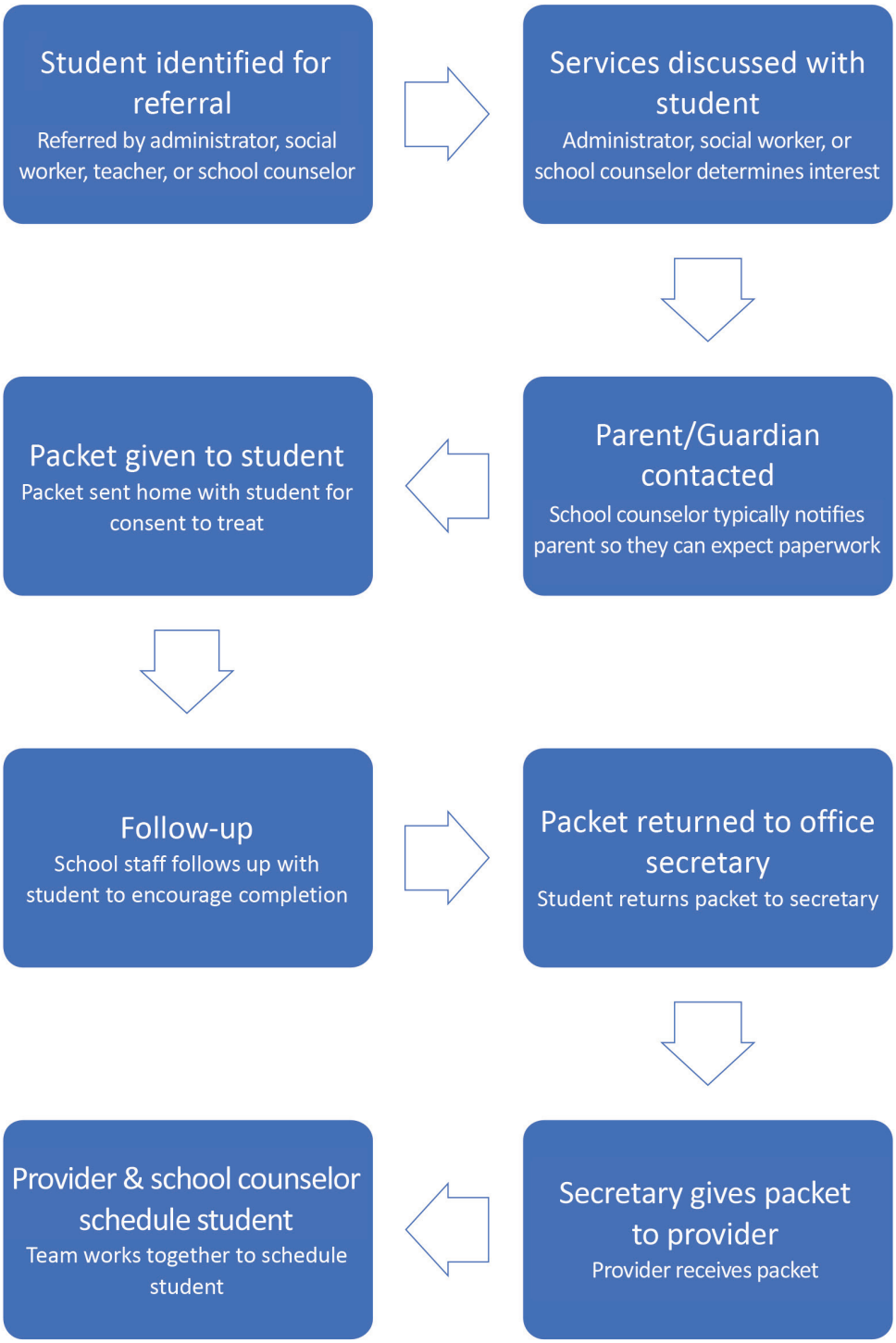
Students without insurance or students with mental health benefits that are cost-prohibitive for them and their families may be eligible for pro bono services with BEHAVIORAL HEALTH AGENCY. Three appointment slots for pro bono clients will be allowed per week per full-time clinician load.

- Intake paperwork is completed and sent to intake at BEHAVIORAL HEALTH AGENCY.
- If client is uninsured, or has private insurance that requires payment, intake will contact parent to let them know that paperwork has been processed, and the expected amount of payment.
- If parent is unable to pay, intake will notify Regional Manager who will determine if client is approved for pro bono or partial payments.
- If approved, clinician and intake will be notified and will determine if there is room in the schedule for a pro bono client upon working with schedule and at the recommendation of school counselors/social worker.

All terms and provisions from the original MOU also apply to this addendum.

IN WITNESS WHEREOF, the parties have caused this Addendum #1 to the original Memorandum of Understanding to be executed.

WORKFLOW


Student identified for referral
Referred by administrator, social worker, teacher, or school counselor
Services discussed with student
Administrator, social worker, or school counselor determines interest
Parent/Guardian contacted
School counselor typically notifies parent so they can expect paperwork
Packet given to student
Packet sent home with student for consent to treat
Follow-up
School staff follows up with student to encourage completion
Packet returned to office secretary
Student returns packet to secretary
Secretary gives packet to provider
Provider receives packet
Provider & school counselor schedule student
Team works together to schedule student

CONSENT PACKET

SCHOOL LETTERHEAD

Beginning the [DATE] school year, [BEHAVIORAL HEALTH AGENCY] and [SCHOOL] have teamed up to integrate mental health services in the school. The clinician providing these services at [SCHOOL] is [CLINICIAN].

Parent consent is required prior to your child receiving any services through [BEHAVIORAL HEALTH AGENCY]. Enclosed is a registration packet that includes three forms: Client Information Form, Authorization and Consent to Treat Form, and Authorization for Use and Disclosure of Protected Health Information. This form allows for communication between [BEHAVIORAL HEALTH AGENCY] and our [SCHOOL] team. The forms also include information about your insurance provider. If you have questions about coverage and billing please call [BEHAVIORAL HEALTH AGENCY] intake coordinator [COORDINATOR NAME] at [208-###-####].

If you have any additional questions, feel free to call your child's school counselor:

[SCHOOL COUNSELOR], [SCHOOL COUNSELOR CONTACT INFORMATION]

Client Information Form

Today's Date: _____

_____
Client Name (First) (Middle Initial) (Last)

_____ _____ Gender: M F
(Date of Birth) (Social Security Number)

Relationship Status: Single Married Divorced Separated Widowed

IF CLIENT IS A MINOR:

_____ _____
(Mother/Guardian's name) (Phone)

_____ _____
(Father/Guardian's name) (Phone)

Child Resides With: _____

_____
(Address) (City) (State) (Zip)

_____
(Mailing Address) ☐ Same as Above (City) (State) (Zip)

_____ _____ _____
(Home/Cell Phone Number) (Work Number) (Email Address)

_____ _____ _____
(Emergency Contact Name) (Phone Number) (Relationship)

_____ _____
(Employer/School) (Phone Number)

_____ _____
(Primary / Referring Physician) (Phone Number)

_____ _____
(Insurance Company) (Policy Number)

Is English your primary language? YES NO

Can you read/understand the English Language? YES NO

Can your legal guardian read/understand the English language? YES NO

Any Known Food/Drug Allergies: _____

How did you hear about [AGENCY]: _____

Client Information Form

Authorization and Consent To Treat

_____ (Initials)

RIGHTS AND RESPONSIBILITIES STATEMENT

I understand (1) my treatment rights; (2) my treatment responsibilities; and (3) AGENCY responsibilities as outlined.

_____ (Initials)

FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize my insurance benefits to be paid directly to AGENCY. I hereby authorize the release of pertinent medical records to the insurance company. I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier(s).

_____ (Initials)

HIPAA: NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I understand the procedure for accessing my medical records and filing a HIPPA violation complaint.

_____ (Initials)

CONSENT TO PHONE MESSAGES

I authorize AGENCY to leave voicemails regarding appointments and treatment.

_____ (Initials)

CONSENT TO TREAT

By signing below I authorize and choose AGENCY to provide evaluation, diagnostic procedures and treatment, to me or my minor child. The frequency and type of treatment services will be decided between my AGENCY Treatment Team and me.

I understand the purpose of any procedures prescribed will be explained to me and are subject to my verbal agreement.

I understand there are potential risks and benefits to accessing mental health treatment. I understand that AGENCY staff will work with me to achieve maximum benefit but there is no guarantee that my mental health will improve.

- A maximum benefit of improved mental health, comfort, and improved functioning in the community as well as decreased symptoms of my mental illness will occur with consistent participation in treatment.
- Risks of treatment may include uncomfortable feelings or memories. Please discuss any concerns or issues related to treatment with your Therapist.
- Please note our services are considered treatment services only. We do not provide custody or visitation evaluations. We do not make recommendations regarding residential time, visitations or custody. We do not act as character witnesses in any way.

I understand that I have the right to refuse services at any time.

I understand that there are other providers in the community that can assist me with my mental health needs.

I understand I can access 24-Hour Behavioral Health Crisis Services for Adults or Children by calling:

(800) 292-0973 (Option 6) or 855-202-0973 (Medicaid Clients Only)

I understand that I may access advocacy services by calling Disability Rights Idaho, statewide toll-free Number:

1-866.262.3462 (TDD/Voice)

I understand that I may access legal assistance through Idaho Legal Aid. Their website is idaholegalaid.org

_____ _____

Participant or Parent/Guardian Signature Date

Client Information Form

COM-HPA-1011.02.B

Consumer Name: _____ ID#: _____

DOB: _____ Insurance ID#: _____

Authorization for Use and Disclosure of Protected Health Information

I authorize the use, disclosure and/or exchange of my protected health information to:

SCHOOL

(Agency or Person to whom the requested use, disclosure and/or exchange will be made) effective on the date of my signature.

Reason for information to be released or exchanged: **Coordination of Care**

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

I consent to the release of information or records created by or disclosed to AGENCY pertaining to: (check all that apply)

_____ Crisis Plan
_____ Service Notes
__x__ School Records
_____ Psychological Evaluation/Assessment
_____ Psychological Summary
_____ Physician Notes
_____ Psychiatric Evaluations
_____ Discharge Summary
_____ Medications
_____ Guardianship Paperwork
_____ Medical Reports
_____ RN Notes
_____ Assessments
_____ Treatment Plans
__x__ Written & verbal communications pertinent to Treatment
_____ Other (Please be specific):

_____

_____

This form implements the requirements for consumer authorization to use, disclose and exchange health information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services.

Once information is disclosed pursuant to this signed authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure. When this agency discloses mental health and developmental disabilities information protected by state law or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), we must inform the recipient of the information that redisclosure is prohibited except as permitted or required by these two laws.

I understand that I may refuse to sign this authorization form. Refusal to sign will not be a condition to obtain treatment, payment for or coverage of services, or eligibility for benefits or enrollment.

I understand that, with certain exceptions, I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to the information that has already been released in response to this authorization.

I have had the opportunity to read and consider the contents of this authorization. I confirm that the contents are consistent with my direction and a copy of this form is as valid as the original to allow release of my records.

Client Information Form

If not revoked earlier, this authorization expires on: _____ (date) not to exceed one year of signature.

Signature of Consumer: _____Date: _____

Signature of legally responsible person: _____Date: _____

Staff/witness signature:_____Date: _____

PEDIATRIC REFERRAL SHEET

Healthy Minds Partnership Schools

Below is a list of schools in the area who are working with local behavioral health agencies to deliver on-site treatment. Please contact the individual listed next to the school where your patient is a student to send a referral.

School	Agency Partner	Contact
Nampa High School	Pathways	Norma Jimenez, Intake Coordinator Ph: 208-459-1039 Fax: 208-459-1038
West Middle School	Pathways	Norma Jimenez, Intake Coordinator Ph: 208-459-1039 Fax: 208-459-1038
Lewis and Clark Elementary School	Terry Reilly Health Services	Laura Alvarez, LPC Ph: 208-649-1119
Melba Elementary School	Terry Reilly Health Services	Melissa Smith, LPC Ph: 208-495-2508 x 1027
Star Elementary School	Terry Reilly Health Services	Sara Iwersen, LPC and Malia Murphy, LMSW Ph: 208-855-4116
Endeavor Elementary School	Terry Reilly Health Services	Kathryn List, LMSW Ph: 208-468-4629 x3932

Statewide Healthcare Innovation Plan

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

Goal 4

Appendices

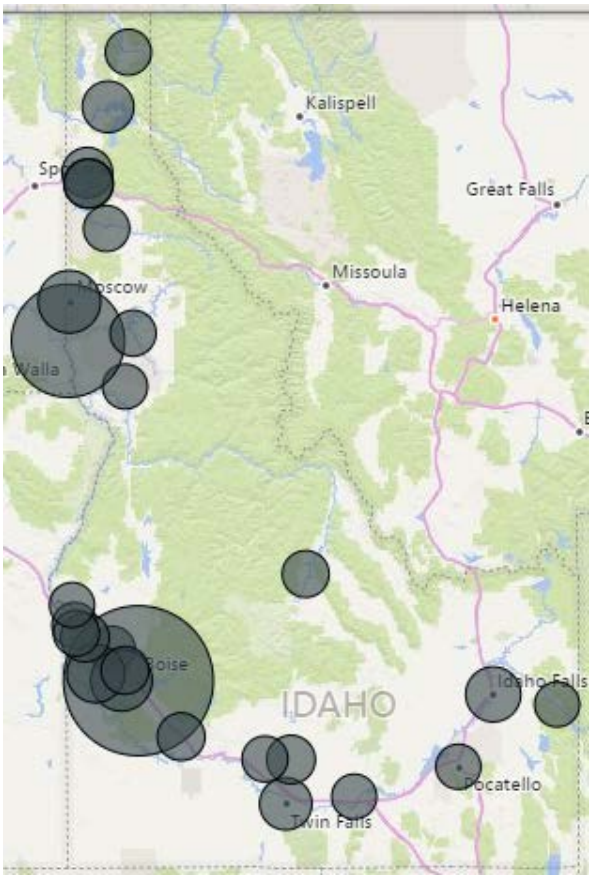
ECHO Idaho 2018 Programs Report

Opioid Addiction and Treatment Program

Time Period: **March 2018 – December 2018**
Number of sessions: **18**
Total Hours: **18**

Attendance

Individual Participants: **131**
Total attendance: **438**
Average attendance: **22** per session
High attendance: **29** (3/15 Intro, 8/2 Cannabis)
Low attendance: **14** (11/8 Acupuncture)
Registered: **234**



By Location
Organizations: **60**
Communities: **29**
Public Health Districts: **7**
Counties**: 22**

By Credential
Physician (MD, DO): **24**
Clinical Pharmacist (PharmD) **10**
Physician Assistant (PA, MHS) **1**
Advanced Practice Nurse (NP, CRNA, CNM, CNS, etc) **9**
Registered Nurse (RN, BSN) **7**
Licensed Practical Nurse (LPN) **0**
Family Nurse Practitioner (FNP) **0**
Medical Assistant (MA, CMA) **0**
Certified Nursing Assistant (CAN) **0**
Registered Dietitian (RD) **0**
Community Health Worker (CHW) **1**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **7**
Certified Health Care Manager (FACHE) **0**
Registered Health Information Technician (RHIT) **0**
Case Manager **0**
Other **72***

*We are working on cleaning the data to make this info more representative. For example, if a clinician has an MD, MPP they are showing up as other.

Presentations

Patient Case Presentations: **15** (= 14 new + 1 follow-ups) by **16** individuals
Didactics: **18** presentations by **12** individuals

ECHO Idaho is led by the University of Idaho and the WWAMI Medical Education Program and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

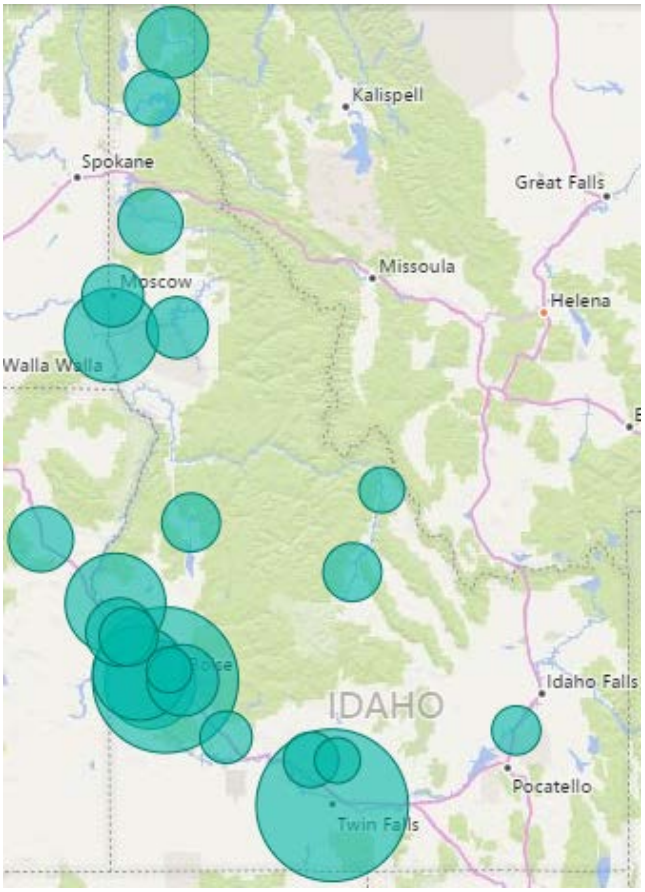
ECHO Idaho 2018 Programs Report

Behavioral Health in Primary Care Program

Time Period: **September 2018 – December 2018**
Number of sessions: **8**
Total Hours: **8 hours**

Attendance

Individual Participants: **59**
Total attendance: **301**
Average attendance: **34 per session**
High attendance: **49** (9/5 Somatic Disorders)
Low attendance: **26** (12/12 Perinatal Mood Disors.)
Registered: **65** in initial pilot, **100** in 2019 cohort



By Location
Organizations: **32**
Communities: **24**
Public Health Districts: **7**
Counties**: 14**

By Credential
Physician (MD, DO): **11**
Clinical Pharmacist (PharmD) **8**
Physician Assistant (PA, MHS) **7**
Advanced Practice Nurse (NP, CRNA, CNM, CNS, etc) **5**
Registered Nurse (RN, BSN) **2**
Licensed Practical Nurse (LPN) **0**
Family Nurse Practitioner (FNP) **0**
Medical Assistant (MA, CMA) **0**
Certified Nursing Assistant (CAN) **0**
Registered Dietitian (RD) **0**
Community Health Worker (CHW) **0**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **8**
Certified Health Care Manager (FACHE) **0**
Registered Health Information Technician (RHIT) **0**
Case Manager **0**
Other **18***

*We are working on cleaning the data to make this info more representative. For example, if a clinician has an MD, MPP they are showing up as other.

Presentations

Patient Case Presentations: **7** (= 7 new + 0 follow-ups) by **7** individuals
Didactics: **8** presentations by **6** individuals

ECHO Idaho is led by the University of Idaho and the WWAMI Medical Education Program and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

ECHO Idaho 2018 Programs Report

MAT DATA 200 Waiver Half and Half Training

Time Period: **Monday December 10, 2018**
Number of sessions: **1**
Total Hours: **4.5** hours

Attendance

Trainers: **2** (Dr. Todd Palmer and Dr. Magni Hamso)
Individual Participants: **65**
Waiver Seeking: **55**
Auditing: **10**
RSVP'd: **70** waiver seeking / **13** audit

Received Waiver: **TBD**
(As high as 25% increase of waivered providers in ID)

By Location
Organizations: **43**
Communities: **29**
Public Health Districts: **6** (all but PHD 7)
Out of State**: 10** (AZ, CA, CO, IL, NC, NJ, NY, SD, WA)

By Credential
Physician (MD, DO): **38**
Clinical Pharmacist (PharmD) **6**
Physician Assistant (PA) **7**
Advanced Practice Nurse (NP, NA, CNM, CNS, etc.) **4**
Family Nurse Practitioner (FNP) **7**
Mental/Behavioral Health Professional
(non-physician: LMHC, LCSW, LPCC, etc.) **1**
Idaho Drug Overdose Prevention Program **2**

KIVI TV media link: https://www.eastidahonews.com/2018/12/idaho-medical-professionals-undergo-training-to-prescribe-suboxone-to-opioid-addicts/

ECHO Idaho is led by the University of Idaho and the WWAMI Medical Education Program and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

ECHO Idaho Materials

Website: https://www.uidaho.edu/academics/wwami/echo/opioid-program/past-sessions

Website includes links to videos and slides for each session

Presentations

ECHO Idaho 2018 Programs Report

ECHO Idaho Overview

Opioid Addition and Treatment Material

Brochures

ECHO Idaho Brochure_V1

Flyers

ECHO Idaho Opioid Flyer_01.2019

ECHO Idaho Opioid Flyer_05.2018

ECHO Idaho Opioid Flyer_07.2018

ECHO Idaho Opioid Flyer_09.2018

ECHO Idaho Opioid Flyer_07.2018_Schedule

ECHO Idaho Opioid Flyer_07.2018_Panel

Post Card

ECHO Idaho Opioid_Postcard_12.2018

ECHO Idaho Postcard_03.2018

Agendas

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Behavioral Health in Primary Care Material

Flyers

ECHO Idaho BH Flyer_12.2018

ECHO Idaho BH Flyer_07.2018

Agendas

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https://iecho.unm.edu/sites/uidaho/download.hns?i=116

https://iecho.unm.edu/sites/uidaho/download.hns?i=123

MAT Waiver Training Material

ECHO Idaho MAT Waiver Flyer

ECHO Idaho

Our vision is to improve healthcare for patients all over Idaho - *FAST*

People need access to specialty care for complex conditions.

There aren't enough specialists to treat everyone, especially in rural areas.

ECHO® trains primary care clinicians to provide specialty care services.

Patients get the right care, in the right place, at the right time.

Project ECHO®

ECHO Idaho is led by the University of Idaho and WWAMI and supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

ECHO IDAHO

Opioid Addiction and Treatment

2nd and 4th Thursday
12:15 p.m. — 1:15 p.m. MT

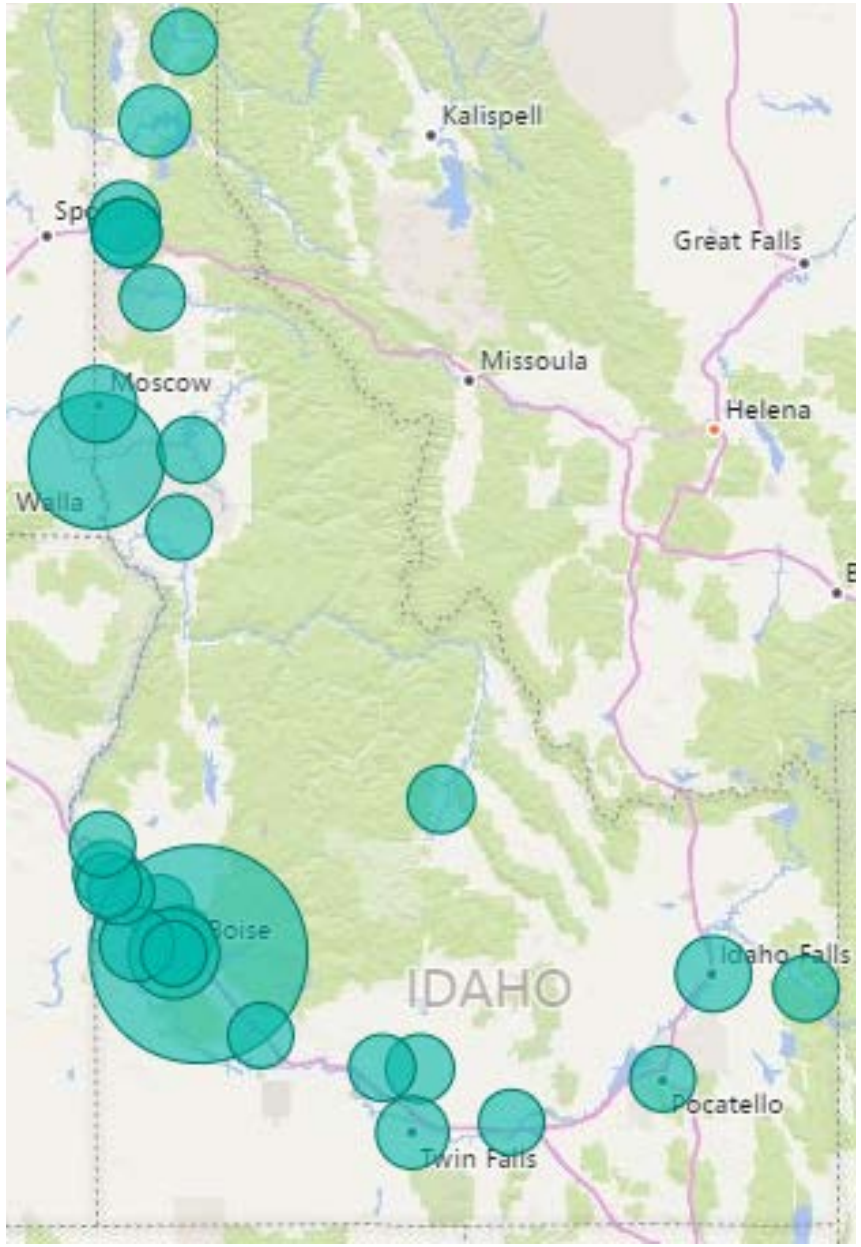
ECHO IDAHO

Behavioral Health in Primary Care

1st and 3rd Wednesday
Noon – 1:00pm MT

- Two programs for Idaho clinicians
- Free to enroll, free CME
- Join from anywhere in the state
- Get feedback on difficult patient cases

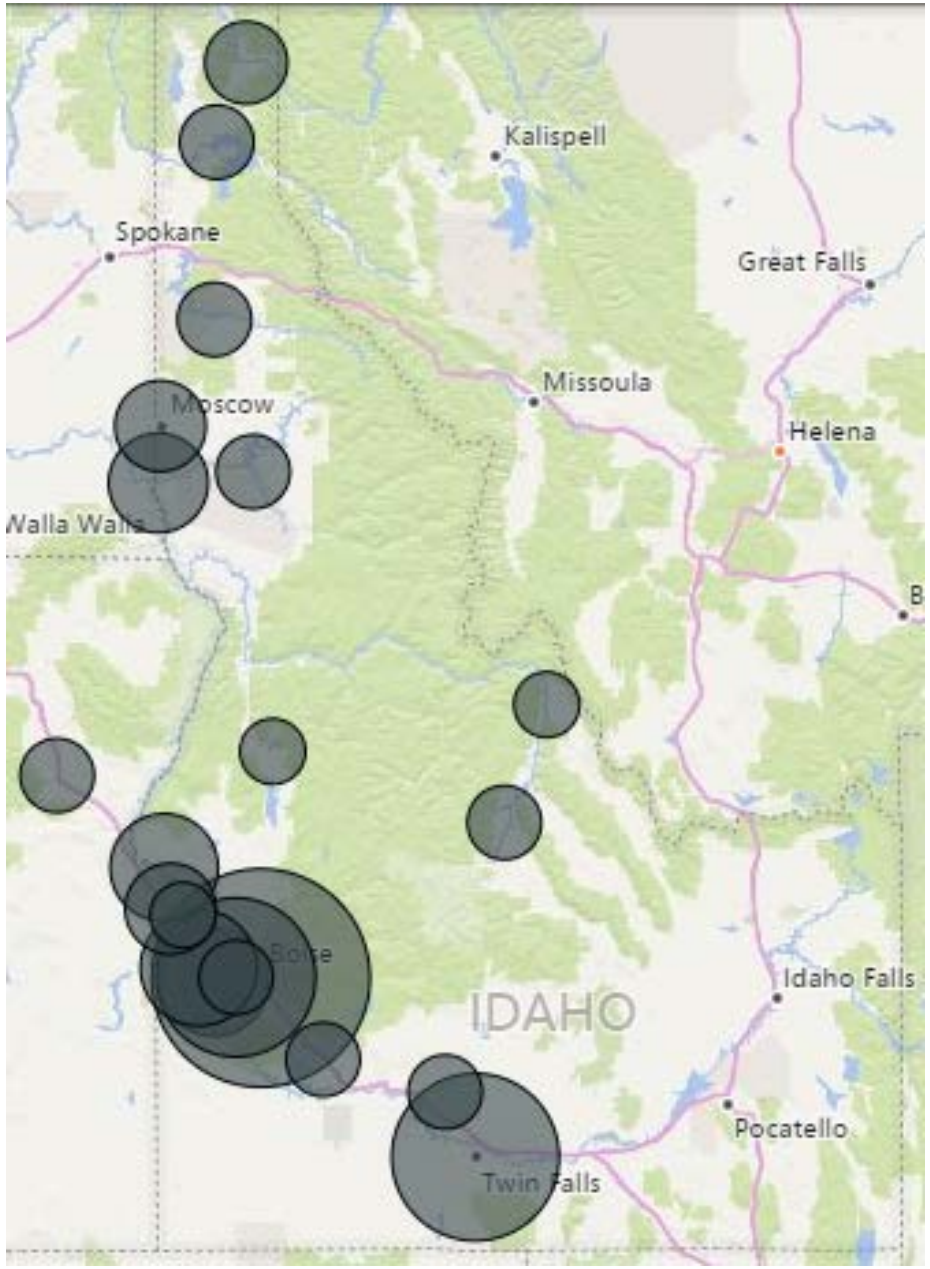
Project ECHO
University of Idaho



Opioid Addiction and Treatment ECHO

People	Contact Hours	Organizations	Communities
112	**344**	**60**	**31**

ECHO IDAHO ECHO Idaho data 9/30/18

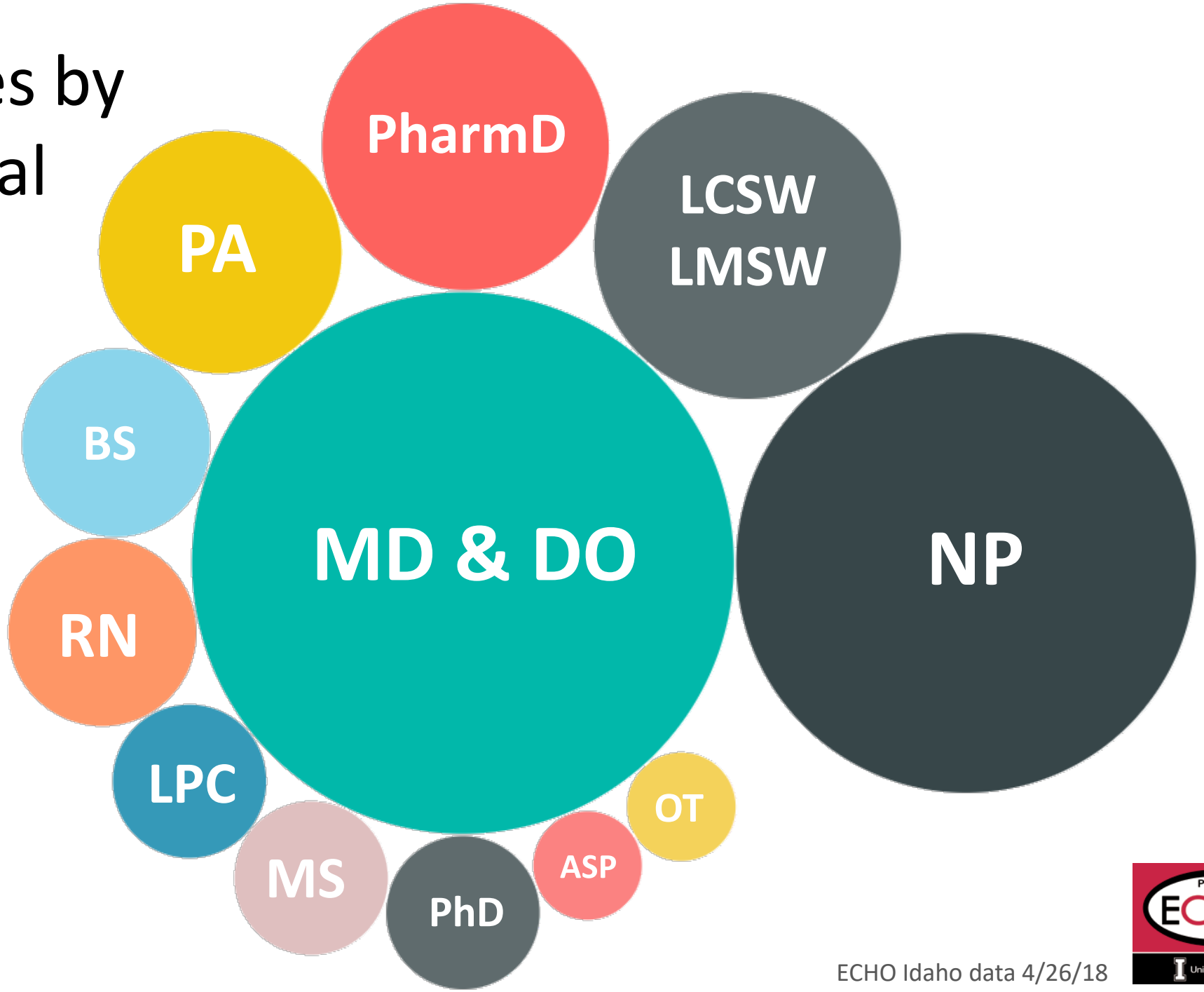


Behavioral Health in Primary Care ECHO

People	Contact Hours	Organizations	Communities
54	99	34	22

ECHO IDAHO ECHO Idaho data 9/30/18

Attendances by Credential



ECHO IDAHO

ECHO Idaho data 4/26/18

Project ECHO University of Idaho

ECHO Idaho Participant Feedback

Excellent practical feedback.

— RN, Bonners Ferry

Very good set up, accessible. Relevant.

— NP, Saint Maries

I learned so much!

— PA, Twin Falls

The session made me think about a couple of my patients and whether or not this condition should be considered for them.

— PharmD, Nampa

Project ECHO gives me hope that I can provide the best care possible to each and every client that comes through my doors.

– LCSW, Caldwell

I love coming to ECHO, it's the best part of my week!

– MD, Boise

It was great to see so many peers from Idaho and get a collaborative input on a difficult case.

— MD, Weiser

Project ECHO University of Idaho

Benefits to Providers

- No cost CMEs
- Professional interaction with colleagues with similar interests
- Access to specialty consultation
- Mix of work and learning
- Learn about community resources
- Fun!

ECHO IDAHO

Project ECHO® University of Idaho

Benefits to Patients

- Saves patients from traveling long distances
- Reduced wait times for specialists
- Better access for rural and underserved patients
- Reduces disparities, improves health outcomes

ECHO IDAHO

Project ECHO® University of Idaho

Benefits to Idaho

- Supports the Medical Home Model
- Rapid learning and best-practice dissemination
  - Reduces variations in care
  - De-monopolizes knowledge
  - Improves quality and safety
- Workforce training and force multiplier
- Higher retention of providers in rural areas
- Cost effective care

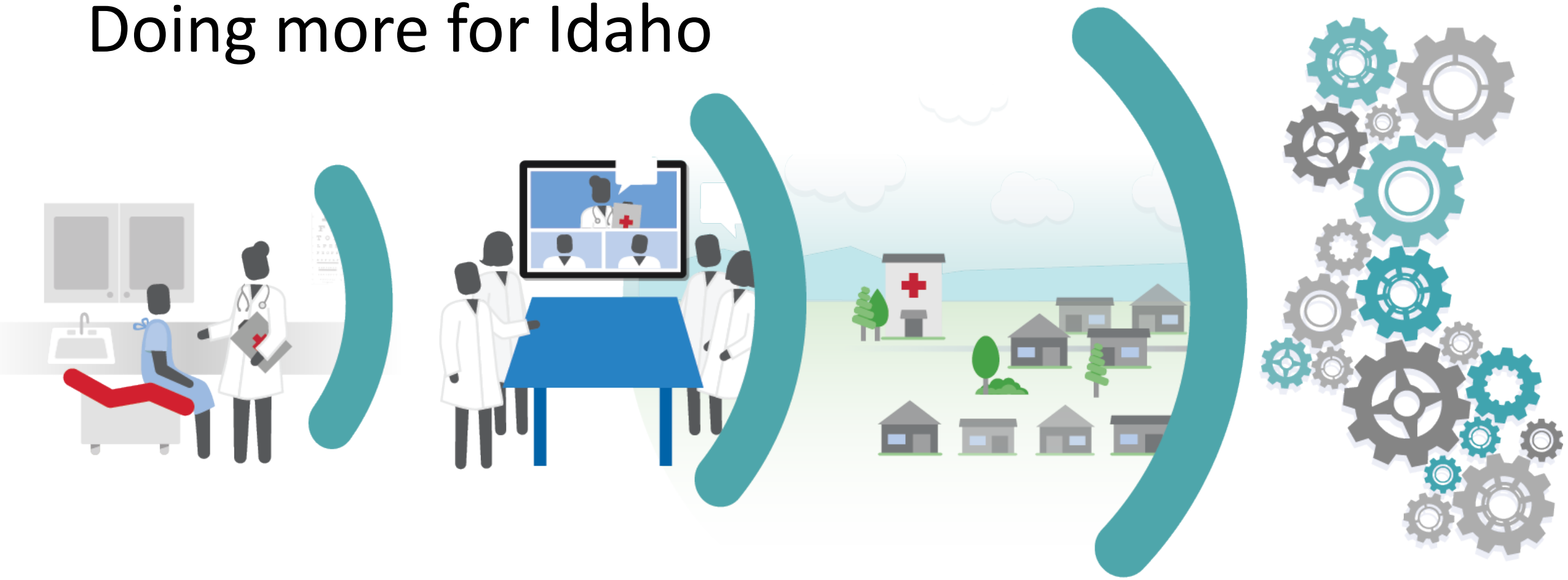
ECHO IDAHO

Project ECHO University of Idaho

ECHO Benefits – Decreased Costs

- Fewer hospitalizations and ER visits
  - New York geriatric mental health ECHO program reduced emergency department visits by 20% and cut costs by 24%. (Journal of American Geriatrics Society, 2011)
- Better quality of care close to home
  - Rural providers in New Mexico trained through Project ECHO to treat Hepatitis C outperformed specialists as reported in a study of patient outcomes. (The New England Journal of Medicine, 2016)
- Treatment of chronic diseases earlier before complications arise
  - New Mexico ECHO program focusing on complex care patients was attributed to a 17% decrease in per patient per month costs among Medicaid patients. (Harvard Medical School Case Study, 2017)

Doing more for Idaho



PATIENT
- Right Care
- Right Place
- Right Time

PROVIDER
- Acquire New Knowledge
- Treat More Patients
- Build Community of Practice

COMMUNITY
- Reduce Disparities
- Retain Providers
- Keep Patients Local

SYSTEM
- Increase Access
- Improve Quality
- Reduce Cost

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ECHO IDAHO

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Statewide **Healthcare Innovation** Plan

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

Appendices
State Led Evaluation Report

Statewide Healthcare Innovation Plan

Idaho Statewide Healthcare Innovation State-Level Final Evaluation Report

12.10.2018

2018

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.

Contributing Authors

for the

State Led Final Evaluation Report (2016-2018)

from the University of Idaho and Boise State University

The University of Idaho

Dr. Scott Metlen, PhD, Principal Investigator, Associate Professor, Business Department Health, College of Business and Economics

Dawn Juker, LMBSW, CCht., CHW, PCMH CCE, Research Associate, University of Idaho

Dr. Janice Lung, EdD, MHS, Research Associate, University of Idaho

Chelsea Stevenson, MA, PCMH CCE, Research Associate, University of Idaho

Molly Volk, MHS, PCMH CCE, Research Associate, University of Idaho

Boise State University

Dr. Janet Reis, PhD, Principal Investigator, Research Professor, College of Health Sciences, Office of Research

Dr. Tim Dunnagan, EdD, Co-Principal Investigator, Dean, College of Health Sciences

Dr. Jayne Josephsen, EdD, RN, CCCTM, CHPN, CHSE, Co-Principal Investigator, Associate Professor, School of Nursing

State Level Evaluation Graduate Assistants:

Jasmine Miller, BS, Graduate Research Assistant

Madeline Priest, BS, CRT, CHSL, Graduate Research Assistant

Boise State University (BSU) Graduate Research Assistants

assigned to the Department of Health and Welfare Office of Healthcare Policy Initiatives

Statewide Healthcare Innovation Plan (SHIP) (2017-2019)

2017 BSU Graduate Research Assistants

Tara Fouts, BS, Boise State University

Adiya Jaffari, BS, Boise State University

Michael Thomas, MS, Boise State University

Molly Volk, MHS, PCMH CCE, Boise State University

2018 BSU Graduate Research Assistants

James Hague, MBA, Boise State University

McKenzie Hansen. BS, Boise State University

Alexis Marcovitz, BS, Idaho State University

Madeline Priest, BS, Idaho State University

2019 BSU Graduate Research Assistants

Jasmine Miller, BS, University of Idaho, MHS, Boise State University

Madeline Priest, BS, CRT, CHSL, Idaho State University, MHS, Boise State University

Statewide Healthcare Innovation Plan

Idaho Statewide Healthcare Innovation State-Level Final Evaluation Report

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Abbreviations

BSU: Boise State University

CHEMs: Community Health Emergency Medical Services

CHW: Community Health Worker

CMMI: Center for Medicare and Medicaid Innovation

CMS: Centers for Medicare and Medicaid Services

EHR: Electronic Health Record

IDHW: Idaho Department of Health and Welfare

IHC: Idaho Healthcare Coalition

MMS: Measures Management System

NCQA: National Committee for Quality Assurance

PCMH: Patient Centered Medical Home

PCMH CCE: Patient Centered Medical Home Certified Content Expert

PCP: Primary Care Provider

Project ECHO: Extension of Community Healthcare Outcomes

QI: Quality Improvement

RA: Research Associate

RC: Regional Collaborative

SD: Standard Deviation

SET: State-Level Evaluation Team

SHIP: Statewide Healthcare Innovation Plan

SIM: State Innovation Model

U of I: University of Idaho

WWAMI: University of Washington's Washington, Wyoming, Alaska, Montana, Idaho Regional Medical School program

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Glossary of Terms

Access to Exercise Opportunities: Measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities (see http://www.countyhealthrankings.org/ for complete definition).

Basic Primary Medical Services: Primary care medical services, laboratory services, urgent care, and preventive health services. These concepts were coded in the patient interviews to create an aggregate measure of Basic Medical Care. (See Appendix E)

Food Insecurity: The core food insecurity model measures the ability for the population to access a constant food supply in addition to measuring their ability to provide balanced meals, and consumption of fruits and vegetables (see http://www.countyhealthrankings.org/ for complete definition).

Frontier: Defined as a county with less than 6 people per square mile residing within the county.

Limited Access to Healthy Foods: The percentage of the population that is low income and does not live close to a grocery store (see http://www.countyhealthrankings.org/ for complete definition).

National Committee for Quality Assurance Patient Centered Medical Home Standards: These 10 building blocks are the conceptual underpinning for the PCMH accreditation standards used in primary care to establish and measure PCMH accomplishments.

Patient Centered Medical Home Primary Care: Care including longitudinal continuity over time, whole person comprehensive care and coordination of care with the medical health neighborhood. These concepts were coded in the patient interviews to create an aggregate measure of Patient Centered Medical Home Care. (See Appendix E)

Patient Centered Medical Home Portal Notes: Portal notes were placed in a site designed to track SHIP PCMH clinic's accomplishments and plans over the course of the clinic cohort year.

Primary Care PCMH Transformation Plan: Plans produced by SHIP PCMH clinics describing their transformation plans detailing and prioritizing the elements of the PCMH model they pursued in their change to a Patient Centered Medical Home

Regional Collaborative: SHIP regional entities formed in each of the seven Idaho Public Health Districts to establish and expand the region's medical health neighborhoods. Each collaborative had a physician and public health co-chair.

Rural: Defined as a county with greater than (or equal to) 6.0 persons per square mile without a population center of 20,000 or more residents.

Statistical Significance: The probability of a given statistical test occurring by chance is .05 or less.

Urban: Defined as county with a population center of at least 20,000.

Windshield Surveys: Environmental scans done by Research Associates to describe the clinic facility and surrounding physical environment. Special attention was given to physical access to the clinic and evidence of available public transportation.

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Executive Summary

Background

Idaho's Statewide Healthcare Innovation Plan (SHIP) was designed as a multi-tiered, interconnected system with the patient at the center of care. The Patient Centered Medical Homes (PCMH) serves as the paradigm to transform primary care to a patient centered focus and to shift payment from volume to value of services. PCMH Standards promulgated by the National Committee for Quality Assurance guided implementation of the majority of Idaho's primary care transformation initiative (National Committee for Quality Assurance, 2018).

SHIP initiatives ranged from implementation and expansion of the PCMH to integration of the medical health neighborhood and cost containment programs. Ultimately, the combined focus of the SHIP was promotion of the health of Idaho citizens through integration of care and support for the transition to a value-based system of health care. A variety of methods were utilized to examine the diverse aspects of the SHIP. The core foundation of the State Level evaluation efforts was to give voice to the experiences, challenges, and accomplishments of consumers/patients, stakeholders, and the primary care practices participating in transformation to the PCMH model. To meet this goal, a descriptive framework was used to document SHIP goals and initiatives. Inclusion of participant perspectives and experiences in the "real time" provide unique perspectives on the efforts of Idaho's SHIP.

The elements of the Patient Centered Medical Home are shown in Figure 1 (Bodenheimer, Ghorob, Willard-Grace & Grumbach, 2014). Implementation of these PCMH elements brings value to both the patient and their healthcare team. Value is realized for clinic staff with an expansion of interdisciplinary team work (Building Blocks #1, 2, and 4) enabling team members to work at the top of their license (Smith, Gerrish & Weppner, 2015). For the patient, the paradigm unites functions central to maintaining and improving individual health which otherwise may be unrecognized and/or uncoordinated within the fee-for-service system (Stewart, Brown, Weston, McWhinney, McWilliam, & Freeman, 2013). Patient care becomes planned over time and

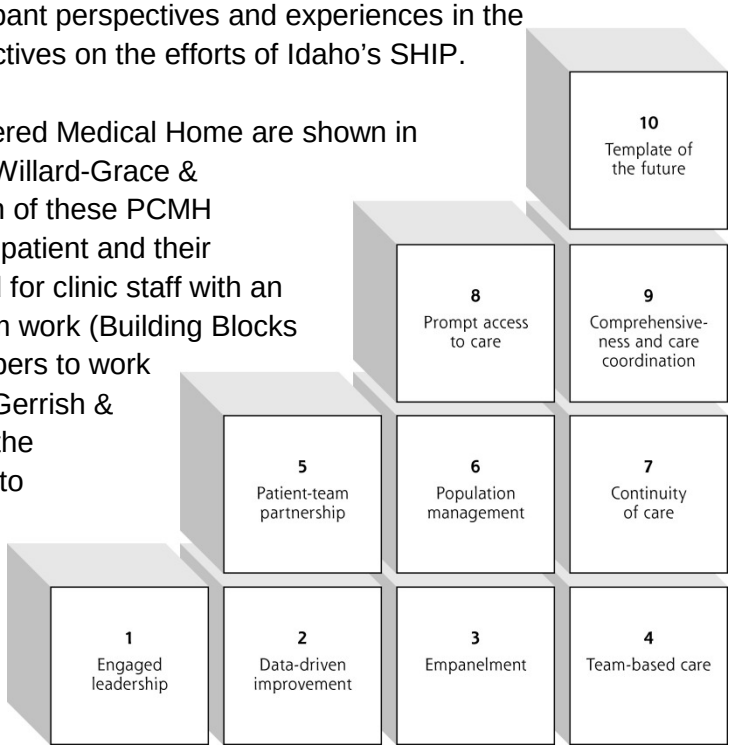

FIGURE 1 Ten Building Blocks for the Patient Centered Medical Home
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guided by data on the patient's risk status (Building Blocks #2, 3 and 6). Services are linked to these longitudinal risk assessments and focused to provide more comprehensive care supportive of patient's needs (Building Blocks #7, 8 and 9). The dynamic is driven by the patient-team partnership (Building Block #5). All told, an established PCMH moves to value-based care and ultimately reduces costs by addressing broader patient needs longitudinally, coordinating care and recognizing the patient's preferences for care (Starfield, 1992).

A total of 24 Idaho counties (44%) had at least one SHIP PCMH clinic. Ninety-two clinics from three cohorts of 166 clinics participated in the patient interview component of evaluation with 1143 clinic patients (average age 43 years, 74% female) volunteering. Of these clinics 25% (23) were in rural counties, 65% (60) clinics were in urban counties and 10% (9) were in frontier counties. The largest number of patients (70%) came from urban counties, followed by patients in rural counties (23%) and frontier counties (7%). Sixty-nine percent of the total target number of 1650 patients were interviewed.

For a synopsis of the goals and related evaluation discussed in this report, please see Appendix W.

Limitations

The following limitations provide a framework for interpretation of the information presented in the State Level Evaluation report.

All data in this report from patients, Primary Care clinic staff, Public Health District SHIP Managers and Quality Improvement Specialists, Regional Collaborative members, Community Health Workers, CHEMS staff and members of the Idaho Healthcare Coalition were obtained from self-reports of self-selected volunteers. Assessment of the reliability of the data is based on inter-rater reliability calculations. Inter-coder reliability kappas across all patient interview codes was calculated as an average of 80% and percent agreement for PCMH clinic interviews averaged the same.

These volunteers do not represent a random sample from a defined population. It is not possible to construct a denominator at an individual clinic or organizational level to determine the representativeness of the sample.

This evaluation efforts did not seek approval to use protected health information. There were not sufficient resources to seek HIPAA approval from up to 166 primary health clinics participating in the SHIP initiative. All health information analyzed in the report was therefore voluntarily shared by the participant in the course of their interview.

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Available resources did not permit formation of a comparison group for any participating entities.

A major health system was not included in the data collection effort for patients because of the system's Institutional Review Board requirements for any staff involved in any aspect of data collection and research.

The timing of participation of clinics and patients varied by scheduling availability, time required by health systems to approve interview protocols, and the availability of the evaluation Research Associates. Both clinic staff and patients' experience with the PCMH therefore varied in terms of the length of time the clinic had been working on their clinic transformation. Further, the maturity of the clinic's PCMH model varied as measured with participation in Idaho Medicaid's Healthy Connections and number of clinics with PCMH recognition from NCQA.

Data collected for this evaluation focused on the patient and clinic input feature of the PCMH logic model. Clinical Quality outcomes were not collected. Clinic performance was not assessed with either short of mid-term outcome measures.

Conclusions

This summary is organized according to the PCMH Building Blocks as they relate to observations from the Idaho SET evaluation. The information from this qualitative evaluation may help guide future planning as the system evolves from reimbursement for volume of services to reimbursement for value of services.

PCMH Building Block #5 (Patient-team partnership) was well endorsed by the patients themselves, in their own words, when asked to delineate the responsibilities of their healthcare team for patient care. The 30% difference is patients desiring a PCMH orientation in their care and self-reports of care received in the past year from their Primary Care Provider suggests that there is room to expand on PCMH services. The PCMH successes cited by the clinics offer a possible continuation of expanding the PCMH model for clinic functions. These were Building Block #8 prompt access to care and, Building Blocks #9, comprehensiveness and care coordination and Building Block #7, continuity of care.

Data-driven improvement (Building Blocks #2) and the related function of Population Management (Building Block #6) appeared multiple times as recognized key PCMH functions and frequently encountered challenges. Of central concern was a basic capacity to generate timely and accurate clinical data from the Electronic Health Records.

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Because of problems with data quality, as one example, capacity was limited for the risk stratification analyses necessary for effective population management (Building Block #6). Clinic's challenges in data generation, particularly for rural, independent clinics, recommends that training modules be developed for mid-level clinic staff in data capture, data aggregation, data validation and data reporting.

The responses of patients to a question on what prevented them from taking care of themselves as well as they would like underscores the necessity of differentiating among the social determinants of health that may be feasibly addressed by a clinic, and determinants requiring support from a broader medical health neighborhood. This question reverts to the role of some version of a Regional Collaborative Organization with capacity to identify and connect resources for primary care providers and their patients.

Patients' feedback on their interest in exercise and nutrition offer an example of collaboration at the clinic and community level within the PCMH and medical health neighborhood paradigms. Primary care clinics could build on patients' interest in the patient team partnership using Motivational Interviewing or similar techniques to assess patient's readiness to change for specific health behaviors. Patients in turn could be referred to options for food and for exercise offered through community partnerships with ongoing follow-up from their healthcare team. Idaho SHIP leaves in place an interconnected, patient-centered system for such initiatives central to improvement of individual health.

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Introduction

The State Innovation Model (SIM) initiative sponsored by the Center for Medicare and Medicaid Innovation (CMMI) provided participating States an opportunity to explore new ways of funding and offering healthcare services. The State of Idaho as one of the Phase 2 SIM States put forward seven Goals (see Table 1) in a Statewide Healthcare Innovation Plan (SHIP). Two levels of evaluation were required as part of the SIM effort. This report summarizes the evaluation efforts at the State level conducted with a partnership between the University of Idaho (U of I) and Boise State University (BSU). The evaluation effort and final report were also completed in conjunction with the Idaho Department of Health and Welfare (IDHW) SHIP staff.

Goal 1	Transform primary care practices across the State into patient-centered medical homes (PCMHs).
Goal 2	Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.
Goal 3	Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood.
Goal 4	Improve rural patient access to PCMHs by developing virtual PCMHs.
Goal 5	Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.
Goal 6	Align payment mechanisms across payers to transform payment methodology from volume to value.
Goal 7	Reduce overall healthcare costs.

TABLE 1 Idaho Department of Health and Welfare Statewide Healthcare Innovation Plan Goals IDWH (2017)

Overview of Evaluation

The State-Level evaluation of Idaho's SHIP is a multi-method, descriptive assessment of the accomplishments and challenges faced over the three years of implementation of the SHIP model. The framework for evaluation designed by the State Evaluation Team (SET) is organized per the six SHIP goals. A multi-pronged approach examined issues related to PCMH implementation for consumers/patients, stakeholders, and the primary care practices themselves.

The logic model of the hypothesized relationships between elements of the PCMH and outcomes in which the SET efforts were designed is shown in Appendix A. This logic model was developed as one of five required logic models in the original State Level evaluation application. Per this model, the focus of the Idaho SHIP State Level Evaluation was on the input element for primary care practices and consumers/patients. There is a body of evidence now available on the introduction and sustainability of PCMH underscoring the importance of understanding the processes by which these new administrative and clinical organizations are established (Nutting, Crabtree, Miller, Stewart, Strange & Jaen, 2010; Petersen, 2013; National Center for

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Medical Home Implementation, 2018) A series of outputs and outcomes follow the "input" of a PCMH some of which have been addressed in the research summaries and reports listed in Table 2 (see page 13).

Another conceptualization of Idaho's State Model Test is given in Figure 2. Idaho's SHIP was designed as a multi-tiered, interconnected system with the patient at the center of care. This model supports the PCMH mission and vision of patient centered care, comprehensive and holistic assessment, and interconnectivity of the health care system. The conceptual approach to the Idaho SHIP evaluation follows this depiction of SHIP as a Principles-Focused Evaluation (Patton, 2018) appropriate for the study of complex systems aimed at fundamental and comprehensive change.

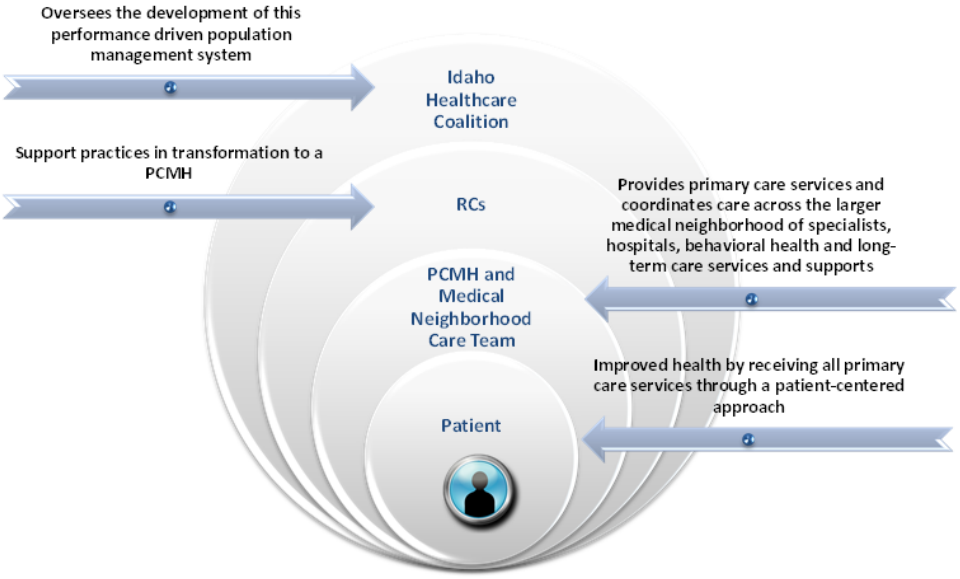

FIGURE 2 Conceptual Model of the State of Idaho's Statewide Healthcare Innovation Plan Retrieved from http://ship.idaho.gov/

The data collection approach employed in this State-level Evaluation is primarily qualitative (Gilner, Morgan & Leech, 2017; Patton, 2016). Qualitative analysis can give an understanding of what the "real life" experience is for stakeholders, providers, and consumers/patients alike (Miles, Huberman, Saldana, 2014). Summary measures for specific SHIP Goals were developed inductively through review of interviews and participant notes. All interview protocols were approved the University of Idaho's Institutional Review Board. This evaluation initiative did not seek any protected patient health information due to the stringent requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA). All reported health status information was volunteered by the patient in the course of their interview.

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

Implementation of Patient Centered Medical Homes (PCMH) in primary health care clinics around the State recognizes the foundational role of primary care in the health care system (Starfield, Shi, & Macinko, 2005).

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Figure 1 in the Executive Summary presents the conceptual building blocks for the Patient Centered Medical Home (Bodenheimer, Ghorob, Willard-Grace & Grumbach, 2014) used widely throughout the United Stated and the United Kingdom (Smith, Gerrish & Weppner, 2015; Stewart, Brown, Weston, McWhinney, McWilliam, & Freeman, 2013). These building blocks are used here to organize the results of the evaluation and for organization of the recommendations for actions with PCMH in Idaho.

Attendant with the dispersion of PCMH models has been a series of research studies measuring impact of patient and staff experiences, utilization of services, costs and other pertinent outcomes. A number of syntheses have also been completed from a distillation of available research. Table 2 presents highlights of summaries of evidence, and, evaluation reports published since 2016. Highlights of each report relevant to the Idaho SHIP State Level Evaluation are given as related to the major evaluation objectives. Of particular interest therefore were reports on changes in patient experience and clinic staff experience with implementation of a PCMH.

	Summaries of PCMH Outcomes	
First Author, Date of publication & Journal	*Title of report & Dates of evidence*	*Highlights relevant to Idaho's SHIP State Level Evaluation*
Williams et al 2012 Evidence Report, Technology Assessment Jackson et al, 2013 Annals of Internal Medicine	Closing the quality gap: revisiting the state of the science the patient-centered medical home The patient-centered medical home: A systematic review Inception of data-bases through 12/11	Small, positive changes in patient and staff experiences
Sinaiko et al, 2017 Health Affairs	Synthesis of research on patient-centered medical homes brings systematic differences into relief 2008-2014	Significant associations found between PCMH programs and decreases in specialty visits and cervical cancer screening.
	PCMH Evaluation Reports since 2016	
First Author, Date of publication & Journal	*Title of report*	*Highlights relevant to Idaho's SHIP State Level Evaluation*
Kern et al, 2016 Annals of Internal Medicine	The patient centered medical home and associations with health care quality and utilization: A 5-year cohort study	The PCMH showed modest improvements in claims-based utilization outcomes compared to practices with EHRs only.
Khanna et al, 2017 Journal of Primary Care & Community Health	Evaluation of PCMH model adoption on teamwork and impact on patient access and safety	Enhanced teamwork observed in communication and leadership (not statistically significant).

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Marsteller et al, 2018 Medical Care	Maryland multi-payer patient-centered medical home program: A 4-year quasi-experimental evaluation of quality, utilization, patient satisfaction and provider perceptions	PCMH program had limited effect on measures of patient satisfaction although survey was administered mid-point.
Sarinopoulos et al, 2017 Journal of General Internal Medicine	Patient experience with the patient-centered medical home in Michigan's statewide multi-payer demonstration: A cross-sectional study	As compared to non PCMH patients, PCMH patients reported better experiences with access, communication and coordination.

TABLE 2 Recent Evaluations of Patient Centered Medical Homes

A crosswalk of the PCMH Building Blocks and the evaluation results summarized in Table 2 show support for clinics implementing a Patient Centered Medical Home having improved teamwork (Building Block 4), positive changes in patient experience with their care (Building Block 5), improved access to care (Building Block 8) and continuity of care (Building Block 7), and enhanced care coordination (Building Block 9).

Accomplishments achieved with Goal 1 were described with summaries of patients' perspective on their primary healthcare and their own role in that care and with PCMH clinic staffs' accounts of their PCMH transformation experience in the framework of the PCMH Building Blocks and the evidence cited above.

Patient Interviews

The patient-team partnership (PCMH Building Block number 5) was addressed in this evaluation through one-on-one interviews with patients recruited from the participating primary health care clinics. Patient and family engagement in their health care is emerging as a driving force in achieving the triple aim of improved health, improved patient experience, and reduced costs (Frampton et al, 2017). The in-person semi-structured interviews were conducted using maximum variation sampling to capture as much as possible the range of patient views and experiences (Marshall, 1996).

"(The clinics) are really good at trying to find somebody that would have the information or could give me the resource that I need."

Survey questions originated from an integrated theory of behavioral change and focused on three domains from this theoretical base including patient's expectations for care received from their healthcare team (Fishbein & Ajzen, 1975), perceptions of additional resources needed to better take care of their health (Bandura, 1986), and readiness to change in the next six months regarding their health (Prochaska, DiClemente & Norcross, 1992). A total of seven patient experience questions were asked in a semi-structured interview. An additional nine questions were asked about access to health care services, beginning with a personal definition of access to health care. The survey questions are given in Appendix B and are also repeated in the

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code book (Appendix D). All questions were open ended and patients could provide as many answers or elements as they wished.

The methodology used to identify, contact and interview patients is given in Appendix X to simplify presentation of the results. Also included in this Appendix is a description of the coding processes following standards described by Boyatzis (1998). Designation of summary coding categories reported below was done by the Evaluation Team including three NCQA Certified Patient Centered Medical Home Content Experts.

Results

Tables 3 and 4 (Appendix X and Y respectively) present the frequencies for the summary variables seen in Appendix E. These measures are analyzed first by designation of patients receiving their care in a rural, urban or frontier county as reported in the 2016 Primary Care Needs Assessment. Characterization of the counties according to this typology is used to identify a range of workforce and health needs across the State. The same variables are analyzed by clinic type as shown in table 4. These designations are taken from records maintained by the SHIP PCMH Project Manager over the course of the three clinic cohorts. It is important to note that the status of the clinics may have changed since recording of clinic type due to mergers of independent practices into hospital systems and other organizational changes.

Within the PCMH domain, communication was by far the most frequent aspect of care sought (55% wished to have a healthcare team that listened to the patient's concerns and 35% wished the healthcare team would make sure the patient understood recommendations for care).

Pearson's Chi-Square measure of association was used to test the relationships between summary variables for patients' views and county status and clinic type. The summaries in both Tables note those relationships find to be statistically significant at the .05 level or less. Appendix E gives the variable name and frequency of occurrence for all the answers to each question within the summary variables, and for the remainder of responses not included in a summary variable.

The number of counties with SHIP PCMH clinics by county status is shown in the last row in Table 3. A total of 24 counties (44%) had at least one SHIP PCMH clinic Frontier counties were the least well represented with 31% of 16 counties having SHIP PCMH clinics. Rural counties and urban counties were 63% and 78% respectively.

One thousand one hundred and forty-three patients (1143) from 92 clinics volunteered to be interviewed. Of these clinics, 25% (23) were in rural counties 65% (60) clinics were in urban counties and 10% (9) were in frontier

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counties. The largest number of patients (70%) came from urban counties, followed by patients in rural counties (23%) and frontier counties (7%)

"Definition of responsibility for own health"
Patients' determination of responsibility for their own health is first organized by three of the State of Idaho's health priorities (tobacco use, obesity, and diabetes) The fourth priority, access to care, is addressed later in the report.

Few patients (3 patients) defined abstention from tobacco products as a personal responsibility, or as a component of their plans to change their health behavior in the next 6 months (3%). Slightly more patients (3%) named weight management as a personal responsibility and no patient described themselves as obese.

Overall, 43% reported receiving at least one element of PCMH services in the past year.

One hundred and forty interviewees identified themselves as diabetic. In the realm of responsibility for their own health and in descending order of the top four responsibilities, these individuals identified as their responsibilities watching their diet/eating correctly (56%), self-care (38%), regular exercise (37%) and medication compliance (33%).

Overall, 68% (730) defined responsibility for own health as a personal responsibility, 54% (621) defined responsibility for own health as following MD and healthcare team's directions, and as a combined subset, 406 (36%) defined responsibility as encompassing both aspects.

Has your healthcare team helped you in the past year ***AND*** Responsibilities of healthcare team in helping patient take care of their own health
Two summary variables were particularly important in describing the patients' experiences with their PCMH clinic. The first overall measure tallies the type of services received in the past year from the patient's healthcare team. The second overall measure asked the patients to list responsibilities of their healthcare team in assisting the patient to take care of their own health. As with all the other questions, these two were open ended and patients could provide as many answers or elements as they wished. The responses to these questions were categorized into Patient Centered Medical Home functions and Medical Services labelled as Basic Medical Care. Summary variables were constructed in order to provide an overall profile of care received.

Seventy percent of patients overall reported receiving at least one basic medical service in the past year. Management of chronic conditions (46%) and regular checkups (43%) were the most frequently reported of these services within this group of patients. Forty three percent overall reported

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receiving at least one element of PCMH services with reciprocal listening (31%) and care coordination (31%) the most frequently cited.

Overall, 78% of all patients named at least one element of PCMH services as something they felt their healthcare team was responsible for, as compared to 43% of these same patients listing at least one basic medical service as a healthcare team responsibility. Within the PCMH domain, communication was by far the most frequent aspect of care sought (55% wished to have a healthcare team that listened to the patients' concerns and 35% wished the healthcare team would make sure the patient understood recommendations for care). Within the medical service domain, the most frequently occurring element patients expected was an informed and accurate differential diagnosis from their provider (60%) and prescribing of correct medications (27%).

78% named at least one element […] as something they felt their healthcare team was responsible for

Things patient should be doing but need more information or help to take more responsibility for own health

This question drew diverse responses, with the top two responses falling in the aggregated categories of additional help from clinic (511 patients (45%) and responsibility for health is with the individual (351 patients (31%). Two hundred and seven (18%) could not identify anything additional they needed.

Changes in patient behavior planned in next 6 months

Sixteen percent of patients when asked if there was anything they would be doing differently in the next 6 months regarding their health said they would be changing nothing if their health situation remained the same. Improvements in exercise and diet were the most frequently cited changes planned for the next 6 months (41% and 31% respectively). Within these two groups saying they were going to change diet or exercise, 17% also stated they had a responsibility to follow through on taking care of themselves and 14% of those committed to improving exercise stated the same principle.

Healthcare team help with planned changes in next 6 months

Overall, 38% of participants affirmed that their healthcare team was doing everything needed and doing a good job. Another 32% could not state any additional role for their healthcare team. One hundred and forty-eight interviewees had specific additional services they would like to receive. Of the eight categories coded from these responses, the top three were: 1. Hopes for further explanation and communication with their healthcare team (32%) 2. Counseling on nutrition (18%) and Care coordination (18%).

Things keeping patient from taking care of themselves as much as they would like

Of the 20 specific barriers to better self-care named by the interviewees, the top three were finances (15%), health issues (12%) and personal motivational

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issues (12%). An additional 29% stated that nothing prevented them from taking better care of their health.

Frequencies of Summary Variables from Patient Interviews by Rural, Metropolitan and Frontier Counties

	Rural County	Urban County	Frontier County
Definition of responsibility for own health	Number (percent)	Number (percent)	Number (percent)
Responsibility for own health is with individual person	170 (65)	553 (71)	57 (66)
Responsibility for own health means following MD and healthcare team's directions	142 (54)	431 (56)	48 (56)
Responsibility for own health is with individual person and following MD and healthcare team's directions[2]	87 (32)	288 (37)	31 (36)
Has your healthcare team helped you in the past year?	Number (percent)	Number (percent)	Number (percent)
Patient Centered Medical Home Care received in past year	111 (42)	343 (43)	43 (50) p=.012
Basic Medical Care received in past year	171 (65)	601 (76)	56 (65)
Both PCMH and basic medical care received in past year[2]	57 (22)	212 (27)	29 (34)
Responsibilities of healthcare team in helping patient take care of their own health?	Number (percent)	Number (percent)	Number (percent)
Healthcare Team has responsibility to provide PCMH care	205 (78)	623 (81)	66 (77) p=.006
Healthcare Team has responsibility to provide basic medical care	105 (40)	331 (43)	51 (59)
Healthcare Team has responsibility to provide PCMH care and basic medical care[2]	66 (25)	226 (29)	33 (38)
Things patient should be doing but need more information or help to take more responsibility for own health?	Number (percent)	Number (percent)	Number (percent)
Additional help from clinic	110 (42)	366 (47)	35 (41)
Health is personal responsibility	77 (29)	252 (33)	22 (26)
No additional help because clinic is doing everything possible	106 (41)	322 (42)	43 (50)
Financial assistance	7 (2)	18 (2)	5 (6)
No additional help needed	50 (19)	143 (18)	14 (16)

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Any changes planned in next 6 months?	Number (percent)	Number (percent)	Number (percent)
No changes-keep everything the same	50 (19)	132 (17)	14 (16)
Changes related to medical care	37 (14)	137 (18)	16 (19)
Changes in specific behaviors (exercise and diet)	129 (49)	419 (54)	47 (55)
Changes in general self-care	54 (21)	172 (22)	16 (19)
Can healthcare team help with planned changes in next 6 months?	Number (percent)	Number (percent)	Number (percent)
No additional help needed	84 (32)	258 (33)	17 (19)
Healthcare team already doing everything they can to help	96 (37)	284 (37)	40 (46)
Patient responsible for health	13 (5)	60 (8)	3 (3)
Suggested new services	40 (15)	153 (20)	21 (24)
Things keeping patient from taking care of themselves as much as they would like?	Number (percent)	Number (percent)	Number (percent)
Personal motivation	21 (8)	102 (13)	10 (12)
Limits in resources	44 (17)	136 (18)	22 (26)
Family/work	78 (30)	227 (29)	17 (20)
Health issues	32 (12)	128 (17)	18 (21)
No issues prevent taking care of own health	76 (29)	233 (30)	20 (23)
Total Number of Patients (1143)	262 (23)	795 (70)	86 (7)
Number of Counties (24)	12	7	5

TABLE 3 Frequencies of Summary Variables from Patient Interviews by Rural, Metropolitan and Frontier Counties[1]

1. file:///C:/Users/wsolomon/Downloads/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf
2. Combined patient group citing both PCMH and basic medical services. Includes MD talked about diet.

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Frequencies of Summary Variables from Patient Interviews by Clinic Type

	Community Health Center	Privately Owned	Hospital Owned	Rural Health Center
Definition of responsibility for own health	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Responsibility for own health is with individual person	374 (49)	192 (25)	137 (24)	11 (79)
Responsibility for own health means following MD and healthcare team's directions	315 (52)	156 (26)	131 (22)	3 (21) p=.051
Responsibility for own health is with individual person and following MD and healthcare team's directions[1]	199 (36)	104 (38)	94 (38)	3 (21)
Has your healthcare team helped you in the past year?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Patient Centered Medical Home Care received in past year	228 (41)	130 (48)	122 (49)	1 -
Basic Medical Care received in past year	390 (70)	193 (71)	189 (76)	5 (36)
Both PCMH and basic medical care received in past year[1]	127 (23)	81 (30)	79 (32)	3 (21)
Responsibilities of healthcare team in helping patient take care of their own health?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Healthcare Team has responsibility to provide PCMH care	450 (80)	213 (78)	203 (82)	8 (57)
Healthcare Team has responsibility to provide basic medical care	234 (42)	136 (50)	97 (39)	4 (29)
Healthcare Team has responsibility to provide PCMH care and basic medical care[1]	163 (29)	85 (31)	64 (26)	3 (21)
Things patient should be doing but need more information or help to take more responsibility for own health?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Additional help from clinic	259 (46)	101 (37)	136 (57)	4 (29)
Health is personal responsibility	178 (32)	90 (33)	77 (31)	2 (14)
No additional help because clinic is doing everything possible	71 (13)	45 (17)	6 (2)	3 (21)
Financial assistance	17 (3)	2 -	11 (4)	0
No additional help needed	82 (15)	65 (24)	46 (19)	4 (29)
Any changes planned in next 6 months?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
No changes-keep everything the same	93 (16)	59 (22)	37 (15)	0
Changes related to medical care	94 (17)	53 (19)	38 (15)	0

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Changes in specific behaviors (exercise and diet)	322 (58)	116 (43)	136 (55)	7 (50)
Changes in general self-care	103 (18)	73 (27)	60 (24)	3 (21) p=.034
Can healthcare team help with planned changes in next 6 months?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
No additional help needed	179 (32)	85 (31)	81 (33)	2 (14)
Healthcare team already doing everything they can to help	201 (36)	116 (43)	89 (36)	5 (36)
Patient responsible for health	31 (6)	20 (7)	22 (9)	3 (21)
Suggested new services	120 (21)	47 (17)	42 (17)	0
Things keeping patient from taking care of themselves as much as they would like?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Personal motivation	74 (13)	32 (12)	27 (11)	0
Limits in resources	11 (20)	45 (17)	40 (16)	2 (14)
Family/work	157 (28)	76 (28)	76 (31)	3 (21)
Health issues	83 (15)	36 (13)	49 (20)	5 (3)
No issues prevent taking care of own health	155 (28)	89 (33)	73 (29)	3 (21) p=.032
Total Number of Patients	615 (54)	238 (21)	248 (22)	14 (1)
Total Number of Clinics (89)[2]	46	26	15	2

TABLE 4 Frequencies of Summary Variables from Patient Interviews by Clinic Type

1. Combined patient group citing both PCMH and basic medical services. Includes MD talked about diet.
2. Free clinic (1 clinic: 11 patients) and “other” clinic (2 clinics: 17 patients) are not included.

Patients were also asked to give their personal definition of access to healthcare. The range of definitions is given in Appendix F. Sixty one percent of the interviewees defined access as being able to see a physician and/or healthcare team when needed.

Eighty-four percent of the patients reported being able to easily schedule an appointment with a doctor when they needed one. The majority of patients also had reliable transportation (89%), ready access to primary care in the past 6 months (88%), access to dental care (60%), and had insurance

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coverage (57%). In contrast, 44% of patients has specialty referrals available and 33% reported access to behavioral health.

Of particular interest was the association between the definition of healthcare as being able to obtain services when needed and access as defined by ability to pay for healthcare services. One hundred and sixty-four patients (164) defined access as both being able to obtain services when needed and being able to pay for these services (chi square 10.05, p = .002). Rural patients reported having the greatest difficulties with the cost of care (21%).
.
The remainder of questions and frequencies of responses pertaining to access to healthcare are presented in Appendix F.

Clinic PCMH Staff Interviews

Clinic staff interviews focused on 7 of the PCMH building blocks shown in Figure 2. (numbers 1(Engaged Leadership), 2 (Data-driven Improvement, 4 (Team-based care), 6 (Populations management), 7 (Continuity of care), 8 (Prompt access to care) and 9 (Comprehensiveness and care coordination) The Idaho SHIP also focused on the State's four health priorities (obesity, tobacco use, diabetes and access to care) Questions about these priorities were also included in the staff interviews. These health priorities are also discussed in the Get Healthy Idaho Plan (http://gethealthy.dhw.idaho/gov/index.php/home/health_data).

Prior to reaching out to clinics in the Research Associate's (RA) designated region, all clinic contact names, phone numbers, and email addresses were verified with the Public Health District Quality Improvement Specialists for that region. The RA's initial contact with each clinic representative was done via phone call or email to introduce themselves and provide background regarding the purposes of the State Evaluator Team (SET). Then, a one-hour meeting was scheduled during the time frame that the RA planned to be traveling in the clinic's region. Attendance at the meeting was requested for the SHIP contact person as well as any other members of the PCMH team that were available, including physician champions, care coordinators, care managers, administrators, etc. Trips to each region were planned for each cohort of clinics. Clinics determined which staff members should participate, with the number of staff ranging from two to six.

Of particular interest was the association between the definition of healthcare as being able to obtain serves when needed and access as defined by ability to pay for healthcare services.

The interview questions were designed to elicit information about the clinic's experiences with PCMH transformation, the ways they've utilized PCMH activities to address State health priorities, and summarize their overall

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experiences with the SHIP program as captured in notes taken by the RA. See Appendix J for the Clinic Staff Survey Questions and coding. Coding was done using NCQA 2017 Standards.

Clinic PCMH Staff Interview Results

The frequency of citation of each NCQA standard was analyzed according to county status (33 clinics in rural counties, 77 clinics in urban counties and 15 clinics in frontier counties) and clinic type (46 Community Health Centers, 32 Private Clinics, 38 Hospital Owned Clinic, 7 Rural Clinics and 3 Other).

Two significant associations ($p < .05$) were observed between county status and reported successes for the 127 clinics. Clinics in urban areas were least likely to report care managements and support as a success (10% of urban clinics) and frontier clinics had the highest reported frequency of success with patient-centered access and continuity (80% of frontier clinics). Since there were otherwise no significant associations by county status or clinic type, the feedback is given in aggregate in Table 5 below.

Frequency of Clinics' Designation of Successful PCMH Functions and Priorities for Coming Year

PCMH Successes	Number of Clinics
PCMH function that was the most successful towards achieving better patient care: **Team-based care and practice organization**	54
PCMH function that was the most successful towards achieving better patient care: **Knowing and managing your patients**	58
PCMH function that was the most successful towards achieving better patient care: **Patient-centered access and continuity**	65
PCMH function that was the most successful towards achieving better patient care: **Care management and support**	31
PCMH function that was the most successful towards achieving better patient care: **Care coordination and care transitions**	64
PCMH function that was the most successful towards achieving better patient care: **Performance measurement and quality improvement**	65

Priorities for Coming Year	Number of Clinics
PCMH functions that are priorities in the coming year: **Team-based care and practice organization**	34
PCMH functions that are priorities in the coming year: **Knowing and managing your patients**	63
PCMH functions that are priorities in the coming year: **Patient-centered access and continuity**	66

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PCMH functions that are priorities in the coming year: **Care management and support**	51
PCMH functions that are priorities in the coming year: **Care coordination and care transitions**	48
PCMH functions that are priorities in the coming year: **Performance measurement and quality improvement**	79
N = 127	

TABLE 5 Frequency of Clinics' Designation of Successful PCMH Functions and Priorities for Coming Year

Table 6 (below) summarizes the type of help clinics seek with their PCMH implementation. The most frequently cited category was no help (32%), followed by mentoring from other clinics (20%) and patient-centered access and continuity (16%). Within this last category, clinics in frontier counties (47% of frontier clinics) were significantly more often to report desiring help with patient-centered access and continuity. With regards to clinic type, rural clinics were most likely to seek help with templates for policies and procedures (57% of rural clinics), and to name an EHR affinity group as an issue they would like help with.

Frequencies of Clinics' Designation of PCMH Functions as Needing more Help

	Number of Clinics
PCMH function that you'd like more help with: **Patient-centered access and continuity**	20
PCMH function that you'd like more help with: **Care management and support**	10
PCMH function that you'd like more help with: **Care coordination and care transitions**	16
PCMH function that you'd like more help with: **Population health**	7
PCMH function that you'd like more help with: **Patient engagement and outreach**	4
PCMH function that you'd like more help with: **NCQA**	18
PCMH function that you'd like more help with: **Affinity group for clinics who use same EHR**	18
PCMH function that you'd like more help with: **Mentoring from other clinics**	25
PCMH function that you'd like more help with: **Templates for policies and procedures**	12
PCMH function that you'd like more help with: **Opioid crisis**	1
function that you'd like more help with: Medicare/Medicaid population	1
PCMH function that you'd like more help with: **None**	40
PCMH function that you'd like more help with: **Team-based care and practice organization**	3
N = 127	

TABLE 6 Frequencies of Clinics' Designation of PCMH Functions as Needing more Help

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PCMH Portal Notes

The Patient Centered Medial Home Portal Notes used over the course of the 3 PCMH clinic cohorts were coded for content using the six National Committee for Quality Assurance (NCQA) PCMH standards. Clinics were asked to place both Goals and Plans in their Portal notes. Appendix G summarized these Goals and Plans along with the number of codes abstracted from the Portal Notes for each standard under specific mechanisms or processes by which the Goal or Plan was described as being used. A NCQA Certified PCMH Content Expert completed the majority of the coding, with the remaining done by a Research Graduate Student under her supervision.

The range of responses to Goals and Plans provides another perspective on the complexities of the clinic's path to achieving their PCMH. As an example, the NCQA PCMH standard Access to Care as operationalized through changes in scheduling was mentioned by 47% of the clinics. Scheduling included providing same day appointments, updating scheduling protocols, monitoring no show rates, deploying advanced access, developing alternative encounters, expanding hours of operation, and increasing the number of encounters. (Appendix G)

The PCMH Portal notes were also coded for successes, barriers and areas of interest or concern. Improved patient access to care was the most frequently cited success (47%). These topics are summarized in Appendix H. Difficulties in forming Team Based Care was the most frequently cited barrier (46%). Examples of the specific codes included in this 15-code set are employee turnover, challenges with huddles, and care plans without adequate tools. Administrative and management issues were by far the largest area of interest or concerns (80%). With 39 specific codes, this are of interest/concern also had the greatest number of specific issues brought forward in the PCMH Portal Notes.

Panel Interviews

A related evaluative effort for Goal 1 is production of PCMH video taped conversations/panel interviews on clinic's experiences with their PCMH journey. There were a variety of panel interviews specific to Goal 1 including a panel of clinic administrators, clinicians, care coordinators, and Physician Champions for the PCMH transformation. All panel participants were volunteered to participate and did sign a release to participate in the videotaping process. The goal of these panel interviews was to gain insight into the context and reality of the transformative experience from a variety of viewpoints as well as to provide a resource for clinics considering becoming a PCMH to be able to learn from others who have already gone through the change and system processes. Please see Appendix I for directions on how to access these video links. A separate report is summarizing the structure of the discussions and lessons learned is also available.

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Goals 2 and 5

> *Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood*
>
> *Goal 5: Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level, and statewide.*

There is ample evidence that effective care coordination efforts rely on good communication between levels of care and providers (Scotten, Manos, Malicoat, & Paolo, 2014). One such avenue to communicate patient information to coordinate care is the use of the electronic health record platform. The use of the EHRs for this purpose meets Meaningful Use guidelines and promotes quality and safety initiatives (Handmaker & Hart, 2015). The use of EHRs's can improve care coordination practices through the collection of data for outcomes-based reporting and risk stratification of patient populations for prioritization of interventions as well promoting evidence-based practice for positive health care outcomes (Hebda, Hunter, & Czar, 2019).

There is ample evidence that effective care coordination efforts rely on good communication between levels of care and providers.

Goals 2 and 5 were examined to identify the experience of users in the health care system as it related to use of the EHR to meet PCMH transformation needs. The SET approached the question of Health Information Technology first with two Use Cases conducted with clinic staff in Eastern Idaho. The first Use Case was held at the Southeastern Public Health District on August 2. The second Use Case was held at the Eastern Public Health District on August 7th.

Presentations were given to 23 participants on use of Excel as a method of producing risk stratification for patient populations and use of work flow analyses to pinpoint where data are obtained and how these data are used in planning care coordination and/or care management and support.

Feedback from clinic staff underscored the wide range of expertise and capacity for dealing with a given clinic's electronic health record system. This theme has been observed nationwide in recently published analyses of primary care's level of preparedness to use electronic Clinical Quality Measures (eCQM). (Cohen, Dorr, Knierim, DuBard, Hemler, Hall et al, 2017; State Health Access Data Assistance Center, 2015)

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To further address challenges in executing tasks in Goals 2 and 5, Boise State University and Health Information Technology consultants have developed an outline for curriculum modules for components of the development and testing process of electronic Clinical Quality Measures (eCQMs). Figure 3, taken from the Centers for Medicare and Medicaid eCQI Resource Center, defines the iterative phases in development and use of an eCQM.

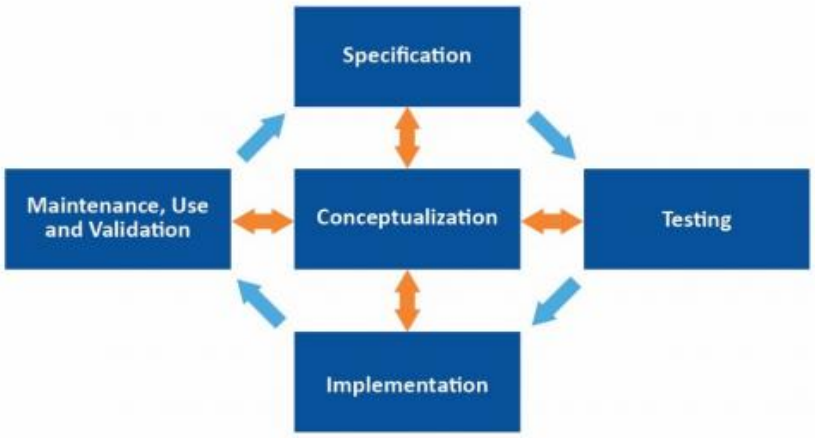

FIGURE 3 Lifecycle of an Electronic Clinical Quality Measure

Weblinks

1. https://ecqi.healthit.gov/content/ecqm-lifecycle downloaded 10/2/18
2. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/BlueprintVer14.pdf
3. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS_InventoryUserGuide_October_2017.pdf

Domains II and III in Appendix K address the conceptualization and specification of an eCQM guided in part by the review process described by Cholan et al (2017) in documenting the life of eQCMs and the August 2018 CMS blueprint (see Weblink 2 above). The modules will be based in part on materials prepared under the SHIP initiative as part of the assistance given to participating clinics working on their PCMH transformation. The curriculum emphasizes specific instructional activities appropriate for Undergraduate and Masters level courses in research methods and health information management.

At the clinic level, the training will be geared for clinic staff with high school through community college educational levels since these are the staff in many rural, independently owned primary care clinics given the responsibility to assemble reports. Examples of workflow analyses will illustrate the importance of protocols for data entry and the consequences for patient care and payment if faulty data are entered into a report. Interactive on-line lessons will be created illustrating use of tools available through the Centers for Medicare and Medicaid's eCQI resource (https://ecqi.healthit.gov/)

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

The seven Idaho Public Health Districts provided a geographical and organizational framework for formation of the seven SHIP Regional Collaboratives (RC). As shown in Figure 2, the RCs are conceptualized to provide a third level of support for the primary care clinic and their patients. A specific objective of the RCs was to identify resources for patient support often previously unknown to the primary health care clinic, thus expanding the medical health neighborhood. Efforts were made to establish initial partnerships with clinics and other community entities which had the capacity to address certain social determinants of health beyond the reach of the primary health clinic.

The SET Research Associates attended as many of the Regional Collaborative meetings as possible both to introduce the purpose of the evaluation and to learn of the scope of the RC efforts in expanding and strengthening the medical health neighborhood. The seven Regional Collaboratives each have histories of accomplishments and lessons learned drawing in part on the distinctive legacies of the Public Health Districts. To better understand the scope of Regional Collaborative's efforts, brief phone interviews were conducted with members of the RCs identified by the seven Public Health District SHIP managers. These reports are provided in separate documents (see Appendix O and P).

Coding of Regional Collaborative Monthly SHIP Manger Public Health District Reports

The SET has prepared a coded data file for the coaching and progress notes collected by SHIP PCMH Managers and Public Health Quality Improvement staff for each of the 55 clinics in Cohort one. This was another prong to evaluating Goal three as these Monthly SHIP Manager reports contained key information related to the PCMH clinic experiences and transformation process

It is important to note that the Portal notes are generated very differently from the in-person interviews conducted the Research Associates with clinic staff. Because of variations in details of reporting across Regions. It is not possible to estimate the degree of under or over reporting in the Portal notes. Rather, the range of entries provide an overview of the scope of the issues discussed across the Regions, and the frequency of occurrence. An overall summary of reported activities for 1/17-1/18 is given for the entire State.

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Table 7 (below) presents a frequency of the 60 activities recorded in the Monthly Reports. These codes were developed iteratively through review of the monthly reports submitted by the Quality Improvement Specialists and PCMH Public Health District SHIP managers. Two inter-rater reliability checks between the Graduate Research Assistant developing the codes and a Faculty Supervisor were done throughout the code development with an overall agreement of 90%.

The activities highlighted in yellow are Patient Centered Medical Home Functions as defined by the 2017 NCQA PCMH standards. Four of the five 2017 NCQA PCMH content areas appear in the top ten most frequently occurring activities. The PCMH content area of Access to Care was cited much less frequently. Five of the seven SHIP Goals also appear in the 10 most frequently occurring activities with the Coaching/PCMH Transformation by far the most commonly reported across the 7 Regions. The activities related to specific Goals are labeled in Table 7 by Goal number.

Frequencies of Regional Collaborative Activities Reported for January 2017-January 2018

Goal 1: Sum of Coaching/Patient Centered Medical Home Transformation	987
Sum of Team Based Care_Behavioral Health	249
Goal 3: Sum of Medical Health Neighborhood	246
Goals 2 & 5: Sum of Electronic Medical Record /Data/Idaho Health Data Exchange	193
Sum of Quality Improvement	170
Goal 4: Sum of Community Health Workers /Community Health Emergency Medical Services	148
Goal 3: Sum of Regional Collaboratives	145
Sum of Care Coordination_Other	124
Sum of Care Management Diabetic Care	120
Sum of Sustainability	89
Sum of Oral Health	82
Sum of Mental Health/Suicide Prevention	80
Sum of Care Management_Other	72
Sum of Other Leadership Meeting	63
Sum of Care Coordination_SpecialtyReferrals	57
Sum of Population Health	46
Sum of Community Health Assessment	43
Sum of Telehealth	42
Sum of Team Based Care_Other	42
Sum of Regional Collabrative (CHC) Meeting	40
Sum of Access to Care_Other	40
Sum of Regional Collaborative Grant/Subgrant	39
Sum of University/Student involvement	37

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Sum of Caregiver Integration Project	37
Sum of Childrens' Mental Health	29
Sum of Sex Education/Health	27
Sum of Care Management_FamilyCaregiverSupport	27
Sum of Public Health	22
Sum of Tobacco	21
Sum of Executive Leadership Meeting	20
Sum of Care Management_Cancer	20
Sum of Senior Citizen	18
Sum of Opthamology	18
Sum of Care Management_Hypertension	17
Sum of Value Based Care	16
Sum of Substance Abuse	14
Sum of Transportation	12
Sum of FoodBank/Nutrition	10
Sum of Self Management	9
Sum of Care Coordination_PharmacyServices	9
Sum of Care Management_GroupVisits	8
Sum of Reimbursement	6
Sum of Medication Assistance	6
Sum of Low Income/Finances	6
Sum of Immunization	6
Sum of Care Management _Obesity	6
Sum of Care Management _HeartDisease	6
Sum of Access to Care_AfterHoursCare	6
Sum of KM	5
Sum of Access to Care_UrgentCare	5
Sum of Care Management _Stroke	4
Sum of Child_Protection_Services	4
Sum of Housing	3
Sum of Home Health	3
Sum of End of life	3
Sum of Legal Assistance	2
Sum of Exercise/Fitness	2
Sum of Rural Health	1

TABLE 7 Frequencies of Regional Collaborative Activities Reported for January 2017-January 2018

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The potential importance of organizations such as the SHIP Regional Collaboratives is seen in Table 8 (below). Entries are taken from the 2017 County Health Ranking data for the State of Idaho. The variables are selected based on responses from patient interview answers to the question of what people planned to change about their health behaviors in the coming 6 months. Increasing exercise and improving diet were frequently cited goals for improvement of personal health.

The regional and county profiles in Table 8 for food security, healthy food availability, and opportunities for exercise provide further insight into the opportunities and challenges at the clinic, county and regional level for achieving personal health goals. Across the Counties participating in SHIP, the percent of residents experiencing food insecurity ranged from 9-21%. In these same counties, the percent of residents with limited access to healthy foods ranged from 2-15% and the percent of residents with access to exercise opportunities ranged from 31-92%.

2017 County Health Rankings Social Determinants of Health Related to Patient Interviews for SHIP Counties 1

Region	County	Percent County Residents with Food Insecurity	Percent County Residents with Limited Access to Healthy Food	Percent County Residents reporting being Physically Inactive	Percent County Residents with Access to Exercise Opportunities	County Status[2]
1	BENEWAH	18	15	25	63	RURAL
1	BONNER	17	6	22	73	RURAL
1	KOOTENAI	15	8	20	76	URBAN
1	SHOSOHNE	19	2	28	82	FRONTIER
2	NEZ PERCE	15	4	24	79	URBAN
3	ADAMS	17	4	21	31	FRONTIER
3	CANYON	14	8	22	78	URBAN
3	GEM	16	14	25	73	RURAL
3	OWYHEE	14	7	25	42	FRONTIER
3	PAYETTE	14	6	24	67	RURAL
4	ADA	14	4	16	92	URBAN
4	ELMORE	16	12	25	82	RURAL
4	VALLEY	15	7	18	70	FRONTIER

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5	JEROME	12	10	22	76	RURAL
5	MINIDOKA	11	6	18	41	RURAL
5	TWIN FALLS	14	4	22	70	URBAN
6	BANNOCK	9	9	18	79	URBAN
6	BINGHAM	13	7	26	57	RURAL
6	FRANKLIN	13	3	18	54	RURAL
6	POWER	11	2	23	71	FRONTIER
7	BONNEVILLE	13	7	20	79	URBAN
7	FREMONT	12	4	20	11	RURAL
7	JEFFERSON	12	5	21	50	RURAL
7	MADISON	21	9	14	69	URBAN
7	TETON	12	2	16	53	FRONTIER

TABLE 8 2017 County Health Rankings Social Determinants of Health Related to Patient Interviews for SHIP Counties

Table Data Retrieved from the following websites:

1. http://www.countyhealthrankings.org/app/32ntra/2018/downloads
2. https://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf

Windshield Surveys

A second more fine grained analysis of the community environment within a RC's medical health neighborhood was conducted by the Research Associates using a windshield survey. The SET utilized a modified windshield survey tailored to capture the immediate environment surrounding the SHIP clinics. This process has been used to understand the community environment within a medical neighborhood. See Appendix L for the windshield survey instrument.

Windshield surveys were performed by the Research Associates either through driving or walking through the neighborhood. The RA would note any observations related to the general area, looking specifically for data related to physical, social or economic issues that would provide a context for the patient and clinic experiences in that community (Center for Community Health and Development, 2018).

Overall frequencies for the items in the windshield survey are given in Appendix L. The availability to taxi cabs and the presence of a public transportation system were the only community differentiating features according to clinic types and county status. Community Health Centers had

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the lowest percent of taxi cab companies (47% versus and average of 90% across the other 3 clinic types) and less likely to be located in a city with a public transit system (41% versus and average of 91% across the other 3 clinic types).

As a group, the 127 clinics surveyed were in communities with green spaces, had adequate and easily accessible parking, and were well maintained. As a group, 46% did not have sidewalks leading to the facility and 60% did not have bus stops visible in the immediate vicinity.

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

Idaho is a large state (11th largest in the nation) with most Idahoans dispersed widely throughout 19 rural (43%) and 16 frontier (36%) of 44 counties. Travel in many areas of the State requires driving through narrow, mountainous roads. The entire State has longstanding challenges with shortages in almost all categories of healthcare professionals. The combination of these factors calls for unique solutions for the delivery of primary healthcare to citizens living outside the State's 9 urban counties. The three components of the virtual PCMH are designed to provide such solutions for far flung, small, rural communities.

The first component, Community Health Workers (CHW) draws on the strength of many of Idaho locales with training and deployment of local residents to address community healthcare needs. CHWs can help patients navigate the healthcare system, arrange for referrals, and follow-up with support with self-care for chronic health issues. The status of CHWs in Idaho is addressed within Appendix S and Appendix T (Appendix R can also be referenced for additional background detail on CHWs).

Training modules for CHWs were developed through SHIP and offered by Idaho State University. Of special note for this training are materials that speak to ethical responsibilities of CHW's joining the clinical care team(s) These responsibilities are articulated in the Code of Ethics produced by the American Association of Community Health Workers, and based on principles that apply to all professionals in the health and social service fields. Clinics and licensed professionals are urged to exercise due diligence in understanding important legal implications that apply to Community Health Workers such as a duty to report harm or abuse present in the communities they serve. Clinics are also reminded that appropriate supervision and policies should be set in place by the organization since Community Health Workers are not licensed professionals. There are currently no formal regulations for Community Health Workers in the State of Idaho that mandate responsibilities, or separate liabilities from the organizations where they may

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be employed. It is recommended that boundaries and protections for patients, clinics, providers and CHW's be given consideration as the role of the CHW is further developed.

The second component, Community Health Emergency Medical services (CHEMs) builds on the training and licensure of paramedic units to provide specific medical and support services more broadly in the communities they serve. For example, expansion of the role of CHEMs with home visits and medication check-ins may help patients better adjust after a hospital discharge for a chronic condition. Agreements executed with community partners may offer alternative locations for transport for non-emergency conditions rather than taking the patient to the Emergency Department for what will be deemed an unnecessary ambulance ride. The SHIP experience with CHEMs was recorded with interviews with CHEMs staff and are summarized in Appendix Q and Appendix V.

There are currently no formal regulations for Community Health Workers in the State of Idaho that mandate responsibilities, or separate liabilities from the organizations where they may be employed.

Telehealth is the third element of the SHIP virtual Patient Centered Medical Home. The opportunities offered by using telehealth to connect patients with specialty consultations and other services has long been of interest in Idaho. SHIP's telehealth efforts were supported by technical assistance and consultation with experts in the area. A telehealth learning collaborative was convened May 23thd to review the status of SHIP's telehealth initiative. The discussion in this stakeholder group led to submission to the Health Quality Planning Commission (HQPC) with a request for review of telehealth reimbursement, scope of practice and related issues. The scope and functioning of the HQPC is found at the following link for the Idaho Legislature: https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch10/sect56-1054/ The HQPC was established by Idaho State Legislative Statute in 2006 to "….promote improved quality of care and improved health outcomes through investment in health information technology and in patient safety and quality initiatives in the state of Idaho".

A summary of telehealth activities is given in Appendix M as submitted to the HQPC. Given the ongoing formative discussion around this complex issue, the SET evaluation report does not include any additional information on telehealth.

In addition to the telehealth initiatives begun with the SHIP, a parallel effort was launched in March 2018 with a Project ECHO sponsored by SHIP and the University of Idaho's WWAMI program. A description of the first offering

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on opioid addiction and treatment is found at this website: https://www.uidaho.edu/academics/wwami/echo. The ECHO activities are officially endorsed by the University of New Mexico, the originator of the ECHO concept for human medicine.

Each ECHO session is led by an expert panel, followed by a patient case presentation submitted by a clinician and using a patient history approved by the University's Institutional Review Board. The opioid addiction and treatment panel is composed of three physicians, a Licensed Clinical Social Worker, a Nurse Practitioner and a Pharmacist. The evaluation results presented here are summaries of the themes coded as emerging from the patient case presentation. Nine presentations were transcribed and coded using the guideline below:

Patient referred from another provider yes/no/ not cited

1. Count of frequency of citation of medication reconciliation challenges
2. Count of frequency of citation of medication/opioid overdose challenges
3. Count of frequency of citation of patient mental health challenges
4. Count of frequency of citation of medication reconciliation tapering/reduction challenges

Response from Expert panel members to each of these issues in terms of recommendations.

Overall verbal rating of case presenter at end of session.

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

A range of efforts initiated under SHIP provide opportunities for case studies of alignment of payment to transform from volume to value. Mercer, the Project Management and Financial Analysis Contract for SHIP prepared Goal 6 Financial Analysis reports, which were submitted to CMMI on an annual basis. The SET Goal Six efforts focused on analyses of CHEMS. Among those efforts amendable to such analyses is the Community Health Emergency Medical Services. Traditional Emergency Medical Services seek to change their business model from a fee-for-service transport system to a value-based system, with value defined in a number of different ways for patients, providers and payers. The Value of Community Health Emergency Medical Services (CHEMS) in the State of Idaho (Appendix V) presents a summary of evidence on the outcomes of CHEMS and a review of issues relevant for Idaho in the expansion of CHEM services.

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Goal 7: Reduce overall healthcare costs:

Mercer is addressing this goal and the SET will not be providing additional information towards this goal.

Recommendations for future Idaho healthcare transformations based on state-level evaluation of Idaho's SHIP

All recommendations are based on the premise that analyses can be done to further operationalize elements of SHIP for primary care healthcare teams. The results of the analyses would give more evidence on the potential of expanded primary care services to improve quality and reduce costs.

Goal 1: Prepare communication materials for patients aimed at explaining the elements of Patient Centered Medical Home services most relevant to their personal healthcare needs and suggestions as to how talk with their healthcare team about these services. The results of the patient interviews completed for SET attest to the importance of these services from the patient's perspective. A tracking mechanism should be set up so that primary care clinics could monitor their patients' use of care coordination and other PCMH services directly relevant to patient care. These data would be part of the analyses for Goal 6.

Goal 2: Prepare a tool kit which supports a primary care practice's ability to conduct regular and systematic assessment of the capacity of primary care clinics' Electronic Health Systems to produce CQMs aligned with nationally defined measures. These assessments would establish a baseline of the feasibility of creating an aggregated health information system. The tools to carry out such analyses are available through the Centers for Medicare and Medicaid. (see https://ecqi.healthit.gov/)

Additionally, the tool kit should contain hands on exercises that guide clinic staff through the reporting functionalities of the Electronic Health Record system, how these reporting functions can be used to assess issues with clinic workflow, and steps to address commonly encountered reasons for "data gaps" (e.g. failure to record services, and placement of data in the wrong EHR location and/or in the wrong format)

Goal 3: Prepare tool kits for primary care practices to use in the assessment of their patients Social Determinants of Health. An example of existing tool kits can be found at https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html. These analyses could be used in turn to guide a primary care practice in identifying community partners ready and able to address additional patient needs related to these social determinants. The tool kit should include examples of Memos of Understanding/Agreement used to implement primary healthcare and community partnerships.

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Goal 4: Conduct analyses which would further define steps necessary for implementation of elements of the virtual PCMH. The analyses would include review of the legal and regulatory issues related to each element, review of the status of Idaho's workforce preparedness for each element, and review of the political and payer level of interest in each element. The sum of this information could serve to further prioritize efforts to implement the virtual PCMH and would be presented in one-page overviews for the diverse audiences interested in the virtual PCMH.

Goal 5: Prepare "primary healthcare clinic friendly" health information technology updates which alert clinic staff to changes in HIT directly relevant to the use of their own Electronic Health Record system and reporting of Clinical Quality Measures to Medicare, Medicaid and commercial payers. The updates would be written in plain English and would offer short, interactive exercises for clinic staff to determine the relevance of the HIT changes for their own workflow and reporting requirements.

The updates would serve as the basis for expansion of EHR affinity groups and ongoing conversation and problem solving within these groups.

Goal 6: Prepare analyses which demonstrate the value of care coordination and care management through tracking longitudinal changes in Clinical Quality Measures (CQMs) and related Value Based Payments occurring as a result of PCMH services. The Diabetes Prevention Program gives elements of best practice for care coordination for diabetic patients which could be documented in primary care practices and used as an example for this type of analysis (see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1282458/).

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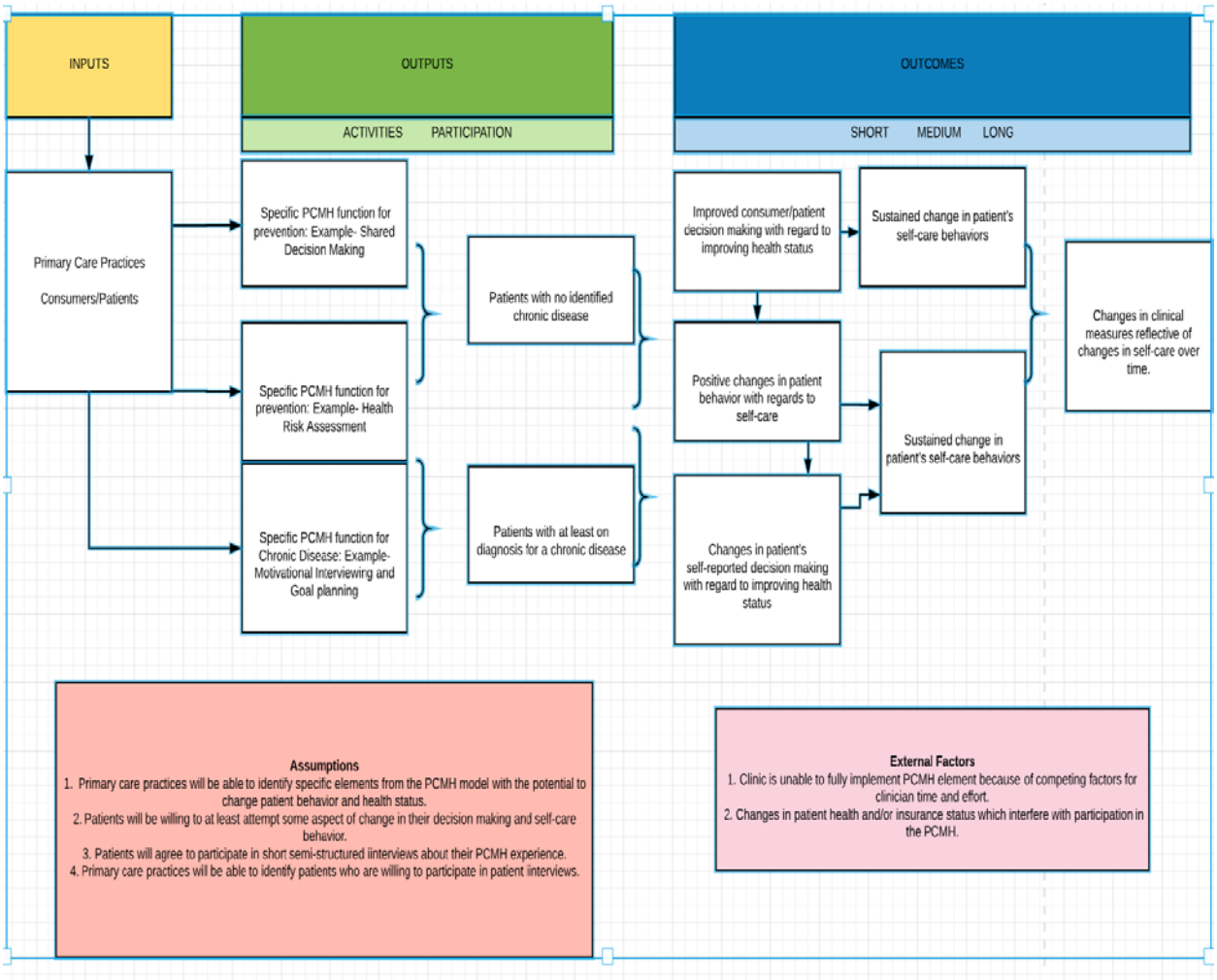
Appendix A

State-Level Evaluation Team's Logic Model for Patient-Centered Medical Home for Goal 1.



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Appendix B

Patient Interview Questions

INTERVIEWER: Thank you for agreeing to participate in this recorded interview. Let me give you some information about how this process works. I will first give you information about your consent to proceed, then I will ask you some questions about your healthcare experience, and then I will turn off the recording. Once the recording is turned off, I will get additional information so I know where to send your participation reimbursement.

At this point, you have agreed to complete a recorded interview. You will be asked to share your thoughts on your healthcare services and ways they might be improved. All information will be confidential and will not be shared with others outside of this project. Participation is voluntary. You may decline to participate or stop at any time. You will not lose access to any services through your clinic if you stop. There is no known risk if you answer these questions and you will not receive any direct benefits if you participate. We hope to learn more about how to help people and their healthcare team offer better care.

This study has been reviewed by the University of Idaho Institutional Review Board (IRB). The Board protects volunteers in research projects. I will send you a copy of this consent which will include contact numbers for Janet Reis, one of the primary investigators, and the IRB office contact information in the event you have any additional questions. **Do you wish to participate?**

INTERVIEWEE: YES

INTERVIEWER: Do you have any questions about participating or proceeding with this interview?

INTERVIEWEE: NO

INTERVIEWER: We are interested in hearing the different ways people take care of themselves, and what things your clinic might do to help you. Just answer the questions the best you can and if you do not know an answer, it is okay to say so. You don't have to make up anything. There are no wrong answers.

We are interested in hearing the different ways people take care of themselves, and what things your clinic might do to help you. Just answer the questions the best you can and if you do not know an answer, it is okay to say so. You don't have to make up anything. There are no wrong answers.

Some people think that patients should take certain responsibilities for their own health. Can you give me an example of things you are responsible for regarding your own health?

INTERVIEWEE:

INTERVIEWER: What has your healthcare team helped you with in the past year?

INTERVIEWEE:

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INTERVIEWER: What responsibilities do you think your healthcare team has for helping their patients?

INTERVIEWEE:

INTERVIEWER: The next two questions are about knowing what to do and when to do it. Confidence and knowledge can be important to managing your own health. **Are there any specific things you think you need to take more responsibility for your health?**

INTERVIEWEE:

INTERVIEWER: Are there things that prevent you from taking care of yourself as well as you would like to?

INTERVIEWEE:

INTERVIEWER: Taking Action - **is there anything new you plan on doing in the next six months to take care of your health?**

INTERVIEWEE:

INTERVIEWER: Is there anything your clinic healthcare team could do to help you be able to do more for your own health over the next six months?

INTERVIEWEE:

INTERVIEWER: Lastly, we would like to ask about your thoughts on access to health care. **What does ACCESS to healthcare mean to you?**

INTERVIEWEE:

INTERVIEWER: **Are you able to schedule an appointment with a doctor when you need one?**

INTERVIEWEE:

INTERVIEWER: Do you have all the healthcare services you need, in your area?

INTERVIEWEE:

INTERVIEWER: Do you have reliable transportation to your appointments?

INTERVIEWEE:

INTERVIEWER: Can you afford healthcare services when you need them?

INTERVIEWEE:

INTERVIEWER: In the last 6 months, how easily have you been able to access the following services if you have used them - Primary care?

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INTERVIEWEE:

INTERVIEWER: Dentistry, if applicable?

INTERVIEWEE:

INTERVIEWER: Counseling, if applicable?

INTERVIEWER:

INTERVIEWER: Specialists, if applicable?

INTERVIEWEE:

INTERVIEWER: That is all I have for now. Do you have anything else you'd like to add that we didn't cover?

INTERVIEWEE:

INTERVIEWER: Ok, well thank you very much for your time today.

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Appendix C

Methodology for Patient Interviews

Patient Participation

Patients participating in the interviews were either selected by their respective clinics and agreed to participate, or, are contacted by a SET Research Associate and agreed to participate. Clinics determined who should go on the potential participant/interviewee lists in a variety of ways. For example, a few clinics chose patients that participated in their care management program. Some clinics randomly selected patients and contacted the patients to see if they'd like to participate. Other clinics provided information on the interview process at the front desk and patients were asked if they would like to sign up. The methods of notification used are summarized in the Table below.

Method for selecting patients

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Diabetes Care Management Program	14	1.2	1.8	1.8
	Unknown	39	3.4	5.0	6.8
	flyers or front desk query	607	53.1	78.3	85.2
	Medicare	3	.3	.4	85.5
	Care management	3	.3	.4	85.9
	Random selection	91	8.0	11.7	97.7
	Convenience	18	1.6	2.3	100.0
	Total	775	67.8	100.0	
Missing	System	368	32.2		
Total		1143	100.0		

Fifty-one percent (25) of the clinics notified their patients in advance of contact from the SET Research Associate. Twenty nine percent (14) of the clinics provided names and addresses used to send letters of introduction to patients. The remaining 10 clinics did not contact their patients. This variable is labelled Notification.

Patient response ranged from 5% to 100% overall. (mean = 54, SD = 24). The Table below presents the range of response rates and frequency of occurrence. A two-way Analysis of Variance found a significant difference in response rates by advance notification ($F = 14.08$, $p = .000$) but not by method of choosing patients.

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Clinic Response Rates for Patient Interviews

Response Rate

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	5.00	1	.1	1.7	1.7
	19.00	1	.1	1.7	3.3
	23.00	1	.1	1.7	5.0
	24.00	1	.1	1.7	6.7
	25.00	2	.2	3.3	10.0
	29.00	2	.2	3.3	13.3
	33.00	2	.2	3.3	16.7
	34.00	1	.1	1.7	18.3
	38.00	1	.1	1.7	20.0
	40.00	1	.1	1.7	21.7
	42.00	2	.2	3.3	25.0
	43.00	1	.1	1.7	26.7
	45.00	6	.5	10.0	36.7
	47.00	1	.1	1.7	38.3
	50.00	6	.5	10.0	48.3
	52.00	2	.2	3.3	51.7
	54.00	1	.1	1.7	53.3
	55.00	2	.2	3.3	56.7
	56.00	3	.3	5.0	61.7
	57.00	1	.1	1.7	63.3
	58.00	1	.1	1.7	65.0
	62.00	1	.1	1.7	66.7
	64.00	1	.1	1.7	68.3
	67.00	3	.3	5.0	73.3
	71.00	2	.2	3.3	76.7
	73.00	5	.4	8.3	85.0
	79.00	2	.2	3.3	88.3
	82.00	1	.1	1.7	90.0
	100.00	6	.5	10.0	100.0
	Total	60	5.2	100.0	

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Patients were contacted by phone or in-person while at their clinic visit. If contacted by phone, a Research Associate (RA) would leave an initial contact message using a prepared script introducing the opportunity to participate in the interview. An area code specific to the State of Idaho was used in order to encourage people to return a voice mail message. The interview began with a statement of informed consent as approved by the University Institutional Review Board and confirmation of the participant's willingness to continue with the interview.

After the patient consented to the recorded interview, the Research Associate (RA) began to record the interview. Once the interview was completed, the recorder was turned off and the RA collected the mailing address of the participant.

Sometimes, patients and clinic staff opted to encourage the patients to complete a questionnaire in written form rather than complete a recorded interview. This made workflow for staff more productive and patients were able to be processed much more expediently, maintaining patient care with clinic personnel as the priority. If the patient answered the questions in a written form, consents were reviewed in person, with formal consent occurring as the 2nd step rather than the 1st step. Each patient who agreed to participate in answering the questions at the front desk prior to their medical exam were escorted to the Research Associate after the exam, received the opportunity to give verbal consent and then acknowledged formal written consent by placing their name on the consent form (they were offered to have a copy if they want), turned in their written worksheet, signed a receipt which was logged in.

Recordings in all regions were logged into the Transcript Checklist, sent to a transcription service or transcribed by a Research Associate depending on the urgency of processing or quality of the recording. (Low quality may have been handled by the Research Associate.) Once the transcription service issued a written transcript, the transcript was then logged into the transcription checklist and reviewed by the Research Associate to determine accuracy against the recording for quality assurance purposes. Occasionally, the transcripts needed corrections due to the service's unfamiliarity with the subject matter or medical terminology. Once the transcripts were completed, they were then packaged and prepared for the Primary Investigator for coding. In the event of a telephone interview, a copy of the formal consent, was mailed to the recipient.

The anonymous, printed transcripts were coded using a coding scheme developed iteratively through reading of each transcript line by line. The overall domains used correspond to the interview questions with specific codes and supporting text segments put into the code book. Each variable was coded to maximize the information available for subsequent aggregation and analysis. (Gilner, Morgan & Leech, 2017) The domains were subsequently coded for recurrent, unifying concepts across the domains related to patient responsibilities, Patient Centered Medical Homes, and preventive and basic medical services per the guidelines of thematic code development. (Boyatzis, 1998; Bradly, Curry & Devers, 2007; Glaser & Strauss, 1968)

The current version represents review of all code categories by five members of the Goal 1 evaluation effort with the aim of combining and clarifying codes. After coding of the first 100 interviews, an inter-rater reliability check using Cohen's kappa coefficient for categorical data was carried out with 20 of the coded interviews independently coded by a second team member (Cohen, 1960). Inter-coder reliability kappas across all codes was calculated at 80%. Reliability checks at 300 and 700 patients with twenty transcripts at each check achieved the same level of agreement overall.

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Appendix D

Codebook for Patient Interviews

These summary variables build on conceptually related constructs and follow the original construction of the interview questions. Questions eliciting positive responses about responsibilities and help needed are grouped together while questions eliciting problems or barriers are grouped together. In other words, all codes for question 9 inquiring about issues preventing a person from better taking care of themselves are grouped separately.

These codes were developed iteratively as each patient interview transcript was read and coded. New codes were added up to the 600th patient interviewed, with the majority of codes identified by the 400th patient. The coding paradigm was developed by a senior research faculty member and all coding was done by this person or by a Graduate Research Assistant. All data were entered by one member of the research team into IBM SPSS Statistics 24.

1. Definition of responsibility for own health	
1a. Being an informed and responsible consumer	• Keeping myself informed on different health problems I have through research • You can do research on the internet, ask other doctors to get a second opinion • You should keep track of the tests that you've had …to let you know what's going on with yourself • It's a lot of work to learn all the different kinds of stuff that I have to do with her • Be proactive in learning what is going on when you do become injured or ill • Writing does questions is the big one. Being prepared to know what and not being afraid to do it either • I am responsible for being my own advocate • I'm responsible for organizing one of the problems and finding out who I need to talk to resolve those problems
1b. Regular exercise	• Use the rec center like four or five times a week to get my cardio in, and a little bit of lifting • I always try to take care of my own health by doing a little exercise and stuff • The way you exercise • Exercise properly
1c. Watch diet/eat correctly	• I try to watch my diet and minimize the carbs • You need to eat right and they talk to us a lot about that We're responsible for eating a healthy diet and making sure that our bodies receive the nutrients they need to stay healthy • The way you eat • Eating properly • Making sure that I eat right
1d. Lab work completed	• Getting appropriate lab work done • Following up on labs
1e. Network coverage	• Checking my own insurance and what they cover in my network

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1f. Medication compliance	• They need to take the proper medication to make sure they're not having to go to the doctor as much • Keep track of prescriptions • Taking your medication like you should • Taking the medication that's prescribed • Keeping track of prescriptions and when they expire, would be one, especially if you take more than one • Taking my medication properly • Making sure that I take the medication at the right time • I always know exactly what medication I'm taking
1h. Make and keep appointments as scheduled	• Call if late or cancel appointments if you have to • I'm responsible for attending my appointments. I'm responsible for communicating with my doctor or the nurse... and say yes, I will be there at my appointment. Show up and if it's a follow-up • Another one is physically getting there; the patient should take charge of that if there's a scheduling problem • Making sure they (children) get to their doctor's appointments • When an appointment is made, keeping it
1i. Self-care Self-care includes activities of daily living, handling/managing stress, listening to one's body, personal hygiene and accepting personal responsibility for health	• Just trying to stay healthy • We should all try to take better care of ourselves • If you don't feel right and you don't take care of yourself, like they say, it's in other words you're not helping yourself • I'm Type 1 diabetic, so I'm responsible for managing my blood sugars and watching what I eat and taking care of myself on a day to day basis with exercise and everything • I'm responsible for keeping my diabetes under control • I learned that I need to take care of my own health • Basically, just the way I take care of myself • Try to get a decent amount of sleep • Good sleep times • How much sleep we get • Personal hygiene • Drink water every day • Managing stress • Being aware of your own body • I'm the main person who's in charge of my health and so the doctors just kind of give you their opinion • You take responsibility for your own actions with your own health • I think a person is very much responsible for their own health • There are some things you just have to do on your own • I am responsible for my health • All responsibility lies with me
1l. Following MD orders	• Number one, following the doctor's directions • Following my physician's instructions regarding medication and diet and exercise • Primarily doing what their doctors have said • Taking his advice and listening and changing my lifestyle • I have to do what the doctor tells me to do all the time • Really follow up on what Dr. is telling you
1n. Weight control	• Be careful about weight • Maintain the weight • I am responsible for maintaining a healthy weight

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1o. Seeing MD when necessary Seeing an MD when necessary includes knowing when to get help and going to doctor when appropriate	• Trying to go after the care that I need • Getting myself to the doctor when I need to • Doing your check-ups properly • If you're sick, you need to go get help • Generally being aware it we need to go to a special doctor's appointment • Going to the doctor when you feel sick
1p. Maintaining mental health	• Mental health is part of my responsibility • Seeking out healthy things that bring me joy • Finding joy • Keeping a healthy relationship between friends and family We try to stay really active. Mentally and physically • Doing things to improve my memory
1q. Temperance/ no smoking	• I don't drink • Quit smoking • I have a lot of health issues. So, for me, it was to take responsibility to quit smoking • I smoke and I know I shouldn't. I know that is my responsibility
1r. Paying for insurance	• Making sure insurance is paid for • Paying my co-pays • I am responsible to the financial aspect of my health • We need to be aware of changes in our insurance • Making sure I contact the insurance company and determine if we are "in network" with our provider choice. Make sure we know what the deductible is and what services are covered • I need to make sure my provider is in network with the insurance carrier
1s. Confidentiality of patient records	• Confidentiality between me and my doctor
1t. Vaccinations/ immunizations	• I have to take them to get immunizations
1u. Relaying information/ communicating with MD/healthcare team	• Like if you are not honest exactly what's going on and they may not be able to help you to the fullest • Making sure I relay the proper information to the doctor • E-mailing one another and communicating • Keep tabs on what I think is going on and to make the doctor understand what it is I'm there for • Making sure I get my needs across to the doctor well • Communicating my health problems and needs to my provider • Knowing what I have. Bringing everything I need to the appointment • I am responsible for knowing how to explain the problems or issues that I am having before I contact my doctor, so that he or she can better assist me
1v. Keeping children safe	• I'd say making sure that they are safe and they don't get hurt • Making sure they live in a safe environment
1w. Don't know	• I don't know how to answer that one

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2. Has your health care team helped in past year?	
	Yes 3 No 2 Don't know 1
	If yes- how helped?
2a. Reciprocal listening between patient and MD	• Doctor is very willing to listen, and she is willing to listen to my information on my own health • She's answered every question I have had about my health • They've just always made time to listen to me and give me ideas of what to do and…they were very very helpful • Yeah, they've been cooperative and they listen to me • They are always willing to answer, call me back, help me with referrals • He actually sat and talked to her and asked her different questions • They give me time to ask questions and they get to the bottom and follow up very well • They've been real understanding, very understanding • My current provider listens well and trusts that I know my body • I appreciate they are concerned with how the kids feel when they come in. They take the time to check them over well and also engage them in a conversation to make them less nervous
2b. Clinic staff talked about diet Clinic staff talking about diet includes conversations about appropriate diet for a diabetic patient	• My personal physician has encouraged me along the lines of, about the diet and minimizing carbs and so has my neurologist • They have given me tips that help with the diet that I need to be on • Have diabetic information that shows you how to maintain your diet • Dr. Prince has helped me eat right, eat better for control of my diabetes • They have given me tips that help with the diet I need to be on • They gave me good health food guides to lose a little bit of weight
2c. Costs of care	• They have helped me use the Terry Riley pharmacy for low cost insulin
2d. Encouragement to patient	• They've been verbally encouraging • They have helped me by being encouraging with my effort • Just encouragement • They're always encouraging
2e. Coordination of care	• She's been so helpful in coordinating and making sure that I get to my appointments that I don't have a problem • She guided me on all the things I needed to do and when I needed to do them by • The Kaniksu center has referred to the services my children need • A case manager actually contacted us to check in • They actually helped a lot with appointments with both of my sons • They changed their staff a few years ago. It's a lot better now and they are more on board with making sure the patients are getting the help they need
2f. Establishing care	• I'm new to the community and am finding a doctor
2g. Provide reminders and follow-up	• They're always willing to take the time to call me back if they're not available right at the moment to answer anything I have • Basically, they call and check to make sure that I'm doing okay and if I have any problem they could help with think they have done a great job in helping me be educated • They wrote down all the information on when my next appointment was and even called to make sure that I remembered it • They're very good at getting the nurse to call back

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2h. Help with managing health issue (s)	• They helped me with my mental health concerns by providing me with both medicinal and therapeutic solutions • They have helped me monitor my blood pressure • They have helped me with advice regarding my medications • My healthcare provider has helped me realize the steps that I need to take to be healthier • They have helped me with weight loss • They have helped me understand that your health depends on how well you take care of yourself
2i. Prescribe and monitor medications	• They have helped me with making sure that I'm on the right medications • Ordering my supplies, making sure my levels are good • They keep me up-to-date on my prescriptions • Helping me find the correct prescriptions • They've helped me by prescribing medicine that helped me to continue work and function • They've adjusted my medications
2j. Provide seminars and/or shared appointment and/or support groups	• Seminars and support groups for diabetic patients • I go to counseling every week and that helps me stay closer to them so I'm comfortable going to them for my needs
2k. Complete differential diagnosis	• The doctor can check you out,….that's their responsibility really and to examine and see what is wrong • My doctor has gone above and beyond I believe to help me try to figure out what is wrong • They ran some blood work stuff and that and found that it was my thyroid doing it • Healthcare team helps me with a quick recovery when I am feeling ill
2m. Regular checkups/ preventive care	• They haven't helped me with anything I've had to do except for a regular check up • Check-ups every year • Full panel of bloodwork to check basic health • We just did some tests to see if anything is going on • Management of my healthcare concerns and wellness • My healthcare team has assisted me with ensuring my preventive screenings are completed pursuant to standards of care and evidence-based guidelines
2n. Provide needed accurate, educational information	• They provided several topics including nutrition • I have received educational information about early prevention and symptoms of disease and I have received appropriate care instructions from my providers • By giving options • Recipes and information on new drugs or new alternatives • I think my clinic does a really good job of educating me and answering my questions • Gets back to me right away with e-mail questions • They're great. They listen, they take us right in and the doctor explains everything in detail • He has helped me understand that my Vitamin D is very low • They have helped me understand lab numbers and what they need

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2o. Manage chronic conditions Includes anxiety and depression	• I'm supposed to see my doctor every 3 months and I make appointments and they have been very good to me over there • They help me try to control me blood sugar • They have been helping me with my ratios and making sure my A1Cs can be a lot better than what they have been • Trying to keep my blood sugars under a manageable rate • Pain management • They've helped me get in with foot care • I've been dealing with severe alcoholism
2p. Urgent Care Services	• She has helped us with emergency stitches • Like I get cut or anything, she has helped me with that • Stitches for my son…ear infections, strep throat, all that good stuff
2q. Lab services	• They have done some lab work for me • Performing necessary lab work • They send me lab results

3. Responsibilities of healthcare provider for helping patient take care of own health	
3a. Specific medical services: e.g. laboratory tests, with diagnosis and follow-up with lab results	• To make sure that I am getting the right tests done for my health issues • Just monitoring my health, you know like they do my blood pressure, and blood sugar, and all that sort of stuff to make sure I'm healthy • Making sure my A1cs are on time • It's their responsibility to get me the correct testing and possibly medications that might help • They give me blood tests and I think it's their responsibility on keeping me informed • Follow up with lab results and testing
3b. Office Management: Appointments and waiting times/return phone calls	• Providers need to help patients get in for appointments and keep waiting time to a minimum • They need to make sure that they return phone calls in a timely manner • I think it is their responsibility to get their appointments set up
3c. Post health information in patient Portal	• He posts the results, or the clinic post the results, on the website where I can access them

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3d. Listen to patient's concerns, answer questions and provide support	• Listen, listen, listen. They really need to listen to what you say, what you are concerned about, and if they don't know the answer look something up and get back in touch with you and things • Answer questions or give us appropriate advice before asking questions • They should tell the person, like myself, what that prescription is for and why I'm taking the amount that I'm taking • The healthcare people, they need to tell the truth of stuff and tell you this is a, you know, tell you your problems and everything and what you should do • To make good decisions with me and for me • Providing me with all the necessary information and answering any questions that I might have • Listening is most important • She had very good advice and was on top of everything that was going with us • To ask you questions of how you've been feeling, what's going on with you • Feeling like your doctor knows who you are and cares who you are • Major responsibility would be listening. They need to listen to their patients • To listen and not circumvent anything that I sat with their own diagnosis • Finding what is reality for the patient and try to help them change their behavior • I think they need to make sure that they're listening and really paying attention to what the patient is saying. I know I like to be heard • I believe listening to the patient is key
3e. Educate patient about health care services and health issues	• My blood sugar was way high and I kind of called and asked if that could have any effect on whatever else was going on. And they were willing to talk to me about • Well to be clear, to make sure that the patient is clear on what procedure or what the path is that they're going down and just general care and be straight up with the patient • Making sure that I understand and am heard • They help me understand what the problem may be • Providing clear communication in answering questions regarding healthcare • I think they have a responsibility to come in and spend time to really talk to use after the examination and explain in plain English what is going on with what we're in for so that we better understand it • I think it is the healthcare team's responsibility to be able to educate the patient on how to prevent and take care of their health • Giving specific advice on healthcare
3f. Take care of overall health	• They are responsible for treating the "whole" patient • They are responsible for taking care of your overall health • To do what's best for them (patient) and not what's best for the doctor • My healthcare team has a lot of responsibilities for their patients • They have the responsibility to help with our health by making sure everything is good • Ensuring that patients are healthy and making sure there aren't further medical concerns • To make sure their patients ae physically, mentally and emotionally okay • They should make sure they feel better • Treating them as a whole person and not just someone with a problem • They are responsible for being partners in my health and helping give me the tools

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3g. Be as informed as possible about medical options and make diagnosis	• They should get the information….and use other physicians if need be • Their responsibility is to know, to not give me something that'll make me worse • Their responsibility is to be familiar with any health issues that your child is facing and answering questions • To diagnosis what's wrong • To search out the reason for pain • My doctor, who I see on a regular basis, is very thorough and she always does the follow up and there's something going on with me • To diagnosis with what's wrong and help me get the medication that I need to take • When we go there with a problem, to see if they can help us find an answer for it • To find out why you're there naturally • They're checking me out….find out what's wrong with me • Making sure that the patient is on the right path to recovery • To provide accurate information and the best, most cost-efficient options on how to manage you • I want them to take care of me to their best of their ability • I think it is important that the healthcare team is well educated in their scope of practice • Knowledge. My doctor is awesome. She is very knowledgeable so when I come in she knows what's going on. Just right • I've had doctors and Pas that have said " I really don't know but let's some research on it and so I think that's really important
3h. Prescribe correct medicine	• Give us the correct medicine • Make sure they give you the right medicines • To determine what prescriptions and then what doses are needed • Help me get the medication I need to take
3i. Facility cleanliness and adherence to Standard Precautions	• Needs to be safe from infection
3j. Friendly professional demeanor/ atmosphere	• Friendliness from staff • She compliments me when I do something right • A staff that is bright and smiling • I think they should treat them with a good attitude and not be condescending • Diagnose what the problem is in a timely manner with a good attitude • Be kind to the patients • I like someone who's going to be straight forward as honest as they can be while still being polite
3m. Schedule follow up appointments/ care coordination	• Do follow up appointments • If it is out of their care, I've certainly had them refer me to a more specialized doctor • She called ahead and set up an appointment for me • They've always been good about making sure I make my appointment • Make is understandable for folks like myself to navigate through the system • Getting parents or patients in touch with the right resources • Mostly following through on return calls and having prompt response • They are responsible for appointment reminders either letters or phone calls
3o. Don't know beyond on what currently doing	• Not that I can think of • I haven't put much thought to that. They have been really good at staying ahead of things. I can't think of anything • It's a tough one. Really don't know beyond what they are doing now

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	• I'm not sure how to answer. I've never really thought about it
3p. Go back to old fashioned medicine	• I think these doctors need to quit being associated with the hospitals
3q. Have consistent provider	• It would be important to see same person every time
3r. Keeping information confidential	• It's keeping my information confidential • Honestly following HIPPA codes
3s. Help with Medication costs/ transportation/ referrals	• They have helped me personally with paying for expenses. I wouldn't normally be able to pay. I pay ½ and they pay the remainder • They are responsible for giving us resources • Lower the prices • They are responsible for assisting patients with getting medications at a lower price
3t. Know patient's health history	• Referencing my records and stuff so they know what my issues have been • I think their responsibility is to know the patient
3u. Providing information to other providers	• Providing all information needed regarding the patient to other providers • They are responsible for putting in referrals if I need specialized testing, helping me figure out who would be a good provider in the event they are unable to assist me with my health-related needs
3v. Patient responsible for health	• The health care team has some responsibilities, but me, the patient is the person one hundred percent responsible for my own health

4. Specific things being done to take responsibility for own health	
4a. No help needed at this time	• No, my husband and I both are still very much able to take care of ourselves. And we have not needed any extra help yet • No, actually no • No because I pretty much know my diabetes and know what to do
4b. Currently working on issues	• I'm working on what I need to be working on • At the end of the day, you're the one that need to take care of it
4c. Managing pain medication	• Maybe trying different things, and trying to manage the pain medication a little bit better
4d. Mange diet	• Yeah, I could watch what I eat better
4e. Manage medication	• I have asthma so I have to make sure I take my azure inhaler every day
4f. Already on target	• I don't think so. I think we're pretty on target with what we need to stay with • I think they're doing fine • I don't think so at this time because like I say, I try to keep up with it and my doctor and nurses are really good about any changes
4g. More patient education	• You need to be educated more…. She is telling me about changing the tubes in my breathing machine and tubing in my – I'm on air right now, and I didn't know that. I didn't know I was supposed to do that
4h. More exercise	• I needed to get more exercise and have started doing that

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5. **Things you should be doing but need more information or help to take more responsibility for your own health**	
5a. Assistance with proper nutrition/diet	• Probably more information on the proper foods to eat, being at my age I am from the old school and like to eat comfort foods • A good food plan or food calendar • Right now, I think I need to improve my diet • I think information on eating more healthy • I try to control my diet when possible and choose healthy options • I need to focus on nutrition. I tend to buy things that are cheap but not so healthy
5b. No additional information or help needed because help has been available from healthcare team	• I think they have provided all the help I need • I think I have all the information I need, I just need to be more disciplined in how I use that information • I have everything I need, I'm blessed I guess • No, whenever I have any questions they always can answer it • I don't think so. I think they are doing a pretty good job • I think that I've been given a lot of needed information from my clinic and everyone has been really helpful • I really can't think of anything that I need that I haven't gotten so far
5c. Dental services	•
5d. Need more information and help from provider	• There are certain things I need to know about, because I have hard time understanding like I need to know how to be more – ask more questions when I go to the doctor, because sometimes I forget to ask questions, I forget to tell them things • This last year I've been given more information. So, I want to say it's working better • If I could afford it, I would monitor my blood pressure, but I'm not sure how • More knowledge about supplements and what you shouldn't be taking • I need more education on it, on more of his diagnosis • I still sometimes wish that I could have a little more direction to get the education about the chronic issues they have • I really don't have enough information on the one child that I need • More education on what forms to fill out or how to fill them out • Need to know when I should go to a doctor • Maybe more information about how to take care of myself better, because sometime I really don't know • Just access to good information. Hard to know what's accurate out on the web
5e. Following MD orders	• Follow the doctor's information • Actually, following the doctor's orders would *be really good* • Seeing a counselor like your doctor ordered • I need to follow through with my doctor's recommendations including exercise and eating a balanced diet
5f. Proper health related equipment to support health	• Right equipment for sure • Need to have proper equipment • Cane • Prothesis • Eyeglasses
5g. Proper medication education	• Right medications • How better to give myself insulin • Need more information on how to reduce medications • Remembering better to take my medication when I'm supposed to
5h. Personal responsibility	• They've given me a lot of resources and it's my responsibility to follow through • I think you need to take a lot of responsibility because if you don't do it, who's gonna do it for you?

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	• I think I am doing the job of taking care of myself. You know like I just said, communicating • It's just me doing what I'm supposed to do • I just need to be more accountable for myself in following through • Knowledge is huge but it's up to you • I'm responsible for my diet, my exercise, my sleeping • I am very responsible for my own health
5i. Will power/ motivation	• I don't need more help, I need more willpower • I just need to discipline myself better • I just need a little help getting started • Whatever will power and gumption that is going to make that happen
5j. Social Support	• I need more social support
5k. Information/ support for exercise	• Doctor encourages me to exercise • Physical fitness schedule • Exercise, I don't do enough walking • Understanding the importance of eating healthy and doing exercise • Exercising more regularly • Information about eating healthier and to be more active • I need to take responsibility for exercising
5l. Weight management	• I need to lose weight • I need to take responsibility for losing weight
5n. Health insurance	• Better health insurance • More affordable insurance
5o. Help with Finances	• The only thing I need is money • The only thing I need right now is a stove • My social security is only $169/month. There would be no healthcare for me that I could afford
5p. Transportation	• I just think geographically I'm limited by the resources that I can access. I don't have a car
5q. Can't think of anything else I might need	• No, I know what I should be doing, and I do it most of the time • I don't think I need any more information • I don't need more information • Nothing in that order for sure. Nothing that I can think of • Really, I don't think I need anything at this point • It's something that I've never thought about that I have to think for a second. At this time, I'll have to say I don't know at this time • Not really, I'm a very healthy person
5r. Health information from computer	• The most important thing to me is the computer. I can go to the completer first and try to identify what the problem is and then make an appointment with the clinics
5s. Improve Lifestyle	• I need to maintain a healthy lifestyle, manage weight and take medications as prescribed • Learn what's best to keep me healthy • As far as things that are within my control, it's lifestyle whether it's sedentary or active or anything in between
5t. Help with diabetes	• I haven't figured out how to handle my diabetes
5u. Establish care with medical provider	• I need to get a regular doctor

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5v. Access to medication	• I need help in getting the medications I need

6. What doing currently to take care of personal health?	
6a. modify diet	• Well I'm trying to watch my diet closer and not over eat, and be more aware of my fats and sugar.
6b. following on personal definition of responsibilities	*(per statements to question 1)* • I'm just spending a lot of time right now taking care of myself. And trying to stay healthy so that I can go out and do enjoyable things like riding a bike • Basically, just eat right, I have done the right things to exercise so that I'm losing the weight I'm getting just because of the illness
6c. More exercise	• I'm getting more exercise

7. Anything new you will be doing for your health in the coming 6 months?	
7a. Modify/ watch diet	• And also, like I said be aware of the foods I eat. • No, I already watch my carbs, but I plan on cracking down on that even more • I'm just cutting back on my food. I'm going to try to just eat every two hours, just a snack or something like a banana and then maybe some egg and toast • Just trying to do better, my diet is the main thing • I've been trying to eat fairly decent • I'm cutting back on drinking all my energy drinks I'm planning on cutting down on my food intake, like my carbs and stuff • I'm doing everything I can relative to diet • I'm trying to cut back on sugars • I need to quit drinking pop
7b. Exercise more	• Yes, I'm going to try to do more walking. • I think maybe this coming year just to get out a little bit more, and we enjoyed going and we like using the machines and stuff, but we just, just trying to do better, my diet is the main thing been lazy about doing it • Just walking • I'm bringing in some of my exercise equipment into the house, so I can pedal a bike and move my arms • And getting plenty of exercise • A little more exercise • I'm walking more when I get the opportunity • I work out at a local wellness fitness center 3 days a week • I plan to start an exercise program after the first of the year • The doctor recommended more exercise, so I'm going to join a gym and start being more active
7c. Don't plan any changes/ Nothing new	• Nothing more than we already do • Pretty much just what I have been doing, which is gym pretty much five days a week and watching what I eat and watching the amount of the carbs I intake • In the next few months, there's nothing I know of that I'm going to do different • Just keeping up with everything • I already take action to improve those things for myself • Not at the moment as long as I stay as healthy as I feel now • I'm going to do it when I can that works for me

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7d. Adhere to medication schedule	• Yes. I have eight medications that I'm on right now, eight of them, and a huge amount of vitamins and that's – those are important that I take them every day and follow that schedule without fail • Taking my medicines like I am supposed to • I'm following my doctor's orders relative to medications • Well, I take my medicine
7e. Weight management	• Always weight management • I have to do the right things to exercise so that I'm losing the weight • Continuing my weight loss program • In my fantasy world I would like to lose weight • I am in a weight loss program • I gained a lot of weight with the prednisone, my goal is to get back to my original weight before prednisone
7f. Follow through on personal responsibility and taking care of self	• If it is to reduce certain medication it's my responsibility to follow through with that • But you know there's a certain point that the patient has to say yeah, I'm willing to do this • Making sure that I am taking care of myself physically • I'm also a diabetic, so every three months I go in like clockwork and have my bloodwork done, and anything else they tell me I have to do • It's being very conscientious of noticing when the kid is not hearing right • Getting adequate amounts of sleep • Taking a deep breath and trying not to get frustrated • Trying to cut back the amount of pain killer I'm taking • Be as happy as I can • I really need to understand that it's okay to take some ME time • Maybe drink less beer
7g. Preventive actions	• I have to go get a flu – not a flu shot, a pneumonia shot because I had the one and I to have a booster I believe • Making sure bathroom is clean • We just have to be careful in our home because we both have had falls there
7j. Quit smoking/ tobacco use	• I recently quit smoking • I'm trying to quit smoking • I think I'm going to try to quit smoking
7k. Doctor visits when needed	• Keep in touch with my doctors and make sure that I'm doing everything right • Not right now if I have to go back to see the doctor and I have problems then we will try something • Getting them to the doctor when they need to go • We definitely do once a year annual wellness checkups with her • Following up with some appointments • Just normal check-ups
7n. Get health insurance	• I hope to put in a disability claim • Get insurance for massage therapy • Medicare so I can afford to do some better health focus
7o. Achieve balance with medication	• I'm trying to balance my medications with everything else
7p. Surgery	• I have to have surgery

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8. Could clinic help with planned changes in next 6 months?	
8d. Patient responsible for own health	• No, that part is mainly just on me. • They've been working with me and my responsibility is just doing what they suggest I do • I think that's just something that I need to do for myself • Honestly no, it is up to me • I don't think so as far as that goes. Because that's just a matter of me doing it • I kind of feel like it's up to me, you know what I do from there • In my opinion that's not their responsibility to do that. It still has to fall down on my shoulders as to the next six months what I do • That's my own responsibility
8e. Clinic healthcare team helping me with what I need	• They are very engaged in my health, when I go there, I ask them like questions, they call me back, and they are very good at making sure that they relay the information to me, probably in a way that I can understand it. • Down there in Driggs, they turn around call me every few weeks and make sure I'm good, all right and I tell them anything and if things don't sound right, they turn around and schedule my appointment with doctor • They have done a great job • I get a lot of encouragement from my provider • They have been remarkable • If I had something come up, I'm sure they would help me with whatever I might need. They're a great team over there • They've done everything that they are supposed to do • I think they're doing an amazing job in helping me out • They are really good at trying to find somebody that would have the information or could give me the resource that I need • They're pretty on top of it • I believe they have done everything above and beyond • They do everything for me whatever I need • No, they are actually really good. So far, I've had a very good experience with them • Just making sure that they are available, they already do that. I just feel like they do an amazing job already • No, I cannot think of anything that they can do better. I think the clinic is pretty wonderful
8f. Follow-up is helpful	• Yes, I'm on a specialist and she calls me once a month. I didn't really think I needed it, but it's been a bigger help than I thought • Just follow-ups and encouragement • Follow through with the results of the test they ordered • They're really good to call as reminders-that's helpful and I appreciate it • Send me to some suggested places that may or may not be of help • They remind us when we completely forget • I feel very confident and if there's any question I always call, leave a voice message, my doctor is very good at returning calls

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8i. No additional help needed from clinic healthcare team at this time (No additional comment provided about clinic services)	• I don't know specifically because pretty much it's up to us, that's really in the home kind of thing • Not that I know of • Don't think there's anything that they can do more to help me • I didn't think they could help me with it really
8j. Suggested new services Suggested new services include help finding exercise programs, helping get needed tools, help with prioritizing health problems, help with transportation, help with cleaning, obtaining additional information	• They might make some suggestions toward different things different workouts or something that would help with knees • I think that providing some resources ….about different gyms • Clinic could provide more information on nutrition • Help with parking- nightmare right now • Being more helpful on the symptoms of diabetes • Help with free inhaler • Maybe help figure out what part I need to be focusing on ….to get to a healthy weight • Remind me that exercise is important • Probably helping me better understand my diagnosis • If I could find something that would affect the pain • Wendy is trying to get an x-ray machine
8k. Scheduling	• Stay open • I would say just having open schedules

9. What kinds of things keep you from taking care of yourself as well as you would like?	
9a. Family issues	• You know when you have a big family there's just no way to avoid stress. It's learning how to deal with it • I don't think, ours is medical, we both had quite a few stressful problems this last year alone, and really the medical profession hasn't helped us. We have found that we really need to depend on each other to keep our peace of mind and things • Family situations • Taking care of all of the home responsibilities
9b. Problems with motivation/ procrastination	• If I don't do it it's just because I don't have sufficient motivation and commitment • Laziness • I can take care of myself, I'm just lazy • Just being lazy in general • It's my own laziness. I know what I need to do. I just don't do it
9c. Will power to alter behavior	• I think my problem is I'm a chocoholic. (Laughter) avoiding the chocolate during the holidays would be great • Most of it is just will power, willing to do it • Just on my part following through with them • The will power to quit drinking pop would be good

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	• Myself. It's that will power, it is the desire to do
9d. Health insurance	• Lack of insurance prevents me from taking care of myself • It is hard to see the doctor since insurance premiums went up and their willingness to pay for services went down • Medical insurance • I still cannot afford my copay, exam, and referrals
9e. Medication complications	• My medicine, it makes me really tired, so a lot of times, I have hard time getting up, especially when there is like appointment time • Taking all the pills, they have me on a zillion and one pills plus vitamins • Forgetting to take your medications
9f. Transportation challenges	• I have to wake up really early and take the transportation, there is not good transportation, and sometimes I can't get up.
9g. Need more living space	• A little bigger place so that I could have wheelchair access
9h. Too many sweets	• Yes, I get a sweet craving
9i. No change: working with clinic	• Really nothing, I follow what she says • I do everything I can for my son. We go to the doctor when there are problems. They are pretty much on top of it
9j. Lack of sleep	• Lack of sleep • What I really lack is sleep or consistent sleep • I work the graveyard shift at the hospital…..it throws off your sleep
9k. Require additional assistance	• Sometimes having the assistance we need • The fact that I have a prosthetic and …..it's very hard to get used to and being able to get out and get where I have to go right away when I think I need to go is very difficult • Help getting through the system- it's a nightmare • Yes, being around the shelter prevents me from getting the proper nutrients that I need. I need help from my providers to take care of myself.
9l. Health issues	• I can't do something, like hiking, you know, because I tore up my legs, fighting forest fires for a lot of years • I've had too many surgeries • I binge eat • When I bend down I get dizzy when I get up • Just my physical health • The physical condition with my hip and back makes it really hard to do the exercise
9m. Weather	• Weather, when you live snowbound half the time, it makes a difference • Cold weather • If the weather is bad and I want to exercise
9n. Work issues	• Work obligations • My work • Job commitments and work stress • Just work
9o. Time management/ too busy	• Finding the time for sure • I'm super busy with going back to school myself • We have four foster children now and so the extra times that I used to use for working out is used to help take care of the kids • I don't have time to do the kinds of self-care or taking care of myself • Time sometimes is a big factor • They taught me how to delegate instead of me being responsible for every single thing • We are all busy and it's not easy to find the time

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	• I feel like sometimes I'm just too busy. We're farmers and there's lots of things that get in the way • Time. I have not time for exercising or cooking healthy meals
9p. Learning self-care	• Learning more to better take care of myself • I have a caregiver. But I should be doing some of that stuff on my own
9q. No access to gym exercise options	• Being in the rural areas I think because I hear there is no gym
9r. Dealing with depression/ anxiety	• I have anxiety really, really badly • My mental health • Yes, like depression • Stress tends to prevent me from managing issues- my anxiety gets in the way
9t. Help getting resources (SSI, etc.)	• I'm trying to get him on SSI …that's been kind of hard because I really don't understand the process of it
9u. Care giving stress	• Remind the parents that their health is just as important • I'm a full-time caregiver for my mother right now so sometimes I feel like time is an issue for me. I'm getting better taking some time to go out and work out or even just go for a walk • When my husband was ill there for a while, I didn't get as much exercise as I needed and as much fresh air so I needed to be out more
9v. Finances	• Cost of health care is expensive • Insurance coverage makes things very difficult..so that's cost • I have a lot of debt so I am not able to pay for services when rendered • I have a very regimented budget. The expense will make me "wait and see" • That fact that I don't have insurance • Money prevents a lot of it • Insurance was cost prohibitive so I just couldn't afford regular MD visits
9w. No issues preventing taking care of self	• We really don't have any barriers. We're pretty fortunate • I would say there is nothing that holds me back, there is nothing • No, those are all my decisions • No, everything is good that way • I can't think of anything because my goal, life goal, is to be shot by a jealous husband when I'm 106
9x. Access to clinic	• Sometimes the ability to get into the clinic • It's not always convenient when I am working at the same time the clinician I need to see is available
9y. Affirmation of barriers to taking care of self	•

10. Role of health care team and dealing with stress/barriers	
10a. Don't know how healthcare team could help with issues	• Well I don't know how • I don't think, ours is medical, we both had quite a few stressful problems this last year alone, and really the medical profession hasn't helped us • Probably nothing that I know of, you know • I really don't know on that one • It's something that I have to learn to do myself • Honestly, I don't know…I don't feel there's anything for me personally • Really nothing, I don't think that's their responsibility • Probably not unless they want to cook meals for me

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10b. Clinic doing their part and great, wonderful, excellent job	• No, I don't think so I think they provide the information and I'm aware of the consequences, if I don't do it, so I think that they're doing a great job. • I can't think of anything that the clinic can do, because of already got the education about the diabetes and all • I think they're wonderful… I'm very pleased with the healthcare I receive at Driggs • They do help me. There's nothing that they can't that they haven't already done • I think they've done everything they need to do • Yeah, it is like a family …they have somebody who calls me • They really did take care of me and set me up • He is an awesome doctor and his nurse is awesome too
10c. Help taking prescriptions	• I wish there was some way of keeping better track of prescriptions
10d. Recommend exercise	• Anna has suggested that I'd try to get to tai-chi
10e. Follow up phone calls	• Doing more phone calls to check in
10f. Help with depression	• Helping me work through my depression • They give me my medications for depression
10g. Provide more information and resources	• One of the nurses does keep an update…on diabetes • Maybe there is some kind of handout that they can give on local resources
10h. Help with planning/time management	• Help me with time management
10i. Improve care coordination in the Medical Health Neighborhood	• We're working on getting a different case manager
10k. Motivation	• They might be able to help me get more motivated to take care of myself • Keep reminding me what the goal is and what steps I need to take to get there

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11. Personal definition of Access	
11a. Access to a physician and/or appropriate healthcare when needed (time, location, clinic hours, staff availability)	• It means being able to see a doctor whenever you need to and being able to get certain tests run when you have a referral. • Anytime I need to get an appointment they always get me in right away • That we have it available whenever we need it • Being able to see a doctor whenever you think you need to • I can make appointments when necessary • Being able to get a call or an appointment with my doctor if I need to • I would like to have it available quickly within a week • Being able to get healthcare when you need it, especially from a primary care physician • I just call and say hey I need an appointment now • Means that there is a doctor that I can go over and see at any time if I need help • To be able to call at any given time whether it's a MD or emergency • Access to healthcare means to me being able to get in to see a doctor when you need to and not having to wait 2-3 weeks • If something is seriously wrong with me, I can schedule an appointment and usually get it within a week • It means if I call, I can have an appointment within a day or two, not two or three weeks
11b. Access to a referral	• A referral, then getting into see the doctor in a reasonable time • Folks helping individuals access the resources that are out there • I want to go where the research has been done and where I have access to doctors who have not just a few experiences with my needs but a lot
11c. Ability to pay/have insurance	• Financial ability to pursue whatever they do • Having decent enough insurance to be able to afford the very costly process of healthcare • Having affordable services • The insurance pays for most of it, if it weren't for insurance I wouldn't be able to do it • Access also means being able to pay for the services • Ability to see provider at a reasonable price range and to be able to obtain necessary care without undue financial stress • That it is available and <u>affordable</u> • I would say cheaper insurance but the same coverage • It means having the ability to obtain healthcare despite financially, income, housing, race, religion and orientation
11d. Follow up care	• One thing that I think was very important is the follow up with the personal care nurse of the doctors PA
11e. Knowledgeable and communicative provider	• That they have the available knowledge and can actually tell you what's going on with you • Have good relationship with a primary care doctor • Just them being helpful and answering questions • Questions answered when I need them • We get in there and they listen to us and then treat us to the best of their ability • Being able to communicate with his office • Just to have questions asked and/or answered relieves a lot of stress

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11f. Use health information technology	• That you can go online and look up your case • They have an online thing….keep looking into it, make sure you check on everything • Maybe like the patient portal. Like being able to see if you are improving • Being able to get hold of my records to check in to the portal • I'm able to get on like the IHDE website and get information • I do use the computer to look things up. I do that quite often • Being able to get an account ….you could go out to like a Saint Al's page and look up that – search for that and see if there's any recommendations on symptoms and remedies like that • It means having online information available
11g. Respond in timely manner to patient's queries	• Call them with a question, they're there to answer or call me back within a reasonable amount of time, which is usually a couple of hours or whatever • I can call, ask and get a response back in a reasonable amount of time • It means I can contact my healthcare team and get a response in a timely manner, meaning labs, phone calls and visits • Adequate response time to questions • Picking up the phone and actually getting to somebody and make an appointment and not to get a lot of runaround • When I have questions I can get immediate answers • Talk to a person to understand information clearly
11h. Knowing about resources	• I mean like knowing our resources • It also means really promoting your programs, telling people in the community what's available, what your offer, when I come in, tell what else is available
11i. Access to personal health information including portal	• That I can get personally health information about myself just by asking for it, identifying myself and nobody else has that privilege • Access means that I can see my records if I want to • That I can obtain my records when I need them • It means being able to retrieve records on the patient portal • Having access to my records on the portal • Access to look at my records online • Seeing labs online
11j. Transportation	• It means that there are appointments available within a reasonable distance and within a reasonable price • Being able to have transportation to a doctor • Healthcare can be obtained within a reasonable time frame for the needed services required within a reasonable distance you are willing to travel without creating a hardship • Having the necessary services available close to home
11k. Prescriptions on time	• Really important that the doctor helps get medications on time • Getting medication refills on time
11l. Cannot define access to healthcare	• I really don't understand that question • I really don't know • The definition, No I wouldn't know • I don't understand, sorry
11m. Physically available	• Access means to me that I live in an area where it is just physically available, there are options • It means proximity

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11n. Information from newspapers and magazines	• You can get access to it through magazines. All newspapers will help.
11o. Access is very important	• It means a lot to me. It's very helpful • It means a lot • It means life and death, to me it does anyways
11p. Self-care	• It means taking care of my body, keeping up with doctors' appointments and seeing that I do what I was asked by my providers

12. Schedule an appointment as part of access	
12a. Scheduling for referral	• Find that some of the specialists that you are referred to have too much of a book calendar
12b. Promptness of appointment	• At my doctor's office there's this gal that will call back. If I call and say that I got something • Seven out of 10 times I usually can
12c. Ease of scheduling an appointment	• It's been usually fairly easy • Getting appointments is really, really super easy • Absolutely, I can just walk into my health clinic and my doctor will see me • Oh yeah, and that's easy • Whenever I can make an appointment it is pretty easy • Within a week or within 1-2 weeks with any doctor
12d. Problem scheduling appointment	• Not always • I don't get in when I hope to • I don't talk to the front desk because they will literally just put off and say well there isn't anything available • Not whenever I need one. Sometimes it's a little hard when they are booked out for months • No, I have trouble with appointments
12e. Scheduling most of the time	

13. Access to Health Services	
13a. Access to Health Services is okay	• I believe we have everything we need • In my area between Twin Falls and Boise there are a lot of services • Oh yes, most definitely
13b. Access to Health Services is a problem	• Oh no, never • I would say some docs that are more specialized in the anxiety area • I do wish they had more availability of some equipment at the clinic • No, I have to travel over 50 miles to get to specialty care • I can't get transportation to it • No because we are so rural • We don't have a hospital • All I have is a doctor. I'm 25 miles from any hospital. So, no I guess • Does anybody? Not really • Services are forty miles away

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14. Reliable Transportation as part of access	
14a. Reliable Transportation available	• I drive like a bat out of hell. Both my husband and I are still capable of driving and have our driver's license, and we are fine. • I have a new car so I don't have any problems with that • Yeah, that's not an issue at all • Sure, I drive myself • Seniors around here can call and say that they need transportation and get it • Yeah, my husband • Yeah, I got two feet, that's about as reliable as I can get
14b. Transportation problems/ challenges	• It's hard, very difficult for me to get out of the house • Don't have transportation all the time • No, I don't drive. You have to drive here • Nobody to take me because I don't drive • No, I don't have a car. My feet are pretty reliable I guess • Not always; it's where if you don't have transportation you can call and get a ride • I ride the bus • I take the bus or get a ride from a friend

15. **Insurance/affordable care as part of access**	
15a. Insurance coverage adequate/able to afford care	• Yes, I have been able to. This certainly is an issue for many Idahoans • Insurance makes a big difference in helping • I've been really fortunate to get into this program they have. I'm able to afford it • I've got good insurance with my employer • I am lucky enough that my wife and I have good health insurance • We have supplemental insurance
15b. Insurance coverage and/or care too costly	• As long as the care I need can be handled in the clinic, if I need anything else, no • Often the people somewhere in the middle get the worst of healthcare. They make enough money so they don't quality for help for the most desperate, but they don't make enough to really afford the care they need • None of it is really affordable, especially when you don't have insurance • I don't have health insurance at all. That is something I'm really worried about • Not all of the services needed are affordable or covered by insurance • Specialists are pretty much out of range because of the co-pay • I have a couple blood pressure medicines that I cannot afford and I have to choose whether or not I am going to take them and most of the time I choose not to take them • I still think healthcare is very expensive. I always think twice before making an appointment • I can't afford healthcare when I need it. Sometimes I have to just wait until it's an emergency, but then it can be even more expensive to treat • I would prefer to have less of my income go towards health care
15c Medicaid	• We have like Medicaid so we don't pay anything, but if we had to pay the full price? No • So far on Medicaid, they pay for all of it • I'm on disability so I have Medicare and Medicaid • I have Medicare and Medicaid, thank goodness. No, I can't afford it
15d. Medicare	• I'm really pretty good between Medicare and my Medicare supplement • I can with my Medicare and my Medicaid • I have Medicare and Medicaid, they cover pretty much everything except vision and dental • Yeah, first with Medicare and I have a supplement. Without Medicare it would be a big problem
15e. Sliding fee	•

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15f. Free	•
15g. Private	•
15h. Self-insured	•

16. How easy to access to primary care in past 6 months	
16a. Access to primary care okay/easy to obtain	• Reasonable it's been reasonable • Yes, anytime I have an issue, if I need to see her, she always works me in. • Able to access pretty well • It's been very easy to get a hold of them.. • Being available-wise, they're always pretty much available and always usually able to help • It's been great actually….haven't had any problems at all • Oh, very much so, I just can them and I could in the same day if I really needed to • Even when I've called to ask a question, the healthcare specialist call me back within the hour and says okay here is what we need to do • Without fail, I've never had a problem reaching her, getting to be seen
16b. Access difficult because of transportation	• But it's just my difficulty walking and even with the walker, I mean I only walk just to the bathroom and back which is a very short distance on a regular basis
16c. Long waits	• Very easily, till she had maternity leave, then it's kind of iffy • Not very well, but our pediatrician has been on maternity leave • Very hard. The wait time is 2 months
16d. Slow response	• Have to wait a long time to hear back
16e. Care too expensive	• It hasn't been super easy…because of the cost associated
16f. Care not needed in past 6 months	• Haven't needed any care
16g. Somewhat/pretty easy	•

17. How easy to access to dentistry in past 6 months	
17a. Don't need dental care because have dentures	• We both have dentures • I go to affordable dentures in Boise • I have false teeth. I don't use a dentist • I've got false teeth • I have dentures so I don't have to personally worry
17b. Need dental care but not going because of expense	• We haven't gone. And we both need to. See that's one of the put off things because it is so expensive • Could really use a trip to the dentist because the teeth have been really bad and breaking off and they're not doing well • I'm trying to buy dental care…it's getting harder and harder to buy a plan to protect yourself
17c. Dental care accessible	• Yes, they are very accessible and I do have a dentist and I feel he is very good • I haven't had an issue with that • Very easy to get in • I haven't had any problems • Pretty good actually • Dentistry is in the same location and easy to get to

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	• We just got the dentist so we're good on that • Yes, I have teeth…been going to same dentist for past 30 years • I would just have a bunch of bad teeth it wasn't for them because it makes it affordable for me
17d. Dental care too expensive	• We do have one that's actually up here but it's really good.… But he is charging sky high prices • Lo and behold, when I got out of there, I was charged $800 for two fillings • Too bloody expensive • There are dentists up here but they are expensive • So difficult to find affordable dental coverage because it is not included in any standard insurance coverage • I have not been able to, because of insurance • Dental coverage sucks
17e. Bad experience with dental care	• Dissatisfied with dentist • We didn't have a great experience with the dentistry part of them
17f. Access to dentistry non-existent or difficult	• There are no dentists available in the area • The only dentist that we get for them is an hour away and has a very full clientele • That is absolutely not accessible at all • Not easily, dentist if 75 miles away and it is not easy to get appointments • Over 50 miles away • Not worth a crap • That's a joke. Medicaid would only pay for certain things
17g. Not applicable/have n't used	• I haven't used any dental services here yet • We have not accessed dentistry • I actually haven't tried, which sounds kind bad • We have not used that here yet, but we have to
17h. Health problem	•
17i. Somewhat easily	• Somewhat easy. It can take a few weeks • Somewhat easy. The wait time is 3 weeks • Somewhat easily. The wait time is ten to twenty days

18. How easy to access to Counseling in past 6 months	
18a. Don't need Counseling	• I don't feel that I need the services • I don't have a need there • I haven't used it or had a need for it • We have not needed counseling
18b. Seeing pain management doctor	• I do have a pain doctor.
18c. Counseling/ Behavioral health useful	• But my doctor, she asked me to go see this one specialist in that area and I'm trying to follow up with that. I'm not opposed to anything, anything that would help me I'm willing to try it, you know, within reason • The psych nurse helped me more in the last year and a half or two than all the rest of my life put together I think
18d. Not applicable/ have not used counseling	• Really haven't had any of that • I don't think it's – not applicable • It's not applicable • That is what the beer is for. I'm just kidding. Not really applicable • Not applicable to me. I have never done it • I don't use counseling. I don't have any mental problems

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	• I have never tried to use that
18e. Counseling/ Behavioral health accessible	• He was in within a day • That's always been available, thankfully • Access fairly good for mental health • If I need to talk to them the counselor just comes looking for me and then we talk before the doctor comes in to see me • My son sees a regular counselor every week
18f. Avoid Counseling/ behavioral health because of stigma	• I just didn't want to go because it's so small, and people up here are so weird about mental health… The stigmatization is real bad up here
18g. Counseling too expensive	• Easy except for payment wise • My husband still can't afford counseling because it would be out of pocket
18h. Long waiting times for Counseling	• Takes 6 months to schedule counseling • It took a long time to get in. By the time I got in there was no need • Very hard, takes about 2-3 week wait time • That is extremely difficult as well. We're currently on a waiting list- we've been on a waiting list for months • Counseling has been very tough as well. My son needs counseling and there is only one center that will work and he's been waiting almost three months. My doctor has been trying to do his best
18i. Patient will not be seen	• I'm not able to get counseling because no one will take me
18j. Interested in Counseling/ mental health but not used	• I would like to go but haven't tried it
18k. Not able to access	• I have not been able to access counseling • This is hard because it is hard to schedule services around my work
18l. Access to counseling somewhat easy	•

19. How easy to access to Specialist Care in past 6 months	
19a. Specialty Referrals accessible	• Referrals made to surgeon • They are easy to get hold of • Getting into acupuncturists is fairly easy • They are all pretty open and quick • I haven't really had a problem with the specialist • When I've gotten refer I've been able to get in within weeks • The choices of medical specialist have grown so much in the last few years here in the Valley • I just call our insurance and they tell me who's on our plan and we are able to use that specialist
19b. Specialty Referrals not needed/not applicable	• No specialists, no referrals • We haven't had a need for any specialist • I haven't used them • So far, I haven't really needed a specialist • Specialist in past 6 months, no • I haven't had to have a specialist • I haven't been sent to one

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19c. Difficulties with specialty referrals	• Referrals process has been frustrating • There might be one clinic for a particular specialty and they are booked far out into the future because there are no other options. Idaho certainly needs more specialty MDs • I will have to travel to Boise, transportation is not a problem but paying for it is going to be a problem • You have to get a referral and wait a long time • Fairly easily, though had to travel 70 miles and doctor not available many days/hours. Not all services are affordable or covered by insurance • Their waiting list was really long for my son and that was hard • As far as a neck specialist, that is fairly difficult. It's almost impossible • I haven't tried. I've given up on specialists
19d. Somewhat easily	•

Note: Questions 4, 6 and 10 were piloted in the first 45 interviews and subsequently modified based on patients' responses.

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Appendix E

Frequencies of Individual Codes from Patient Interview

Questions by Domains and associated codes from the patient interviews are presented below.

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Patient Centered Medical Home Services Received by Patient in Past Year						
2a. Reciprocal listening between patient and MD	151	13.2%	992	86.8%	1143	100.0%
2c. Finances	17	1.5%	1126	98.5%	1143	100.0%
2d. Encouragement to patient	80	7.0%	1063	93.0%	1143	100.0%
2e. Coordination of care	136	11.9%	1007	88.1%	1143	100.0%
2g. Provide follow-up reminders	51	4.5%	1092	95.5%	1143	100.0%
2j. Seminars and support groups	6	0.5%	1137	99.5%	1143	100.0%
2n. Provide needed educational information	148	12.9%	995	87.1%	1143	100.0%
Medical Services Received by Patient in Past Year						
2i. Prescribe and monitor medications	192	16.8%	951	83.2%	1143	100.0%
2k. Complete differential diagnosis	65	5.7%	1078	94.3%	1143	100.0%
2m. Regular check-up	352	30.8%	791	69.2%	1143	100.0%
2o. Manage chronic conditions	370	32.4%	773	67.6%	1143	100.0%
2p. Urgent care services	56	4.9%	1087	95.1%	1143	100.0%
2q. Lab services	37	3.2%	1106	96.8%	1143	100.0%
Patient Responsible for Specific Behaviors Related to Health						
1b. Regular exercise	461	40.3%	682	59.7%	1143	100.0%
1c. Watch diet	616	53.9%	527	46.1%	1143	100.0%
1n. Weight control	38	3.3%	1105	96.7%	1143	100.0%
1p. Mental Health	21	1.8%	1122	98.2%	1143	100.0%
1q. Don't use alcohol	57	5.0%	1086	95.0%	1143	100.0%
1e. Checking network coverage	3	0.3%	1140	99.7%	1143	100.0%
1r. Paying for insurance	19	1.7%	1124	98.3%	1143	100.0%
Patients Responsible for Following Healthcare Team's Directives						
1d. Lab work	11	1.0%	1132	99.0%	1143	100.0%
1f. Medication compliance	358	31.3%	785	68.7%	1143	100.0%
1h. Keep appointments as scheduled	153	13.4%	990	86.6%	1143	100.0%
1l. Patient follows MD orders	135	11.8%	1008	88.2%	1143	100.0%
1o. Seeing MD when needed	278	24.3%	865	75.7%	1143	100.0%
Other Patient Responsibilities						
1s. Confidentiality of patient information	1	0.1%	1142	99.9%	1143	100.0%
1t. Immunizations	32	2.8%	1111	97.2%	1143	100.0%
1m. No smoking	2	0.2%	1141	99.8%	1143	100.0%

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1v. Children's safety	9	0.8%	1134	99.2%	1143	100.0%
1w. Don't know how to answer	2	0.2%	1141	99.8%	1143	100.0%

	Valid		Cases Missing		Total	
	N	Percent	N	Percent	N	Percent
Patient Centered Medical Home Services Designated by Patients as Responsibilities of Health Care Team						
3b. Waiting times in office	44	3.8%	1099	96.2%	1143	100.0%
3c. Post health information in patient portal	3	0.3%	1140	99.7%	1143	100.0%
3d. Listen to patient's concerns	498	43.6%	645	56.4%	1143	100.0%
3e. Confirm that patient understands care	322	28.2%	821	71.8%	1143	100.0%
3f. Overall health	110	9.6%	1033	90.4%	1143	100.0%
3j. Friendly manner	83	7.3%	1060	92.7%	1143	100.0%
3m. Schedule follow up appointments/care coordination	177	15.5%	966	84.5%	1143	100.0%
3s. Help with medication costs, transportation	28	2.4%	1115	97.6%	1143	100.0%
3t. Responsibility to know patient	28	2.4%	1115	97.6%	1143	100.0%
3u. Provide information to other providers	20	1.7%	1123	98.3%	1143	100.0%
Basic Medical Services Designated by Patients as Responsibilities of Health Care Team						
3a. Specific medical services (labs, diagnosis)	123	10.8%	1020	89.2%	1143	100.0%
3g. Be as informed as possible and give accurate differential diagnosis	293	25.6%	850	74.4%	1143	100.0%
3h. Give correct medicine	134	11.7%	1009	88.3%	1143	100.0%
3i. Facility cleanliness and adherence to Standard Precautions	16	1.4%	1127	98.6%	1143	100.0%
3r. Keeping information confidential	10	0.9%	1133	99.1%	1143	100.0%
3o. Don't know beyond what currently doing	29	2.5%	1114	97.5%	1143	100.0%
3p. Return to old medical model	2	0.2%	1141	99.8%	1143	100.0%
3q. Have consistent MD	7	0.6%	1136	99.4%	1143	100.0%
3v. Patient responsible	2	0.2%	1141	99.8%	1143	100.0%
Additional Resources Named by Patient as Helping them Increase Responsibility for Their Own Health						
5a. Assistance with proper nutrition	223	19.5%	920	80.5%	1143	100.0%
5c. Exercise	9	0.8%	1134	99.2%	1143	100.0%
5d. Need more information and help from provider	110	9.6%	1033	90.4%	1143	100.0%
5e. Following MD orders	38	3.3%	1105	96.7%	1143	100.0%
5f. Proper equipment	13	1.1%	1130	98.9%	1143	100.0%
5g. Proper medications	36	3.1%	1107	96.9%	1143	100.0%
5k. Information/support for exercise	206	18.0%	937	82.0%	1143	100.0%
5n. Health insurance	17	1.5%	1126	98.5%	1143	100.0%
5p. Transportation	7	0.6%	1136	99.4%	1143	100.0%
5t. Diabetes	3	0.3%	1140	99.7%	1143	100.0%
5v. Access to medication	1	0.1%	1142	99.9%	1143	100.0%
5o. Money	30	2.6%	1113	97.4%	1143	100.0%

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5b. No additional information needed because help has been available	132	11.5%	1011	88.5%	1143	100.0%
5h. Personal responsibility	352	30.8%	791	69.2%	1143	100.0%
5i. Will power	17	1.5%	1126	98.5%	1143	100.0%
5l. Weight management	37	3.2%	1106	96.8%	1143	100.0%
5q. Need no help at this time	211	18.5%	932	81.5%	1143	100.0%
5j. Social support	3	0.3%	1140	99.7%	1143	100.0%
5r. Health information from computer	12	1.0%	1131	99.0%	1143	100.0%
5s. Lifestyle	29	2.5%	1114	97.5%	1143	100.0%
5u. Establish care with medical provider	32	2.8%	1111	97.2%	1143	100.0%

	N	Percent	N	Percent	N	Percent
Changes Planned in Next 6 Months to Improve Health						
7c. Don't plan any changes as long as things stay the same	196	17.1%	947	82.9%	1143	100.0%
Changes related to medical care						
7d. Adhere to medication schedule	26	2.3%	1117	97.7%	1143	100.0%
7k. Doctor visits	171	15.0%	972	85.0%	1143	100.0%
Changes in specific health related behaviors						
7a. Modify diet	351	30.7%	792	69.3%	1143	100.0%
7b. Exercise more	477	41.7%	666	58.3%	1143	100.0%
7e. Weight management	84	7.3%	1059	92.7%	1143	100.0%
7j. Quit smoking	32	2.8%	1111	97.2%	1143	100.0%
Changes in general self-care						
7f. Follow through on personal responsibility and taking care of self	223	19.5%	920	80.5%	1143	100.0%
7g. Preventive activities	27	2.4%	1116	97.6%	1143	100.0%
7n. Get insurance	14	1.2%	1129	98.8%	1143	100.0%
How Could Healthcare Team Help with Changes Planned in Next Six months						
8d. Patient responsible for own health	77	6.7%	1066	93.3%	1143	100.0%
8e. Clinic supportive of patient's efforts	436	38.1%	707	61.9%	1143	100.0%
8f. Follow up helpful	69	6.0%	1074	94.0%	1143	100.0%
8i. No additional clinic help needed	365	31.9%	778	68.1%	1143	100.0%
What Keeps Patient from Taking Care of themselves as much as they would like to						
9w. No barriers to self- care	334	29.2%	809	70.8%	1143	100.0%
Personal motivational issues						
9b. Problems with motivation	108	9.4%	1035	90.6%	1143	100.0%
9c. Self-control	31	2.7%	1112	97.3%	1143	100.0%

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Resource limitations						
9d. Health insurance	17	1.5%	1126	98.5%	1143	100.0%
9f. Transportation challenges	15	1.3%	1128	98.7%	1143	100.0%
9g. Need more living space	1	0.1%	1142	99.9%	1143	100.0%
9k. Require additional assistance	9	0.8%	1134	99.2%	1143	100.0%
9q. No gym available for exercise	3	0.3%	1140	99.7%	1143	100.0%
9t. Assistance with resources	6	0.5%	1137	99.5%	1143	100.0%
9v. Finances	170	14.9%	973	85.1%	1143	100.0%
9x. Scheduling appointment	5	0.4%	1138	99.6%	1143	100.0%
Family/work issues						
9a. Family issues Interview Question	54	4.7%	1089	95.3%	1143	100.0%
9n. Work issues	88	7.7%	1055	92.3%	1143	100.0%
9o. Time management	178	15.6%	965	84.4%	1143	100.0%
9u. Care giving stress	77	6.7%	1066	93.3%	1143	100.0%
Medically based issues						
9e. Medication	4	0.3%	1139	99.7%	1143	100.0%
9l. Health issues	136	11.9%	1007	88.1%	1143	100.0%
9r. Depression	45	3.9%	1098	96.1%	1143	100.0%
9i. No change: doing everything	9	0.8%	1134	99.2%	1143	100.0%
Other barriers to health						
9h. Too many sweets	2	0.2%	1141	99.8%	1143	100.0%
9j. Lack of sleep	17	1.5%	1126	98.5%	1143	100.0%
9m. Weather	14	1.2%	1129	98.8%	1143	100.0%
9p. Learning self-care	4	0.3%	1139	99.7%	1143	100.0%
9y. Things prevent person from taking care of themselves	5	0.4%	1138	99.6%	1143	100.0%

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Patients Asserting Personal Responsibility for Own Health						
1u. Relaying information	53	4.6%	1090	95.4%	1143	100.0%
3v. Patient responsible	2	0.2%	1141	99.8%	1143	100.0%
5h. Personal responsibility	352	30.8%	791	69.2%	1143	100.0%
7f. Follow through on personal responsibility and taking care of self	223	19.5%	920	80.5%	1143	100.0%
8d. Patient responsible for own health	77	6.7%	1066	93.3%	1143	100.0%

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Appendix F

Overall Frequencies for Access Questions

	Cases					
	Valid		Missing		Total	
Questions	N	Percent	N	Percent	N	Percent
11a. Access to physician and/or healthcare when needed	755	66.1%	388	33.9%	1143	100.0%
11b. Access to a referral	24	2.1%	1119	97.9%	1143	100.0%
11c. Ability to pay	283	24.8%	860	75.2%	1143	100.0%
11d. Follow up care	8	0.7%	1135	99.3%	1143	100.0%
11e. Knowledgeable and communicative provider	60	5.2%	1083	94.8%	1143	100.0%
11f. Accessing records on line	29	2.5%	1114	97.5%	1143	100.0%
11g. Call back promptly	49	4.3%	1094	95.7%	1143	100.0%
11h. Knowing about resources	23	2.0%	1120	98.0%	1143	100.0%
11i. Access to personal health information	90	7.9%	1053	92.1%	1143	100.0%
11j. Transportation	24	2.1%	1119	97.9%	1143	100.0%
11k. Access to medications	9	0.8%	1134	99.2%	1143	100.0%
11l. Cannot define access to healthcare	57	5.0%	1086	95.0%	1143	100.0%
11m. Physically available	17	1.5%	1126	98.5%	1143	100.0%
11n. Newspaper and magazine information	2	0.2%	1141	99.8%	1143	100.0%
11o. Access very important	51	4.5%	1092	95.5%	1143	100.0%
11p. Self-care	19	1.7%	1124	98.3%	1143	100.0%
11q. patient approval for health care	1	0.1%	1142	99.9%	1143	100.0%
12a. Scheduling for referral	11	1.0%	1132	99.0%	1143	100.0%
12b. Promptness of appointment	13	1.1%	1130	98.9%	1143	100.0%
12c. Scheduling appointment is easy	963	84.3%	180	15.7%	1143	100.0%
12d. Problem scheduling access	57	5.0%	1086	95.0%	1143	100.0%
12e. Schedule most of the time	8	0.7%	1135	99.3%	1143	100.0%
13a. Access to health services	905	79.2%	238	20.8%	1143	100.0%
13b. Access to health services is a problem	133	11.6%	1010	88.4%	1143	100.0%
14a. Transportation available	1017	89.0%	126	11.0%	1143	100.0%
14b. Transportation problems/challenges	46	4.0%	1097	96.0%	1143	100.0%
15a. Insurance coverage	648	56.7%	495	43.3%	1143	100.0%
15b. Insurance too costly	362	31.7%	781	68.3%	1143	100.0%
15c. Medicaid	115	10.1%	1028	89.9%	1143	100.0%
15d. Medicare	91	8.0%	1052	92.0%	1143	100.0%
15e. Sliding scale	28	2.4%	1115	97.6%	1143	100.0%
15f. Free	16	1.4%	1127	98.6%	1143	100.0%
15g. Private	206	18.0%	937	82.0%	1143	100.0%
15h. Self -funded	51	4.5%	1092	95.5%	1143	100.0%

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16. Primary care accessible in past 6 months	1	0.1%	1142	99.9%	1143	100.0%
16a. Access to primary care okay	1002	87.7%	141	12.3%	1143	100.0%
16b. Access difficult because of transportation	5	0.4%	1138	99.6%	1143	100.0%
16c. Long waits	42	3.7%	1101	96.3%	1143	100.0%
16d. Slow response	3	0.3%	1140	99.7%	1143	100.0%
16e. Care too expensive	9	0.8%	1134	99.2%	1143	100.0%
16f. Care not needed in past 6 months	8	0.7%	1135	99.3%	1143	100.0%
16g. Scheduling primary care somewhat easy	39	3.4%	1104	96.6%	1143	100.0%
16h. Scheduling very hard	1	0.1%	1142	99.9%	1143	100.0%
17a. Don't need dental care because have dentures	50	4.4%	1093	95.6%	1143	100.0%
17b. Need dental care but not going because of expense	16	1.4%	1127	98.6%	1143	100.0%
17c. Dental care accessible	681	59.6%	462	40.4%	1143	100.0%
17d. Too expensive	105	9.2%	1038	90.8%	1143	100.0%
17e. Not happy with dentist	14	1.2%	1129	98.8%	1143	100.0%
17f. No access to dental care	94	8.2%	1049	91.8%	1143	100.0%
17g. Not applicable	110	9.6%	1033	90.4%	1143	100.0%
17i. Somewhat easily	47	4.1%	1096	95.9%	1143	100.0%
18a. Don't need behavioral health	45	3.9%	1098	96.1%	1143	100.0%
18b. Seeing pain management doctor	1	0.1%	1142	99.9%	1143	100.0%
18c. Behavioral health useful	32	2.8%	1111	97.2%	1143	100.0%
18d. Not applicable	485	42.4%	658	57.6%	1143	100.0%
18e. Access to behavioral health okay	377	33.0%	766	67.0%	1143	100.0%
18f. Avoid behavioral health because of stigma	3	0.3%	1140	99.7%	1143	100.0%
18g. Costs	15	1.3%	1128	98.7%	1143	100.0%
18h. Long waiting list	35	3.1%	1108	96.9%	1143	100.0%
18i. Providers will not take patient	1	0.1%	1142	99.9%	1143	100.0%
18j. Interested in counseling but never used	11	1.0%	1132	99.0%	1143	100.0%
18k. Cannot access counseling	12	1.0%	1131	99.0%	1143	100.0%
18l. Counseling somewhat easy to access	37	3.2%	1106	96.8%	1143	100.0%
19a. Specialty Referrals available	499	43.7%	644	56.3%	1143	100.0%
19b. Specialty Referrals not needed	265	23.2%	878	76.8%	1143	100.0%
19c. Difficulties with specialty referrals	168	14.7%	975	85.3%	1143	100.0%
19d. Somewhat easily	61	5.3%	1082	94.7%	1143	100.0%

Questions on access to healthcare are also included in the Bureau of Vital Records and Health Statistics June 2018 Idaho's Behavioral Risk Factor Surveillance System (BRFSS) Report. The question most comparable to the questions about access to healthcare asked here has to do with health insurance.

" Q3.1 Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, government plans such as Medicare, or Indian Health Service?"

In the current sample, 418 individuals indicated they had health insurance, or, were enrolled in Medicaid (:23 patients, enrolled in Medicare: 22 patients, or were in a private plan: 37 patients). One hundred and eighty-seven patients reported health insurance too costly with 8 individuals from this same group also stating they had health insurance. The final percentage of people reporting health insurance will be reported in the final report taking into account the missing data

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from non-responses, and other categories of coverage such as sliding fees and free care. Comparison with the reported BRFSS results however must be done with caution since the reported 84.5% with insurance does not include the responses of “Don’t Know” and “Refused” along with a few other classification and sampling issues.

A version of the question Q3.3 “Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?” will also be explored with the SET data in the final report. (Yes (14.1%) 2 No (85.9%)

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Appendix G

Overall Frequencies for PCMH Portal Notes

	Valid		Number of Items Coded		Total	
	N	Percent	N		N	Percent
PCMH STANDARD Access Goal using Portal	15	13.6%	3		110	100.0%
PCMH STANDARD Access Goal using scheduling changes	50	45.5%	7		110	100.0%
PCMH STANDARD Access Goal using Care Team	30	27.3%	5		110	100.0%
PCMH STANDARD Access Goal using Administrative processes	21	19.1%	7		110	100.0%
PCMH STANDARD Plan for Access using Portal	24	21.8%	5		110	100.0%
PCMH STANDARD Plan for Access using Scheduling	34	30.9%	9		110	100.0%
PCMH STANDARD Plan for Access using Care Team	17	15.5%	5		110	100.0%
PCMH STANDARD Plan for Access using Administrative processes	68	61.8%	14		110	100.0%
PCMH STANDARD Team Based Care Goal using Administrative Processes	39	35.5%	14		110	100.0%
PCMH STANDARD Team Based Care Goal using Management of Care	67	60.9%	12		110	100.0%
PCMH STANDARD Team Based Care Goal using Patient Outreach	9	8.2%	7		110	100.0%
PCMH STANDARD Plan for Team Based Care using Administrative Processes	66	60.0%	21		110	100.0%
PCMH STANDARD Plan for Team Based Care using Management of Care	58	52.7%	19		110	100.0%
PCMH STANDARD Plan for Team Based Care using Patient Outreach	16	14.5%	5		110	100.0%
PCMH STANDARD Population Management Goal using Administrative Processes	52	47.3%	13		110	100.0%
PCMH STANDARD Population Management Goal using Patient Engagement	20	18.2%	3		110	100.0%
PCMH STANDARD Population Management Goal using Care Team	10	9.1%	6		110	100.0%
PCMH STANDARD Population Management Goal using Screenings	24	21.8%	7		110	100.0%
PCMH STANDARD Population Management Plan using Administrative Processes	67	60.9%	19		110	100.0%
PCMH STANDARD Population Management Plan using Patient Engagement	24	21.8%	3		110	100.0%
PCMH STANDARD Population Management Plan using Care Team	17	15.5%	6		110	100.0%

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PCMH STANDARD Population Management Plan using Screenings	24	21.8%	6		110	100.0%
PCMH STANDARD Care Management Goal using Administrative Processes	51	46.4%	17		110	100.0%
PCMH STANDARD Care Management Goal using Care Team	33	30.0%	10		110	100.0%
PCMH STANDARD Care Management Goal using Patient Outreach	7	6.4%	6		110	100.0%
PCMH STANDARD Care Management Plan using Administrative Processes	63	57.3%	13		110	100.0%
PCMH STANDARD Care Management Plan using Care Team	31	28.2%	14		110	100.0%
PCMH STANDARD Care Management Plan using Patient Outreach	17	15.5%	4		110	100.0%
PCMH STANDARD Care Coordination Goal using Administrative Processes	55	50.0%	16		110	100.0%
PCMH STANDARD Care Coordination Goal using Management of Care	28	25.5%	7		110	100.0%
PCMH STANDARD Care Coordination Plan using Administrative Processes	60	54.5%	21		110	100.0%
PCMH STANDARD Care Coordination Plan using Management of Care	32	29.1%	8		110	100.0%
PCMH STANDARD Quality Improvement Goal using Clinic Processes	46	41.8%	15		110	100.0%
PCMH STANDARD Quality Improvement Goal using Clinical Quality Measures	29	26.4%	5		110	100.0%
PCMH STANDARD Quality Improvement Goal using other processes	12	10.9%	5		110	100.0%
PCMH STANDARD Quality Improvement Plan using Clinic Processes	32	29.1%	11		110	100.0%
PCMH STANDARD Quality Improvement Plan using Clinical Quality Measures	24	21.8%	2		110	100.0%
PCMH STANDARD Quality Improvement Plan using other processes	26	23.6%	13		110	100.0%

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Appendix H

Patient Centered Medical Home Portal Notes: Successes, Barriers and Areas of Interest or Concern

	Number of Items Coded				
	Valid			Total	
	N	Percent	N	N	Percent
PORTAL Success with Access	53	48.2%	3	110	100.0%
PORTAL Success with Team Based Care	39	35.5%	11	110	100.0%
PORTAL Success with Population Management	28	25.5%	8	110	100.0%
PORTAL Success with Care Management	34	30.9%	6	110	100.0%
PORTAL Success with Care Coordination	29	39.4%	16	110	100.0%
PORTAL Success with Quality Improvement	23	20.9%	6	110	100.0%
PORTAL Success with Administrative Changes	28	25.5%	7	110	100.0%
PORTAL Barrier with Access	29	26.4%	3	110	100.0%
PORTAL Barrier with Team Based Care	51	46.4%	15	110	100.0%
PORTAL Barrier with Population Management	35	31.8%	6	110	100.0%
PORTAL Barrier with Care Management	8	7.3%	8	110	100.0%
PORTAL Barrier with Care Coordination	25	22.7%	6	110	100.0%
PORTAL Barrier with Quality Improvement	20	18.2%	7	110	100.0%
PORTAL Barrier with Administrative Processes	39	35.5%	16	110	100.0%
PORTAL Concern or interest with Access	5	4.5%	2	110	100.0%
PORTAL Concern or interest with Team Based Care	37	33.6%	9	110	100.0%
PORTAL Concern or interest with Population Management	39	35.5%	5	110	100.0%
PORTAL Concern or interest with Care Management	47	42.7%	13	110	100.0%
PORTAL Concern or interest with Care Coordination	51	46.4%	14	110	100.0%
PORTAL Concern with Quality Improvement	20	18.2%	15	110	100.0%
PORTAL Concern with Administrative Processes	88	80.0%	39	110	100.0%

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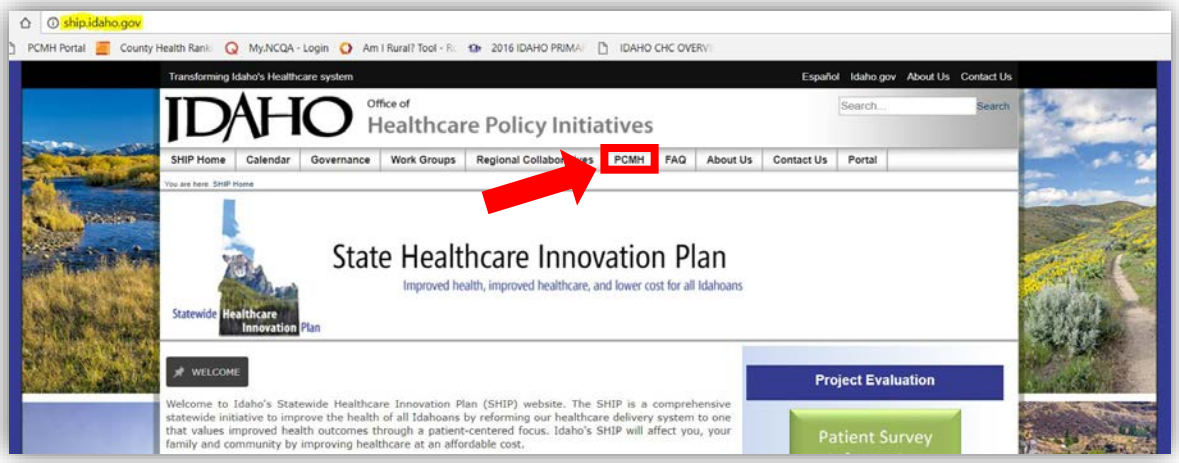
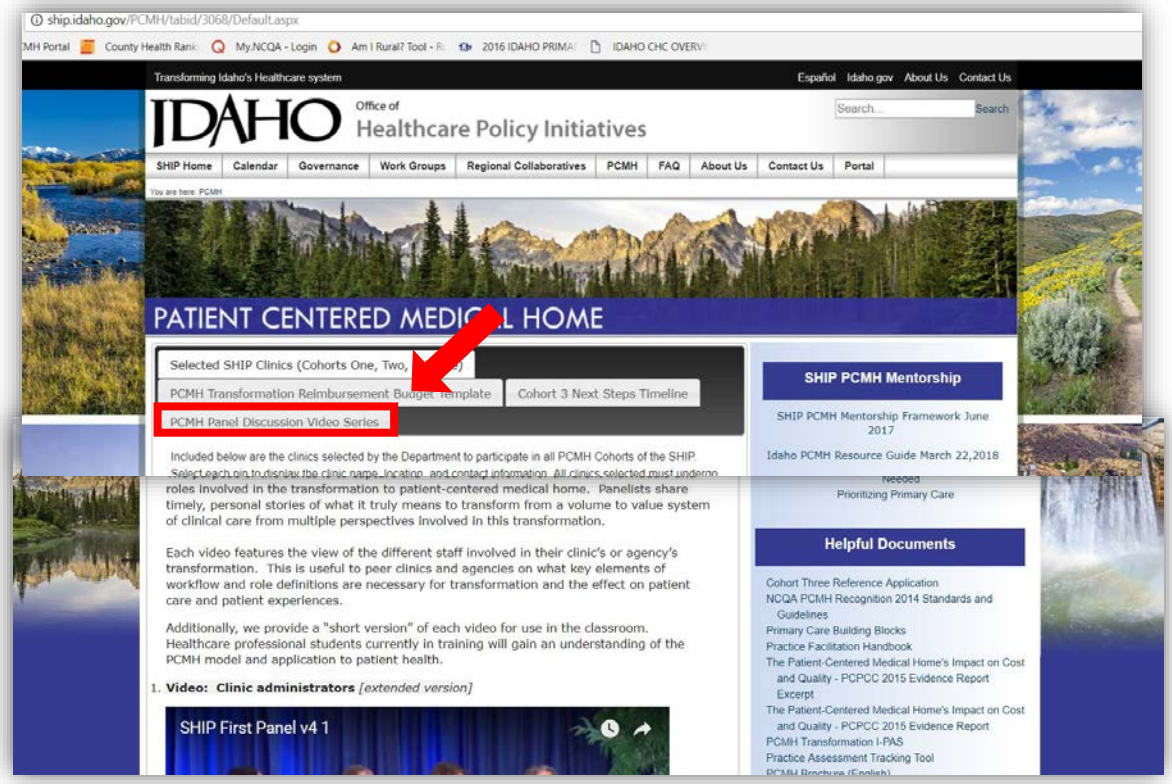
Appendix I

How to Find and Watch PCMH Panel Interview Videos

Navigate to the SHIP homepage at http://ship.idaho.gov and click on “PCMH”



Click on “PCMH Panel Discussion Video Series”



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Appendix J

Clinic Staff Interview Questions and Codes

SHIP State Evaluator Clinic Interview Questions

Attendees:
Date:

Goals of the project are to reflect key stakeholders' views on the history, the progress so far, and future accomplishments of Statewide Healthcare Innovation Program. While this interview provides insight to key stakeholders, the benefit to you is an opportunity to reflect on the project you've been committed to for the last few months or so, and to offer feedback for future consideration.

I'm going to ask you 7 questions, provide you with an opportunity to respond as fully as you like. As I hear your responses, I may pause and ask for clarification, or ask a follow-up question to further elaborate your key points.

Please answer each question as thoughtfully and frankly as possible.

Do you have any questions? Let's begin.

1. What are the top 3 PCMH functions or activities you think are the most successful in helping your clinic achieve better patient care?
2. How do you define patient engagement? Do you think PCMH transformation has helped your patients engage with their own health? If so, how?
3. SHIP's State Health priorities are Diabetes, Smoking Cessation, Overweight/Obesity and Access to Primary care.
    a. Are there specific PCMH functions or activities that you think helped your patients deal with these health priorities?
4. What are the top 3 PCMH functions or activities that are priorities for your clinic in the coming year?
5. Are there specific PCMH functions or activities you would like more help with?
6. How do you define the Medical Health Neighborhood? What are your experiences coordinating care for your patients within your medical health neighborhood? (for example, home health, food banks, specialty physicians).
7. Have you heard of Project ECHO? (If so, have you participated? If not, would you like more information?)
8. Is there anything else you would like to tell us about regarding your PCMH and your SHIP experiences so far?

Ok! Again, thank you so much for your time today. On behalf of the SHIP State Evaluators Team, administrators and myself, we greatly appreciate your time and participation in this process with us.

And hope you have a great day.

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Clinic Coding Worksheet

Clinic Name: _____

Cohort:

- ☐ **1**
- ☐ **2**
- ☐ **3**

Region:

- ☐ **1**
- ☐ **2**
- ☐ **3**
- ☐ **4**
- ☐ **5**
- ☐ **6**
- ☐ **7**

City: _____

County: _____

Idaho Health Home:

- ☐ **Yes – 1**
- ☐ **No – 2**

Electronic Medical Record Vendor:

_____

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1. What are the top 3 PCMH functions or activities you think were the most successful in helping your clinic achieve better patient care?
1.Team-based Care and Practice Organization • Community Health EMS (CHEMS) • Community Health Workers (CHWs) • Developed /refined roles, responsibilities, teams • Huddles • Working to level of licensure 2. Knowing and Managing Your Patients • Patient engagement • Patient education / development of educational materials • Pre-visit planning • Measuring patient satisfaction • Shared medical appointments • PHQ-9 / Depression Screenings 3. Patient-Centered Access and Continuity • Integrated behavioral health services • Integrated dental health services • Patient centered construction/design of facilities 4. Care Management and Support • Care management • Plans of Care • Hired case manager 5. Care Coordination and Care Transitions • Referral tracking • Care transitions • Comprehensive Care • Following up with patients after hospital visits • Hired care coordinator 6. Performance Measurement & Quality Improvement • HMA Technical Assistance (World Café, coaching calls, etc.) • Improved utilization of EHR • CQMs • Standardization • Refined processes / protocols • PDSA cycles • Public Health QI Specialist support • Quality Improvement • Mentoring

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2. How do you define patient engagement? Do you think PCMH transformation has helped your patients engage with their own health? If so, how?
How do you define patient engagement?
1. Isn't formally defined within clinic 2. Compliance - patient follows care plan as designed by clinic and/or clinic and patient 3. Empower - to give education, direction, guidance resulting in patient activation 4. Activation - patient uses knowledge, skills, and confidence to self-manage care
Do you think PCMH transformation has helped your patients engage with their own health?
1. Yes 2. No 3. Don't Know
If so, how?
1. Team-based Care and Practice Organization • Involving entire staff • Trained staff on patient engagement • Culture shift 2. Knowing and Managing Your Patients • Shared medical appointments • Administer PAM Survey • Empowering patients • Patient centered language/phrasing 3. Patient-Centered Access and Continuity • Following up with no-shows • Increased opportunities to help patients • Integrated care • Portal use 4. Care Management and Support • Behavioral health specialists meet with patients to develop SMART goals • Medication assistance program • Case management • Continuing conversations with patients after visits • Pain management Program 5. Care Coordination and Care Transitions • Care coordination • Actively works to involve patients • Follow through on gaps • Follow up with specialists • Improved communication 6. Performance Measurement & Quality Improvement • Improved processes

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3. SHIP's State Health priorities are Diabetes, Smoking Cessation, Overweight/Obesity and Access to Primary care. a. Are there specific PCMH functions or activities that you think helped your patients deal with these health priorities?	
Diabetes?	1. Behavioral Health Integration 2. Care coordination 3. Care management • Care plans / plans of care 4. Process / administrative • Changed workflows • Scripts for providers • Employee training 5. Group classes / Shared Medical Appointments 6. Screenings • Comprehensive health assessments 7. Patient empowerment • Health coaches • Patient education • Preventative reminders for patients • Sharing success stories of other patients 8. State-level resources • Working with PHD 9. Team-Based Care and Practice Organization • CHWs
Smoking Cessation?	1. Behavioral Health Integration 2. Care coordination 3. Care management • Care plans / plans of care 4. Process / administrative • Changed workflows • Scripts for providers • Employee training • EHR modules • Standing orders 5. Group classes / Shared Medical Appointments 6. Screenings • Comprehensive health assessments 7. Patient empowerment • Health coaches • Patient education • Preventative reminders for patients • Sharing success stories of other patients 8. State-level resources • Idaho Quit Line • Project Filter • Working with PHD 9. Team-Based Care and Practice Organization • CHWs

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Overweight / Obesity?	1. Behavioral Health Integration 2. Care coordination 3. Care management • Care plans / plans of care • Dietitian 4. Process / administrative • Changed workflows • Scripts for providers • Employee training • EHR modules • Standing orders 5. Group classes / Shared Medical Appointments 6. Screenings • Comprehensive health assessments 7. Patient empowerment • Patient education • Health coaches • Preventative reminders for patients • Sharing success stories of other patients 8. State-level resources • Working with PHD 9. Team-Based Care and Practice Organization • CHWs
Access to Primary Care?	1. Behavioral Health Integration 2. Care coordination 3. Care management • Coordinate transportation 4. Process/administrative • Changed workflows • Convened Access Committee • Employee training • Standing orders • Templates 5. Group classes / Shared Medical Appointments 6. Patient-centered scheduling • Extended hours • Increase availability of appointment times • Provide same day appointments • Walk-in appointments 7. Patient empowerment • Patient education • Patient Portal • Preventative reminders for patients • Sharing success stories of other patients 8. State-level resources • Working with PHD 9. Dental health integration 10. Community health / wellness integration 11. Team-Based Care and Practice Organization • CHWs

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4. What are the top 3 PCMH functions or activities that are priorities for your clinic in the coming year?
1. Team-based Care and Practice Organization • Community Health Workers • Huddles • Provider and c-suite buy-in 2. Knowing and Managing Your Patients • Cancer screenings • Diabetes prevention program • Incorporating social determinants into care • Patient education/outreach • Population health • Preventative care • Targeted outreach to vulnerable populations 3. Patient-Centered Access and Continuity • Access • Behavioral Health Integration • Oral Health Integration • Telehealth 4. Care Management and Support • Lower A1c threshold • Integrated care plans with medical and mental health • Vision screening • Care management • Plans of care • Obesity / weight loss (programs, billing, etc.) • Increasing annual Medicare wellness visits 5. Care Coordination and Care Transitions • Care coordination • Transitional care implementation • Decreasing ED visits • Follow-up with ED discharge patients • Patient follow-up methods 6. Performance Measurement & Quality Improvement • Electronic Medical Record upgrades • Patient satisfaction surveys • Policy and procedure documenting • Remodel / new construction • Quality Improvement measures • Transformation of partner clinics • Value-based Payment preparedness • Embracing PCMH transformation • Monthly QI/PCMH meeting to track goals • NCQA 2017 • New Electronic Medical Record

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5. Are there specific PCMH functions or activities you would like more help with?
1. Patient-Centered Access and Continuity • Telehealth • Behavioral Health Integration 2. Care Management and Support • Care management • Group visits • Obesity programs 3. Care Coordination and Care Transitions • Care coordination • Referral tracking • Hospital follow-up 4. Population Health • Clinical Quality Measures • Risk Stratification 5. Patient engagement and outreach 6. NCQA • Submission • Transition to 2017 7. Affinity group for clinics who use same Electronic Medical Record 8. Mentoring from other clinics 9. Templates for policies and procedures 10. Opioid Crisis 11. Medicare / Medicaid Population 12. No 13. Team-Based Care and Practice Organization • CHWs • Staff engagement/buy-in • Huddles • Culture shift

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6. How do you define the Medical Health Neighborhood? What are your experiences coordinating care for your patients within your medical health neighborhood? (for example, home health, food banks, specialty physicians).
How do you define the Medical Health Neighborhood?
1. Health Care System Related Services • Fire Department / EMS • Specialists • Care coordinators / case managers • Physical Therapy • Imaging • Periodontal • Indian Health Services • Health related resources in the area • Home health • Emergency departments Behavioral health / mental health 2. Social Determinants Related Services • Housing • Transportation • Food banks • Home helpers / CHWs 3. Health Related Services • Public Health Department • Community Resource Center • Anyone who touches their patients • Area Agency on Aging • Wellness centers • Portneuf Quality Alliance • Regional Collaborative • Tribal Services • Resource Guide on Public Health Department website 4. Mentoring other clinics
What are your experiences coordinating care for your patients within your medical health neighborhood?
1. Positive 2. Negative 3. Mixed (select this if clinic cites both positive and negative experiences)

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7. Is there anything else you would like to tell us about regarding your PCMH?
1. Positive feedback - HMA/Briljent 2. Frustrations with HMA/Briljent 3. Positive feedback - SHIP Central 4. Frustrations with SHIP Central 5. Positive feedback - Public Health District 6. Frustrations with Public Health District 7. Positive feedback - Regional Collaborative 8. Frustrations with Regional Collaborative 9. Positive feedback - IHDE 10. Frustrations with IHDE 11. Benefits of PCMH 12. Challenges of PCMH 13. Positive feedback – Physician Champion 14. Would like more data / better follow-up on data 15. Improvements from SHIP Cohort 1 to Cohort 2 16. Improvements from SHIP Cohort 2 to Cohort 3

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Appendix K

Curriculum HIT Outlines

Free Resources Available on "Homepage"
These will be self-reviewed, non-assessed resources available for free. Resources to be grouped in topic areas with appropriate descriptions.

- Data Use and Reporting
- Promoting Interoperability (PI) Programs
  - Certified EHR Technology (CEHRT)
  - eCQM Resources - https://ecqi.healthit.gov/ecqms
- PCMH Transition Resources
  - Templates (no resources yet)
  - NCQA Accreditation Resources (PCMH 25, 209/220, 325, 441/485, ,449 458)
  - Job Descriptions (no resources yet)
- Value-Based Programs
  - Value Based Payment Models (204/223, 239/240)
  - Merit-Based Incentive Payment System (MIPS)
  - Medicare Access and CHIP Reauthorization Act (MACRA) (PCMH 192)
  - VBP In Action (PCMH 331)
- PCMH Success Stories (PCMH 350/351/352, 425/426/427, 430/431/432, 434/435/436, 480, 331, 332, 333, 341/342/353)

Fee-Based Resources for CEU/Credit or Badge/Certificate
These will be task-based modules with assessments. Resources to be grouped in topic areas with appropriate descriptions. Individual modules may be eligible for continuing education credit. Combinations of modules may lead to badge, academic credit, or certificate. Resources listed contain related content, but may not be all-inclusive of material (or exclusive of other material). Ideas for badges: Data Use and Reporting, PCMH Transformation, Quality Improvement…

- **Domain I: Care Management, Coordination, and Transitions (CMCT)**
  - CMCT 100: Introduction to Care Management and Care Coordination (PCMH 11/113/114 & 324)
    - NCQA Standard CM: Care Management and Support
  - CMCT 101: Transitional Care Coordination (PCMH 17/117/118, 336/338/354, & 483/484/488)
    - NCQA Standard CC: Care Coordination and Care Transitions
  - CMCT 102: Chronic Care Management (PCMH 233/231/232 & 479)
  - CMCT 103: Creating a Care Management Program (PCMH 479)

Resources: PCMH 11/113/114 Care Management Care Coordination (slides/notes/recording); PCMH 17/117/118 Care Transition Models (slides/notes/recording); PCMH 231/232/233 Chronic Care Management Solutions (notes/recording/slides); PCMH 324 Enhanced Systems Care Management and Behavioral Health Integration (slides); PCMH 336/338/354 Care Transitions and Coordination (notes/slides/recording); PCMH 479 Creating Sustainable Care Management Programs (slides); PCMH 483/484/488 Care Coordination & Transition Follow-Up (notes/slides/recording)

- **Domain II: Confidentiality, Privacy, and Security (CPS)**
  - CPS 100: Introduction to Confidentiality, Privacy, and Security (PCMH 31)
  - CPS 101: HIPAA and Other Federal Regulations

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Resources: PCMH 31 Accessing and Using Data to Drive Change (slides)

- **Domain III: Data Integrity, Use, and Reporting (DATA)**
  - DATA 100: Data Collection and Structure (PCMH 190/215 & 201/227)
  - DATA 101: Data Integrity and Validation with an emphasis on Harmonization as defined below (PCMH 31)

Harmonization

"The standardization of specifications for related measures with the same measure focus (for example, influenza immunization of patients in hospitals or nursing homes); related measures for the same target population (for example, eye exam and HbA1c for patients with diabetes); or definitions applicable to many measures (for example, age designation for children) so that they are uniform or compatible, unless differences are justified (in other words, dictated by the evidence). The dimensions of harmonization can include numerator, denominator, exclusions, calculation, and data source and collection instructions. The extent of harmonization depends on the relationship of the measures, the evidence for the specific measure focus, and differences in data sources. Value sets used in measures (especially eCQMs) should be harmonized when the intended meaning is the same. Harmonization of logic in eCQMs is beneficial when the data source in the EHR is the same." (Page 342 Blueprint for the CMS Measures Management System)
https://ecqi.healthit.gov/content/glossary-ecqi-terms

  - DATA 102: Accessing Data and Running Reports
  - DATA 103: Data Analysis (PCMH 190/215 & 201/227)
  - DATA 104: Data Display (PCMH 31)

Resources: PCMH 31 Accessing and Using Data to Drive Change (slides); PCMH 190/215 Idaho Quality Metrics (slides/slides); PCMH 201 Quality Metrics (slides); PCMH 227 Quality Metrics and Creating Effective Data Plans (slides); PCMH 320 Risk Stratification and Population Health Management (slides)

- **Domain IV: Access to Integrated and Collaborative Care (ICC)**
  - ICC 100: Patient-Centered Care (PCMH 16, 17/117/118, & 430/431/432)
    - NCQA Standard AC: Patient-Centered Access and Continuity
  - ICC 101: Behavioral Health (PCMH 44/111/112, 324 & 479)
  - ICC 102: Oral Health (PCMH 344/345/346)
  - ICC ?: Pharmacy Integration (no resources yet)
  - ICC 103: The Patient-Centered Medical Home (PCMH) Model (PCMH 25, 255/256/257, 271, 305/306, 325, 449, & 479)
  - ICC 104: Telehealth (PCMH 123/126/127)
    - Virtual Patient Medical Center (PCMH 228/229)
  - ICC 105: Patient Engagement (PCMH 194/218 & 318)

Resources: PCMH 16 Patient Centered Access (slides); PCMH 17/117/118 Care Transition Models (slides/notes/recording); PCMH 25 High Performing Primary Care (slides); PCMH 44/111/112 Behavioral Health Integration (slides/recording/notes); PCMH 123/126/127 PCMH Transformation - Telehealth (slides/notes/recording); PCMH 194/218/318 Patient Engagement (slides); PCMH 228/229 Virtual Patient Center (slides); PCMH 255/256/257 & 271 NCQA Mapping Changes (slides/notes/recording); PCMH 305/306 & 449 2017 NCQA PCMH Redesign (slides/recording); PCMH 324 Enhanced Systems Care Management and Behavioral Health Integration (slides); PCMH 325 Getting Started on becoming a PCMH (slides); PCMH 344/345/346 Oral Health Strategies (notes/slides/recording); PCMH 430/431/432 Relationship Centered Medical Home: Building Relationships (recording, slides, notes); PCMH 479 Creating

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Sustainable Care Management Programs (slides); PCMH 481 Blending Cultures - Clinics and Hospitals Working Together (slides)

- **Domain V: Leadership (LEAD)**
  - LEAD 100: Adaptive Leadership (PCMH 203/211 & 321)
  - LEAD 101: Change Management (PCMH 18/115/116, 27, 196/225, 298/299/300, 450, & 455/486/487)
    - Provider Engagement in Change (PCMH 334/335)
  - LEAD 102: Lean Management (PCMH 272/273)

Resources: PCMH 18/115/116 Leadership and Change (slides/notes/recording); PCMH 27 Building Support Facilitating Change (slides); PCMH 196/225 Managing Change (slides/notes); PCMH 203/211 Adaptive Leadership (slides); PCMH 272/273 Lean Thinking and Value Stream Mapping (slides/recording); PCMH 298/299/300 Change Management (notes/slides/recording); PCMH 334/335 Provider Engagement in PCMH Transformation (slides/recording); PCMH 450 Leading the PCMH Journey of Change (slides); PCMH 455/486/487 Change Management (recording/slides/notes)

- **Domain VI: Paying for Healthcare (PFH)**
  - PFH 100: Healthcare Reimbursement Methodologies (PCMH 25)
  - PFH 101: Clinical Documentation Improvement
  - PFH 102: Clinical Classification Systems (PCMH 25 & 233/231/232 & 479)
  - PFH 103: Value-Based Payment Models (PCMH 123/126/127, 192, 204/223, 238/239/240, 305/306, 331, 449 & 479)

Resources: PCMH 25 High-Performing Primary Care (slides); PCMH 123/126/127 PCMH Transformation - Telehealth (slides/notes/recording); PCMH 192 MACRA Overview (slides); PCMH 204/223 Value Based Payment Models (slides); PCMH 231/232/233 Chronic Care Management Solutions (notes/recording/slides); PCMH 238/239/240 SHIP PCMH Transformation - Value Based Payment (notes/slides/recording); PCMH 305/306 & 449 2017 NCQA PCMH Redesign (slides/recording); PCMH 331 Navigating MIPS (slides); PCMH 479 Creating Sustainable Care Management Programs (slides)

- **Domain VII: Quality-Based Care (QUAL)**
  - QUAL 100: Performance and Quality Improvement (PCMH 441/485)
    - NCQA Standard QI: Performance Measurement and Quality Improvement
  - QUAL 101: Quality Improvement Coaching (PCMH 26)
  - QUAL 102: Quality Improvement Models (PCMH 9, 30, & 272/273)
  - QUAL 103: Quality Metrics (PCMH 190/215, 201/227, & 305/306)
    - Evidence-Based Best Practice
    - Quality Metrics and the Electronic Health Record
    - Alignment with Policies and Procedures

Resources: PCMH 26 A Day in the Life of a Practice Facilitator (slides); PCMH 9 QI PDSA Model (slides); PCMH 30 Model for Improvement (slides); PCMH 190/215 Idaho Quality Metrics (slides); PCMH 201/227 Quality Metrics (slides); PCMH 272/273 Lean Thinking and Value Stream Mapping (slides/recording); PCMH 305/306 & 449 2017 NCQA PCMH Redesign (slides/recording); PCMH 441/485 Moving from Process to Performance Improvement (slides/notes)

- **Domain VIII: Risk and Population Health Management (RPHM)**
  - RPHM 100: Risk Management
  - RPHM 101: Risk Stratification and Population Health Management (PCMH 10/119/120; PCMH 13; PCMH 221 & 320)

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        - NCQA Standard KM: Knowing and Managing Your Patients
    - RPHM 102: Empanelment (PCMH 205/214)

Resources: PCMH 10/119/120 Population Health (slides/recording/notes); PCMH 13 PCMH Tools Population Health (slides); PCMH 205/214 Empanelment (slides); PCMH 221 Risk Stratification (slides); PCMH 320 Risk Stratification and Population Health Management (slides)

- **Domain IX: Interprofessional Team-Based Care (TEAM)**
    - TEAM 100: Teams and Teamwork (PCMH 15/121/122, 28, 195/222, & 319)
        - NCQA Standard TC: Team-Based Care and Practice Organization
    - TEAM 101: Roles and Responsibilities of Team Members (PCMH 40)
    - TEAM 102: Shared Values and Ethics
    - TEAM 103: Interprofessional Communication

Resources: PCMH 15/121/122 Team-Based Care Management (slides/recording/notes); PCMH 28 Facilitating High Functioning Teams (slides); PCMH 40 The Practice Team in Team-Based Care (slides); PCMH 195/222 Team-Based Care (slides); PCMH 319 Steps to Team-Based Care (slides)

Other standalone Domains for consideration as requested by the SMEs

- Behavioral Health Integration
- Pharmacy Integration

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Appendix L

Clinic Community Windshield Survey

SHIP State Evaluator Windshield Survey
CLINIC NAME & ADDRESS:
Any special notes about the population served at this clinic?
Observer(s):
Day/Date/Time:
Season:
Temperature & Weather:

CITY/TOWN DEMOGRAPHICS
City/Town Name:
Population:
Population Special Notes:

COUNTY DEMOGRAPHICS
County Name:
Population:
Population Special Notes:
Median Income:
Education Level (Graduation Rate, % Some College):
Main Industry:
Clinical Care rank in Idaho:

CITY/TOWN INFORMATION

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Does the city have a taxi company?
Does the city have a public transit system?
Are there indoor recreation spaces? (e.g. YMCAs, fitness centers, community centers, etc.)
Does the city have green space, parks, recreational paths? 79 (74)

CLINIC APPEARANCE
Is there adequate, easily-accessible parking? 102 (96)
Are there sidewalks leading to the facility allowing people to walk easily and safely to the building from elsewhere in town? 57 (54)
Are there any bus stops visible in the immediate proximity? 42 (40)
Is the building and surrounding area well-maintained? (e.g. no trash, appropriate landscaping/lighting, etc.) 90 (85)
Is there clear signage leading to the clinic's entrance? 104 (98)
Is the signage in English, Spanish, another language? 94 (89) 12 (11) 4 (4)
Does the pathway into the clinic appear to meet ADA requirements? 104 (98)

SURROUNDING AREA*
Is the clinic in a residential, industrial, commercial area? 39 (37) 6 (6) 87 (82)
Are there sidewalks in the surrounding area? 69 (65)
Is there trash or rubble in the surrounding area? 2 (2)
Is there evidence of homelessness, crime, vandalism? 2 (2)
Any other notable observations?

*Surrounding area is defined as the area surrounding the clinic within a 1-block radius

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SUMMARY OF OVERALL IMPRESSIONS	
Near Other Health Facilities	62 (59)
On busy highway/road	7 (7)
Isolated from town	5 (5)
Strip mall type building	7 (7)
Newer facility	4 (4)

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Appendix M

Telehealth Summary

Idaho Telehealth Planning Meeting Executive Summary
Wednesday, May 23, 2018
9:00am – 4:30pm JRW Building –
Boise, ID

On May 23, 2018, the Idaho Department of Health and Welfare hosted a telehealth planning meeting in Boise. The purpose of the meeting was to convene a diverse set of telehealth subject matter experts to identify and discuss barriers, challenges, and opportunities for advancing telehealth in Idaho. Over 40 telehealth stakeholders from across the state representing hospitals, urban and rural health clinics, health systems, Community Health EMS (CHEMS), government, insurance, telehealth consulting experts, associations, and academia participated. Through the convening, attendees built consensus around the value and need for advancing telehealth services across Idaho. The group concluded that its best course of action is to seek the partnership of the Idaho Healthcare Coalition (IHC) to advocate on behalf of the future of telehealth in Idaho.

The meeting came near the conclusion of the multi-year Statewide Healthcare Innovation Plan (SHIP) which has been working to transform healthcare to a value-based system and transform primary care practices across the state into Patient-Centered Medical Homes (PCMHs). The SHIP initiative concludes January 31, 2019. As a part of the larger SHIP initiative, significant work has been done to nurture the use of telehealth strategies to increase access to quality healthcare throughout the state. The efforts have included the development of a telehealth toolkit, a series of webinars, and two rounds of grantmaking. These grants supported new or expanding telehealth programs resulting in twelve sub-grant awards to eight clinics and one CHEMS agency, a technical assistance program to all grantees across the state, and the May 23 planning meeting.

Stakeholders at the meeting identified the most pressing barrier as the existence of a complex reimbursement landscape that has resulted in the inconsistent, or overall lack of reimbursement for telehealth services beyond the recent progress made with Idaho Medicaid telehealth policies. The group also voiced a concern about the lack of an operational coordinating body with adequate capacity to meaningfully advance telehealth. Other barriers included a lack of training and workflow processes that address telehealth's impact, limitations on managing prescriptions, and addressing technology requirements. (For a full meeting summary, see the attached minutes).

As the group moved on to identifying opportunities, there was general agreement about the potential of telehealth to help overcome the specific challenges of provider shortages and rural and frontier community isolation which contribute to significant areas of underserved populations due to lack of access to care. They identified the models and applications for telehealth that can improve access to primary care and specialists, support patient and provider education, and share real time actionable data. Additionally, the group recognized that the complex issues surrounding telehealth must be addressed by stakeholder collaboration to thrive within a very complex healthcare system.

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By the end of the day, there was emerging consensus that continued, coordinated growth of telehealth as a resource for addressing healthcare needs in the state is urgent. Participants considered it crucial that dialogue continue post-SHIP among stakeholders, particularly payers, and all were interested in continuing the dialogue.

Given the previously narrow scope of the now inactive Telehealth Council, its low membership, inactivity, and lack of resources, participants agreed that another coordinating body with adequate capacity is needed to advance telehealth. Stakeholders decided to ask the IHC to advocate on their behalf, by communicating the need for the continued prioritization of telehealth to the Health Quality Planning Commission and asking their help in continuing the momentum of the telehealth work that has begun and finding potential solutions to identified challenges.

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Appendix N

Goal 1 PCMH Transformation: Panel Discussion Video Series

Patient-Centered Medical Home Transformation:
Panel Discussion Video Series

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702
Prepared by
Idaho SHIP State-level Evaluation Team
Principal Investigator: Dr. Janet Reis

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.

The Patient-Centered Medical Home (PCMH) Transformation Panel Discussion Video Series sought to capture the “lived” experience of different individuals and roles involved in the transformation to PCMH. Panelists shared timely, personal stories of what it means to transform from volume to value-based care from multiple perspectives.

Each panel features the view of the different staff involved in their clinic or agency transformation, as well as within the community. Additionally, we provide a “short version” of each video for use in the classroom. Healthcare students will gain an understanding of the PCMH model and application to patient health.

A Research Associate with the State-Level Evaluation Team facilitated each panel discussion. The facilitator is experienced in clinic management and knowledgeable in matters related to SHIP PCMH transformation. The series of panel discussions included the following:

1. Panel of clinic administrators
2. Panel of community health EMS
3. Panel of clinicians
4. Panel of care coordinators
5. Panel of physician champions
6. Panel of community health workers

Two overall themes emerged from the series. First, the experience and challenges of transformation vary greatly among individuals, and it depends on their role in the clinic or the community. Second, regardless of role individuals sincerely believe in the patient-centered medical home model of care.

In summary, implementation of the patient-centered medical home throughout the primary care system in Idaho requires redefinitions of staff roles and responsibilities and redirection of certain clinic workflows if the clinic is to succeed in providing patient-centered care. This restructuring of the clinic work environment occurs for the professionals involved in direct patient care, and their administrative support teams.

The PCMH Transformation Panel Discussion Series is a lasting resource for clinics and communities across Idaho. Each video provides testimony on what key elements of workflow and role definition are necessary to transform, as well as the perception of what subsequently happens to patient care and patient experiences. Furthermore, the videos will be valuable to students who will graduate in a rapidly altering and realigning health care system with major changes in the expectations and responsibilities for their own professional roles.

The remaining pages of this report provide details of each panel discussion. This includes the list of panelists along with clinic and community descriptions.

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Panel Discussion Video #1: Clinic Administrators
December 2017

In this discussion, we sought to capture the "lived" experience of clinic administrators involved in the transformation to patient-centered medical home. Panelists share timely, personal stories of what it truly means to transform from a volume to value system of care.

Panelists included:

- **Stephanie Atkinson, Grant Specialist at Family Health Services.** Family Health Services is a Federally Qualified Health Center with eight medical clinics located in seven communities. The mission of Family Health Services is to make high quality, culturally sensitive, primary medical and dental care, behavioral health and social services affordable and accessible to the people of South Central Idaho.

- **Bethany Gadzinski, Director of Quality and Risk Management at Terry Reilly Health Services.** Terry Reilly Health Services is a Federally Qualified Health Center providing comprehensive, integrated health care in communities spanning three counties in Southwest Idaho. Terry Reilly operates 4 integrated medical/dental/behavioral health clinics, 2 medical/dental clinics, 3 medical/behavioral health clinics, 3 dental clinics, 4 specialty behavioral health clinics and a detox/mental health crisis facility.

- **Michael Ryan, Business Process Manager at Bingham Memorial Hospital.** Bingham Memorial Hospital is a large healthcare provider located in Blackfoot, Idaho with family medicine practitioners in Blackfoot, Idaho Falls, Pocatello, Shelley, and Soda Springs. Their family medicine doctors work with patients of all ages and care for all general medical needs.

- **Rachel Stephenson, MHS, Quality Payment Program Specialist at Saltzer Medical Group.** Saltzer Medical Group is a network of physicians located in Nampa, Idaho. Physicians provide technically advanced care in the areas of aesthetic services, eye care, family practice, internal medicine, medical imaging, neurology, obstetrics & gynecology, osteoporosis, pediatrics, pulmonology, quick care, rheumatology, sleep disorders, and sports medicine.

- **Amber Villelli, Director of Performance Improvement at Kaniksu Health Services.** Kaniksu Health Services is a Federally Qualified Health Center located in Sandpoint, Idaho. Kaniksu provides medical, pediatric, dental, and behavioral care as well as veteran care for over 25,000 residents throughout two counties, including patients who may be uninsured, homeless, seasonal and migrant farmworkers, and living in rural areas.

Panelists discussed:

1. What aspects of teamwork have changed through PCMH?
2. How have your clinical roles changed from before PCMH transformation to after?
3. What does it mean for you to work at the top of your license?
4. Has PCMH transformation impacted patient engagement? How so?
5. Looking back, what do you know now that you wish you had known when you began?

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Panel Discussion Video #2: Community Health EMS
March 2018

An important aspect of the transformation underway through SHIP is the expanding role of Community Health Emergency Medical Services in their Medical Health Neighborhood. Panelists share what it means to augment EMS services in ways that add new value for the health and well-being of patients, their families, health care providers, law enforcement and social services agencies.

Panelists included:

- **Mark Babson, Community Paramedic, Ada County Paramedics**. Ada County Paramedics serves the population of Ada County as healthcare providers and patient advocates. The agency includes 14 stations located in Boise, Meridian, and Star. Primary CHEMS initiatives include: post-hospital discharge follow-up, mobile influenza vaccination clinics, a psychiatric emergency team, and a field referral program.

- **Juan Bonilla, Division Chief at Donnelly Rural Fire Department.** Donnelly Rural Fire Department provides a full-service fire department and emergency medical services to rural Valley County. Since introducing CHEMS two years ago at regional coalition meetings, the agency garnered support from key stakeholders and started with an initiative to address behavioral health needs of patients who frequently call 911 for non-emergencies.

- **Travis Spencer, Community Paramedic, Payette County EMS.** Payette County Paramedics provides paramedic level emergency care to the population of rural Payette County and surrounding areas. The agency has established CHEMS over the past year, focusing on hospital transitions and behavioral health. The agency is actively building partnerships and exploring more ways to better meet the needs of this population.

Panelists discussed:

1. What motivated you to become involved in the CHEMS program?
2. How did you make the transition from the standard model of emergency transport runs to the CHEMS concept of providing health care?
3. What was involved in your agency's transition to a CHEMS model? Were there specific aspects of workflow and role definitions that needed transformed?
4. In what ways has the integration of CHEMS services affected how your EMS providers interact with patients during a regular EMS call?
5. If you imagine 10 years forward, how many EMS providers in Idaho do you think will have transitioned to providing CHEMS services?
6. What is the major barrier you would urge your fellow CHEMS agencies to be aware of as they start their CHEMS journey?
7. In what ways does the CHEMS model contributes to value-based health care?
8. Looking back on your transformation to a CHEMS agency, what do you know now that you wish you had known at the beginning?

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Panel Discussion Video #3: Clinicians
May 2018

In this discussion, we sought to capture the "lived" experience of clinicians representing primary care clinics involved in the transformation to patient-centered medical home. Panelists share timely, personal stories of what it truly means to transform from a volume to value system of care.

Panelists included:

- **Christopher Stock, Director of Population Health and Quality at Saint Alphonsus Medical Group.**

- **Judy Ziemer, Population Health RN at Saint Alphonsus Medical Group.**
  Saint Alphonsus Medical Group is a four-hospital regional health system serving communities in southwest Idaho and eastern Oregon. Over 5,000 medical staff and associates serve 700,000 people. St. Alphonsus began its PCMH transformation in 2013.

- **Elizabeth Bauer, Family Nurse Practitioner at Adams County Health Center.**
  Adams County Health Center, Inc. serves over 3000 residents and visitors of a large rural geographic area including communities in three counties. With Healthcare facilities few and far between, ACHC offers myriad services to meet the healthcare needs of rural Idahoans. The healthcare team includes Family Nurse Practitioners, a Psychiatric Nurse Practitioner, two Dentists, a Dental Hygienist, an Optometrist and a Physical Therapist.

Panelists discussed:

1. What aspects of teamwork have changed through PCMH?
2. How have your clinical roles changed from before PCMH transformation to after?
3. What does it mean for you to work at the top of your license?
4. Has PCMH transformation impacted patient engagement? How so?
5. Looking back, what do you know now that you wish you had known when you began the journey?

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Panel Discussion Video #4: Care Coordinators
June 2018

In this discussion, we sought to capture the "lived" experience of care coordinators representing primary care clinics involved in the transformation to patient-centered medical home. Panelists share timely, personal stories of what it truly means to transform from a volume to value system of care.

Panelists included:

- **Jennifer Wilson, Population Health RN at Saint Alphonsus Medical Group.** Saint Alphonsus Medical Group is a four-hospital regional health system serving communities in southwest Idaho and eastern Oregon. Over 5,000 medical staff and associates serve 700,000 people. St. Alphonsus began its PCMH transformation in 2013.

- **Julie Woolstenhulme, LPN, Chronic Care Coordinator at Teton Valley Health Care.** Teton Valley Health Care is a federally designated Critical Access Hospital. It is comprised of Teton Valley Hospital, and three health clinics serving residents and visitors of a geographically isolated community in the Teton Valley. In 2016, TVHC became the first CAH to earn three advanced-care certifications: Level IV Trauma Center, STEMI II (cardiac emergency care), and Stroke III emergency response expertise.

- **Rabon Peterson, RN, Care Manager at Adams County Health Center.** Adams County Health Center is a Federally-Qualified Health Center serving over 3000 residents of a large rural geographic area including communities in three counties. With healthcare facilities few and far between, ACHC offers myriad services to meet the healthcare needs of rural Idahoans. The healthcare team includes Family Nurse Practitioners, a Psychiatric Nurse Practitioner, two Dentists, a Dental Hygienist, an Optometrist and a Physical Therapist.

- **Tami Cameron, RN, Case Manager Lead at Valley Family Health Care.** Valley Family Health Care is a Federally-Qualified Health Center that provides high quality, patient-centered, primary care in 10 locations in southwest Idaho and eastern Oregon. VFHC provides medical services, dental services, behavioral health services, and outreach and community health services.

Panelists discussed:

1. How does your clinic define care coordination?
2. What kinds of activities do you do in your role as a care coordinator?
3. How do your care coordination activities contribute to transitions in care?
4. What resources or tools do you use to manage or coordinate care with your patients?
5. How has care coordination contributed to meeting the Triple Aim? What is the value of care coordination in PCMH transformation?
6. Looking back, what do you know not that you wish you had known when you began the journey?

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Interview Compilation Video #5: Physician Champions
Spring 2018

This compilation of one-on-one interviews examines PCMH transformation through the lens of four physician champions representing primary care clinics in different stages and with various experiences in transforming their health care settings into a patient centered medical home across the state of Idaho.

Physicians included:

- **Dr. Kelly McGrath, Clearwater Valley Health Clinic.** Clearwater Valley Hospital and Clinics partners with St. Mary's Hospital and Clinics to form a regional health care system in North Central Idaho. Together, the partnership serves 45,000 patients in Kamiah, Kooskia, Nezperce, Craigmont, Pierce, Cottonwood, Grangeville and Orofino.

- **Dr. Angela Beauchaine, Primary Health Medical Group.** Primary Health Medical Group provides high quality care that is both convenient and comprehensive. Founded by physicians more than 25 years ago, today Primary Health is the largest independent medical group in Idaho with multiple locations throughout Southwest Idaho. Clinics are based on a patient-centered model where medical decisions respect the unique needs of each patient and their families.

- **Dr. Karl Watts, Saint Alphonsus Medical Group.** Saint Alphonsus Medical Group is a four-hospital regional health system serving communities in southwest Idaho and eastern Oregon. Over 5,000 medical staff and associates serve 700,000 people. St. Alphonsus began its PCMH transformation in 2013.

- **Dr. Chris Heatherton, Bingham Memorial Hospital.** Bingham Memorial Hospital is a large healthcare provider located in Blackfoot, Idaho with family medicine practitioners in Blackfoot, Idaho Falls, Pocatello, Shelley, and Soda Springs. Their family medicine doctors work with patients of all ages and care for all general medical needs.

Physicians discussed:

1. Why did you choose to champion PCMH?
2. What has it meant to manage a family practice around value- based payment?
3. What has been the impact of PCMH transformation on patient outcomes?
4. Looking back, what do you know now that you wish you had known when you began the journey?

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Panel Discussion Video #6: Community Health Workers
July 2018

In this discussion, we sought to capture the "lived" experience of individuals involved in the integration of Community Health Workers in community and clinical healthcare settings. We record key insights from the view of CHWs, supervisory CHWs and organization administrators.

Panelists included:

- **Rebeca Arteaga, Health Services Manager at Community Council of Idaho.** Community Council of Idaho is a multi-service organization serving Latinos to improve the social and economic status of local communities. Three federally qualified health centers in Eastern Idaho provide primary care and behavioral health services. CC Idaho services impact more than 16,000 individuals annually.

- **Jonathon Farrell, Community Health Coordinator at Genesis Community Health.** Genesis Community Health is a faith-based, integrated healthcare facility providing primary care, basic dental, mental health, specialty referral, and medication assistance to uninsured and low-income residents. Over 125 volunteer healthcare providers work with staff and volunteers who connect patients to resources that impact health and well-being.

- **Leah Kaschmitter, Community Health Worker at St. Mary's Hospital.** St. Mary's Hospital and Clinics is part of a collaboration of five healthcare systems, two community organizations and the Idaho North Central Public Health District. A significant population of people in these rural, historically underserved communities have serious medical issues, yet do not routinely access medical services.

- **Luis Lagos, Community Outreach Program Manager at Family Medicine Residency of Idaho.** Family Medicine Residency of Idaho (FMRI) immerses a medical residency program within a Federally Qualified Health Center comprised of 8 clinics throughout southwest Idaho. FMRI serves low income, uninsured, disabled, and other vulnerable populations in a Patient Centered Medical Home.

- **Emily Straubhar, Community Health Worker at St. Alphonsus Health Alliance.** St. Alphonsus Health Alliance is a network of more than 3,000 primary and specialty care providers. At the heart of the physician-led organization is a Clinically Integrated Network (CIN). The Alliance Clinical Team includes CHWs within a multidisciplinary team that targets high risk, complex patients in Southwest Idaho and Southeast Oregon communities.

Panelists discussed:

1. Why did your organization come to implement/integrate a CHW program?
2. What role do CHWs play in your community or clinic?
3. How do CHW job functions impact individuals engaging with their health?
4. How do CHWs determine the health needs of individuals or communities?
5. What strategies do CHWs utilize to connect individuals to resources in the community?

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Appendix O

Goal 3 Regional Collaboratives (RC) Member Interviews

Regional Collaboratives (RC)

Member Interviews

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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Idaho's Statewide Healthcare Innovation Plan (SHIP) established seven Regional Collaboratives (RCs) to support the integration of patient-centered medical homes (PCMH) within a broader medical health neighborhood. The RCs bring local area expertise to reflect regional characteristics and respond to community needs. Idaho's seven Public Health Districts (PHDs) are the conveners of the RCs, and they serve as the main facilitators of the regional effort to achieve Idaho's goals of healthcare system transformation.

As key stakeholders, RC members have unique perspectives regarding the progress and future accomplishments of the RCs. The SHIP State-level Evaluation Team sought to capture this feedback during the summer of 2018. The purpose of this report is to report key themes from the project.

Methods

In July 2018 researchers from the SHIP State-level Evaluation Team contacted members of the seven RCs by email to request their participation in a 15-minute, one-on-one, confidential interview. A total of 25 members participated in the interviews. The conversations were recorded for accuracy and transcribed for qualitative coding and analysis. Researchers asked seven questions:

1. How would you describe the medical health neighborhood in your region to someone who is not familiar with it?
2. How would you describe the RC contributing to your medical health neighborhood in your region?
3. How would you describe your experience as a member of the RC?
4. Would you recommend that others in your community become RC members? Please explain.
5. Looking forward, what role do you think a <u>group like</u> this should have in the medical health neighborhood in your region?
6. Looking forward, what roles and responsibilities do you think an <u>RC member</u> should have if a group like this continued?
7. Is there anything else you would like to add about the Regional Collaboratives?

Two members of the evaluation team developed coding categories to each question upon initial review of early interview transcripts. As the complete set of transcripts were reviewed, some categories were collapsed or nested within others; additional categories were added later. Table 1 presents the final response coding categories to each question.

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Table 1. Coding Categories for Interview Questions

Question	Response Categories
Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?	1a: Medical community 1ai: Dominated by health care system(s) 1b: Integrated health care 1c: Community services, resources (SDOH) 1d: Potential to meet needs 1e: Other (fragmented) 1f: Unmet potential 1g: Improving outcomes 1h: Collaboration, work together
Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?	2a: Sharing experiences, lessons 2b: Coordinating community resources (includes SDOH) 2bi: Specifically medical resources 2c: Training and sharing resources (includes PCMH training) 2e: 2ei: Convener of people 2eii: Convener of meetings 2eiii: Convener of working together 2f: Other 2i: Improve health outcomes 2j: Unmet potential
Question 3: How would you describe your experience as a member of the RC?	3a: Positive 3ai: Networking 3aii: Learning about community resources 3aiii: Working together to address needs, solve problems 3aiiii: Learning about PCMH 3b: Little to no impact 3c: Challenges, concerns 3ci: Data (lack of receiving data) 3d: Less than I hoped-lack of physicians
Question 4: Would you recommend others in your community become RC members? Please explain.	4a: Yes 4ai: Benefits of participation 4aii: Being a part of the process – having input 4aiii: Full representation of community – SDOH 4aiiii: Better outcomes 4aiiiii: Strengthen relationships, coordinate, work together 4b: Concerns
Question 5: Looking forward, what role do you think a group like this should have in a medical health neighborhood in your region?	5b: Role as convener 5c: ACO-type role 5d: SDOH 5e: Best fit for a group like this (public health) 5f: Statewide reporting 5g: Care coordination 5h: No need for a group like this (already exists, no buy-in) 5i: Other (support staff, expand neighborhood, address Idaho needs, garner resources, bring payers to table, etc.)
Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?	6a: Attendance 6b: Sharing 6c: Engagement 6d: Other 6di: consultant, expertise 6dii: support staff 6diii: public health, governing body 6diiii: represent organization, profession, patients, SDOH 6diiiii: data 6diiiiii: only so much to ask of a volunteer

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Question 7: Is there anything else you would like to add about RCs?	7a: Value of RC's 7b: Hope RC's continue 7c: Suggestions going forward (more: data, resources, visibility) 7d: Other 7di: payers 7dii: leadership 7diii: lack of state vision 7diiii: public health partners

Two researchers independently read and coded each transcript. They compared and discussed differences in coding to reach consensus. The next section of this report provides a summary of the interview participants as well as the most frequent responses to the interview questions.

Results

Interview Participants

Of the 60 RC members who were sent an email invitation to participate in the confidential phone interview, 25 (42%) agreed to participate. Five of the interviewees were from Region 6, four each were from Regions 1, 2, 3, and 4, and two each were from Regions 5 and 7.

Interview participants represented the full scope of sectors that participated in the SHIP Regional Collaboratives. This included health care providers, public health administrators, community organization leaders, and professional association representatives.

Most frequent responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	10
Dominated by health care system(s)	4
Community services, resources (SDOH)	10
Integrated health care	8
Potential to meet needs	6

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	12
Coordinating community resources (including SDOH)	6
Training and sharing resources (including PCMH)	6
Sharing experiences, lessons	4
Convener of meetings	4
Convener of working together	4

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	21
Networking	8
Working together to address needs, solve problems	7
Learning about community resources	6
Learning about PCMH	4

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Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	21
Benefits of participation	13
Full representation of community – SDOH	7
Being a part of the process – having input	5
Concerns	6

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Role as convener	16
Other (support staff, expand medical health neighborhood, address Idaho needs, garner resources, payers to table, etc.)	13
No need for a group like this	8
ACO-type role	6

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	16
Sharing	11
Attendance	5
Other: Represent organization, profession, SDOH, patients	5

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	9
Value of RC's	5
Other (public health partners)	5
Hope RCs continue	4

The complete table of responses to each question is included in Appendix A. The next section of this report provides a summary of the interview responses.

Summary

Twenty-five individuals who were members of Regional Collaboratives throughout Idaho participated in interviews. Five RC members were from Region 6, four each were from Regions 1, 2, 3, and 4, and two each were from Regions 5 and 7.

The two most frequently provided descriptions of the medical health neighborhood were "medical community" (n=10), to which four individuals added is "dominated by a health care system," and "community services and resources" (n=10) which address the social determinants of health.

The most frequently provided description of the RC contribution to the medical health neighborhood was "convener of people" (n=12). Other descriptions included "coordinating

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community resources" (n=6), "training and sharing resources" (n=6) toward PCMH, "sharing experiences, lessons" (n=4), "convener of meetings" (n=4), and "convener of working together" (n=4).

Nearly all interview participants (n=21) described their experience as a member of the RC as positive. The most frequently cited reasons related to "networking" (n=8), "working together to address needs" (n=7), "learning about community resources" (n=6), and "learning about PCMH" (n=4).

Nearly all interviewees (n=21) would recommend that others in their community become RC members. The most frequently cited reasons related to "benefits of participation" (n=13), "full representation of the community" (n=7), and "being a part of the process" (n=5). Some interview participants (n=5) expressed concerns about recommending that others become involved.

When asked about the role a group like this should have in the medical health neighborhood in the future, the most frequently provided role was "convener" (n=16). This included convening people, meetings and working together. A wide variety of "other" (n=13) roles included things like being support staff, expanding the medical health neighborhood, addressing needs of Idaho, garnering resources and bringing payers to the table. Some interview participants (n=8) felt this is no need for a group like this, either because it already exists or a lack of buy-in.

When asked about the role an individual member should have if a group like this continued, the most frequently provided responses related to "engagement" (n=16), an umbrella term for a host of activities, such as being accountable to the group, taking ownership, etc. Another frequently provided response related to "sharing" (n=11) of resources, information, etc. Some interview participants (n=5) suggested "attending" and "representing" (n=5) either their organization, profession, SDOH perspective, or patient in the group.

When asked if there was anything they wanted to add about the Regional Collaboratives, interview participants provided "suggestions going forward" (n=9), like the need for more money, data and visibility. Others added "value of RCs" (n=5), commented on "partnerships with public health" (n=5) and "hope RCs continue" (n=4).

Discussion

In July 2018, researchers from the SHIP State-level Evaluation Team interviewed 25 individuals who participated in Regional Collaboratives in the seven regions throughout Idaho. Interview participants included health care providers, public health administrators, community organization leaders, and professional association representatives.

Interview participants used the word "community" to describe the medical health neighborhood in their region. For some this was the medical community, which offers integrated health care. For others this was all of the services and resources to address the social determinants of health within the local community. This difference is perspectives likely reflects the different lenses held by members of the RCs.

Interview participants used the words "convener" and "coordinator" to describe the Regional Collaboratives. These are complementary to each other—bring people and resources to meetings and trainings in order to work together. They are also the kinds of roles that are difficult to fill in a community.

With few exceptions, interview participants described their experience as positive, and nearly all would recommend that others in their community become members of the Regional Collaborative. It seems that the Regional Collaboratives benefit the individual members, their

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clinics, and their communities through the work they all do together to achieve the goals they all share.

Looking beyond the SHIP grant, most interview participants want a group like this to continue to serve as the convener in their communities. They identified additional roles, likely to address some of the concerns that emerged through the initial experience. They want Individual members who are willing to offer their unique perspectives to meetings, share resources and information. They want members who are willing to own the group goals and be held accountable for working together to meet the needs of their communities. If a group like this does continue, it will be important to acknowledge that some individuals do not think it is needed.

In summary, interview participants valued the role and their experience with the Regional Collaborative in their communities. They hope the RCs or a group like this continues, and they have suggestions for the group and group members going forward. Additional comments highlighted the need for a statewide vision, leadership, and continued partnership with public health. Based on their experience, some individuals felt very strongly about the need for community level data, and greater financial support as well as visibility in order for any group like the Regional Collaboratives to be successful in their communities.

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Appendix A: All provided responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	10
Dominated by health care system(s)	4
Community services, resources (SDOH)	10
Integrated health care	8
Potential to meet needs	6
Other (fragmented)	4
Unmet potential	2
Improving outcomes	4
Collaboration, work together	3

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	12
Coordinating community resources (including SDOH)	6
Training and sharing resources (including PCMH)	6
Sharing experiences, lessons	4
Convener of meetings	4
Convener of working together	4
Specifically medical resources	1
Other	2
Improve health outcomes	2
Unmet potential	2

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	21
Networking	8
Working together to address needs, solve problems	7
Learning about community resources	6
Learning about PCMH	4
Little to no impact	2
Challenges, concerns	1
Data (lack of receiving data)	1
Less than I hoped-lack of physicians	3

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	21
Benefits of participation	13
Full representation of community – SDOH	7
Being a part of the process – having input	5
Concerns	6

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Better outcomes	3
Strengthen relationships, coordinate, work together	3

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Role as convener	16
Other (support staff, expand medical health neighborhood, address Idaho needs, garner resources, payers to table, etc.)	13
No need for a group like this	8
ACO-type role	6
SDOH	2
Best fit for a group like this (public health)	1
Statewide reporting	2
Care coordination	3

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	16
Sharing	11
Attendance	5
Other: Represent organization, profession, SDOH, patients	4
Other	
consultant, expertise	2
support staff	2
public health, governing body	2
data	2
only so much to ask of a volunteer	2

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	9
Value of RC's	5
Other (public health partners)	5
Hope RC's continue	4
payers	2
leadership	1
lack of state vision	2

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Appendix B: Region 1 (n=4) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Community services, resources (SDOH)	2
Integrated health care	2
Unmet potential	2

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	3

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	4
Less than I hoped-lack of physicians	2

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	3
Full representation of community – SDOH	2
Concerns	2

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
ACO-type role	3
No need for a group like this	2

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	2
Other: Represent organization, profession, SDOH, patients	2

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	2
Need for more data, more money	2

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Appendix C: Region 2 (n=4) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	2
Community services, resources (SDOH)	2
Collaboration, work together	2

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	2
Sharing experiences, lessons	2

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	2
Networking	1
Working together to address needs, solve problems	1
Learning about PCMH	1

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	2
Benefits of participation	2

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Role as convener	3

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	3
Sharing	3

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	1
Hope RC's continue	1

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Appendix D: Region 3 (n=4) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	2

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	3

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	4
Working together to address needs, solve problems	2

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	4
Benefits of participation	3

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Role as convener	4

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	3
Sharing	2

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	2
Value of RC's	2

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Appendix E: Region 4 (n=4) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Community services, resources (SDOH)	3
Integrated health care	2

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Coordinating community resources (including SDOH)	3
Other	2

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	4
Networking	1
Working together to address needs, solve problems	1
Learning about community resources	1

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	4
Full representation of community – SDOH	2
Being a part of the process – having input	2

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Role as convener	3
Other (support staff, expand medical health neighborhood, address Idaho needs, garner resources, payers to table, etc.)	3

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	3

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Other (public health partners)	2

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Appendix F: Region 5 (n=2) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	
Dominated by health care system(s)	1
Integrated health care	1
Potential to meet needs	1
Collaboration, work together	1

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	1
Training and sharing resources (including PCMH)	1
Sharing experiences, lessons	1
Unmet potential	1

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	1
Networking	2

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	1
Benefits of participation	1
Full representation of community – SDOH	1
Concerns	1

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Other (support staff, expand medical health neighborhood, address Idaho needs, garner resources, payers to table, etc.)	2

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	2

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

No Responses Provided	

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Appendix G: Region 6 (n=5) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	3
Community services, resources (SDOH)	2
Integrated health care	2
Improving outcomes	2

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Training and sharing resources (including PCMH)	2
Convener of meetings	2
Convener of working together	2

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	5
Networking	3
Working together to address needs, solve problems	3

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	5
Benefits of participation	4

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
Other (support staff, expand medical health neighborhood, address Idaho needs, garner resources, payers to table, etc.)	4
Role as convener	3

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Engagement	3
Sharing	3

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	3

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Appendix H: Region 7 (n=2) top responses

Question 1: How would you describe the medical health neighborhood in your region to someone who is not familiar with it?

Response Category	Frequency
Medical community	1
Integrated health care	1
Potential to meet needs	1

Question 2: How would you describe the RC contributing to your medical health neighborhood in your region?

Response Category	Frequency
Convener of people	1
Training and sharing resources (including PCMH)	1
Sharing experiences, lessons	1

Question 3: How would you describe your experience as a member of the RC?

Response Category	Frequency
Positive	1
Networking	1
Learning about PCMH	1
Little to no impact	1
Challenges, concerns	1

Question 4: Would you recommend that others in your community become RC members? Please explain.

Response Category	Frequency
Yes	2
Benefits of participation	1
Being a part of the process – having input	1

Question 5: Looking forward, what role do you think a group like this should have in the medical health neighborhood in your region?

Response Category	Frequency
No need for a group like this	2
Role as convener	1
ACO-type role	1

Question 6: Looking forward, what roles and responsibilities do you think an RC member should have if a group like this continued?

Response Category	Frequency
Sharing	1
Attendance	1
Other	
support staff	1
public health, governing body	1

Question 7: Is there anything else you would like to add about the Regional Collaboratives?

Response Category	Frequency
Suggestions going forward	1
Value of RC's	1

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Appendix P

Goal 3 Regional Collaboratives (RC) Success Snapshots

Regional Collaboratives (RC)
Success Snapshots

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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Idaho's Statewide Healthcare Innovation Plan (SHIP) established seven Regional Collaboratives (RCs). The RCs bring local area expertise to reflect regional characteristics and respond to community needs. Throughout the SHIP grant period, leaders from the RCs have regularly presented reports to the Idaho Healthcare Coalition (IHC) regarding their progress. With few exceptions, the RC's have been regarded as one of the most recognized accomplishments of SHIP.
Among widespread accomplishments, RC initiatives in three particular regions especially captured the spirit and objectives of SHIP. The three regions and their initiatives are:

- Region 3: Care Coordination and School-Partnered Behavioral Health and Trauma-Related Issues
- Region 4: Caregiver Integration Project and Idaho Integrative Behavioral Health Network
- Region 6: Suicide Prevention Initiative

This project sought to capture different stories of success with RCs throughout Idaho. In November 2018 members from the State-Level Evaluation Team spoke with select leaders of the three RCs to learn more about the need, development, and future outlook of the initiatives listed above. We asked three questions:

8. Can you please explain the need in your community you sought to address through this initiative?
9. Can you please describe how the Idaho Statewide Healthcare Innovation Plan (SHIP) led to the development and implementation of this initiative in your region?
10. Can you discuss the future outlook for this initiative?

What emerged were snapshots of success. The snapshots demonstrate what can happen when individuals from the medical community come together with members of community-based organizations in an open forum to share thoughts and ideas about how to identify and address the most pressing health needs in the community. This leads to partnerships that, leveraged with local resources, build capacity. The capacity to improve the health of communities throughout Idaho.

The remaining pages of this report provide snapshot details of the initiatives.

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SHIP Region 3
Care Coordination

Community Need
There is a real need for coordination of care across all health care entities in our communities. Through the RC meetings, we learned that in addition to this need for care coordination, it appears there is also an overlap in primary care coordination and hospital care coordination.

Role of SHIP
Idaho's SHIP promotes dialogue and collaboration among members of the Regional Collaboratives. At one Region 3 RC meeting, a discussion unfolded about best practices in care coordination. We were surprised to learn that a primary care coordinator and a hospital care coordinator in the discussion were both doing similar functions in their roles and yet did not know of each other. This insight revealed a gap in care coordination that we wanted to address.

We used funding from the SHIP RC grants to support the development of a Region 3 Care Coordination Network. The Care Coordination Network connects hospitals, emergency departments, primary care, behavioral health, oral health, and specialty care. It included two primary components: care coordination training, and a web-based directory of referral resources in primary health, oral health, behavioral health, and the full scope of specialty care.

Future Outlook
We are pleased that the Care Coordination Network will continue, even post-SHIP. We have received feedback that the value of the network is so great that individuals will continue to meet to promote the coordination of care in the region.

Clinics in Region 3 and across Idaho will continue to have access to online care coordination training through the SHIP website as well as the Boise State University site.

We are skeptical about the durability of the web-based directory. We hope an agency will dedicate an individual to maintain the directory, and although there is interest, there is not yet a commitment at this time.

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SHIP Region 3

School-Partnered Behavioral Health and Trauma-Related Issues

Community Need

Idaho is a mental health provider "shortage area," and this shortage uniquely and critically affects youth with mental health and substance use concerns. Schools feel this strain particularly acutely as they work to respond to child and youth needs without sufficient staffing and funding.

Role of SHIP

Idaho's SHIP established multiple entities and working groups to focus on specific healthcare needs throughout the state. To address the community need for youth behavioral health, the Region 3 RC created partnerships among the Southwest Health Collaborative, local schools, providers, and a variety of community partners. Two initiatives emerged from the collaborations.

The first is the Healthy Minds Partnership that connects schools with behavioral healthcare professionals. Behavioral health providers are now placed in schools to deliver traditional therapy to students and reduce access issues such as transportation and time away from class. Based on the success of this initiative, the RC created a "Healthy Minds Roadmap" to share with other communities in Idaho.

The second is the Trauma Response Network within local school districts. This emerged as the workgroup developed a relationship with local schools and learned of the need to surge resources for schools in times of crisis. The workgroup collaborated with the school district, local providers, hospitals and the health district to identify resources to respond to this need. The group created a "Trauma Response Network" in which local providers are activated in times of need. The RC hopes to scale this initiative to other Idaho regions as well.

Future Outlook

We are positive about the outlook for behavioral health partnerships and are confident this initiative will live "beyond SHIP." We are pleased that Blue Cross of Idaho Foundation for Health has agreed to provide leadership of the Health Minds Partnership work, publishing the roadmap for other communities throughout Idaho.

The Trauma Response Network will also continue post-SHIP under the direction of the Public Health Preparedness team at Southwest District Health in collaboration with community partners.

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SHIP Regions 3 and 4
Idaho Integrative Behavioral Health Network

Community Need
Idaho is a mental health provider "shortage area." Our primary care physicians and care teams all across the state need help in addressing mental health issues in a clinical setting.

Role of SHIP
Idaho's SHIP encourages Regional Collaboratives to build partnerships among members. The RCs in regions 3 and 4 recognized the need for help in addressing these issues in a clinical care setting. During an RC event, we brought together primary care and behavioral health providers to learn more about this topic.

Because of the partnerships our RC had built, we were able to expand on an existing effort originally facilitated and convened at St. Luke's Health Partners. The convening and facilitation moved to the public health districts, which is a neutral entity. Due to SHIP we were able to expand to RCs all across the state, include competing health systems, and bring more partners to the table, such as: Family Medicine Residency of Idaho, Terry Reilly Health Services, St. Luke's, St. Alphonsus, Idaho Primary Care Association, and others. We created regional "hubs," such as a hub for regions 1 and 2, and hub for regions 3 and 4, and a hub for regions 5, 6 and 7.

The network includes (a) a forum that brings together behavioral health consultants with primary care providers to learn about different behavioral health integration models, and (b) a group that provides training, outreach and resources to providers across the state.

Because of our work, we created Idaho's first annual Idaho Integrative Behavioral Health conference. We are already underway for a bigger conference next year.

Future Outlook
Will continue to grow in Idaho. Each region has an individual who has stepped up to lead the hub – convening meetings and facilitating partnerships between behavioral health and primary care providers.

People want to see it grow – the annual conference, I can see more efforts around advocacy and policy development related to behavioral health, and other projects which have grown out of this as well.

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SHIP Region 4
Caregiver Integration into Primary Care Project

Community Need
Huge need for services and resources to support caregivers in our community. This includes things like respite, help with finances, support groups, and more. Many of these services can be integrated into the primary care team.

Role of SHIP
The concept of a medical health neighborhood in Idaho's SHIP encourages Regional Collaboratives to bring together members from the medical clinics with individuals from a variety of sectors. When we learned of a funding opportunity through SHIP RC grants, we brought this diverse group of members to the table to discuss how we could best utilize this opportunity to meet the most compelling needs in our community. Our members identified a variety of critical needs and then, after hearing presentations, we agreed to work together to address the need for caregiver services.

We learned that some of our member agencies—the Idaho Caregiver Alliance and Community Partnerships of Idaho, Care Plus (a care coordination organization)—were already providing many of these important services. We felt our best role would be to support their work by through our SHIP PCMH clinic care teams. Essentially, we created a referral resource so that clinic care teams working with patients and caregivers could connect them to the services they need.

We piloted a referral resource (Careline) as part of Care Plus for 9 months. Our initiative culminated in a networking event that brought together our SHIP clinic care teams with over 40 organizations that offer services for caregivers. During the networking event (which was designed to be like speed dating events), care team members met different vendors and learned about their services for caregivers. The goal of the event was for primary care teams to make connections for referrals; our event facilitated over 400 connections.

Future Outlook
Unfortunately, the referral resource (Careline) will no longer continue, as the RC grant funding has ended. Fortunately, the connections made through this initiative will continue; our PCMH primary care teams will be able to connect patients and caregivers with the community resources and services they need.

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SHIP Region 6
Suicide Prevention Initiative

Community Need
Idaho has one of the highest suicide rates in the nation, and suicide is especially prevalent in counties of Region 6. In rural states, primary care providers often serve as behavioral health providers in the community, so it is critical for primary care clinicians to be well prepared to provide high quality suicide screening and prevention for patients.

Role of SHIP
SHIP medical health neighborhoods allow Regional Collaboratives to leverage regional resources, and partnerships with local providers and non-health organizations to improve the health of the broader regional population. Our partnership with primary care clinics involved in SHIP helped us to recognize that they have a key role in suicide prevention. When the RC Grant Funding opportunity became available, our RC chose to prioritize the response to suicide within primary care.

In addition to primary care, other partnerships that had been built within the RC included Idaho State University, and a regional behavioral health board. We saw opportunities to connect the dots and come together with many members of the medical health neighborhood to serve the rural communities throughout our region.

Given the timeframe, and what our region most needed, we identified suicide prevention training as most feasible. Through research, we located free online toolkits and brought in leaders from the groups to facilitate trainings. The suicide prevention trainings grew to a regional suicide prevention symposium.

Future Outlook
Very positive outlook for ongoing suicide prevention efforts and partnerships.

1. Continued regional promotion of free, online training and use of the Columbia Scale. Organizations can consider adding annual C-SSRS training requirements as part of their professional development policies and include in new employee onboarding.
2. Distribution of the WICHE Toolkits to all clinics in SHIP cohorts 1, 2, and 3. A letter from the Idaho Healthcare Coalition Chair, Dr. Ted Epperly, will accompany the Toolkits with endorsement of suicide prevention screening as a best practice standard for primary care.
3. Continued collaborations with partners and alignment of local strategies with national, state, and local suicide prevention goals.
4. Indication from Dr. Kelly Posner, the developer of the C-SSRS of willingness to assist with promotion of widespread adoption and use of the assessment tool in Idaho.
5. Continued work with regional law-enforcement agencies to promote gun locks and gun safety education.

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Appendix Q

Goal 4 Telling the Story of Community Health EMS (CHEMS) in Idaho, Spring, 2018 Case Study

Telling the Story of Community Health EMS (CHEMS) in Idaho

Spring, 2018 Case Study

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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In Idaho's rural, frontier, and medically under-served communities Community Health EMS (CHEMS) agencies are working to increase access to healthcare and extend the reach of primary care into the patient's environment. The number of CHEMS agencies and services in Idaho has been steadily growing due to the implementation of the Statewide Healthcare Innovation Plan (SHIP). As stakeholders consider how to best sustain momentum of CHEMS it is valuable to assess progress and identify areas for further development.

Methods

The purpose of this project was to tell the story of CHEMS in Idaho. A research associate (RA) with the State-level Evaluation Team (SET) scheduled discussions with individuals representing a total of five CHEMS agencies, one hospital, and one family practice throughout the state. The individuals and agencies held different perspectives of CHEMS and were in different stages of implementation.

To get a perspective from communities prior to CHEMS implementation the RA spoke with a team of administrators from a rural community hospital as well as leaders from Donnelly Rural Fire Department and Idaho Falls Fire Department who were preparing to implement a CHEMS program. To get a perspective from communities who currently have a CHEMS program the RA spoke with leaders of Ada County Paramedics, Canyon County Ambulance District, Payette County Paramedics, and a primary care physician in the small community of Sandpoint, Idaho (Bonner County).

The RA recorded and transcribed discussions, which lasted approximately 60 minutes. With variation, depending on the perspective of the individual, the RA asked questions similar to the following:

Part I: Operational Questions

1. What specific, additional services has your CHEMS agency provided in collaboration with your hospital and/or clinic? (e.g. post hospital discharge & short-term follow-up, helping with frequent and non-emergent 911/ED users, chronic condition monitoring/management)?
2. What was involved in establishing an expanded partnership (Memos of Understanding, review by Legal Counsel, approval by medical staff, approval by home health staff, etc) What documentation was required of you to demonstrate appropriate level of CHEMS training?
3. What additional administrative costs has your agency incurred such as costs related to data sharing, tracking, report generation, etc?
4. Based on your experience with your community, how do you think patients have responded to additional CHEMS services you described earlier?
5. Given all that is going on with Value Based Payments, do you think Commercial payers have responded favorably to CHEMS as one potential way to improve patient experiences and potentially to lower costs?

Part II: Patient and Community Experience

6. Describe in your own words the important elements your CHEMS agency.
7. What challenges faced by healthcare providers in your community is your CHEMS agency uniquely able to address?
8. What unique contributions is your CHEMS agency able to make to address those challenges and provide better healthcare?
9. What might a typical patient interaction look like?

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10. What might a typical patient say about your CHEMS agency?
11. What might the hospital / clinic in your community say about your CHEMS agency?
12. How would you summarize the impact your CHEMS agency has made on the health of your community?

In addition to individual discussions, the RA transcribed two CHEMS panel discussions. The first panel took place at the January CHEMS Learning Collaborative; panelists included agency leaders from Donnelly Rural Fire Department, Payette County Paramedics, Bonner County EMS, and Shoshone County EMS. The second panel took place at the March meeting of the Idaho Healthcare Coalition (IHC); panelists included agency leaders from Ada County Paramedics, Donnelly Rural Fire Department, Payette County Paramedics, and a primary care physician from Sandpoint.

The following section includes responses from the seven discussions and two panel discussions.

Results

The purpose of this project was to tell the story of CHEMS in Idaho. This section includes responses from the seven discussions and panel discussions. The responses are presented in the context of five themes. The themes are (a) demonstrating value of CHEMS; (b) response from payers; (c) motivation that led to expansion into CHEMS model; and (d) barriers.

Theme #1: Demonstrating value of CHEMS.
Many of the responses in individual and panel discussions provide examples of CHEMS services that demonstrate the value of CHEMS. The examples are presented here in nine specific CHEMS events.

Medication/diet reconciliation based on CHEMS home visit. Agency members from Canyon and Payette Counties described CHEMS services to identify issues and address concerns regarding medication or diet/food. In Payette County a medication assessment is part of the initial 1 ½ hour CHEMS assessment.

Fall prevention based on CHEMS home visit. Members from Canyon and Payette County agencies identified this service for residents. CHEMS in Payette conducts falls assessments in the homes of patients and offers fit and fall courses, home fall check sheets and a “Lift Assist” service. The interviewee from Idaho Falls anticipates that “trip and fall evaluation” will be part of the typical patient interaction. In Payette County falls assessment is also part of the initial 1 ½ hour CHEMS assessment.

Panelists brought up this area as well. In Payette County EMS responders now look at the home environment when responding to 911 calls. The panelist stated, “we used to just show up to a 911 call and get them out of there, take care of them. Now we look at it in a different way: ‘holy cow, look at all these fall risks.’”

CHEMS referral of patient with mental health issues to primary healthcare provider. The Payette County CHEMS agency member stated that EMS workers are trained to recognize when “this patient needs help” and get them necessary care. The team of hospital administrators stated as a vision for CHEMS—to identify super-users and connect them to care that keeps them out of the ER. The agency member from Canyon County shared that primary

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care physicians often do not know their patients are calling 911 25 times in a year; and indicated this as a CHEMS service.

Panelists brought up this area as well. The panelist from Bonner County stated “when I receive a 911 call, I ask myself, ‘do they really need to go to the ER?’ If not, I’ll pick up the phone and call the family physician—let them know what’s going on.”

Companionship to isolated homebound person. Agency members from Payette County and Sandpoint shared that some CHEMS services have an additional component of providing companionship to patients whose social or geographic isolation may exacerbate health conditions.

During one panel discussion, the agency member from Payette County told of one patient, a complete shut-in, who had made frequent 911 calls for falling. He helped her address her fall risks by helping her address excessive drinking by helping her address depression by spending time with her and getting her out of her home. He described how he was able to connect her to behavioral health care.

Appropriate use of health equipment based on CHEMS home visit. While agency members did not specifically mention this area, the physician in Sandpoint shared that he has seen cases when CHEMS home visits resulted in patients getting necessary durable medical equipment, such as a wheelchair, and supplies. He said, “CHEMS personnel are able to see when equipment (and medications) need to be adjusted. They can prevent a crisis from occurring.”

CHEMS referral to other community resources (SDOH). Nearly all the individuals described CHEMS services in their communities that connect patients to much-needed health or social resources. The individual from Donnelly stated that referrals are the primary value to patients. He described one man who called 911 22 times in 2 weeks; because of working with CHEMS personnel, he was willing to go to a mental health facility. This is an example of how CHEMS has the power to “disrupt behavior of high utilizers.”

Agency members from Canyon and Payette Counties cited “getting patients the resources they need,” “let’s get you in touch with,” and “the ability to provide resources to patient who may feel they’ve been left alone, who don’t know what resources are out there.” One shared that getting patients to the appropriate community resource may address providers’ concerns related to: “why aren’t you following…?” Physicians don’t often know what’s going on when a patient leaves the clinic. Even transportation to doctor appointments is one of the referrals CHEMS sometimes makes.

The agency member from Canyon County said, “patients appreciate that someone cares enough to ask questions and ‘get me the help I need;’ case workers love us, because it would be weird for them to go in patients’ homes, but we’re already there; so this benefits them also.” Linking patients to community resources for behavioral health and counseling was a value that emerged in panel discussions as well.

Access to primary care screenings based on CHEMS home visit. Four individuals mentioned this motivation. In remote communities, lack of access to healthcare is a challenge, and CHEMS agencies in Idaho Falls, Payette County, and Donnelly recognize “we can get in the patient’s door easily,” and “we can consult with patients, provide access to screenings” and more. According to the agency member from Idaho Falls, still in the planning stage of development, CHEMS services in Swan Valley will save residents countless trips to Idaho Falls

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and improve access to preventive care to meet their healthcare needs. They plan to provide vital screenings for residents. He added, “We’re in a unique position to dramatically impact health care of the community who has little access and high independence.” In Payette and Canyon counties, the initial 1 ½ - hour CHEMS visit includes a head-to-toe assessment, depression screening, and development of a healthcare plan for patients who previously relied on 911.

During one of the panel discussions, the panelist from Donnelly stated, “our district is a sub-servient workforce; most of our residents are either under-insured or not insured at all. Individuals are not getting the care they need in certain aspects.” The panelist from Payette identified CHEMS services as: “first point for primary care.” The physician from Sandpoint told of a patient who was unable to leave his home for 2 years due to a severe foot infection. He requested CHEMS personnel to check on the patient in his home, and they continued to provide healthcare to this patient.

Post-hospital re-admission prevention based on CHEMS home visit. Agency leaders from Idaho Falls, Ada and Payette Counties and the physician from Sandpoint all described CHEMS services related to post-hospital recovery. The Idaho Falls CHEMS agency plans to provide frequent in-home care and follow-up for Congestive Heart Failure patients; the agency member stated, “the hospital is able to utilize us to ensure post hospital needs of the patient are being met.” Payette County residents fall beyond the 30-mile limit for post-hospital transition care. According to the agency member, CHEMS services provide this kind of healthcare for residents.

Referral to specialized care based on CHEMS home visit. The agency member from Canyon County provided two examples of CHEMS services that resulted in referral to needed specialized care. CHEMS personnel referred one patient to a neurologist; they worked with the family of another patient, who had fallen at home, to move the patient to more safe living arrangements in a care facility.

Theme #2: Response from payers.
CHEMS stakeholders seem to agree that commercial payers may be more willing to pay for the CHEMS model of health care when they see the value in it. The previous section included specific CHEMS events that demonstrate value; this section includes the responses that describe how payers have responded.

Members of agencies still in the planning stages of implementation (Donnelly, Idaho Falls), and the team of hospital administrators, were unable to discuss payer response. Ada County CHEMS has received some inquiries from a private payer; additionally, the CHEMS program receives indirect support from a private payer-funded initiative. According to the agency member, conversations with payers generally relate to patient experience and potential to lower costs.

The individuals from Canyon and Payette Counties stated there has been no local response from payers, but both cited national movement in this area. One of them said that MedStar in Texas is discussing a value proposition with hospitals; the other stated “payers are hesitant, but national stuff is going on. Blue Cross is providing payments for non-emergency transports.”

According to the physician from Sandpoint, the numbers are still too small to pique the interest of payers. The small community and relatively few CHEMS patients, most of them on Medicare, is not enough to draw responses from commercial payers.

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During one panel, a discussion emerged around the amount of money a payer is willing to pay for CHEMS programs and creating buy-in from payers. The discussion left off at the point of talking with payers about how much patients are costing them. At the other panel, the physician stated, “MDs don’t’ understand shared savings; MD’s won’t pay out of pocket for CHEMS.

Theme #3: Motivation that led to expansion to a CHEMS model.
What led EMS agencies and Fire Departments around Idaho to expand their services to a CHEMS model? This was not asked during the individual or panel discussions, but responses to other questions revealed a motivation behind agency efforts. This section includes five different but related motivations.

Access. The motivation for the CHEMS agency in Idaho Falls is to provide primary access to health care for residents who live in a very remote community 45 minutes away from Idaho Falls. There is no hospital, no pharmacy, very few services in Swan Valley. His agency has an ambulance in the community along with highly trained crew who have a lot of extra time. He said, “Our paramedic crew is already in the homes – responding to falls. We can provide access to screenings.” Individuals from Payette County, Canyon County and Donnelly shared similar motivations.

Mission. The individual from Donnelly stated, “it’s what we should have always been doing with EMS.” “We are a Fire and EMS agency –90% of our workload is EMS.” In one panel discussion he said, “we like the idea because the Donnelly Fire Department and Valley County like to be progressive and unique in emergency response.” The interviewee from Ada County said something similar: “we knew CHEMS was a concept we believe in.” “When we started with CHEMS, we started with the mission and then figured out how to pay for it.”

Need. The individual from Canyon County described helping patients get the resources they need: “Let’s get you in touch with…” From Payette: “the ability to provide resources to patients who may feel they’ve been left alone.” Both cited communication across the healthcare system as a challenge for providers and presented CHEMS as an opportunity to help patients overcome that challenge.

PCMH. The agency member from Donnelly framed a number of his responses in the context of the medical health neighborhood. He stated, “CHEMS contributes to a healthy population as a member of the team.” In one panel he stated, “I attend the healthcare coalition meetings and really pushed the CHEMS effort.” “We brought people to the table who we felt needed to be there.” “This is what our community needs.” He said, “Individuals are not getting the care they need in certain aspects for better population health.” In the second panel, he identified the medical health neighborhood meetings as an avenue to developing partnerships.

The individual from Ada County alluded to patient-centered medical care when he said, “if a clinical plan does not work, we’re one of the first healthcare providers to know.”

Already there. Many individuals identified this overarching theme as a supporting motivation. Repeatedly, they stated, “We’re already in the homes…” “We’re already in the homes, so let’s provide access to primary care.” “We’re already in the homes so let’s expand, because it’s who we are.” “We’re already in the homes so let’s meet the needs of patients that aren’t getting met.” “We’re already in the homes, so let’s contribute to team-based care.” One panel member said, “the healthcare system denies service, but we get through.”

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Theme #4: Intensity of effort (barriers)
This section includes individual and panel discussion responses concerning some of the barriers to implementation CHEMS agencies have had to overcome.

Legal. The individual from Ada County stated there was "a lot more legal work than we were used to." It might be that, as a pioneering agency in Idaho, Ada County addressed this barrier as no other individuals identified it. The interviewee from Idaho Falls identified the challenge of maintaining confidentiality in compliance with HIPAA—if the CHEMS agency does transport medication between Idaho Falls and Swan Valley. The hospital administrators added: "The legal team is already busy."

Allocation of time. Four agency members identified time. The individual from Ada County said, "The time it takes to harvest information is time intensive," and a challenge. The individual from Canyon County stated, "there is not a CHEMS repository of protocols; no standardized algorithms. Each CHEMS agency is developing their own."

The panelist from Payette County stated, "We're spending 2 hours with a patient, then 30 minutes faxing notes. Data entry seems over the top." The panelist from Shoshone County said, "We need another person to get all this stuff done."

Establishing partnerships. Five agency members and the physician identified barriers related to expanding partnerships. In one panel the individual from Donnelly stated, "We had to continually remind nurses we were not going to go above our scope of practice." The individual from Ada County said, "We first had to educate about the 911 systems work. Our partners did not know a lot about our work, our training, what EMS does. We had to spend a lot of time with our partners to educate them. We're not just car crashes and heart attacks." He later identified "consistent referral source" as a challenge for CHEMS. The panelist from Shoshone County echoed this. "Even though I had been talking about CHEMS for so long, [other agencies] had no idea what was going on. Took time to re-educate." He also said, "I wish I had squashed public criticism sooner." He later said, "In a discussion with a hospital administrator I learned about the concern 'public health is not in the mission of EMS.' I had not thought about that."

The panelist from Bonner County stated, "We're a small community. Getting referrals is a hurdle. Some members in the community didn't understand what CHEMS was and may be resistant to anything 'government' beyond 911." The physician from Sandpoint stated, "MDs forget to make referrals, or they just don't understand CHEMS is an opportunity to see patient's home. There is a need to market CHEMS, especially the difference between CHEMS and home health or other providers."

The panelist from Payette County anticipates a barrier of working with the hospital system in a nearby community that is in another state.

Data reporting. Three agency members and the hospital administrators identified data reporting as a barrier—particularly to prove value. The interviewee from Donnelly stated, "Data must prove cost benefit." The panelist from Payette County said, "We receive no funding from an outside source, except for grant money. Stakeholders who could support CHEMS financially say to us, 'show us it works.' So we need to find a way to gather that data and communicate it." The panelist from Ada County stated, "The current system of data reporting is great for 911, but not necessarily for CHEMS. The hospital administrators identified this as a "must next step: how can we prove results? We have performance data, we have success stories, but how can we prove results?"

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Results: Responses to Discussion Questions

This report moves now from the discussion of themes to (a) responses to discussion questions, and (b) complete discussion notes from all individuals. Finally, the report includes transcribed notes from two panel discussions in which CHEMS agency representatives shared their experiences with CHEMS implementation in their respective communities.

Background Information

Donnelly Rural Fire Department

- From 3-4 CHEMS agencies (Ada County, etc.), we learned from their mistakes
    - 5-6 patient types
    - 1-2 patient types
- Stakeholders in population health neighborhood
    - $0 implementation with stakeholders
- SHIP CHEMS from ground zero
- But it's done here. Strategic planning
    - Adding a pharmacist to accompany paramedic to home visit (Med Tech in Texas)
    - P.A. to participate also
    - Accompany 1-2 times/week
    - The Rock to assess patient needs
    - Behavioral health patients start this fall
    - Work with hospital team

Idaho Falls Fire Department

- Swan Valley is very remote – 45 miles from Idaho Falls.
    - There's nothing there
    - We have an ambulance
    - Couple hours per week for a health clinic
    - No pharmacy, no store
    - We get about 90 calls/year
    - We have a highly trained crew who receive only a few calls; they have a lot of extra time.
- Evolved nicely since conception in spring, 2017
- Nicely with the state – support, advice, funding
- We will expand as community needs

Ada County Paramedics

- When we first started, we did not know which direction to take, but we knew CHEMS was a concept we believed in. In Jan 2012 our paramedics went through additional education to prepare for an expanded role
- We made a strong push for stakeholder engagement
    - We wanted to make sure we had buy-in from our system partners and they were invested in our success
    - Leverage services instead of duplicating
    - Many different areas of expertise represented
        - Helped assess community needs. They knew where the gaps were in patient care.
- We explained what EMS was and determined if / how we could help with the gaps
- After two years of foundational work, we developed three main initiatives (outlined below)

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- One of maybe 4 CHEMS programs nationally

Canyon County Ambulance District
- Started 1 year ago.
- We are self-funded.
    - There is no money from outside agencies etc.
    - Self-funded training, education, etc.
    - Due to that, our primary focus was high 911 utilizers.
- We have an EHR software. We ran a report to identify high 911 users (transport to hospital)
- The numbers were surprising.
    - An example is one individual who called 911 25 times in a year for non-emergencies. Others called 10, 11, 12 times in a year. This is not normal.
    - Patients may use us because they don't have a ride to the hospital.
- Top Ten users became who we work with.
    - We wanted to develop a patient-tailored system
    - CHEMS staff looked at "what do they need?"
    - Then put them in the program to connect them with resources to try and get them to use the EMS less.

Payette County Paramedics
- We started working with one patient in October 2017
- CHEMS program officially started in December 2017

Specific, additional CHEMS services provided

Donnelly Rural Fire Department – Not discussed

Idaho Falls Fire Department
- Our goal is to provide primary access; consultation; Pharmacy delivery; basic blood pressure screenings and wellness checks
- We could partner with hospital
- Post discharge calls
- Home checks
- If hospital identifies someone, hopefully they'll call us and we can do the home checks.

Ada County Paramedics
- Hospital Transitional Program:
    - Thirty -day post hospital discharge follow-up with Congestive Heart Failure Patients
    - Pilot project with 2 different hospitals in the area – both successful
        - One is continuing
        - One is seeking additional funding - So we are piloting a Post ED transitional follow-up called (CARE) with 3 different options: 7-day, 14-day, or 30-day **Collaborative Resource Acquisition (CARE)**- Community Paramedic Aligning Care Reducing Cost and Engaging Patients and Family piloting a Post ED transitional follow-up called (CARE) with 3 different options: 7-day, 14-day, or 30-day (from above)
- Ada County Employees (1700 employees) Mobile Influenza Vaccination Clinic (since 2013)
    - Provide vaccinations to all county employees at the different work locations.
- EMS Partnerships:

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- Psychiatric Emergency Team (PET) (pilot in 2013)
  Ada County Paramedics + IDHW Mobile Crisis Unit+ Law Enforcement
  - Bypass ED and get mental health services more quickly.
  - EMS does medical assessment – then Mobile Crisis Unit does a mental assessment and works on placement in mental health facility – then law enforcement transports patient to the facility
  - First phase: medical screening and pilot for 6 months
- Community Paramedic Field referral program (2014)
  Fire Dept. + Police Dept. + Dispatch
  - If certain conditions (i.e. no PCP, or fall risk, or some other concern)
  - Goal is to address the concern
    - Refer patient to resources, or coordinate resources
    - Help patients manage health, navigate the health system or connect with the system

- How to Fund the Programs?
  - All paramedics work 48 hours/week: 24 hours 911 response + 24 hours community paramedic role
  - Leadership took a measured approach - funding in support of mission to attain excellence and innovation
  - Fund 100% in normal budget – but not sustainable!
    - Needs additional education
  - Some new revenue streams
    - flu vaccinations at a contracted rate
    - post ED discharge with a fee for service from a grant from a private payer through the health system
    - allocation from county indigent services fund
    - grant through St. Luke's community excellent
  - Emphasize funding is tied to outcomes

Canyon County Ambulance District

- For each Top Ten, we review EHR to see why they called EMS; then plan to connect them with resources.
  - We figure out what they need and determine what we can do. We reach out to the patient and ask if we can help
  - We go to their home, conduct a home assessment (using an Assessment Form from ISU CHEMS training)
    - Maybe diet/food, medication counts, fall risk/hoarding, lack of transportation
  - We use a resource list Rachel Blatton (SHIP) gave us
  - During the first home visit, we try to set goals with them centered around getting them the resources they need so they don't have to call 911. And other resources available as well.
  - Then we send the completed assessment form to the Primary Care Physician

Payette County Paramedics

- Initially, just referrals from ED personnel for us to follow up with patients re: social concerns, chronic users. We worked with the patients in their home to develop plans.
- Then, the ED personnel shared CHEMS with hospital transition team

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- Hospital referred 2 CHF patients to work with us. We've been very successful working with the patients to identify and address issues and concerns about medication, treatment plan, etc.
    - St. Luke's referred a VA (AFIB) patient to us. We were able to keep him out of the hospital for the 30-day transition period.
- We just added a primary care service. We have a few referrals.
    - Still clarifying – short-term follow-ups for 3 days, long-term follow-ups for 30 days.
- We're also expanding our services to include internal referrals for frequent 911 callers.
    - "Lift assist" for patients who fall frequently.
    - We go in their home and see "this patient needs help." We're able to get the patient necessary medical care.
    - We recently connected with Home Health & Hospice. We're able to identify issues in the patients' home they wouldn't otherwise know. So we can consult with the health care team.

Primary Care Physician

- Post hospital discharge (cardiology)
    - Patients tertiary center
    - CHEMS visit home
- In our clinic:
    - Chronic condition patients
        - isolated (socially or geographically)
        - don't have good support locally
        - generally older; things aren't going well
    - We notice them in the clinic, red flag – the patient is vulnerable; teetering at home.
        - We need "eyes on the ground" to see what's going on at home
            - CHEMS go in the home; able to medically assess
        - Able to keep these patients out of the ER
            - The crisis-ambulance-ER cycle is harmful to their health and costly to health system

Establishing an expanded partnership; required documentation

Donnelly Rural Fire Department

- Learned in CHEMS course
    - No legal or liability
    - Some HIPAA
- Can access hospital EHR as a reader
- Referrals from hospital (like Ada County)
- Start with just behavioral health
    - Then later, add another type – maybe diabetes
- Work out all the communication issues before expanding
- Measuring group – how frequently patient is seen
- All based on the healthcare team
- Cooperative agreements with hospital by end of year
    - See Ada County
    - Use of EHR

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    - HIPAA – Chain of custody with information
    - Scope of practice – referrals, level, etc.
    - Funding mechanism
    - Strategic Plan to County Commissioners (fiscal)

Idaho Falls Fire Department

- Two paramedic personnel have been trained through ISU
- We're developing protocol and plans
- We've had a lot of conversations (scale of 1-10)
    - County commissioners (10)
    - Local hospital (5 – interest only)
    - Idaho Heart Institute (8)
    - Pharmacy (Mike's Pharmacy (8 – eager; just figuring out how to make delivery service work)
    - Everybody has been eager; challenge will be how to maintain HIPAA in plan.

Hospital Administrators

- Legal counsel services – difficult. Legal team is busy. Red flags around data, confidentiality
- Physician services
- Liability? Agreement w/ EMS providers. Poses a risk for large health system.
- Difference among EMS personnel (vehicle extraction vs. home visit). Physician perception of EMS personnel.
- PCMH already here
    - Medicine management being handled by Care Coordinators
    - 2 nurse care coordinators
    - CHW
    - Financial
    - Behavioral health LCSW
    - We are well set for the needs of CHEMS- we have hospice, home health nurses. We would prefer to address frequent users directly and internally with Medicare and Medicaid
    - We have a Rapid Cycle Process – this could be a CHEMS pilot
        - Identify super-user, meet to discuss and solve, pilot the solution, outcomes and assessment (yes continue or revise)
        - We could ask other doctors here for insights, feedback about super-users and CHEMS
        - Frame the risk stratification. Why here?
    - SHIP – Regional Collaboratives

Ada County Paramedics

- A lot more legal work than we were used to
    - Prosecuting Attorney's Office review
        - Higher level of liability: From simple negligence to gross negligence
    - Representative Luke Malek sponsored legislation (HB 0153)
        - Support higher level of liability
        - CHEMS agency must be a part of 911 system
        - Defined Community EMT, Community Paramedic, CHEMS
        - Includes EMS providers of all licensure throughout Idaho

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- MOU's
    - St. Luke's
    - St. Al's
    - Each health system may include multiple contracts, depending on what entity of system we're working with (foundation, etc.)
    - PacificSource – foundation funded a pilot in Oregon, contracted with us for vaccines
- Independent Advisory Council – established very early on
    - 16-17 individuals from all aspects of public health, nursing, nonprofits, CMS, etc.
    - Mission, vision, review all aspects, and make recommendations
    - Meet quarterly
    - Community champions for CHEMS

Process for Determining Services? Initiative –specific inclusionary and exclusionary criteria for referral

- St. Al's ED referral
    - Diagnosis and inclusionary criteria determine length of program (7, 14, or 30 day)
        - ED provider introduces program to the patient.
            - Permission to refer to CARE program?
            - Contact information
            - CHEMS contacts patient
    - Standard 2-hour home visit and weekly support (possibly another home visit)
    - Generate standard report
    - Fax to provider, PCP, or specialist
    - Phone call to confirm fax in patient folder or hands of provider
- EMS Partnerships program a different process
    - FD ask for permission to refer to Field Referral program
    - Or just refer, then CHEMS staff get contact information
    - Let patient know about resources like Meals on Wheels
    - May send to PCP, or may not – Patient-specific
- Vaccination Clinic -Try to apply the Triple Aim to each of the 3 programs
    - Improve health through vaccinations
    - Encourage patient to communicate with PCP to keep EMR accurate
    - Tried to find ROI Calculator online (subjective)– maybe saved $80K in reduced sick days

Canyon County Ambulance District

- We already work with St Luke's ER in Nampa
    - Met with CEO
    - Full support
    - We continue to meet monthly to review successes/challenge
    - Sometimes they provide names of individuals who may over utilize the system, so we can connect with patient post ER discharge but before visit to primary care provider. They ask us to check in with the patient over the weekend.
- No MOU's because we're not doing anything beyond what we already do with hospitals
- We are discussing with them to look at funding for CHEMS from the hospitals.

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    - Working on gathering data to work out compensation and possibly expand the services. We have only used data from other CHEMS agencies so far. Med STAR mobile health is a good example of CHEMS
- Met with Primary Care Clinics (St. Al's, St. Luke's, Terry Reilly) to increase visibility
    - Rachel Blatton (SHIP) connected us
    - Often the PCP has no idea patient has been calling 911, or patient may not even have a PCP
    - We ask, "can we work together to help patients get the resources they need?"
- HIPAA Concerns
    - We have a HIPAA form. We have the patient sign it and we send that form with the information to the PCP.

Payette County Paramedics

- Initially just legal documents - Pulled legal paperwork from NAEMT's (Release of information)
- Met with Home Health agencies – will get referrals from us
- Not a lot of issues – St. Al's and St. Luke's already have the processes since working with Ada County Paramedics
- Access to charts has been an upward battle
- Medical director at my agency is also the medical director for Canyon County agency, so not that hard.
- Hospitals are not asking to see documentation of our training. We let them know our community paramedics have completed the CP course at ISU.

Primary Care Physician

- Physician – we work with patients
- Nurses – 6th sense
- Behind the scenes
    - Meeting up front: EMS provider + EMS Supervisor + Me + Cardiologist
    - Put it together
    - Start small – build once we figure out
- County Commissioners gave some money + SHIP
- Don't recall legal counsel; maybe EMS
- Malpractice and liability like normal
- Don't recall MOU
- Several forms to be used by EMS when visit and generate forms
    - Generic
    - Disease specific (COPD, Heart, Diabetes, etc.)

Additional administrative costs incurred by agency

Donnelly Rural Fire Department

- Data must prove cost benefit
    - Cost to us of patient in CHEMS vs. Cost to us of patient not in CHEMS
    - Volunteer EMTs out in the public during non-emergency experiences
    - Patients low to no insurance
        - Laborers of the county
        - Not one doctor; 3 doctors = 3 x medication

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            - Diabetes patient calls 911: Medication assessment can help with no need for ER
    - 2 staff currently in the ISU class
    - 2 staff will start in January
- Will build the program
        - Add a P.A.
        - Add a Pharmacist
        - Awaiting certificate
            - Already paying the pharmacist and P.A. as EMS staff, so using time EMS time in CHEMS is an obvious assignment
- Cost Savings to health neighborhood could fund CHEMS

Idaho Falls
- Minimal administrative costs
    - I'm salaried
    - Additional training has been supported
    - Staff are already assigned to Swan Valley
- Don't have hard numbers on report
    - Maybe a few thousand dollars/year
    - Need good data in and out

Hospital Administrators
- Concern discussed above
- Question about County Commissioners and the indigent fund

Ada County Paramedics
- Time it takes to harvest information is time intensive (additional man-hours)

Canyon County Ambulance District
- **Lack of adequate CHEMS staff is a concern**
    - One of two trained CHEMS staff left the district, so just one left for now.
    - Two currently enrolled in training class
    - One will begin next month
    - (Concern about the ISU CHEMS class: first ½ of curriculum about program development and outreach that our CHEMS providers don't need for CHEMS care. Need a shorter program just for CHEMS providers)
    - Looking into other training (maybe online) programs

- **Our Physician Medical Director needed to sign off on this so they could develop protocols**
    - Diabetes, etc.
    - What needed to be evaluated, when to contact PCP, when it was an emergency
    - There is no CHEMS repository of protocols; no standardized algorithms. Each CHEMS agency is developing their own
    - A lot of room to work together on this in the future
- **Education Budget** - SHIP Grant
- **Extra hours for CHEMS providers overtime** – SHIP Grant
- **Administrative staff time**

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    - This is a new program
    - Research, outreach, time

Payette County Paramedics

- We set aside about $10k for CHEMS this year and have SHIP $
- Staffing costs
    - the initial appt. with a patient conducted during shift overtime. Then, 10-15-minute appt to keep costs down.
    - We would like to have a community paramedic 5 or 7 days/week. This full-time employee would cost about $150k.
        - We're telling insurance companies and hospitals "We can provide better service"
        - It's also easier to generate and track data
        - We're working with the State to pilot CP charting program which we can run in minutes

Primary Care Physician

- Not really
- Referral Coordinator – when we see a need, we ask her to send homemade form for referral to EMS
    - Demographic need
    - Paperwork back - review

Patient response to additional CHEMS services

Donnelly Rural Fire Department

- Patient called 911 22 times in 2 weeks
    - Manic
    - Nobody else there
    - We helped patient go to mental health facility
    - I just had to change my view of him

Idaho Falls

- Patients will be very positive once word gets out and once physicians are on board
- The valley is self-supported; people rely on each other; fiercely independent; reluctant to town or ask for help from neighbors.
- CHEMS will save trip to Idaho Falls or need to ask others for help
- Anticipate significant health care savings to them, since they can get help without having to go to hospital
- Access to preventive care

Hospital Administrators

- Sounds good.
- Operational details are the issue
- Hot spotters – care coordinators
    - Use predictive analytics to identify future hot spotters – care coordinators
- Our long-term vision – identify the super-user, cost containment

Ada County Paramedics

- Patient Experience Survey – Results pretty good
    - Influenza Clinic – 30% response rate

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        - Area for improvement - signage
    - CARE Program (In house survey based on HCAP Survey) – 48% response rate
        - Area for Improvement – CHEMS person didn't listen

Canyon County Ambulance District
- Example: High utilizer seizure patient
    - Able to get in touch with a neurologist, medication, manage care
    - Did not use EMS system for 3 months. Recent uptake due to change in medication
- When asked to participate in the CHEMS program, all patients willing
- Patient Experience Survey coming soon

Payette County Paramedics
- Very good response from patients
    - "The one thing I look forward to each week."
    - "You are going to come back, right?"
- Survey results indicate patients appreciate that we care, we take the time, we're there for them. They can call us anytime – but only 1 patient ever calls me.
    - Patients are more comfortable with us, because we know their background.

Primary Care Physician
- Mostly very positive – "Wow - somebody cares!"
    - Get Durable Medical Equipment (wheelchair, etc.) and supplies they need; meds adjusted.
    - CHEMS can get into a home and prevent a crisis from occurring
- A few grumblers – "leave me alone; I don't want…"

Commercial payers' response

Donnelly Rural Fire Department – Not discussed
Idaho Falls Fire Department - No insights here.
Hospital Administrators
- Commercial insurers vs. Medicaid

Ada County Paramedics
- Some inquiries from private payer
- Receive indirect financial support from a private payer funded initiative
- (Seen NM, Arizona for examples related to Medicaid, VA)
- Conversations with payers relate to patient experience and potential to lower costs

Canyon County Ambulance District
- No indication
- Nationally, Med STAR visit with payers; using value to talk to hospitals

Payette County Paramedics
- Payers are definitely heading in that direction. They're hesitant, but national stuff going on. Blue Cross payments for non-emergency transports.

Primary Care Physician
- Numbers still too small
    - 18-20 total visits in 1 ½ year
    - Most are Medicare

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  - Haven't really seen yet
- Will payers appreciate we're able to keep patients out of ER? Yes. But, small numbers.
  - When fixed rate to take care of 70-year old
    - If you want to save money in health care – keep patients out of the hospital
  - Small community, small scale,
    - Maybe talk, nothing public
    - County $20,000 investment to serve citizens

Important elements your CHEMS agency.

Donnelly Rural Fire Department – Not discussed

Idaho Falls Fire Department

- Buy-in from stakeholders – politicians, community members, medical community
- Value for the community
  - We are supported by fees + Bonneville County EMS tax
  - Maximize ROI for the county

Ada County Paramedics

- From the beginning, stakeholder and community engagement was huge
- By listening to our system partners, we were able to learn about the gaps in care and identify expanded role for us
- As a result of external outreach – we have not run into road blocks as others have
- System partners are invested in developing the CHEMS program with us rather than competing with us

From the administrators' perspective:

- The important elements is finding the right people who really want to do this CHEMS work (that isn't always emergencies)
- CHEMS has changed how I approach 911 calls. I ask more questions than I used to (for example: smoking cessation)
- Another important element is the mission. When we started with CHEMS, we started with the mission and then figured out how to pay for it.
- Some programs do not work for CHEMS. That's okay. For example: DOTS for TB patients did not work. It's learning as we go.
- As we're building the program, strong relationships with system partners and medical director of hospital.
- As we identify things to change, be okay with that and local tailoring.

Canyon County Ambulance District

- Getting patients the resources they need. Tailored to individual patients: "let's get you in touch with…"
- Benefit to us – No non-emergency 911 to hospital or ED
- Benefit to patient – increased quality of life, increased care, decreased financial burden

Payette County Paramedics

- Ability to provide resources to patients who may feel they've been left alone, who don't know what resources are out there.

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- We offer patients a happier life, we help them manage their health care and prevent self-harm.

Challenges faced by healthcare providers CHEMS agency uniquely able to address

Donnelly Rural Fire Department – not discussed

Idaho Falls Fire Department
- Remote community
- Lack of access to healthcare

Ada County Paramedics
- We first had to educate about the 911 systems work. Our partners did not know a lot about our work, our training, what EMS does, Community Paramedicine, how a 911 call is handled.
- We had to spend a lot of time with our partners to educate them! We're not just car crashes and heart attacks.

Canyon County Ambulance District
- Communication across disciplines: 911 to ER to Primary Care. PCP's do not know their patients are calling 911 25x in a year.
- How can we keep communication open to PCP? And maybe as part of the PCMH?
- Even transportation to appts. With PCP

Payette County Paramedics
- Providers don't know what's going on when the patient leaves the clinic.
    - Providers may think, "why aren't you following…?" "why aren't you doing…?"
- So much of healthcare is time sensitive
- In a 20-minute appt., most of the time is spent on evaluation; little time left for educating the patient (how to use medications, discharge instructions, etc.)

CHEMS agency unique contributions to address those challenges and provide better healthcare

Donnelly Rural Fire Department
- Pre-hospital
    - We can get in the patient's door more easily
    - Frequent flyers – check-in
        - How are you today? Hold their hand
- CHEMS contributes to a healthy population as a member of the team

Idaho Falls Fire Department
- Our paramedic crew is already in homes – we can consult with patients, respond to falls, provide access to screenings

Ada County Paramedics
- 28,000 EMS calls through 911. We can handle most complaints. We understand patient questions.
- Unique perspective! If a clinical plan does not work, we're one of the first healthcare providers to know.

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Canyon County Ambulance District
- We're already in the homes of patients. High utilization patients all the time.

Payette County Paramedics
- We are able to follow-up with the patient in their own environment
- We're able to spend time the patient needs to become educated.
- We're providing falls assessments in the home to patients of age
- We've opened prevention classes – smoking cessation, fit and fall course, home fall check sheets, etc.

Typical patient interaction

Donnelly Rural Fire Department – not discussed

Idaho Falls Fire Department
- Two typical interactions
  - Trip and Fall evaluation, vital screenings
    - Through advertising the service within the community at health fairs, open house at fire dept., social media, BBQs
  - Patient/physician/hospital
    - Treatment plan
    - CHF patient in home
    - Pre-identified patient condition
    - Follow-up

Ada County Paramedics - See initiative descriptions

Canyon County Ambulance District
- Most common is the initial home visit
  - We share with PCP, but don't hear back from them (wish we did)
  - Can we schedule a meeting with doc to develop a plan for the patient?
- Then, develop a plan and work with patient until they graduate from the program

Payette County Paramedics
- Initial assessment 1 – 1 ½ hour
  - Vitals
  - If condition warrants, an EKG
  - Medication assessment
  - Ask about health care team and if patient is up to date on appts.
  - Head-to-toe assessment
  - Weight
  - Falls assessment
  - Depression screening
  - Additional services based on concerns

Typical patient say about CHEMS agency

Donnelly Rural Fire Department – not discussed

Idaho Falls Fire Department
- We hope they will say they have an improved Quality of Life and increased access to meet their healthcare needs

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Ada County Paramedics
Canyon County Ambulance District
- This is unusual. We already have rapport, which helps.
- Good things to say
- Family members have a lot of good things to say also. One patient fell; contacted family members; patient could not live safely on his own. Now living in a care facility.
- Someone cares enough to ask questions and get me the help I need

Payette County Paramedics
- Pretty positive

Hospital / clinic in community say about CHEMS agency

Donnelly Rural Fire Department – Not discussed

Idaho Falls Fire Department
- Depends on the hospital
    - Heart Institute – better patient outcomes (quality of life, not in hospital or town, comply with hospital plan)
    - Hospital – able to utilize us to ensure post hospital needs of patient are being met

Ada County Paramedics
- We believe most of our partners will say our organization is organized and excited about being part of the larger healthcare delivery system. We seek out and listen to input/ recommendations from our system partners.

Canyon County Ambulance District
- Case workers: Love it! Weird for case workers to go in the homes, but CHEMS already there. Beneficial.
- Hospitals: if we could make this successful, I'd pay for 10 of your providers
- EMS is uniquely capable of providing in home care

Payette County Paramedics
- Good at helping people improve their quality of life.
- They'll value even more, when more agencies know about our CHEMS

Impact your CHEMS agency on community health

Donnelly Rural Fire Department – Not discussed

Idaho Falls Fire Department
- Unique position to impact health care of community who has little access, high independence
- Maintain health while staying at home as long as they like

Ada County Paramedics
- We feel like the impact is positive and growing.

Canyon County Ambulance District
- A lot of potential in there. Only scratched the surface of capability.
- Movement will continue to make CHEMS part of 911

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- When we're seeing patients 25x in a year, there's potential there.

Payette County Paramedics
- Positive and growing; helping people improve their lives

Anything Else?

Donnelly Rural Fire Department
- It's what we should have always been doing with EMS
- Listen to me know; believe me later
- We'll work with EHR – or stand alone
- We are a Fire and EMS Agency – 90% of our workload is EMS
- Check our MedStar
- Community Care Clinic – Sara Jessup Excellent Patient Stories

Hospital Administrators
- Must next-step: How can we prove results? We have performance data, we have success stories, but how can we prove results?
- CHEMS in the context of risk
- Using EHR data in a more analytic way

Payette County Paramedics
- Be patient with policies and procedures
- Referral can take 3-4 weeks before action
- It all works out

Primary Care Physician
- Why don't we do it more? Why isn't CHEMS more popular?
    - We're not used to having that availability
    - We don't think of CHEMS; it doesn't come to our mind
- We need familiarity, training, service is available
- Expand on so ALL docs in community are using CHEMS
    - ALL patients discharged from hospital

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Results: Complete Notes from All Individual Discussions

This report moves now to complete notes from all individual discussions. Finally, the report concludes with transcribed notes from two panel discussions in which CHEMS agency representatives shared their experiences with CHEMS implementation in their respective communities.

Ada County Paramedics
Mark Babson, Shawn Rayne, John Blake

Some Background

- When we first started, we did not know which direction to take, but we knew CHEMS was a concept we believed in. In Jan 2012 our paramedics went through additional education to prepare for an expanded role
- We made a strong push for stakeholder engagement
    - We wanted to make sure we had buy-in from our system partners and they were invested in our success
    - Leverage services instead of duplicating
    - Many different areas of expertise represented
        - Helped assess community needs. They knew where the gaps were in patient care.
- We explained what EMS was and determined if / how we could help with the gaps
- After two years of foundational work, we developed three main initiatives (outlined below)
- One of maybe 4 CHEMS programs nationally

Part I: Operational Questions

What specific, additional services has your CHEMS agency provided in collaboration with your hospital and/or clinic?

- **Hospital Transitional Program:**
    - Thirty -day post hospital discharge follow-up with Congestive Heart Failure Patients
    - Pilot project with 2 different hospitals in the area – both successful
        - One is continuing
        - One is seeking additional funding - So we are piloting a Post ED transitional follow-up called (CARE) with 3 different options: 7-day, 14-day, or 30-day **Collaborative Resource Acquisition (CARE)**- Community Paramedic Aligning Care Reducing Cost and Engaging Patients and Family piloting a Post ED transitional follow-up called (CARE) with 3 different options: 7-day, 14-day, or 30-day (from above)
- **Ada County Employees (1700 employees) Mobile Influenza Vaccination Clinic (since 2013)**
    - Provide vaccinations to all county employees at the different work locations.
- **EMS Partnerships:**
    - **Psychiatric Emergency Team (PET) (pilot in 2013)**
      Ada County Paramedics + IDHW Mobile Crisis Unit+ Law Enforcement
        - Bypass ED and get mental health services more quickly.
        - EMS does medical assessment – then Mobile Crisis Unit does a mental assessment and works on placement in mental health facility – then law enforcement transports patient to the facility
        - First phase: medical screening and pilot for 6 months

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- **Community Paramedic Field referral program (2014)**
  Fire Dept. + Police Dept. + Dispatch
  - If certain conditions (i.e. no PCP, or fall risk, or some other concern)
  - Goal is to address the concern
  - Refer patient to resources, or coordinate resources
  - Help patients manage health, navigate the health system or connect with the system

- **How to Fund the Programs?**
  - All paramedics work 48 hours/week: 24 hours 911 response + 24 hours community paramedic role
  - Leadership took a measured approach - funding in support of mission to attain excellence and innovation
  - Fund 100% in normal budget – but not sustainable!
    - Needs additional education
  - Some new revenue streams
    - flu vaccinations at a contracted rate
    - post ED discharge with a fee for service from a grant from a private payer through the health system
    - allocation from county indigent services fund
    - grant through St. Luke's community excellent
  - Emphasize funding is tied to outcomes

What was involved in establishing an expanded partnership?

- **A lot more legal work than we were used to**
  - Prosecuting Attorney's Office review
    - Higher level of liability: From simple negligence to gross negligence
  - Representative Luke Malek sponsored legislation (HB 0153)
    - Support higher level of liability
    - CHEMS agency must be a part of 911 system
    - Defined Community EMT, Community Paramedic, CHEMS
    - Includes EMS providers of all licensure throughout Idaho
- **MOU's**
  - St. Luke's
  - St. Al's
  - Each health system may include multiple contracts, depending on what entity of system we're working with (foundation, etc.)
  - PacificSource – foundation funded a pilot in Oregon, contracted with us for vaccines
- **Independent Advisory Council** – established very early on
  - 16-17 individuals from all aspects of public health, nursing, nonprofits, CMS, etc.
  - Mission, vision, review all aspects, and make recommendations
  - Meet quarterly
  - Community champions for CHEMS

Process for Determining Services? Initiative –specific inclusionary and exclusionary criteria for referral

- St. Al's ED referral
  - Diagnosis and inclusionary criteria determine length of program (7, 14, or 30 day)

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        - ED provider introduces program to the patient.
            - Permission to refer to CARE program?
            - Contact information
            - CHEMS contacts patient
    - Standard 2-hour home visit and weekly support (possibly another home visit)
        - Generate standard report
        - Fax to provider, PCP, or specialist
        - Phone call to confirm fax in patient folder or hands of provider
    - EMS Partnerships program a different process
        - FD ask for permission to refer to Field Referral program
        - Or just refer, then CHEMS staff get contact information
        - Let patient know about resources like Meals on Wheels
        - May send to PCP, or may not – Patient-specific
    - Vaccination Clinic -Try to apply the Triple Aim to each of the 3 programs
        - Improve health through vaccinations
        - Encourage patient to communicate with PCP to keep EMR accurate
        - Tried to find ROI Calculator online (subjective)– maybe saved $80K in reduced sick days

What additional administrative costs has your agency incurred such as costs related to data sharing, tracking, report generation, etc?

- Time it takes to harvest information is time intensive (additional man-hours)

Based on your experience with your community, how do you think patients have responded to additional CHEMS services you described earlier?

- Patient Experience Survey – Results pretty good
    - Influenza Clinic – 30% response rate
        - Area for improvement - signage
    - CARE Program (In house survey based on HCAP Survey) – 48% response rate
        - Area for Improvement – CHEMS person didn't listen

Given all that is going on with Value Based Payments, do you think Commercial payers have responded favorably to CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- Some inquiries from private payer
- Receive indirect financial support from a private payer funded initiative
- (Seen NM, Arizona for examples related to Medicaid, VA)
- Conversations with payers relate to patient experience and potential to lower costs

Part II: Patient and Community Experience / Testimonials
Describe in your own words the important elements your CHEMS agency.

- From the beginning, stakeholder and community engagement was huge
- By listening to our system partners, we learned about gaps in care and identify expanded role for us
- As a result of external outreach – we have not run into road blocks as others have
- System partners are invested in developing the CHEMS program with us rather than competing with us

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From the administrators' perspective:

- The important elements are finding the right people who really want to do this CHEMS work (that isn't always emergencies)
- CHEMS has changed how I approach 911 calls. I ask more questions than I used to (for example: smoking cessation)
- Another important element is the mission. When we started with CHEMS, we started with the mission and then figured out how to pay for it.
- Some programs do not work for CHEMS. That's okay. For example: DOTS for TB patients did not work. It's learning as we go.
- As we're building the program, strong relationships with system partners and medical director of hospital.
- As we identify things to change, be okay with that and local tailoring.

What challenges faced by healthcare providers in your community is your CHEMS agency uniquely able to address?

- We first had to educate about the 911 systems work. Our partners did not know a lot about our work, our training, what EMS does, Community Paramedicine, how a 911 call is handled.
- We had to spend a lot of time with our partners to educate them! We're not just car crashes and heart attacks.

What unique contributions is your CHEMS agency able to make to address those challenges and provide better healthcare?

- 28,000 EMS calls through 911. We can handle most complaints. We understand patient questions.
- Unique perspective! If a clinical plan does not work, we're one of the first healthcare providers to know.

What might a typical patient interaction look like?

- Depends on initiative

What might a typical patient say about your CHEMS agency?
What might the hospitals/clinics in our community say about your CHEMS agency?
We believe most partners will say our organization is organized and excited about being part of the larger healthcare delivery system. We seek out and listen to input/ recommendations from our system partners.

How would you summarize the impact of your CHEMS agency on the health of our community?
We feel like the impact is positive and growing.

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Canyon County Ambulance District
Dan Bates, Dept. Chief of Operations

Some Background

- Started 1 year ago.
- We are self-funded.
    - There is no money from outside agencies etc.
    - Self-funded training, education, etc.
    - Due to that, our primary focus was high 911 utilizers.
- We have an EHR software. We ran a report to identify high 911 users (transport to hospital)
- The numbers were surprising.
    - An example is one individual who called 911 25 times in a year for non-emergencies. Others called 10, 11, 12 times in a year. This is not normal.
    - Patients may use us because they don't have a ride to the hospital.
- Top Ten users became who we work with.
    - We wanted to develop a patient-tailored system
    - CHEMS staff looked at "what do they need?"
    - Then put them in the program to connect them with resources to try and get them to use the EMS less.

Part I: Operational Questions

What specific, additional services has your CHEMS agency provided in collaboration with your hospital and/or clinic?

- For each of our Top Ten, we review the EHR to see why they called EMS and then plan to connect them with resources.
    - We figure out what they need and determine what we can do. We reach out to the patient and ask if we can help
    - We go to their home, conduct a home assessment (using an Assessment Form from ISU CHEMS training)
        - Maybe diet/food, medication counts, fall risk/hoarding, lack of transportation
    - We use a resource list Rachel Blatton (SHIP) gave us
    - During the first home visit, we try to set goals with them centered around getting them the resources they need so they don't have to call 911. And other resources available as well.
    - Then we send the completed assessment form to the Primary Care Physician

What was involved in establishing an expanded partnership?

- We already work with St Luke's ER in Nampa
    - Met with CEO
    - Full support
    - We continue to meet monthly to review successes/challenge
    - Sometimes they provide names of individuals who may over utilize the system, so we can connect with patient post ER discharge but before visit to primary care provider. They ask us to check in with the patient over the weekend.
- No MOU's because we're not doing anything beyond what we already do with hospitals
- We are discussing with them to look at funding for CHEMS from the hospitals.
    - Working on gathering data to work out compensation and possibly expand the services. We have only used data from other CHEMS agencies so far. Med STAR mobile health is a good example of CHEMS

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- Met with Primary Care Clinics (St. Al's, St. Luke's, Terry Reilly) to increase visibility
    - Rachel Blatton (SHIP) connected us
    - Often the PCP has no idea patient has been calling 911, or patient may not even have a PCP
    - We ask, "can we work together to help patients get the resources they need?"
- HIPAA Concerns
    - We have a HIPAA form. We have the patient sign it and we send that form with the information to the PCP.

What additional administrative costs has your agency incurred such as costs related to data sharing, tracking, report generation, etc?

- Lack of adequate CHEMS staff is a concern
    - One of two trained CHEMS staff left the district, so just one left for now.
    - Two currently enrolled in training class
    - One will begin next month
    - (Concern about the ISU CHEMS class: first ½ of curriculum about program development and outreach that our CHEMS providers don't need for CHEMS care. Need a shorter program just for CHEMS providers)
    - Looking into other training (maybe online) programs

- Our Physician Medical Director needed to sign off on this, so they could develop protocols
    - Diabetes, etc.
    - What needed to be evaluated, when to contact PCP, when it was an emergency
    - There is no CHEMS repository of protocols; no standardized algorithms. Each CHEMS agency is developing their own
    - A lot of room to work together on this in the future
- Education Budget - SHIP Grant
- Extra hours for CHEMS providers overtime – SHIP Grant
- Administrative staff time
    - This is a new program
    - Research, outreach, time

Based on your experience with your community, how do you think patients have responded to additional CHEMS services you described earlier?

- Example: High utilizer seizure patient
    - Able to get in touch with a neurologist, medication, manage care
    - Did not use EMS system for 3 months. Recent uptake due to change in medication
- When asked to participate in the CHEMS program, all patients willing
- Patient Experience Survey coming soon

Given all that is going on with Value Based Payments, do you think Commercial payers have responded favorably to CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- No indication
- Nationally, Med STAR visit with payers; using value to talk to hospitals

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Part II: Patient and Community Experience / Testimonials
Describe in your own words the important elements your CHEMS agency.

- Getting patients the resources they need. Tailored to individual patients: "let's get you in touch with…"
- Benefit to us – No non-emergency 911 to hospital or ED
- Benefit to patient – increased quality of life, increased care, decreased financial burden

What challenges faced by healthcare providers in your community is your CHEMS agency uniquely able to address?

- Communication across disciplines: 911 to ER to Primary Care. PCP's do not know their patients are calling 911 25x in a year.
- How can we keep communication open to PCP? And maybe as part of the PCMH?
- Even transportation to appts. With PCP

What unique contributions is your CHEMS agency able to make to address those challenges and provide better healthcare?

- We're already in the homes of patients. High utilization patients all the time.

What might a typical patient interaction look like?

- Most common is the initial home visit
    - We share with PCP, but don't hear back from them (wish we did)
    - Can we schedule a meeting with doc to develop a plan for the patient?
- Then, develop a plan and work with patient until the graduate from the program

What might a typical patient say about your CHEMS agency?

- This is unusual. We already have rapport, which helps.
- Good things to say
- Family members have a lot of good things to say also. One patient fell; contacted family members; patient could not live safely on his own. Now living in a care facility.
- Someone cares enough to ask questions and get me the help I need

What might the hospitals/clinics in our community say about your CHEMS agency?

- Case workers: Love it! Weird for case workers to go in the homes, but CHEMS already there. Beneficial to case workers
- Hospitals: if we could make this successful, I'd pay for 10 of your providers
- EMS is uniquely capable of providing in home care

How would you summarize the impact of your CHEMS agency on the health of our community?

- A lot of potential in there.
- Have only scratched the surface of capability.
- Movement will continue to make CHEMS part of 911
- When we're seeing patients 25x in a year, there's potential there.

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Donnelly Rural Fire Depart
Juan Bonilla

Idaho CHEMS Curriculum

- Idaho Curriculum- EMT, Advanced EMT
- We are currently building a CHEMS curriculum with ISU that can be delivered online throughout the state

Background / Status

- From 3-4 CHEMS agencies (Ada County, etc.), we learned from their mistakes
    - 5-6 patient types
    - 1-2 patient types
- Stakeholders in population health neighborhood
    - $0 implementation with stakeholders
- SHIP CHEMS from ground zero
- But it's done here. Strategic planning
    - Adding a pharmacist to accompany paramedic to home visit (Med Tech in Texas)
    - P.A. to participate also
    - Accompany 1-2 times/week
    - The Rock to assess patient needs
    - Behavioral health patients start this fall
    - Work with hospital team

Rationale

- Pre-hospital
    - We can get in the patient's door more easily
    - Frequent flyers – check-in
        - How are you today? Hold their hand
- CHEMS contributes to a healthy population as a member of the team

Data must prove cost benefit

- Cost to us of patient in CHEMS vs. Cost to us of patient not in CHEMS
- Volunteer EMTs out in the public during non-emergency experiences
- Patients low to no insurance
    - Laborers of the county
    - Not one doctor; 3 doctors = 3 x medication
        - Diabetes patient calls 911: Medication assessment can provide help with no need for E.R.
    - Patient called 911 22 times in 2 weeks
        - Manic
        - Nobody else there
        - We helped patient go to mental health facility
        - I just had to change my view of him
        - 2 staff currently in the ISU class; 2 staff will start in January
- Will build the program
    - Add a P.A.
    - Add a Pharmacist
    - Awaiting certificate
    - Already paying the pharmacist and P.A. as EMS staff –

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        - So, using time EMS time in CHEMS is an obvious assignment
- Cost Savings to health neighborhood could fund CHEMS

Program Development

- Learned in CHEMS course
    - No legal or liability
    - Some HIPAA
- Can access hospital EHR as a reader
- Referrals from hospital (like Ada County)
- Start with just behavioral health
    - Then later, add another type – maybe diabetes
- Work out all the communication issues before expanding
- Measuring group – how frequently patient is seen
- All based on the healthcare team
- Cooperative agreements with hospital by end of year
    - See Ada County
    - Use of EHR
    - HIPAA – Chain of custody with information
    - Scope of practice – referrals, level, etc.
    - Funding mechanism
    - Strategic Plan to County Commissioners (fiscal)

Data Collection Metrics

- CHEMS Workgroup
- Our own data set
    - Here's what we're doing
        - Cost of patient on CHEMS vs. Cost of patient not on CHEMS
        - Medication management
- We're also doing Patient Care Reports
    - First visit
    - 3 months
    - 9 months
    - De-identify the patient report
    - Code and write
        - Patient stories
        - Responder stories – we actually already receive these
        - State reporting processes – Wayne Denny

Additional Comments

- It's what we should have always been doing with EMS
- Listen to me know; believe me later
- We'll work with EHR – or stand alone
- We are a Fire and EMS Agency – 90% of our workload is EMS
- Check out MedStar

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Idaho Falls Ambulance
Eric Day

Part I: Operational Questions

What specific, additional services has your CHEMS agency provided (or hope to provide) in collaboration with your hospital and/or clinic?

- Swan Valley is very remote – 45 miles from Idaho Falls.
    - There's nothing there
    - We have an ambulance
    - Couple hours per week for a health clinic
    - No pharmacy, no store
    - We get about 90 calls/year
    - We have a highly trained crew who receive only a few calls; they have a lot of extra time.
- Our goal is to provide primary access; consultation; Pharmacy delivery; basic blood pressure screenings and wellness checks
- We could partner with hospital
    - Post discharge calls
    - Home checks
    - If hospital identifies someone, hopefully they'll call us and we can do the home checks.

What was (or will be) involved in establishing an expanded partnership? What documentation was required of you to demonstrate appropriate level of CHEMS training?

- Two paramedic personnel have been trained through ISU
- We're developing protocol and plans
- We've had a lot of conversations (scale of 1-10)
    - County commissioners (10)
    - Local hospital (5 – interest only)
    - Idaho Heart Institute (8)
    - Pharmacy (Mike's Pharmacy (8 – eager; just figuring out how to make delivery service work)
    - Everybody has been eager; challenge will be how to maintain HIPAA in plan.

What additional administrative costs has your agency incurred (or anticipate) such as costs related to data sharing, tracking, report generation, etc?

- Minimal administrative costs
    - I'm salaried
    - Additional training has been supported
    - Staff are already assigned to Swan Valley
- Don't have hard numbers on report
    - Maybe a few thousand dollars/year
    - Need good data in and out

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Based on your experience with your community, how do you think patients have responded (or will) to additional CHEMS services you described earlier?

- Patients will be very positive once word gets out and once physicians are on board
- The valley is self-supported; people rely on each other; fiercely independent; reluctant to town or ask for help from neighbors.
- CHEMS will save trip to Idaho Falls or need to ask others for help
- Anticipate significant health care savings to them, since they can get help without having to go to hospital
- Access to preventive care

Given all that is going on with Value Based Payments, do you think Commercial payers have responded (or will) favorably to CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- No insights here.

Part II: Patient and Community Experience / Testimonials

Describe in your own words the important elements of your CHEMS agency.

- Buy-in from stakeholders – politicians, community members, medical community
- Value for the community
    - We are supported by fees + Bonneville County EMS tax
    - Maximize ROI for the county

What challenges faced by healthcare providers in your community is your CHEMS agency uniquely able to address?

- Remote community
- Lack of access to healthcare

What unique contributions is your CHEMS agency able to make to address those challenges and provide better healthcare?

- Our paramedic crew is already in homes – we can consult with patients, respond to falls, provide access to screenings

What might a typical patient interaction look like?

- Two typical interactions
    - Trip and Fall evaluation, vital screenings
        - Through advertising the service within the community at health fairs, open house at fire dept., social media, BBQs
    - Patient/physician/hospital
        - Treatment plan
        - CHF patient in home
        - Pre-identified patient condition
        - Follow-up

What might a typical patient say about your CHEMS agency?

- We hope they will say they have an improved Quality of Life and increased access to meet their healthcare needs

What might the hospital / clinic in your community say about your CHEMS agency?

- Depends on the hospital

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  - Heart Institute – better patient outcomes (quality of life, not in hospital or town, comply with hospital plan)
  - Hospital – able to utilize us to ensure post hospital needs of patient are being met

How would you summarize the impact your CHEMS agency has made on the health of your community?
- Unique position to dramatically impact health care of the community who has little access and high independence
- Maintain health while staying at home as long as they like

Anything else?
- Evolved nicely since conception in spring, 2017
- Nicely with the state – support, advice, funding
- We will expand as community needs

Payette County Paramedics
Travis Spencer

Some Background
- We started working with one patient in October 2017
- CHEMS program officially started in December 2017

Part I: Operational Questions

What specific, additional services has your CHEMS agency provided in collaboration with your hospital and/or clinic?
- Initially, just referrals from ED personnel for us to follow up with patients re: social concerns, chronic users. We worked with the patients in their home to develop plans.
- Then, the ED personnel shared CHEMS with hospital transition team
  - Hospital referred 2 CHF patients to work with us. We've been very successful working with the patients to identify and address issues and concerns about medication, treatment plan, etc.
  - St. Luke's referred a VA (AFIB) patient to us. We were able to keep him out of the hospital for the 30-day transition period.
- We just added a primary care service. We have a few referrals.
  - Still clarifying our role – short-term follow-ups for 3 days, long-term follow-ups for 30 days.
- We're also expanding our services to include internal referrals for frequent 911 callers.
  - "Lift assist" for patients who fall frequently.
  - We go in their home and see "this patient needs help." We're able to get the patient necessary medical care.
  - We recently connected with Home Health & Hospice. We're able to identify issues in the patients' home they wouldn't otherwise know. So we can consult with the health care team.

What was involved in establishing an expanded partnership?
- **Initially just legal documents**
  - Pulled legal paperwork from NAEMT's (Release of information)
- Met with Home Health agencies – will get referrals from us

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- Not a lot of issues – St. Al's and St. Luke's already have the processes since working with Ada County Paramedics
- Access to charts has been an upward battle
- Medical director at my agency is also the medical director for Canyon County agency, so not that hard.
- Hospitals are not asking to see documentation of our training. We let them know our community paramedics have completed the CP course at ISU.

What additional administrative costs has your agency incurred?

- We set aside about $10k for CHEMS this year and have SHIP $
- Staffing costs
    - the initial appt. with a patient conducted during shift overtime. Then, 10-15-minute appt to keep costs down.
    - We would like to have a community paramedic 5 or 7 days/week. This full-time employee would cost about $150k.
        - We're telling insurance companies and hospitals "We can provide better service"
        - It's also easier to generate and track data
        - We're working with the State to pilot CP charting program which we can run in minutes

Based on your experience with your community, how do you think patients have responded to additional CHEMS services you described earlier?

- Very good response from patients
    - "The one thing I look forward to each week."
    - "You are going to come back, right?"
- Survey results indicate patients appreciate that we care, we take the time, we're there for them. They can call us anytime – but only 1 patient ever calls me.
    - Patients are more comfortable with us, because we know their background.

Given all that is going on with Value Based Payments, do you think Commercial payers have responded favorably to CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- Payers are definitely heading in that direction. They're hesitant, but national stuff going on. Blue Cross payments for non-emergency transports.

Part II: Patient and Community Experience / Testimonials
Describe in your own words the important elements your CHEMS agency.

- Ability to provide resources to patients who may feel they've been left alone, who don't know what resources are out there.
- We offer patients a happier life, we help them manage their health care and prevent self-harm.

What challenges faced by healthcare providers in your community is your CHEMS agency uniquely able to address?

- Providers don't know what's going on when the patient leaves the clinic.
    - Providers may think, "why aren't you following…?" "why aren't you doing…?"
- So much of healthcare is time sensitive

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- In a 20-minute appt., most of the time is spent on evaluation; little time left for educating the patient (how to use medications, discharge instructions, etc.

What unique contributions is your CHEMS agency able to make to address those challenges and provide better healthcare?

- We are able to follow-up with the patient in their own environment
- We're able to spend time the patient needs to become educated.
- We're providing falls assessments in the home to patients of age
- We've opened prevention classes – smoking cessation, fit and fall course, home fall check sheets, etc.

What might a typical patient interaction look like?

- Initial assessment 1 – 1 ½ hour
  - Vitals
  - If condition warrants, an EKG
  - Medication assessment
  - Ask about health care team and if patient is up to date on appts.
  - Head-to-toe assessment
  - Weight
  - Falls assessment
  - Depression screening
  - Additional services based on concerns

What might a typical patient say about your CHEMS agency?

- Pretty positive

What might the hospitals/clinics in our community say about your CHEMS agency?

- Good at helping people improve their quality of life.
- They'll value even more, when more agencies know about our CHEMS

How would you summarize the impact of your CHEMS agency on the health of our community?

- Positive and growing
- Helping people improve their lives

Anything else?

- Be patient with policies and procedures
- Referral can take 3-4 weeks before action
- It all works out

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Community Hospital Administrators

Do you think there are specific, additional services CHEMS could provide in collaboration with your hospital and/or clinic?

- Concerns about
  - Additional costs and resources involved in administering.
  - Strings attached – incentive $ is nice, but, with free money…
  - Efficacy
  - Expertise of EMS
  - Overlap with CHW – duplication of services
  - Interaction with patients – HIPAA regulations, etc.
  - Different views by different EMS chiefs
  - Depends on community
- Guarded, but interested
  - Case studies demonstrate results
  - Access to services
- We are already doing a version of CHEMS in a nearby community
  - How many people?
  - Who are the emergency transports?
  - Who are making the non-emergency calls?
  - What structure is in place to track patients?
    - Describe what's going on. Who. What level. What is the impact.
  - How can we set up the work to collect data NOW?
  - CHEMS workgroup metrics? What structures are there for data collection?

If yes to question 1, what would be involved in establishing an expanded partnership? What would you require as documentation of appropriate level of CHEMS training?

- Legal counsel services – difficult. Legal team is busy. Red flags around data, confidentiality
- Physician services
- Liability? Agreement w/ EMS providers. Poses a risk for large health system.
- Difference among EMS personnel (vehicle extraction vs. home visit). Physician perception of EMS personnel.
- PCMH already here
  - Medicine management being handled by Care Coordinators
  - 2 nurse care coordinators
  - CHW
  - Financial
  - Behavioral health LCSW
  - We are well set for the needs of CHEMS- we have hospice, home health nurses. We would prefer to address frequent users directly and internally with Medicare and Medicaid
  - We have a Rapid Cycle Process – this could be a CHEMS pilot
    - Identify super-user, meet to discuss and solve, pilot the solution, outcomes and assessment (yes continue or revise)
    - We could ask other doctors here for insights, feedback about super-users and CHEMS
    - Frame the risk stratification. Why here?
  - SHIP – Regional Collaboratives

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Would you anticipate additional administrative costs occurring such as costs related to data sharing, tracking, report generation, etc?

- Concern discussed above
- Question about County Commissioners and the indigent fund

Based on your familiarity with your community, how do you think patients would respond to additional CHEMS services as listed in question 1, or other CHEMS services?

- Sounds good.
- Operational details are the issue
- Hot spotters – care coordinators
    - Use predictive analytics to identify future hot spotters – care coordinators
- Our long-term vision – identify the super-user, cost containment

Given all that is going on with Value Based Payments, do you think Commercial payers would have an interest in learning more about CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- Commercial insurers vs. Medicaid

Additional thoughts:

- Must next-step: How can we prove results? We have performance data, we have success stories, but how can we prove results?
- CHEMS in the context of risk
- Using EHR data in a more analytic way

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Sandpoint Family Health Center – Bonner County
Dr. Dunn

What specific, additional services has CHEMS provided in collaboration with your organization?

- Post hospital discharge (cardiology)
  - Patients tertiary center
  - CHEMS visit home
- In our clinic:
  - Chronic condition patients
    - who are isolated (socially or geographically)
    - don't have good support locally
    - generally older
    - things aren't going well
  - We notice them in the clinic, red flag – the patient is vulnerable; teetering at home.
  - We need "eyes on the ground" to see what's going on at home
    - CHEMS go in the home; able to medically assess
  - Able to keep these patients out of the ER
    - The crisis-ambulance-ER cycle is harmful to their health and costly to health system

Do you know what was involved in establishing an expanded partnership? What do you require as documentation of appropriate level of CHEMS training?

- Physician – we work with patients
- Nurses – 6th sense
- Behind the scenes
  - Meeting up front: EMS provider + EMS Supervisor + Me + Cardiologist
  - Put it together
  - Start small – build once we figure out
- County Commissioners gave some money + SHIP
- Don't recall legal counsel; maybe EMS
- Malpractice and liability like normal
- Don't recall MOU
- Several forms to be used by EMS when visit and generate forms
  - Generic
  - Disease specific (COPD, Heart, Diabetes, etc.)

Has your organization incurred additional administrative costs occurring such as costs related to data sharing, tracking, report generation, etc?

- Not really
- Referral Coordinator – when we see a need, we ask her to send homemade form for referral to EMS
  - Demographic need
  - Paperwork back - review

Based on your familiarity with your community, how do you think patients have responded to additional CHEMS services?

- Mostly very positive – "Wow - somebody cares!"

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    - Get Durable Medical Equipment (wheelchair, etc.) and supplies they need; meds adjusted.
    - CHEMS can get into a home and prevent a crisis from occurring
- A few grumblers – "leave me alone; I don't want…"

Given all that is going on with Value Based Payments, do you think Commercial payers have an interest in learning more about CHEMS as one potential way to improve patient experiences and potentially to lower costs?

- Numbers still too small
    - 18-20 total visits in 1 ½ year
    - Most are Medicare
- Haven't really seen yet
- Will payers appreciate we're able to keep patients out of ER? Yes. But, small numbers.
- When fixed rate to take care of 70-year old
    - If you want to save money in health care – keep patients out of the hospital
- Small community, small scale,
    - Maybe talk, nothing public
    - County $20,000 investment to serve citizens

Anything else?

- Why don't we do it more? Why isn't CHEMS more popular?
    - We're not used to having that availability
    - We don't think of CHEMS; it doesn't come to our mind
- We need familiarity, training, service is available
- Expand on so ALL docs in community are using CHEMS
    - ALL patients discharged from hospital

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Community Health Emergency Medical Services (CHEMS)
Learning Collaborative – January 17, 2018
Panel Discussion

Panelists:

1. Travis Spencer, Payette County Paramedics
2. Bill Holstein, Shoshone County EMS
3. Jason Creamer, formerly at Bonner County
4. Juan Bonilla, Donnelly Rural Fire Department

Areas Discussed:

- Stakeholder Engagement and Local Governance
  - Accomplishments
  - Hurdles
- Successes and Lessons Learned
  - What's working
  - Areas of opportunity
- What's Next
  - Direction
  - Needs

Introduction and Background
Juan Bonilla, Donnelly Rural Fire Dept.

- We've been engaged in this project for about 28 months
- It's taken this long to get fully educated and actually learn what CHEMS is
  - I heard about it in DC at EMSAT
  - Heard more about it here in Idaho through SHIP and CHEMS workgroup
- I've become totally involved in building our program
  - We like the idea because the Donnelly Fire Dept. and Valley County like to be progressive and unique in emergency response
  - I like that the state program includes ALS, ILS, and BLS

Jason Cramer, formerly at Bonner County EMS

- Historically, Bonner County had had a community paramedic program
  - Started about 2011
  - Challenged to maintain its ability to see patients, mainly through attrition
  - As part of SHIP I went through the ISU CP course – ground foundations and step by step how to set up a CP program
  - So, we were doing a lot of things – One credentialed CP still involved in program

Bill Holstein, Shoshone County EMS

- Started with CHEMS in 2013
  - SHIP grant
  - I'm also on SHIP regional collaborative and the board as a CHEMS representative
  - We worked hard to set up CHEMS funding in the north region

Travis Spencer, Payette County Paramedics

- Payette County Paramedics run by city of Fruitland, so we don't have as many people to answer to. The county contacts their stuff to us.

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- When I approached my director about setting up a CHEMS program, she said “go for it.”
- Developing in the past year –
    - small steps, learning curve,
    - benefitting by all the establishments made by Ada county and Canyon County

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Stakeholder Engagement and Local Governance: Accomplishments and Hurdles
Juan Bonilla, Donnelly Rural Fire Dept.
Stakeholder Accomplishments

- I listened to and learned from the trials of Ada County and Bonner County
    - Getting things approved
    - Other agencies were getting frustrated because they weren’t getting the support they thought they needed from the stakeholder agencies
- I attend the Valley County Healthcare Coalition meetings and really pushed the CHEMS effort
    - I shared thorough notes and information I learned through others that point to why CHEMS is important; what it does for our population health
    - The EMS Coordinator and I got very involved in stakeholder engagement. We brought people to the table who we felt needed to be there
        - Went straight to the top of area hospitals: “this is what our community needs”
    - We had huge sections of time in our Valley County Healthcare Coalition meetings that were dedicated to “What is Donnelly doing about CHEMS, when are we gonna get it, and what’s the program gonna look like?”
    - A few major individuals were very interested – support from the top to get this done
        - New administrator of local hospital - met with him a few times, brought him to our coalition meetings, and explained to him “this is what Donnelly needs, this is what Valley County needs
    - Our district is a sub-servient workforce; most of our residents are either under-insured or not insured at all –
        - Gap analysis – individuals not getting the care they need in certain aspects for better population health
        - We also utilized an analysis of ED time, clinical time, and 911 calls repeatedly. We are looking at all of that playing a factor.
    - We’re also looking at the Foundational Grant which provided insight into more individuals that was specific to behavioral health and mental illness
        - We helped them derive a set of questions for the questionnaire completed by people who go to the ER or the clinic
            - We could see the clusters of where people need help with behavioral health
            - They built up healthcare providers to address them, and that’s where we identified the patients we should see first.

Hurdles

- Hard to communicate with some individuals
    - We had to continually remind nurses we were not going to go above our scope of practice

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- Put someone in our CHEMS program, eventually they graduate from our program or we move them on to the next level of care – that's what we're looking to do with our behavioral health.

Jason Cramer, formerly at Bonner County EMS
Stakeholder Accomplishments

- We reached out to our stakeholders
  - Began with our local government – and getting buy in from the County Commissioners
    - They were very receptive – quick to buy into the process
    - Anytime we could promote to our elected officials what we as an agency could bring, they were usually in support
      - Question: how are we going to fund it?
      - We were able to discuss pros and cons with them
      - They gave us seed money
  - Also, Bonner general hospital – nurses
    - Again, very supportive – CEO, hospital administrators very supportive
    - First thing they said, "why don't we start with mental health?" huge problem nationally, state-wide and in our community.
      - Our chief did not want us to go down that path until we had a good plan, so we tabled that.
    - Consulted with a local physician at Family Health Clinic in Sandpoint– came back to table
      - Developed protocols with provider specialists (cardiologist)
        - Specialty and referral source
  - Secondary money came late from grants (Mary Sheridan) – SHIP CHEMS funding

Hurdles

- Small community
  - Getting patients, getting referrals
  - Some members in community didn't understand what CHEMS was and resistant to anything "government" beyond 911.
    - Community support and SHIP resources helped us to inform the community and do outreach. Allayed concerns that were out there.

Bill Holstein, Shoshone County EMS
Stakeholder Accomplishments

- Community Care Collaboration that meets monthly at our local hospital
  - I started pitching CHEMS since 2013
  - Frequent turnover in the group, but it's where I got my list to invite to stakeholders meeting
    - Great turnout at the event, great support from health districts, all three county commissioners, home health providers, hospice providers – everybody showed up but the only PCMH in the area.

Hurdles

- Even though I had been talking about CHEMS for so long, both home health agencies had no idea what was going on. Took time to re-educate.
- I wish I had squashed public criticism sooner.

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- Resistance to move forward didn't make sense
    - In discussion with hospital administrator I learned about the concern "public health is not in the mission of EMS." I had not thought about that.
- Local community members thought too many state SHIP were talking about CHEMS; they wanted to hear from more local providers.

Travis Spencer, Payette County Paramedics
Stakeholder Accomplishments

- Our major player in Payette (St. Luke's) already knew about CHEMS, so we didn't have to do a lot to convince them to let us start seeing patients.
    - St. Luke's already has a transition team, but they won't go anywhere beyond 30 miles from where they are.
    - St. Luke's in Fruitland doesn't even have a transition team. So that was a great selling point for us.
    - Very fast conversation – let's go!
    - We approached ER director who is also ER director in Nampa; she got us in there pretty quickly; much of the legwork was already done.
- Health Dept. has also been great.
    - A lot of great connections on email – which is great for rural areas.

Hurdles

- We deal with St. Al's Ontario also, which is crossing state lines.
    - We haven't yet had the CHEMS discussion with them.
- Getting financial support
    - No funding from an outside source, except for grant money
    - Stakeholders who could support financially say to us, "show us it works." So we need to find a way to gather that data and communicate it
- Administrative tasks are a drag
    - Now spending 2 hours with a patient, then 30 minutes faxing the notes, data entry seems over the top
- Stakeholder engagement– getting stakeholders to drive out to a rural area for a stakeholder meeting is tough; we're trying to think of ways to do online meetings, so they don't have to drive out to us.

Successes and Lessons Learned - What's working & Areas of opportunity
Juan Bonilla, Donnelly Rural Fire Dept.
One thing that's working the best

- Being involved from the get go
- Networking, networking, networking & communication, communication, communication to close the gaps
    - Because of all of our hard work, our neighbors have heard about us, and now one of our neighbors has come on board (Cascade Rural)
        - Now they have an individual in the class and we're already talking about how we can collaborate. We now have one voice for Valley County. My hope is we have so much success that our partners to the north want to participate.

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    - Our communication with the hospitals – because of the health coalition and the population group within our health district and the CHEMS initiative, our partnership with St. Luke's McCall has allowed them to see we really are a tool in their toolbox.
- We can be talking the same language, because we're involved in the same initiatives

One thing that's the most area of opportunity
- St. Luke's has been saying to us, "what funding do you need?" "how come you're not doing this right now?" So, this is an opportunity.
- Funding – for data collection and implementation. Money is there through grants.
- St. Luke's Foundation is looking at us as a huge pilot program, for other agencies to get involved. Opportunities are there!

Jason Cramer, formerly at Bonner County EMS
One thing that's working the best
- Seeing patient's limitless opportunity to make positive change for patients
    - Transition patients –
        - referred to us
        - Processes – sometimes not such a great idea to see them too soon. See them 2 days out after family members have left. No longer experiencing the care from the hospital; seeing them in their home environment. True view of them and their circumstances outside the hospital. We're able to see reactions to medications, risks, etc. and call them in to the physician, address right away. Able to help the patient (medication changes) in their environment at the right time. Excellent patient treatment that keeps them out of the emergency department.

One thing that's the most area of opportunity
- Continued funding; development of the program – that sort of thing. Starting to come together.
- Bonner County is now starting to shift from transition patients to psychiatric needs.

Bill Holstein, Shoshone County EMS
One thing that's working the best
- CHEMS license in 2014. To get things started I partnered with hospital and signed a contract for EMS and community paramedics to fill gaps within the hospital (within their scope of practice).
    - Not a true CHEMS model, but got us started, gave us some great experience with in-depth assessments – things like that.
    - Helped us build trust with hospital

One thing that's the most area of opportunity
- Just finished class, so hoping to get a few patients by end of year to qualify for grants, etc.
- One of the biggest challenges was change in rules related to critical care transport service that kind of stuff (on the 911 side). We ended up revising our policies for transport service, and that pulled us away from our CHEMS work (on the CHEMS side).

Travis Spencer, Payette County EMS
One thing that's working the best
- 7 patients!
- Patient success stories.

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- Example of one patient who is a complete shut-in.
    - I've learned how people get the medications to their home, their food, their cigarettes – I didn't know that before.
    - I've helped her address her drinking by addressing her depression by getting her out of her home. Connecting her to behavioral health care.
    - I drop by her house to play Yahtzee with her.

One thing that's the most area of opportunity
- Telehealth grant from the state. Making progress, but waiting for IT, HIPAA compliance, etc.

What's Next – Direction & Needs
Juan Bonilla, Donnelly Rural Fire Dept.
Direction
- Full implementation of CHEMS program with patients
- Continue active involvement with CHEMS collaborative –
    - Identification of patients who need CHEMS for
    - Work with patients build programs that contribute to population health
- Working with SET on measurement requirements for evaluation and expand on to tell our story
- For best practices- show in detail: here's a patient with CHEMS – here's a patient not with CHEMS
    - Here's the benefit of being with the program
    - For patient referrals

Needs
- Continue work with CHEMS learning collaboratives and workgroup – share information even after SHIP
- We need to help each other grow – because we're going to be the ones that mentor all the other agencies and help them grow.

Jason Cramer, formerly at Bonner County EMS
Direction
- Developing CHEMS programs because the need is so great, even (and especially) in rural areas.
- I would like to see every county in Idaho have a CHEMS program, because the need is so great
- Funding and resources to pay for on a consistent basis
- Flow of information from state and other agencies; We don't always understand everything that's going on.

Bill Holstein, Shoshone County EMS
Direction
- Complete what we're trying to do by end of month
- Reengage and collaborate with hospice and home health; Sharing resources

Needs
- Another person to get all this stuff done!

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Travis Spencer, Payette County EMS
Direction

- Figuring out finances; how we're going to fund this.
- Get initial data within the next 6 months.
- Increase hours of community paramedic – my vision for the future, 24-hours x 7 days. Is it possible? We'll figure it out.
- Talking with the jail about what we can do with jail responses.
    - One of our biggest problems is frequent calls from the jail to ER
    - We want to figure out telehealth to save ER transport costs to the jail and taxpayers
- Excited about crisis center that might be opening in Canyon County –
    - Whole new world with what we can do with mental health as community paramedics
- Continue to work on telehealth
- Work on improving charting. 911 charting is not designed for CHEMS
- Two paramedics finishing class; three will start next semester; more education – and full staff
    - Can we do more tasks on shift, when we're at full staff?

Bonus Question: How has CHEMS changed the way you deliver healthcare/interact with patients during your 911 hours?
Travis Spencer

- Yes! Opened up my eyes on the 911 side. Before we used to just show up to a 911 call and get them out of there, take care of them. Now we look at it in a different way, "holy cow, look at all these fall risks." We talk differently with patients – more open to all their information, not just specific questions about symptoms.
- Attitude improved.

Bill Holstein

- Made a difference. Changed the conversation during the 35-minute critical care transport. We used to just talk about "how long have you lived here?" Now, we're talking a lot more about medical issues, what's going on, how long? More education for them. "Strike when the iron's hot:" smoking cessation, etc.
- Think differently as we look at the patient.

Jason Creamer

- Any change to one side of the practice will change the other side.
- When I receive a 911 call, I ask myself, "do they need to go to the Emergency Dept.?" If not, I'll pick up the phone and call the family physician – let them know what's going on.
- That's what we do: care for the patient in that environment.
- We develop relationships with these people!

Juan Bonilla

- Absolutely. The difference in what we can do for patients is how we sold the program to our stakeholders.
- We used our frequent flyers as examples – we wouldn't have to see them 14 times if they were better managed.
- Example of patient we saw 22 times in 14 days. Extremely manic. Nobody wanted to deal with him. I was the only person who showed up for him the last 14 visits. He started taking his meds. During a transport, I asked him, "did you pull your catheter out because

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you wanted to see us again?" He said yes. This is why we need CHEMS. For people like this. Not only did we help him; I was able to get this person the help they need. I miss him – he's getting the care he needs; he hasn't called.

- Develop compassion for the patients we see.

Group discussion around

- **COST of CHEMS is a basis of the conversation with stakeholders**
    - Difference between cost to provide a service and amount of money a payer is willing to pay for the service
    - If this is a concern, start by creating buy-in to the concept and then move to the discussion of cost.
    - Conversation with payers about how much patients are costing them
- **Ada County created a Community Paramedic Liaison and Advisory Council with about 16 members**
    - We present to them and get feedback about what we should tweak
    - They have agreed to be internal champions in their area of expertise.
- **Building trust with patients and seeing the patient as a whole rather than his/her problems.**
- **Partnership with PCMH clinics**
    - Within the RC's – makes sense!
    - Engaged through the RC's originally, but they're doing their own thing now
    - I haven't presented them with a plan
    - Some opportunities for the state; Medicaid; SHIP PCMH
    - Our hospital is an engaged stakeholder – made the clinics happen
    - Hasn't happened yet
- **For EMS agencies building their programs**
    - Will run into bumps and bruises along the way – don't give up; it's worth it.

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Community Health Emergency Medical Services (CHEMS)
Idaho Healthcare Coalition – March 14, 2018
Panel Discussion – Partial Notes

Panelists:

- Juan Bonilla, Donnelly Rural Fire Department
- Mark Babson, Ada County Paramedics
- Travis Spencer, Payette County EMS
- Dr. Dunn, Sandpoint

Areas Discussed:

1. Challenges
2. What works
3. Partnerships
4. CHEMS different from 911
5. Infrastructure support needed

Challenges

Mark

- Consistent referral source
- Allocation of time
- Current system of data reporting great for 911, but not necessarily for CHEMS

Travis

- Hold up with the grant money
- Identify need but can't fulfill
- Patient compliance

What Works

Mark

- Patient experience survey – CARE survey – 49% return
- Outreach efforts – dissemination

Travis

- Easy partnerships because of Ada county model
- HIPAA compliant referral
- 90% acceptance rate - 11 patients since December
- Internal referrals- fall risk, social issues

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Partnerships

Juan
- Attending medical health neighborhood meetings
- Partnerships have grown – home health, behavioral health and counseling agencies
- Boots on the ground link with other social/medical services

Mark
- Psychiatric diverted team - CHEMS on scene with counselor, mobile crisis
- Mobile Influenza Clinic – provide vaccines for 1700 county employees
- Liaison Advisory Council – meet quarterly to receive feedback

Travis
- First point for primary care
- Home health, hospice
- Crisis Center/CHEMS
- Medicaid Transport for patients
  - *Free from Smoking* training
  - Fall prevention

CHEMS different from 911

Juan
- Enhances infrastructure – see patients differently
- Being utilized with more time with patients
- Patient seeing benefit of having CHEMS there
- Become better paramedics because get to know patients better

Mark
- Spending more time on CHEMS
- Asking different questions now because of CHEMS – looking more broadly about health
- Way of assessment has changed – looking at more holistically
- Converting colleagues
- Learned about health care system complexities

Travis
- More accepting of person's problems
- Looking at substance abuse in context of situation at home
- Early identification of problems
- Sign up of a community member needing mental health, primary care
  - Can avoid ED
  - 1 hour each week of friendship, one step at a time, avoiding long term care

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Infrastructure & Support Needed
Juan
- Have support of County Commissioners and county governing board
- Hospitals, EMS bureau, etc.

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- Continuing to build network – looking to see more types of patients

Mark

- Infrastructure linked to advocacy of IHC

Travis

- Continual outreach
- Working with state on data management to chart CHEMS patients
- Financial support- done now out of county funds
    - Patients seen over time; need time with patients
    - Need to expand definition of billable hours
- Considering response to inmates in area jail
    - NP available only one day each week;
    - Inmates call EMT for ride to ED – sometimes just to have social time
    - Cost of $350,000 in medical expenses
    - 90% do not need ED
    - Find way to bill for what they do

Dr. Dunn

- Great response from patients. Welcome EMS in home
- A few patients can be skeptical – getting word out to patients
- One patient homebound for 2 years
    - Sent CHEMS to check on him in his home
    - He had a foot infection
    - Not a candidate for home health because he had to get out of house
    - CHEMS helping him
- MDs forget to make referrals
    - OR don't understand CHEMS is an opportunity to see patient's home
- Need to market CHEMS
    - Difference between home health & CHEMS & other providers
- Good start in Sandpoint – focus on cardiovascular
    - Segment patient by funding or by programs
        - Medicare Advantage
        - Scope of patients
        - What should payment source be?

IHC Discussion

Juan

- Hospital block grant
    - Behavioral mental health
    - Will add other patient types
    - Added extra paramedics will have 1 per shift in addition to 911
- Will go back to commissioner

Mark

- Inclusionary criteria specific to program
    - Criteria of vulnerability

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- Psychiatric emergency patients
- Driven by community needs
- Analytics identify patients and therefore partner with CHEMS with payment
- Match patient rising risk with payment

Travis

- Medicare & Medicaid
- High utilizers and high risk
- Change from 911 to CHEMS vs. ED use

Dr. Dunn

- PMPM/not in reality
- Downside risk of innovation and value-based system
- MDs don't understand shared savings
- MDs won't pay out of pocket

Larry

- 80 codes out of the whole CPT codebook are for telehealth
- Can CHEMS do remote monitoring?
- Fund for remote patient monitoring – need to check on in-home monitoring
- CHEMS could help patients understand value
- Value based plans need business models

Juan

- Rural communities and mental health
- Donnelly decided to start with mental health as priority.
- Utilization of ED: emergent vs. non-emergent
- EMS had 25 responses for 1 patient – what would the patient be with CHEMS?
- System denies service, but CHEMS gets through

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Appendix R

Goal 4 Community Health Workers (CHWs) Fall, 2016 Course Feedback and Messages

Community Health Workers (CHWs)
Fall, 2016 Course Feedback and Messages

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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Community Health Workers (CHWs) are an important component of the virtual Patient Centered Medical Home (PCMH) in Idaho's Statewide Health Innovation Plan (SHIP). Eleven students completed the inaugural Fall 2016 CHW online training course through Idaho State University, and the evaluation report presented data that indicated they felt positive about the course and improved CHW skills. The purpose here is to further describe the course training experience of participants. Feedback may inform continuing course development and provide positive messages for recruitment materials given to the Regional Collaboratives and SHIP Public Health staff to disseminate in their communities.

Upon completion of the course and evaluation, I spoke by phone with three participants from the Fall 2016 course and summarized their responses. The first was a course instructor who has extensive research and experience with CHWs. The second was a student who is employed as a CHW in a rural area. The third was a student who is a clinic administrator in a rural community. These were individuals with whom I had previously talked to learn about the CHW course, and all three had expressed willingness to provide more information. With some variation, I asked all three the following questions:

1. Now that you have completed the course, what general feedback can you provide?
2. What did you most like or find valuable about the course?
3. What lessons did you learn?
4. How are you utilizing the information in your current employment?
5. How has the course enhanced your skill set and helped your employer?
6. What do you still not know about CHW's that you wish you did?

Responses

Now that you have completed the course, what general feedback can you provide?

Instructor. Three-hour synchronous online class presented some problems. Difficult to keep students fully engaged online for three hours. Plus, if a student missed one class, they missed three hours of instruction. Not possible with this format for students to learn the material. We should consider tweaking the format for more 50/50 asynchronous (out-of-class) with synchronous (online) instruction. Such a wide variety of students and needs. Meeting the needs of everyone is tough.

Consider somehow integrating the CHW training into RC meetings. This would bring far greater visibility to their training and potential role in meeting the healthcare needs of patients in the community. Perhaps the CHW's could report at the RC meetings as well.

CHW student. It was nice to understand what other CHW's are doing. We didn't really have a job description. Now I see more opportunities for myself as a CHW, such as focusing on the needs of the community. Planning weight loss groups, diabetes trainings, etc.

Clinic administrator student. This course was very useful in helping me to understand the role of CHWs. I talked with our executive director and was able to enroll our newest MA in the course. The course is really useful for a person with MA or Social Work training.

Participants who have basic MA or clinical role are more fundable. As a practice administrator, I have to justify every FTE. I could maximize the value of this role with an MA.

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What did you most like or find valuable about the course?
Instructor. Hearing the feedback of the students who are currently engaged in their community. Hearing what's going on in their community. Opportunity for students to conduct a community assessment using the community health rankings and asking them, "how would this affect your work as a CHW?"

Emphasis on CHW as part of an interdependent team – team -based care. Clearly defined roles and boundaries. Healthcare system – I am just one part of this healthcare system. This is my role. Respect for others. **Recommendation: resources for providers regarding role of the CHW on the healthcare team (ASHTO or CDC)

CHW student. The community assessment and individual needs assessment.

Learning basic medical things such as diabetes that I wasn't knowledgeable about before the class. I want to grow in that area. Going to patients' homes now, I can follow up with questions since I know symptoms now. Better prepared if necessary to say, "Let's get you to the hospital."

Clinic administrator student. The information on population health. Micro and macro information and resources approach of how to build the CHW into a team to address population needs.

What lessons did you learn?
Instructor. CHW is part of an interdisciplinary team providing team-based care with clearly defined roles and boundaries. Teaching CHW's in isolation of other team members is tough. Others don't know the potential contributions of the CHW outside of medical treatment – addressing the SDOH. **ASHTO and CDC both offer CHW training for providers. Excellent resource to know what CHW's are.

In terms of the course itself: time and content constraints. Health is more than a factor of access to a provider. Due to time constraints, we were unable to provide adequate content about SDOH. Not enough opportunity for students to focus on SDOH.

CHW student. How important it is to keep in contact with other CHW's. Would love to see Idaho monthly CHW events or even phone calls. I wish we could continue to network, share resources, and support.

Clinic administrator student. The CHW embodies the shift in primary care to the PCMH. The patient is everybody's responsibility. There's a level of coordination in this team approach.

How are you utilizing the information in your current employment?
Instructor. Half of the students in the course were not and will not be CHW's. Some might have better knowledge of what CHW's can do. One student is a CHEMS worker – maybe helped broaden her scope of vision.

Since CHW's work on a team, how they utilize the course material will depend on their role and their team. Their role should be to address the SDOH, but that isn't the emphasis of most healthcare teams. I worry that the CHW role will become over-medicalized. Consider placing SHIP CHW's within the public health districts and RC's rather than clinics.

CHW student. I'm using all the information every day in various ways. I've been using the community needs assessment to understand the medical issues in my community.

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Since learning about motivational interviewing in the course, I'm going to have someone come do a training for other staff members about motivational interviewing.

Clinic administrator student. We're beginning to think about how to use the MA in our clinic differently. I identified an MA, and she is now enrolled in the current course. We're writing a grant to beef up the MA role to more outreach and home-based care. I'm working with the director of a local coalition for drug prevention about reorganizing as a community health center to promote overall health and wellness for teens. We could parlay funding for MA-CHW into schools a few hours a week. We could tie in local healthcare clinics and talk with school kids about basic self-care concepts, address the gap in local after school system by CHW as a steady bridge to local elementary school. The role of paraprofessionals in rural communities is significant. We want to get them to the highest standards for their scope of practice. With a paraprofessional school nurse, the CHW is tied to a medical peer group. Establishing peer relationships may be more important in rural areas.

How has the course enhanced your skill set and helped your employer?
Instructor. In the final assignment students presented a case to health care professionals, which helps develop their communication and ability to contribute as a team member within the system. I recommend you talk with the care providers and patients to learn more about the change in the CHW before/after the class.

CHW student. When I go out into the community, it helps that I can be the liaison between the patient and the clinic. The course has helped me better understand what other CHWs are doing (safety checks, etc.).

Clinic administrator student. Helped me to see the CHW is the most obvious person for understanding the broad scope of community needs and meeting the community needs.

What do you still not know about CHW's that you wish you did?
Instructor. Regarding the CHW training elective modules: listen to what the communities and patients need and how the clinics use the CHW. The elective modules should be determined by each clinic.

CHW student. Since I work in St. Luke's, I wish I was more knowledgeable about medical issues like blood pressure. I know very little. I would like to pursue more training in medical issues.

Clinic administrator student. I wish I knew what direction the CHWs are heading with respect to certification and credentialing. What direction is the state going? It's critical to funding. A visit is covered when the person is certified by the state of Idaho like a LSW, LPN, RN, NP. Otherwise, the CHW is just a really cool volunteer title. The state needs to define and recognize CHWs. This is a really attainable credential that will allow more paraprofessionals to contribute to their community. Our MA was honored and excited to be recommended for the CHW course.

Themes

General feedback
Course instruction. The instructor expressed concern with the three-hour weekly synchronous online course. It is difficult to keep students engaged, has limitations for skill development, and hinders students who have to miss a week. He suggested more out-of-class assignments that students complete prior to class, followed by online discussion. *(Note: classes are recorded for later retrieval.)* This was not a concern mentioned by the two students with whom I spoke.

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Course promotion. The instructor suggested integrating the course into the RCs. This would look different for each RC, but his ideas included holding the class before the RC meetings, or using the RCs to recruit or sponsor students in order to better promote the CHW role and increase understanding of CHW education and training.

CHW networking. Both students valued the opportunity to learn from other CHWs. Hearing what others are doing helped the CHW see more possibilities for herself in her community. Understanding what CHWs can do helped the clinic administrator to see more possibilities for her clinic and her community.

Most valuable content

Community needs. All three individuals identified community needs assessment as one of the most valuable course topics. The instructor described how students used *County Health Rankings* to discuss health needs. The CHW stated she is motivated to better understand the needs in her community and offer needed programs. The clinic administrator identified the CHW as the most obvious person for focusing on community needs and collaborating with relevant community groups to address them.

CHW unique to healthcare team. In different ways, and from different perspectives, all three described the CHW as an important part of an interdependent healthcare team embedded its community. The instructor added that it would benefit the team if the others understood the value of CHWs in addressing non-medical social determinants of health. The administrator noted the unique perspective the CHW brings to be truly patient-centered.

The CHW expressed a desire for further training to more substantially contribute. She wants to learn more procedures she could to do, such as monitoring diabetes and blood pressure. She also wants to know how to identify medical emergencies and be able to respond when she is at a patient's home.

Lessons learned

No themes emerged here. The instructor suggested a greater emphasis on addressing the social determinants of health. The CHW reiterated her desire for continued contact with CHW's. She would love to see monthly Idaho CHW events or phone calls. "I wish we could continue to network, share resources, and support." The clinic administrator reflected that the CHW embodies the shift in primary care to the PCMH. "The patient is everybody's responsibility. There's a level of coordination in this team approach."

Utilizing course material

Yes. Both the CHW and the clinic administrator indicated they are utilizing the course material. The CHW stated, "I'm using all of the information every day in various ways." She mentioned she has been using community needs assessment and has plans to bring in a trainer to help others learn more about motivational interviewing.

The clinic administrator described plans to "beef up the role" for the MA in her clinic to (a) provide more outreach and home-based care, and (b) build coalitions for health programs that better meet the community needs.

Enhanced skills

Advocate for patient, community. The instructor and the CHW reported that the course enhanced students' abilities to advocate on behalf of patients. The instructor described the final

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assignment in which students presented patient cases to healthcare professionals. The CHW indicated she can be the bridge from the patient to the clinic. The clinic administrator identified her understanding of the value of CHWs in understanding the community.

Still to learn

Responses varied greatly here. The instructor referred to course electives, which he stated should be clinic specific, based on the needs of the patients and community. The CHW stated she would like to pursue clinical skill development. The clinic administrator wondered about the plan for CHW certification and credentialing. The direction, she stated, is "critical to funding."

Summary

The purpose of this effort was to further explore the Fall 2016 Community Health Worker online training course. I spoke with three course participants who have different perspectives—an instructor, a student who is employed as a CHW, and a student who is a clinic administrator. I identified four themes that emerged from their responses.

1. **Community needs.** All three individuals identified community needs assessment as one of the most valuable course topics. The instructor described how students used *County Health Rankings* to discuss health needs. The CHW stated she is motivated to better understand the needs in her community and offer needed programs. The clinic administrator identified the CHW as the most obvious person for focusing on community needs and collaborating with relevant community groups to address them.

2. **Healthcare team.** In different ways, and from different perspectives, all three described the CHW as an important part of an interdependent patient-centered healthcare team. The administrator noted the unique perspective the CHW brings to be truly patient-centered. The instructor added it would benefit the others to understood more about the value of CHWs in addressing social determinants of health. The CHW indicated she will pursue further clinical training to contribute more to the medical needs.

3. **Advocate for patient, community.** The instructor and the CHW reported that the course enhanced students' abilities to advocate on behalf of patients. The instructor described the final assignment in which students presented patient cases to healthcare professionals. The CHW identified herself as the bridge from the patient to the clinic. The clinic administrator noted a greater perspective of the value of CHWs in understanding the community.

4. **CHW networking.** Both students valued the opportunity to learn from other CHWs. Hearing what others are doing helped the CHW see more possibilities for herself in her community. Understanding what CHWs can do helped the clinic administrator to see more possibilities for her clinic and her community.

Furthermore, I identified two areas of difference among the three participants.

1. **Course instruction.** The course instructor identified concerns with synchronous, online learning platform, but the two students did not. It is possible that, because the two live in rural areas, they are more likely to accept online learning platforms that enable them to participate without the need to travel. This is important given the geographical locations of the communities SHIP is striving to reach.

2. **Role of CHWs.** There may be a disconnect between the three perspectives on how CHWs best serve patients, the community and the healthcare team. The instructor

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indicated that CHWs (and the course) should address the non-medical SDOH; the CHW wants more (and plans to pursue) clinical skill development. The clinic administrator provided responses that indicate she believes the CHW is the best person to collaborate with coalitions and programs to address patient and community needs. It is possible that these different roles/emphases are best resolved by the needs of the community and healthcare team as well as the personality of the individuals who fill the CHW roles. However, SHIP designers should be aware of the differences.

Based on conversation with three participants from the Fall 2016 Community Health Worker online training, I offer the following suggestions for consideration.

1. **CHW and course promotion.** Integrate community health workers into the RC meetings. This would reinforce CHWs as an important component of the virtual Patient Centered Medical Home (PCMH). This could raise awareness about the accomplishments of CHWs in addressing community needs and contributing to healthcare teams. This could allow others to see how CHWs bridge patients to the healthcare systems. It could also provide opportunities for CHW networking and professional development.

   Furthermore, integrating CHWs into the RC meetings would raise awareness about their training and abilities. For some this may be the first introduction to an actual CHW. By interacting with someone who can speak intelligently about community health needs or working on a healthcare team, possible skeptics may be more comfortable with CHWs in their own communities.

   Finally, integrating CHWs into the RC meetings would promote the course and encourage recruitment and enrollment and ultimately training and preparation.

2. **Course development.** Course developers at Idaho State University may want to encourage healthcare providers to enroll in the course or consider offering a parallel ASHTO or CDC course mentioned (above) by the course instructor. As stated, this would provide a more complete understanding of the role of CHWs to address the SDOH.

3. **Professional development.** Explore how best to provide networking and professional development opportunities for CHWs. The clinic administrator cautioned against CHWs becoming “a really cool volunteer title.” Upon completion of the second CHW course, a collective group will exist in Idaho – educated and motivated to make a difference in their communities.

   Secondly, this feedback supports the value in continuing to dialogue about how to make formal and sustainable the credentialing, administration and funding of CHW’s in order to maintain and advance this valuable component of SHIP.

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Promotional Messages
After taking the CHW course…

I am able to better serve my community:

I've been conducting community needs assessment to understand the health needs and plan programs in my community.

I now see the CHW is the most obvious person for understanding the broad scope of community needs and meeting the community needs.

The role of paraprofessionals is very important in rural communities. The CHW credential gets them to the highest standards for their scope of practice.

The students used a variety of tools to conduct community needs assessments. Then they discussed, "how does this affect my work as a CHW?"

I am able to better contribute to a healthcare team:

The students presented a patient case study. Learning to talk to healthcare providers and communicate within the system helps them to work better on a team.

In the PCMH the patient is everybody's responsibility, and there's a level of coordination in this team approach. The CHW embodies this shift in primary care.

I am able to better serve patients:

I can be the liaison between the patient and the clinic.

I know the important symptoms and warning signs now. Going to patients' homes, I can follow up with questions and am better prepared to say, "let's get you to the hospital."

From a course instructor:

The community health worker is part of an interdisciplinary team providing team-based care with clearly defined roles and boundaries. This course helped them develop the skills and the confidence to work better on this team.

From a CHW:

We didn't really have a job description, so it was nice to understand what other CHWs are doing. Now I see more opportunities for myself as a CHW.

From a clinic administrator:

This course was very useful in helping me understand the role of CHWs. I am already thinking of how I can structure the role of the CHW in our community.

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Appendix S

Goal 4 Building a Sustainable Community Health Worker (CHW) Workforce in Idaho: Learning from the Experiences of Other States

Building a Sustainable Community Health Worker (CHW) Workforce in Idaho

Learning From the Experiences of Other States

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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Introduction

Community Health Workers (CHWs) are able to extend healthcare services to medically underserved areas. Idaho's Statewide Healthcare Innovation Plan (SHIP) expanded the patient-centered medical home (PCMH) team to include CHWs in a Virtual PCMH model. A recent evaluation of state innovation (SIM) models across the country found that CHWs were included in 35% of innovations, and only SIM innovations using CHWs resulted in lower healthcare costs (RTI, 2018).

According to Idaho SHIP documents, the Idaho Healthcare Coalition (IHC) oversaw the expansion of Community Health Workers in Idaho and designated a portion of SHIP grant funds to establish Virtual PCMHs in rural communities. A CHW workgroup selected and adapted a CHW training curriculum and designated Idaho State University to deliver the training course. The IHC supported integration of CHWs through trainings, peer mentoring programs, learning collaboratives, and other resources. Finally, the IHC promoted CHWs through reimbursement payments to SHIP clinics who integrated CHWs into their PCMH model of care. Despite efforts to develop a CHW workforce in Idaho, progress in this area has been slow.

The purpose of this project was to learn from the experiences of other SIM states that seemed to have made significant progress in developing a CHW workforce. The intent was to identify key strategies and infrastructure that have been effective elsewhere that might be useful here. The end goal was to make recommendations to key stakeholders in Idaho in order to continue to develop a sustainable CHW workforce. Results of this project have the potential to advance CHWs, and as a result better meet the needs of rural, frontier, and medically underserved communities throughout the state.

Methods

In fall 2017, researchers from the State-Level Evaluation Team (SET) used Zoom© or phone to conduct interviews with representatives from five SIM states: Connecticut, Maine, Montana, Oregon, and Texas. Interviewees were staff members from a variety of agencies, including state health departments, Area Health Education Center (AHEC) chapters, and/or SIM projects. The interviews lasted approximately one hour. Researchers recorded and transcribed the conversations for accuracy. Then we independently read and coded the transcripts for analysis. Finally, we compared codes and discussed differences to reach consensus.

Additionally, we reviewed pre-recorded sessions from the Centers for Disease Control and Prevention (CDC) E-Learning Training Series on Community Health Workers. Session 6 highlights the efforts and experiences in Massachusetts and Minnesota (National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention, 2016).

The first part of the interviews and reviews was qualitative. We asked four broad questions about the history and experience regarding the CHW workforce within the state. To analyze this data we utilized an ordered matrix design borrowed from Miles, Huberman, and Saldana (2014). This allowed us to compare participants' responses and identify similar factors and relationships between variables across different states. Patterns and themes emerged through clustering and counting responses even through the unique stories of the different SIM states. These informed our recommendations for Idaho's CHW workforce.

The second part of the interviews and reviews was descriptive. We asked thirteen focused questions about specific elements of workforce development. To analyze this data we utilized a

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similar approach of clustering and counting responses. Again, patterns and themes emerged across the different SIM states, which informed the strategies and infrastructure elements we recommend at the conclusion of this report. Please see the interview questions listed below.

Interview Questions

Part One: Broad Questions

1. How would you describe what you have accomplished with CHWs in your state?
2. How would you describe the pathway to get where you are?
3. Where has the political muscle come from?
4. What steps are you taking now to sustain the CHW workforce in your state?

Part Two: Focused Questions

5. State legislation regarding CHWs
6. Designated state agency to oversee CHW workforce
7. CHW training course and curriculum
8. Certification requirement
9. Certification process
10. Designated state agency to manage certification
11. Required skill set
12. Policies regarding: mandatory reporting, safety of CHWs, etc.
13. Percent of CHW time expected to be about prevention versus some level of chronic disease management? How does certification address this?
14. Integration of CHWs into PCMH
15. Potential employers responding in terms of salary, liability coverage, placement in a clinical setting, supervision? Do these issues vary by rural versus urban locations?
16. Payment options
17. What do payers require in order to pay CHWs?

Interview transcripts and notes from each of the interviews are provided in appendices A-F. However, we made the decision not to use the information from the interview with the individual from Montana, when we determined the CHW workforce is less developed there.

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Results

Part One

Question 1: How would you describe what you have accomplished with CHWs in your state?

Themes	**Frequency Count**
Certification	7
Legislation	6
Employment opportunities	5
Stakeholder engagement	6
CHW governing organizations developed	5
Financing examined / addressed	4
Engaging CHWs	3

Question 2: How would you describe the pathway to get where you are?

Themes	**Frequency Count**
Stakeholder engagement	7
Changing the approach to healthcare	6
Formalizing CHW role / scope of practice	5
Examining / Researching CHW ROI (Return on Investment)	6
Legislation	5
Creating awareness of CHW role	4

Question 3: Where has the political muscle come from?

Themes	**Frequency Count**
Community organizations and stakeholders	6
Legislator, legislation	5
State government committees and agencies	6
Formalization of the CHW role	4

Question 4: What steps are you taking now to sustain the CHW workforce in your state?

Themes	**Frequency Count**
Integration on healthcare team	4
Stakeholder involvement	3
Billable services	3
Education	4
Legislation (related to Medicaid)	3
Research / ROI	2

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Four overarching themes emerged from the responses to the qualitative questions in part one.

1. The first theme was formalization of the CHW role. This includes elements like certification, scope of practice, and CHW organizational bodies.
2. The second theme was state-level governance. This includes elements like legislation, designated state agencies, and scope of practice.
3. The third theme was stakeholder engagement. This also includes awareness campaigns.
4. The fourth theme was financing and payment for CHW services. This includes Medicaid, billing, external grants, and researching return on investment (ROI).

The discussion section of this report will discuss the themes in greater detail. Please see Appendix G for the complete broad thematic analysis from Part One of the interviews.

Part Two

Questions 5, 6, and 10: State Governance

Legislation	**Frequency Count**
State legislation > 3	2
State legislation 1-3	3
No state legislation	1
Proposed	1

Designated State Agency	**Frequency Count**
Oversee CHW workforce	6
Oversee CHW certification	5
Proposed	1

Questions 7, 8, 9, and 11: Workforce Development

Training Course	**Frequency Count**
Standardized program	6
Competency-based	5
160 hours	2
80 hours	2
40 hours	1
In flux	1

Certification	**Frequency Count**
Required	0
Voluntary with benefits	3
Voluntary	1
Standardized process	4
Proposed	1

Required Skills, Competencies	**Frequency Count**
Standardized (minimum standards)	4
Proposed	1

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Question 12: Policy

Statewide	**Frequency Count**
Mandatory reporting	1
CHW safety	1

Employer-based	**Frequency Count**
Mandatory reporting	3
CHW safety	3

Questions 13, 14, and 15: In the Workplace

Emphasis	**Frequency Count**
Prevention	2
Disease Management	0
Both	3
SDOH	1

PCMH Integration	**Frequency Count**
Team-based care	6

Salary	**Frequency Count**
Related statewide policy	1
Employer-based	3
In review	1

Liability	**Frequency Count**
Related statewide policy	1
Employer-based	4

Clinical Placement	**Frequency Count**
Related state-wide policy	1
Employer-based	3

Supervision Requirement	**Frequency Count**
Statewide policy	1
Employer-based	2

Vary by Urban vs. Rural	**Frequency Count**
Yes	0
No	1

Questions 16 and 17: Payment

Options	**Frequency Count**
Medicaid	5
Grants	4
Consideration of Value (positive ROI)	3

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Payer Requirements to Fund CHWs	**Frequency Count**
Certification	2
Supervision	2
In development	2

Please see Appendix H for SIM States descriptive analysis Results for Part Two. The next section of this report will discuss the four overarching themes and the descriptive responses in greater detail.

Discussion

The first part of our interviews explored six SIM states' experience with CHW workforce development. The second part delved further by exploring specific strategies and infrastructure in place. This section of the report discusses the four themes from Part One and supporting information from Part Two of the interviews.

Formalization of the CHW role. The first theme that emerged from the interviews was formalization of the CHW role. This includes elements like certification, designated agency to oversee the workforce, scope of practice, and organizational body. Four of the six SIM states encourage certification and half reward certification. Nearly all states base certification on ability to demonstrate a required skill-set or competency and these are the foundation for standardized CHW training courses.

All of the six states have designated, or proposed, a state agency to oversee certification; all have designated a state agency to oversee the entire CHW workforce.

This theme reflects an important piece of Community Health Worker workforce development. It aligns with one of the three national trends—standards and credentialing—discussed by Carl Rush during the CHW Learning Collaborative held in July 2018 in Idaho.

State-level governance. The second theme that emerged from the interviews was state-level governance. Nearly all of the six SIM states have passed at least one piece of legislation regarding CHWs, and two of the states have passed three or more. Interviewees from Oregon and Texas identified at least one act of legislation that was instrumental in advancing the CHW workforce in their states.

During the CHW Learning Collaborative, Rush discussed the difficulty in CHW policymaking (governance) at the state level (2018). According to him, the generally accepted definition of CHWs provided by the American Public Health Association (APHA, 2018) makes operational sense, but is difficult for policy making at the state level. He stated, "this is an employer concern" (Rush, 2018). This is consistent with the responses to the policy-related questions in the interviews. Only one of the six SIM states interviewed indicated state-level policies related to mandatory reporting or CHW safety had been developed. Three of the states indicated employers typically set policy here. This was also the case with responses related to policies around CHW salary, liability, clinical placement, and supervision requirement.

Even as Rush noted the difficulty in CHW policymaking (governance) at the state level, he stated "only two states are not at some stage of considering policies on CHWs" (Rush, 2018). Likely, governance and policymaking will continue to change and accelerate in the states and nationally.

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Stakeholder engagement. The third theme that emerged was stakeholder engagement. Stakeholder engagement not only created buy-in and support, but also led to things like awareness campaigns and other ways to generate more buy-in and involve multiple stakeholders and representation. This was not explored in the second part of our interviews. However, the importance of stakeholder engagement is undisputed.

In all interviews, individuals from Connecticut, Maine, Oregon and Texas identified different stakeholders, including CHWs, employers, providers, consumers, health departments, community organizations, and educators. Nearly all interviewees provided examples of legislators and state leaders who championed CHW initiatives in their state.

The online reviews of Massachusetts and Minnesota identified stakeholders as responsible for the growth of the CHW workforce in their states and laid out the pathway to move stakeholders along a continuum of development from awareness to understanding, interest, perceived benefits, commitment, participation, and finally leadership (CDC, 2016).

Financing and funding CHWs. The fourth theme that emerged was financing and funding the work of CHWs, such as external grants, Medicaid, billing, and examining return on investment (ROI) to engage payment resources. Four of the six SIM states continue to rely on grants as a source of funding. Five of the states include the option of Medicaid. Interviewees described a contact between state Medicaid programs and the state “managed care organization,” or “accountable care organization” in which CHWs and their services are integrated into a PCMH model of team-based care. In two of the states, this funding comes with the requirement that CHWs are certified, and in two states CHWs must be supervised.

This theme aligns with second of the three national trends—financing/payment—discussed by Carl Rush during the July 2018 CHW Learning Collaborative. In his presentation, Rush noted that Medicaid may be the main avenue for potentially sustainable financing of CHWs. Beyond Medicaid he shared a model published by State and Territorial Health Officials to engage CHW employers in financing (Rush, 2018). Strategies include relating CHW capabilities to needs, business case / evidence, internal pilots, advocating for policy change, among others (Rush, 2018).

Individuals from three of the six SIM states mentioned their states are considering the value and positive ROI of CHWs. The element of CHW value, in the context of funding and financing is significant. A meta-analysis funded by the Centers for Medicare and Medicaid concluded that among the six different types of innovation components evaluated, only CHWs lowered total costs of healthcare (Bir, et. al., 2018). As the trend in healthcare continues to move away from fee-for-service and towards population-health and value-based funding, CHWs may become more integral to team-based care.

Summary and Recommendations

The purpose of this project was to learn from the experiences of other SIM states that seemed to have made significant progress in developing a CHW workforce. The intent was to identify key strategies and infrastructure that have been effective elsewhere that might be useful here. The end goal was to make recommendations to key stakeholders in Idaho in order to continue to develop a sustainable CHW workforce. Based on themes and patterns that emerged from analysis of the experience of other states, we offer the following recommendations.

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1. Strengthen stakeholder engagement. Bring back individuals and organizations who participated in initial SHIP efforts related to CHWs. This workgroup made substantial progress in agreeing on a statewide definition of a CHW, researching, adopting and delivering a training curriculum, and organizing a CHW Learning Collaborative. Additionally, bring in key players who can take this effort to the next level. Certain kinds of stakeholders can play a more prominent role in different aspects of workforce development. This may require work to move new stakeholders through the stages of development followed in Massachusetts and Minnesota—awareness, understanding, interest, perceived benefits, commitment, participation and leadership. Finally, continue to rely on members of Idaho's recently formed CHW Action Group. These individuals have been regularly participating in monthly calls and many of them are involved in efforts to establish a formal statewide CHW Association.

2. Introduce state legislation, regulation, and policy. The CHW workforce will continue to develop as it becomes more widely recognized and regulated. Idaho Representative Malek championed HB 153, which supported Community Health EMS (CHEMS) in Idaho. This legislation acknowledges EMS personnel as a resource where access to a health care facility within a community may be limited. If one or more legislators emerge as CHW stakeholders, they may be willing to champion similar measures to advance a recognized CHW profession in Idaho. Consider also statewide policy on matters related to ethics, reporting, and other workforce-related issues. Most of the states in this project consider these employer-based matters; this may be the case in Idaho as well. It bears consideration.

3. Designate a state agency to oversee the CHW workforce. This could be a state agency, such as a public health department, as is the case for the SIM states in this project. It could also be a department of licensing which, in one of the six SIM states, shares oversight. It could even be the CHW Association, particularly if the CHW association resides within public health. A governing body provides oversight of legal issues, certification requirements and registries, and other aspects related to the CHW workforce.

4. Study the feasibility of a CHW certification and process. Individuals ought to have the option to become certified, and payers (including Medicaid as well as private payers) may be more likely to pay for services provided by a certified Community Health Worker. Leading to certification is a competency-based training program. Idaho adopted the CHW training curriculum developed in Massachusetts. Currently, CHWs earn a certification of completion. The infrastructure is in place, but at this time it is uncertain whether this will continue post-SHIP.

In closing, this project involved months of identifying SIM states and individuals with whom to speak. Researchers from the State-level Evaluation Team conducted, transcribed and coded hours of interviews. We analyzed and discussed the responses and themes. After all this, the recommendations we outlined above are not new or innovative. We did not uncover a hidden strategy to growing a CHW workforce. Our recommendations are simply what has worked elsewhere. Furthermore, they are mutually supportive of the three components outlined in the document, *Idaho Community Health Workers: Report and Formal Recommendations for*

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Sustainability by WRG Services, LLC. When implemented, the four recommendations pave the way to the ultimate recommendation, which is to pursue sustainable funding via Medicaid for state Medicaid beneficiaries and payment of CHW services via private payer sources. With sustainable funding in place, a workforce of Community Health Workers can truly help to meet the needs of rural, frontier, and medically-underserved communities throughout Idaho.

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Appendix A

Connecticut Interview Notes

CHW Accomplishments in Connecticut

Connecticut Area Health Education Center Program: Southwestern AHEC (one of four AHEC centers based out of UCONN health centers).

AHEC has been advancing CHWs for a very long time-- since 2002. We have provided training for CHWs. We've helped various community partners with grants. One grant with the Connecticut Health Foundation, a champion in the state, who have provided grant funding sources to reach the state, employers, and individuals in need of services. Everything that we do, we've included all the partners together. We've hosted various conferences, CHW symposiums, and each time we have any health conference, we promote CHWs.

We've supported the CHW Association of Connecticut which has branched as a section under the Connecticut Public Health Association. We've provided education, recognition, and training. Using CHW Association as a community partner as much as possible. One of the major challenges we still find is that CHWs have so many different titles, and those who are functioning in one of the roles of CHWs don't know that they can qualify to be a CHW.

Then, SIM came along in addition to the C3 project (a national effort to define CHWs and develop a scope of practice. We used the C3 recommendations as a reference in the CHW Advisory Committee meetings)

SIM has really been the true champion in including CHWs in health care throughout Connecticut, building our AHEC network, building the CHW workforce through the CHW association. Working through SIM, our workgroup is called the CHW initiative. We work with the vendor to provide technical assistance to the practicing entities (PE's) as they try to develop a new model of care and include the CHW as a piece of that care. We are trying to provide as much hands–on and behind-the-scenes support to that process. We work very closely with the SIM office and Jenna's team, and the PE's who have signed on and received upfront money to launch this pilot. The goal is to make it sustainable; we're trying to support them in including a CHW in their model of care, build it around the CHW's, and achieve the two standards.

Through SIM:

Most concrete policy success at this point: Worked with a CHW Advisory Committee. Multi-stakeholder group (CHWs, employers, providers, consumers). Committee met March, 2016 – June, 2017. Put out a set of recommendations around definition of CHW's, scope of practice, certification, sustainable financing. During the legislative session, this year a bill (SB 126) was passed that included most of the definitions recommended by the committee. Tasked the SIM Director and Dept. of Public Health (DPH) in the state and the committee "feasibility study for certification for CHWs." We're moving pretty rapidly through the options and are hoping to put forth another bill in the next legislative session (February) that would establish a certification program (voluntary certification).

Other success: The Community and Clinic Integration Program

Requires the use of CHWs to (1) improve care for complex patients, and (2) address health equity gaps within the system. Recognized as potentially useful with a (3) behavioral health integration component. Three ACO-type entities are participating in the program have committed to achieving the three standards; they are required to hire and use CHWs or use CHWs within the community. This program in the middle of its first phase; we are supporting the

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participating organizations as they work to integrate CHWs (among other activities they've committed to).

In summary, a CHW workforce has been in Connecticut for about 15 years. Through SIM we've been able to jumpstart the workforce and really move it forward.

Pathway.
The SIM strategy included a number of stakeholders and champions that were involved in the design and development. CHWs were built into many aspects of SIM. It's really about – "if we're going to be moving to value-based payment model, we cannot get the outcomes we need without changing the way we approach healthcare. CHWs are such a significant aspect of how we do that." It makes sense if you think about SIM as a whole as to why CHWs would be so integrated.

Accountable Care Organizations (ACO's) (Connecticut uses the term "advanced networks")
In the Community and Clinic Integration Program, two/three advanced networks are participating. They are large hospital-based systems, and they have a number of shared-savings agreements. They were able to participate in the Community and Clinic Integration program (CCIP) because they elected to participate in the newly launched Medicaid shared-savings program (SSP), which is also part of SIM. To expand on the requirements to participate in the SSP program, they committed to achieving the CCIP standards (above). They received a $500,000 transformation award to make changes to the way they deliver care in order to achieve the standards; all have committed to hire CHWs without funding in order to achieve the standards. One has committed to retain CHWs beyond SIM – hopefully they will all agree to retain CHWs once they demonstrate the effectiveness of the intervention.

Demonstrate effectiveness
Grappling with this. SIM Standards developed in a way similar to NCQA PCMH – checking off boxes whether or not something has been done instead of the effect it has. Trying to figure out how to measure what CHWs are contributing to overall outcomes of the organization. Recent discussions about measuring ROI for CHW. We're close to launching a strategy for how we're going to do that.

Legislative process
SB 126 championed by Health Equity Solutions – a consulting group affiliated with Connecticut Health Foundation, which is the largest health philanthropic foundation in the state. SIM worked with them to insert language recommended by the CHW advisory committee to make sure definition got in in the way the committee envisioned. (This was a tumultuous year in Connecticut. The state still has no budget). The bill got held up for a while; the night before session ended, it got passed narrowly. Tie breaker by Lt. Gov. who is a SIM advocate. Having champions in the right places who recognize importance of CHWs was important.

Language and content of legislation was also important. The multi-stakeholder CHW advisory committee worked over the course of a year going through the definition, scope of practice, and recommendations for certification. This took 12 months of meeting monthly with additional design groups. We went back and forth with Dept. of Public Health about what was feasible, checking with Health Equity Solutions about what might be the right language to include in the bill and coming out and building consensus among the CHW advisory committee about what was going to be put forth to the legislative steering committee to give to Health Equity Solutions to put forth in the legislative process. From where we started to the final – it changed a lot to become a public act. Where it ended up is good. Everyone is very satisfied that it got passed

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and that the language is what we originally wanted. There was a roadblock in between, where it changed dramatically, it didn't mean what it was intended to at first, but then it changed again. So, it changed about four times before the end.

Sponsored by a legislator. We have a public health committee in the legislature. Chair of the public health committee was the lead on the bill.

In summary, CHW initiative is a good example of how we approached all of our initiatives in SIM: Get stakeholder buy-in from every stakeholder group, all along the way. Even when we felt that we didn't need to go through a step (we already had a definition), even when it may have felt like a tedious process, it mattered to have the buy-in from all of the members of the committee. When we got up to having a bill, you knew you had the complete backing of everyone in the group. It also went through the SIM steering committee, which is chaired by Lt. Gov., and includes payers and consumer advocates. The Connecticut Health Foundation championed the bill to the steering committee – so very much making sure we had that support all the way around. When it came around to voting on the bill, it was a tie breaker vote. Support!

Does buy-in = lobbying? Not formally through SIM, but stakeholder buy-in led to indirect lobbying. This was a rare example of legislative action. We felt it was the best route for this initiative.

Also, very timely to have the national C3 project recommendations come out in April 2016. We started in March 2016 – the work we had done with definition and roles, we able to use that as our research and evidence base to gain consensus from the stakeholders; it all made a lot of sense. Without that, we would have had a difficult time accomplishing that scope of work within this advisory group.

Sustainability

How are provider groups reacting and looking at changing landscape of reimbursement and what CHWs might do with complex medical cases? Still in early stages of integrating CHW's in CCIP initiative. We're trying to demonstrate effectiveness for providers from a payment reimbursement/value-based payment method. There is no mechanism for that yet. Funding through CCIP is essentially still grant funding.

Calls from certain stakeholders to lobby payers and Medicaid to pay for CHW fee-for-service. We don't see that as a viable path: (1) Medicaid tremendous cuts in the state, (2) does not fit with philosophy of value-based payments. We're trying to work with partners to demonstrate ROI from a purely financial perspective when CHWs are fully integrated into participating entities of CCIP. We believe that will help us as we move into the next phase of thinking about value-based payment.

We also view shared savings as a limitation in terms of generating the amount of money to sustainably fund CHWs in the way we should be utilizing them. ROI tends to be a short-term view, and no one's going to invest money into something that's not going to have a benefit for 10 years; if they can't see the shared savings from it next year.

We're focusing on how we can demonstrate the effectiveness of what we have right now. Collect the information and use it to compel the state to that next point of value-based payment beyond shared-savings.

SIM is time limited. We're already thinking beyond the grant.

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Responses to Questions 5-17
State legislation: Senate bill – SB 126: SIM director shall consult with the CHW Advisory Committee and Commissioner of Public Health to

- study feasibility of creating a certification program for CHWs
- examine fiscal impact of implementing a certification program
- include recommendations for:
    - requirements for certification and renewal of certification of community health workers, including any training, experience or continuing education requirements;
    - and methods for administering a certification program, including a certification application, a standardized assessment of experience, knowledge and skills, and an electronic registry, and
    - requirements for recognizing training curricula that are sufficient to satisfy the requirements of certification.

Designated state agency to oversee CHW workforce— To be finalized in next phase.

CHW training course and curriculum— Currently, two different tracks in Connecticut: Southwestern AHEC has been training individuals currently employed and performing as CHWs since 2002. In-house curriculum based off the *Foundations for CHWs* textbook (2009, 2016, City College of San Francisco, Wiley). A combination of the *Foundations* textbook + in-house information from various trainings we've incorporated.

Three community colleges provide CHW coursework for up and coming CHWs (no experience yet). Also based on the *Foundations* textbook and core competencies. 160 hours, $1600-$1900/student. More comprehensive - includes an internship.

AHEC curriculum is half the cost and half the hours of community colleges. Targeted to the needs of employers and flexible to accommodate schedule of working CHWs.

The two different curricula now are a challenge. Going forward the ideal situation would be working together to develop one standardized curriculum the meets the needs for currently employed, and up and coming CHWs. AHEC curriculum would need to grow – apprenticeship includes more information like motivational interviewing, etc.; college curriculum would need to shrink.

From the Draft Report of the CHW Advisory Committee (May 30, 2017)**:**

- "DPH approved" CHW training programs based on a standardized curriculum review.
- Use the definition and scope of practice developed by the CHW Advisory Committee as the basis for developing curriculum standards; build on other training program currently in use including the comprehensive CHW training program used by Community Colleges
- Establish a CHW advisory committee to advise DPH on development of the training program and competency assessment standards and corresponding to certification procedures, with at least 50% of seats reserved for CHWs

Are different sectors (employers, payers) asking about CHW training (contact hours, content, rigor)? Right now, most employers and payees don't know about CHWs.

Employers who do hire CHWs might say, "this is the population you'll be working with, these are the skills we want you to have while you're here. But at the same time your role is just care

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coordination or just health education. Because that's all we can pay you for." The training fits for different roles.

In terms of payment models – some programs have been using CHWs successfully and trying to expand their roles. The issue of how to sustain that has not been resolved. Part of larger discussion about payment models.

Certification requirement -- From the Draft Report of the CHW Advisory Committee: The CHW advisory committee recommends that DPH establish a voluntary CHW certification program. Under this program CHWs will receive an individual 2-year certification issued by DPH and be placed on a CHW registry if they complete (1) a designated "DPH approved" training program and (2) pass a standardized competency-based assessment

- Establish a standardized competency assessment process that assesses both skills and knowledge that is reasonably accessible to individuals with language barriers and appropriately assesses cultural competency
- Allow for grandparenting during first 2 years certification is offered
- Administer a continuing education and experience verification process
- Establish a certified CHW registry

Certification process-- Above

Designated state agency to manage certification— To be finalized in next phase.

Required skill set—Align with core competencies outlined in *Foundations for CHWs*. From the Draft Report of the CHW Advisory Committee:

- Communication skills
- Interpersonal and relationship-building skills
- Service coordination and navigation skills
- Capacity building skills
- Advocacy skills
- Education and facilitation skills
- Individual and community assessment skills
- Outreach skills
- Professional skills and conduct
- Evaluation and research skills
- Knowledge base

Policies. None yet regarding mandatory reporting, safety of CHWs, etc. We do have the CHW Association Code of Ethics. Policies are employer-based.

Percent of CHW time prevention vs some level of chronic disease management-- From the Draft Report of the CHW Advisory Committee (May 30, 2017): 10 Roles to define the scope of practice for CHWs in Connecticut – most are prevention.

How does certification address this? Based on the roles and skills

Integration of CHWs into PCMH—CCIP (Community and Clinic Integration Program) Standards require Advanced networks and FQHCs to develop CHW capabilities and fully incorporate CHWs into primary care team
All based on employers responding in terms of

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- Salary --
- Liability coverage --
- Placement in a clinical setting – Challenge is change.
- What kind of supervision --
- Rural versus urban locations? All different environments and settings. Vary by population needs and illness rather than by geography.
- HIPPA-- SIM money given to entities that hire CHW's and CHW's therefore fall under the privacy policies for that given organization.

Payment options? Currently funded by time-limited, program-specific grant funding through foundations, non-profit organizations, or state funds.

- Shared savings with advance payments. Based on our first foray into Medicaid shared savings program. Most of our large hospital systems have their own shared-savings agreements with commercial payers. Mixed results with shared-savings programs. CMMI has put out materials as advancing along the continuum of alternative payment models. As a long-term vision, we just don't see shared-savings panning out in terms of the changes we would like to see in the care system. Dependence on short-term ROI; if providers aren't going to see shared-savings in 1 – 2 years, they're not willing to invest in something like obesity. Having a comprehensive obesity management strategy, they may not see the results of that for another 10 years. Shared savings is still on the fee-for-service model, it doesn't give flexibility for providers that we want to see. If you are a primary care physician, and you want to bring on multiple CHWs, you want to do telehealth, you want to have group sessions for chronic disease management - all of the things that we talk about as truly getting at the care delivery we all want and know that we need. We don't see shared-savings as being able to deliver on that. We're already starting to think about how do we go on further beyond shared savings.
- primary care bundles with advanced payments
- global payments

What do payers require in order to pay CHWs?
We're in a formative stage of introducing CHW workforce to networks and payers. They don't have enough of a sense about what they want to use CHWs for to be able to have a strong opinion about the requirements, etc. One of the questions coming into play in terms of certification – what do we want to build in that doesn't exclude CHWs who have been in the field for a long time, and also satisfy the eventual desires of the payers and provider community?
A balance between "we have a new service, a new type of worker" and "fee-for-service model in which we're going to reimburse for this, and this, and this and that's it."
This has become a problem for other states that have done this. It takes away from the ability and the skill sets that a CHW brings when you say, "I can only reimburse you for this." This is why we want to stay away from the fee-for-service strategy. Not a real option in the current budget climate anyway.

At this time a lot of variation in the training and preparation of CHWs. You might consider some more qualified than others. Door is still open right now.

Organizations & Workgroup: CHW Association of Connecticut, CHW Advisory Committee, Connecticut Area Health Education Center Program

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Appendix B

Maine Interview Notes

MECHWI – Maine Community Health Worker Initiative
CHW accomplishments in Maine

In terms of infrastructure and systems work to support and build the CHW workforce: when we started, we were probably kindergarten – 1st grade level and by the time SIM wrapped up we made our way to 7th - 8th grade. We did not have a history of support for the CHW workforce but were not infant or toddlers. The place where I was employed before SIM had employed CHWs for over 10 years. We had created a career pathway within our organization, we were connected to regional and national activity specific to CHWs.

Three legs to our stool: *payment* leg, *employment opportunities* leg, and *core competency/ standardized training* leg. The employment leg (creating demand and building a robust workforce) was a bit of a chicken and egg with the payment leg, and we knew we could not build a robust workforce if there weren't jobs for CHWs. Other states spent quite a bit of time on detailed plans of what it meant to be credentialed, and what training should be to lead someone to be certified or registered, and we heard from those states there weren't necessarily jobs for those CHWs. So, we were very mindful that whatever we built was sustainable and to scale to our state and the resources that were available. But the real nut to crack is the component of payment. We knew we needed to have those three legs in place for the workforce to be able to grow and move forward into the post-SIM world (end of 2016 for Maine).

Pathway to get there
Our SIM CHW project was in many ways about expanding exposure and buy-in to using CHWs in new settings. So, a lot of what we gained in SIM was threading the needle: creating buy-in, creating awareness, creating understanding and making sure people really understood what a CHW is and isn't.
Educating about CHWs is something you will do again, and again, and again. Payers have got to understand the model and have that ah ha(!) moment. The Dept. of Licensing and Regulatory Services have to see how this might fit into Direct Care Workers or registries that they run (including other paraprofessionals who earn certificates and are recognized by state entities). They all have to buy-in, understand where CHWs fit. Even within community-based organizations where there may already be CHWs may have to be re-educated.

Our Bureau of Health put out an RFP to fund five CHW pilot projects. Getting the RFP approved and released took almost 14 of our 38 months. The funded pilot projects only had about 26 months. If I were to do it differently, I'd look at how much can you frontload, how much can you plan out? Triple Aim work is not something you can set up in 6-8 weeks and be ready to go; a lot of frontloading and design work to get things off the ground.

The RFP drew from the ICER (Institute for Clinical Effectiveness and Review) report that came out in 2013. This organization looks at a treatment modality or health care intervention, and they try to determine if it is clinically effective and cost effective. They found that CHWs could meet the threshold around effectiveness from a cost and care perspective, when they were working on supporting mgmt. of chronic diseases, providing connections to preventive screening, and working with individuals who have high utilization patterns.

In the RFP, we provided the big-picture health data to understand "this is Maine." The high-level stuff. Then, we provided the ICER framework. Then, we asked them to tell us what health need,

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disparity, issue would be best served in the community by a CHW and detail the expertise and capacity to do this work.

Four projects were funded: we had a FQHC, a public health department, an area agency on aging, and a prevention program that's embedded in a hospital system. Two were extensions of clinical settings, 1 was linked to a clinical setting.

The community design led to four very different CHW projects: doing home visits, working with elderly or disabled people, working with individuals with 2 or more chronic diseases, increasing breast cancer screenings, increasing colorectal cancer screenings, addressing uncontrolled asthma. All looking at data from their own community or country – an unmet need. But that made evaluation difficult (model fidelity perspective or aggregating the data).

One of the goals was to increase the number of CHWs engaged in the systems-building. Built into the requirements of the pilot projects – CHWs must be allowed to help work on and develop and review the core competencies, standard curriculum, and guidance on becoming a registered CHW.

CHW Open advisory group: set up 3rd or 4th month of project being funded. Focused on "how do we get people in Maine engaged in helping to inform and build a system of CHW workforce?" We could tell the states who had made a sig amount of progress had robust networks of CHWs and allies doing the world collectively.

Political muscle
Because Maine is a small state, it is easy to get face time with decision makers. Commissioner of HHS required us to report out to her and Sr. Staff each quarter. Full presentations. Easy to open doors, make connections. Associate Director of SIM had worked with CHWs and written proposals to fund CHW work in her past.

We had an insurance co-op under ACA – the CEO got in place staff who got the model. The message of cost savings resonated with Governor. Double-edged sword for CHWs actually. Danger in pursuing the cost savings and ROI of CHWs.

Some folks involved in different parts of SIM who were familiar enough with CHWs that when there were opportunities, they built CHWs in. For example, PCMH model (Community Care Teams) include CHWs. Some individuals advocates of ICER and Camden Coalition. Some happenstance, some good fortune

Sustainability
Hard to keep momentum going when hard stop in funding. The advisory group made up of CHWs, employers, people who are invested in public health workforce issues, maybe from large healthcare agencies, interested in future training of CHWs who can keep the engagement. Some folks still involved who carry the knowledge forward after 2 or 3 years of being involved. Number = 45-50 names; 5-7 super active individuals. Others came in and out of meetings and committee work.

Responses to Questions 5-17
State legislation

- 2011 – Registry of CNAs and Direct Care Workers (CHWs could be included as a Direct Care Worker).

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- 2015 – Minimums for DCWs. Has not gone into effect yet. The primary champions have left the dept.; starting back at building relationships that champions had.

Designated state agency to oversee CHW workforce—Maine Dept. of Health / Public Health; Maine CDC
CHW training course and curriculum—

- CHW training provided by Maine CDC, Maine Mobile Health Program, and Inland Hospital,
- Core Competency curriculum developed by the Institute for Public Health Innovation offered by Maine CDC Mobile Health Program.
- Also offers additional public health dept. trainings.
- Training provided by employers or tied to specific projects.
- MECHWI has developed a core competency/skills/roles cross-walk to inform the development of training recommendations.

No requirement for certification.

- Will be a state registry of CNAs and DCWs (includes CHWs). Will include background check. GED, high school, foreign credentials, 18 years.
- Can be re- certified every two years.
- Designated state agency to manage certification--

Required skill set—

- Did not set the bar high in terms of pre-requisites. Did not want this to be a barrier to entering the workforce.
- C3 Project – what are those inherent skills that you cannot train for (life experience, community membership, walked the path)? What are the soft skills, inherent but can be developed (empathy, connect with humility and respect, etc.)? What are the skills that are based on training, lived experienced, transferred from other jobs (oral communication, motivational interviewing, etc.)?
- C3 credentialing provides the national standards that payers may require for payment.
- The SIM pilot projects required to screen CHWs for skills based on the needs of their projects.

Policies regarding: mandatory reporting, safety of CHWs, etc.--
Percent of CHW time expected to be about prevention versus some level of chronic disease management--

Integration of CHWs into Health Homes

- Practices involved in Maine's Health Homes program must include a Community Care Team (CCT), and CHWs are explicitly listed as potential team members. CCTs are reimbursed through Medicaid Health Homes.
- Maine SIM had 4 pilot projects in which CHWs were integrated into health homes. What integration "looks like" depends on the setting.
    - In most instances CHW is providing support around SDOH
    - Working with higher needs individuals – higher medical needs and also higher needs for stable housing, need for dentures for better nutrition, need to address behavioral health issues that impede medical care.
    - Relationship building with patient in order to identify what is most needed in their life.
    - Higher needs for social or community resources.

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- Hot Spotting work? Integrating a CHW into discharge team for long term care for patients who had at least one behavioral health issue as well. Older adults with little to no family or social support. High utilization rates or impinge on someone's ability to live independently.

Potential employers responding:

- Liability coverage – medical community afraid of being sued; not the culture of community-based work, and not aware of a CHW ever being sued nationally. Large social service agencies probably maintain insurance to cover anyone working in the community.
- Placement in a clinical setting --
- What kind of supervision – No health professional supervisor required.

Payment options – "This nut has not been cracked." Can't make it work to fund CHW at 1.0 FTE at Medicaid reimbursement rate.

- Still trying to figure out how CCTs will be reimbursed through Medicaid Health Homes – bundled payments, etc.
- Practices involved in Maine's Health Homes program must include a Community Care Team (CCT), and CHWs are explicitly listed as potential team members. But…
- Very few states have been able to "make it work."
- All part of the value-based payments discussion. Private payers "up to their eyeballs" in terms of figuring out a payment model that would realize savings and better care on a global level. Hard to hold the CHW piece in the discussion of different models. Something that may become an add-on, but never really created the buy-in from private payers to try new models and providers and healthcare organizations, or physician organizations to take on the risk - what happens if we don't see the savings? What if we don't meet the quality metrics? How is this risk going to be shared? Too many looming threats to the status quo – unknowns for people to be comfortable to do so.
    - Private payers: "We want Medicaid to take the first step." We don't want to be the one to lose money.
- CHWs were identified as a best practice under the ACA. Payment models to support CHWs (3 promising models offered by Harvard); but don't see a path forward.
- Some smaller private payers have integrated CHWs into HMO/triage/Care Connection. May take a couple more to see and be able to show savings.

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Appendix C
Oregon Interview Notes

Today, so much success and major achievements.
Organized rules guide scope of practice.
Agency to manage workforce
Importance of health system organizing the CHW in the state.

CHW movement
Main person in 1990s – 2000s was (????), a CHW champion. CHWs with farm workers and immigrant communities. Focus on promatoras (CHWs in Spanish).

2010 a real opportunity when ACA and federal legislation kicked in. Some of the key aspects were mention of CHWs and other behavioral health providers, and other workforce providers, like patient navigators.

2011 – Oregon adapted a model we call Coordinated Care Organizations (a group of health systems providers, like health insurance, hospitals, etc.) that came together in Oregon to form a model of CCO where they are adopting health insurance run through the state and managed by delivery aspect through these organizations.

State Legislation referencing the ACA put this into viability of workforce. Mentioned CHWs and other behavioral health providers in the state legislation. Set a foundation for CHWs as recognized through legislation. Led to …

2013 – Group of champions for CHW movement in the state. Opportunity to mobilize CHW movement in Oregon. Make it a professional organization. Led to…

House Bill 3407 – Created traditional health workers which used to be called non-traditional.

2012 – Oregon CHW Association was founded by invested organizations to mobilize the workforce. Refugee community, health systems, providers, health insurance. Recognizable profession.

Between 2011, 2012, 2013 – CHW Association advanced CHWs as healthcare providers. Organize professional workforce in Oregon.

Another champion: Oregon Office for Equity & Inclusion a division in Oregon Health Authority responsible for Medicare, Medicaid and major marketplace for health insurance for the state of Oregon.

Muscle
Power came from community-based organizations (CBOs). Our office is the key office to advance health for marginalized populations. Champion within the state. Work closely together. Talk to legislators. House program. Ally of CBOs.

Community voiced concern. Legislators were also champions of health-related issues. (3 key really understood the importance of ___) see community partners.

Big Muscle comes from intersection of Legislators + State Agencies + CBOs to push the agenda forward.

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Not simple legislation ("yay this is great!"). In the 2013 legislation, push back came from AMA as nurses, MAs, behavioral health organization felt their jobs might be gone if CHWs perceived as cheap labor and perceived to create work issues for nurses. AMA perceived CHWs not highly educated on managing chronic disease. Perceived risk of ethical violation. Resolution: create a commission (Oregon Health Authority) to set the standards and guidelines, create a scope of work so CHWs not step on toes. 19-member commission: CHW association has 6 seats. Other seats filled by nurses' association union, AMA, Labor, CCO, Community – Based Orgs, Behavioral health. Diverse voices heard in the commission; set the agenda to move forward for the CHW workforce.

Sustainability
Sustainability is current theme in Oregon for CHW workforce now. State $ 1/2 million to Dept. of Education to community college and workforce development to develop curriculum, create a workforce. Goal was 300 CHWs in state to fill gaps in services. CBOs were left out. Community colleges trained so many CHWs, but jobs not there.

Two types of CHWs: CHW in community – based settings & CHWs in clinical settings: Trained in context

$ - grants, etc.

CCOs (the main healthcare providers in the state) required to find a way to integrate CHWs as part of care team.

15 CCOs throughout Oregon choose their own route (fund, invest, grants) to sustain CHWs

In the last 5 years – Integrated Healthcare Division creates policy –who is a payer, who is a provider in the system and how the provider gets paid.

2016 legislation mandated CCOs divest $10 million out of general fund every 3 years (as grants) to cultural specific CBOs who work with CHWs

Sustainability through CMS-billing codes. Billable for CHWs in clinical setting as a provider. For example: Diabetes management – CHW part of care team for patient. CHWs do charting, SDOH as part of Case Mgmt. within health care team chart. Billing code adapted this year for services in clinical setting (this week or next). Down the road: billing code for CHW services in community-setting; LCSW sign off on CHW services.

CCO in a large area (Tri County) invest $3 million for CHW association to come up with a structured payment model for CHWs. Other CCO's will come up with their own model.

Sustainability is not a one-size-fits-all model in Oregon. Go after the money anywhere – health system dollars, billing dollars, etc.

Responses to Questions 5-17
Key Legislation discussed above. 2016 legislation for $10 million investment did not pass due to state deficit issues. Other earlier legislation in 2015 addressed CHWs and oral health, anatomy & physiology

State agency is the Oregon Health Authority, Division of Equity and Inclusion is the main state agency designated through legislation responsible to oversee the CHW workforce in general.

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Training Course and Curriculum. CHWs required to have 80 hours of training, which includes a set of parameters and guidelines around what needs to be included in the curriculum. Main driver of the curriculum is what came out of the curriculum developed earlier. The curriculum was adopted and developed by community colleges as their own – but the parameters and guidelines never change.

Movement now is cultural-specific curricula (Asian, Pacific-Islander, African, Middle Eastern, Latino, etc.). The parameters, guidelines, objectives, scope of practice, etc. don't change, but become developed for more cultural appropriateness.

Certification requirements in Oregon based on 2 different types of licenses: certification or license. CHWs who want to be certified by the state of Oregon must complete 80hours of training from Oregon approved training program. Must come from a community they belong with (geographic, sexual orientation, ethnic, rural).

Some CHWs have a history of incarceration. The program looks into history and transformation.

Certification process. Application along with completion of 80 hours along + background check. Certified for 3-years. Within the 3 years, required 20 hours of CEU's as CHW (OHA approved or broader). Registry of certified CHWs.

State agency to manage certification. Oregon Health Authority – Division of Equity & Inclusion

Skills developed through CHW training. Communication, empowerment techniques, identification of community, cultural competence, conflict resolution. Additional skills and training for clinical setting (e.g. Blood pressure, etc.). In the community-based setting, knowing (and being from the community) is key.

Policies.

- Oregon Administrative Rule specifically for CHWs in Oregon guided by traditional health workers rule in Oregon. Lays out mandatory reporting (abuse, etc.).
- Some policy guidelines specific to the agency employing the CHW.
- Complaint form followed-through investigated by our Division

Prevention vs. Disease Mgmt.: No specific parameters, but generally will be emphasis on prevention in the community setting, and chronic disease mgmt. in clinical setting. That's how they're paid through Medicaid.

PCMH

- Clinical setting – Integrated into health care team.
- An organization, Care Oregon – employs CHWs on the care team.
- Example: If a high utilizer (like a homeless person) goes to the ER, and identified this falls under their insurance, the patient is informed care coordination is a big role. If no provider, then CHW is brought into the ER, introduced to the patient, and informed about what the patient may need for the long-term (PCP, clinic, health insurance, whatever). Set up health care needs. Eastern Oregon CCO (EOCCO) uses this model mostly for the CHW – other organizations use this model as well.

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Employer Response

- All certified CHWs are paid.
- Promotores embedded in Provident Health System (insurance + hospital system) may be paid in stipend, Most CHWs employed by CBOs paid through grants are paid through salary or hourly.
  In county agencies, paid salary ($18/hour) + benefits.
  Health systems paid salary ($15-$17/hour)
- Varies – Salary, or hourly, but 10% or less are voluntary or stipend.
- Supervision – training tailored for supervision. CHW supervision training used by Oregon CHW Association. Developed by (????) Organization. Add on to help supervisors understand CHWs,
- Liability falls on individual for ethical issues (remove state certification). Mostly insured through employer.

Payment options

- Small movement for Oregon private insurers to pay for CHWs to save $$.
- Most of the payment for CHW services come through grants and contracts.
- Clinical setting sometimes comes through Medicaid.
- CCO's working with individual clinics and entities – use flexible funding as grants to cover administrative costs.
- CHWs are going to be assigned a code as a provider to bill for services. First, for pregnancy and chronic disease management. Planning to have a waiver amendment to incorporate more billable codes for CHWs in community settings.
- Seek diverse funding sources – grants, foundations, Medicaid

Payers require certification

Anything else: if Idaho has a vision to embed CHWs, recognizing as a profession is the only way forward. Otherwise, CHWs will stay in the shadows. Legislation worked for us, but maybe won't work everywhere. One size does not fit all. Oregon is progressive; some policies don't fit well for Idaho. Liberal vs. Conservative: movers and shakers.

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Appendix D

Texas Interview Notes (includes promotores)

CHWs and promotores have been working in Texas for some time

About 40% work along the Texas–Mexico border;

About 60% practice anywhere in Texas.

Broad pathway

Mid-1990's momentum to formalize CHW role picked up

1999 legislation:

Texas became the first state to legislate a statewide voluntary training and certification program. Established a committee under the direction of the Texas Department of Health (TDH) to study the feasibility and elements of training and certification and make recommendations for implementation. Widespread stakeholder engagement: CHWs, public members, TDH, higher education, workforce development, border health services, etc. In the 2-year term, the committee met all objectives toward establishing CHW certification program.

2001 legislation:

Senate Bill 1051 – required CHWs who receive compensation for their services to be certified.

Senate Bill 751 – required state HHS agencies to use certified CHWs to the extent possible for recipients of medical assistance.

Together, these mandates increased the immediate need for approved training programs and a standardized certification process.

2001 - Advisory Committee

Texas *Promotor(a)* or CHW Training and Certification Advisory Committee was established to oversee the certification process. This committee, reporting to the TDH, determines the eligibility of and recommends certification for *promotores* or CHWs, instructors, and sponsoring institutions or training programs. Nine members approved by the Texas Health and Human Services incudes certified CHWs, members from public, higher education, and professionals who work with CHWs.

2002 – Implementation!

Committee had finalized the certification application form for CHWs. Six certifications were conferred at an official ceremony at the 2002 CHW state conference, and the committee conducted several promotional workshops to distribute certification applications and instructions

2003 – Certification database implemented

224 certifications were conferred; certification IDs were accepted as proof of qualifications by all organizations; certification renewal forms created; web site for the Texas *Promotor(a)* or CHW Training and Certification Advisory Committee was launched.

2004 – 337 CHWs certified; 24 instructors, and 3 training programs certified

2005 - more than 700 certified CHWs in public health mainstream.

2010 legislation

HB 2610 - DSHS, in coordination with HHSC - Study and make recommendations related to: maximizing employment of and access to CHWs to provide publicly and privately

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funded health care services; and identifying methods of funding and reimbursement, including outline of costs to the state.

2011 legislation

Senate Bill 1051 (77th Texas Legislative Sessions)- Texas DSHS to establish and operate a training and certification program for persons who act as CHWs, instructors and sponsoring institutions/training programs.

2013 Texas CHW Study Report to the Legislature required by HB2610. Seven recommendations:

- Promote CHW education and professional development
- Promote understanding and recognition of CHW workforce, including opportunities to enhance understanding of CHW services and roles, CHW certification in Texas, and development of the workforce.
- Explore feasibility of applying successful Medicaid models from other states in Texas.
- Identify or explore amendments to the HHSC Uniform Managed Care Contract.
- Continue current efforts to incorporate CHWs into PCMH and related care management structures.
- Identify opportunities to increase utilization of CHWs in public health and behavioral health programs and initiatives.
- Consider potential roles for CHWs in the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver project.

Political muscle

Stakeholders have been employees, clinics, hospitals, health departments, community organization, faith-based organizations

Sustainability -

CHWs in Texas, for the most part, work in an integrated fashion within the health and human services system and seldom work with a specific “carve-out” or solely funded CHW program. Therefore, sustainability of CHW programs may not be a major issue for Texas. As with all federally funded or state or locally funded programs, sustainability is an issue regardless of the types of individuals providing services to their communities. Institutions are at a greater legal risk if their CHWs are not certified, because many of these workers visit clients in their homes and are at greater personal risk if they cannot visibly and legitimately identify themselves with an organization.

Responses to Questions 5-17

State legislation – see above. Much legislation since 1996

Designated state agency - Texas Department of State Health Services (DSHS), in Community Health Promotion and Chronic Disease

Training Course and Curriculum –

160 hours – initial, core curriculum. 20 hours x 8 core competencies
40 training centers provide initial training
Work with CHW instructor training & development
Colleges and educational entities, CHW Association, community health centers

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Great variability throughout Texas in training courses and curriculum, policies, roles and responsibilities, integration on health care teams, salary, liability, etc. All focus around the 8 core competencies

Certification requirement – Texas resident, 18 years, completion of approved training program certified by DSHS, or 1000 cumulative hours of CHW services within the most recent six (6) years.

Certification process—Application which includes certificate of completion.

Designated state agency to manage certification-- Texas Department of Health Services (DHS) in consultation with CHW advisory committee

Required skill set – see competencies

Policies.

- Training and certification embeds reporting in safety, ethics, advocacy
- Rules revised every 4 years – will be surveying employers statewide

Prevention versus some level of chronic disease management. Not regulated. How does certification address this? NA

Integration of CHWs into PCMH-

- New care delivery model – team-based care. Baylor HealthCare System employs over 100 CHWs in health care teams.
- Medicare – Houston area health care systems involved in projects.
- Well-integrated Chronic disease management, education, follow-up

Employer responses

- Salary – Texas is researching options.
- Liability coverage -- No state model.
- Placement in a clinical setting -- Employed by community-based organizations
- What kind of supervision -- Vary by employer
- Do these issues vary by rural versus urban locations

Payment options? Not Medicaid

What do payers require in order to pay CHWs? Some private payers pay for CHW services

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Appendix E
Massachusetts Online Review Notes

Massachusetts
For decades, community health workers (CHWs) have played a critical role in public health efforts in Massachusetts to improve population health and to ensure that all residents of the state receive quality services. The Massachusetts Department of Public Health (DPH) has long been a national leader in supporting the CHW workforce through programmatic and policy initiatives. Massachusetts' comprehensive health care reform, as well as national health reform (the Patient Protection and Affordable Care Act), explicitly created opportunities to employ CHWs as part of achieving what has become known as the Triple Aim. DPH is committed to assuring that CHWs are integrated into primary care and related health care teams (Massachusetts Dept. of Public Health. 2015. Achieving the Triple Aim: Success with Community Health Workers. Retrieved from https://www.mass.gov/files/documents/2016/07/xb/achieving-the-triple-aim.pdf)

According to the CDC eLearning module (2016. Retrieved from https://www.cdc.gov/dhdsp/chw_elearning/s6_p1.html), Massachusetts is one of the first states to have an actual office of CHWs, located in the state health department's health care workforce division. As noted earlier, the state health department also used its clout as a prominent funder of health services to influence the inclusion of CHWs in the delivery of services and to encourage stakeholders to come to the table.

Legislation adopted in Massachusetts has had both practical and symbolic value. It has both helped to direct resources to actual policy change and attracted decision makers' attention to the fact that the inclusion of CHWs in legislation was a high priority for the state's political leaders.

In a sign of the times, one of the state's three CHW core training programs lost its funding in the same legislative session in which the CHW certification bill passed. Although development of the final certification policies and procedures will take several years to implement, the fact that they are under development will probably increase demand for CHW training. This outcome would demonstrate the interconnectedness of all areas of policy involving community health workers.

Pathway
Different parts of the process call for more prominent roles for certain kinds of stakeholders. For example, if state legislation is involved, legislators often want to hear from people directly affected, such as patients, clients, employers, and CHWs themselves, rather than researchers and executive branch officials. The list includes:

- Potential employers and their associations
- Third-party payers, including the state
- Workforce development agencies, including education provider organizations
- CHWs themselves
- Community leaders and interest groups
- Other professional associations
- Key legislators and staff

Stages of Stakeholder Development:

- Awareness

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- Understanding
- Interest
- Perceived benefits
- Commitment
- Participation
- Leadership

The process in Minnesota and Massachusetts involved identifying stakeholders and moving them along a continuum of development from awareness to understanding, interest, perceived benefits, commitment, participation, and, finally, leadership. Some stakeholders may leap ahead in the process, but most will start at an early stage, such as awareness, and they must be cultivated at that stage before they can be asked to move to the next. For example, an employer who has never heard of CHWs may not be ready to take a leadership role in advocating for a policy change that might affect their organization in ways they don't understand.

Experience suggests that the greatest hurdle is in persuading stakeholders to sign on to an initiative after they have acknowledged credibility of the claimed benefits of CHWs. Anyone involved in processes of change has experienced a reaction such as, "That all sounds very good, but I'm really busy right now," or "…, but this is not among my top priorities."

In each state, a core stakeholder group was organized at the beginning of the process. This group was responsible for collecting CHW workforce data, obtaining funding to commission basic workforce surveys, or both. This basic background data was summarized in a brief report and then used by the core stakeholder group to recruit champions at higher levels in the public and private sectors into a larger, second-stage stakeholder group.

In parallel to the initial data collection effort, the core stakeholder group devoted early attention to cultivating participation from CHWs, including the statewide CHW network or association. This activity began earlier in the process in Massachusetts than in Minnesota, although individual CHWs were involved in the initiative from the beginning in Minnesota.

Stages of the policy change process common to Minnesota and Massachusetts also include:

- Enlist pivotal leadership institutions
- Formal reports documenting CHW success and offering strategies for sustainability
- Establish educational pathways early in process
- Introduce major legislation and policy change after other pieces are in place

Once a larger stakeholder group was organized, one or more pivotal institutions in each state began to take a more visible leadership role. In Minnesota, this role was primarily played by the state college and university system, with strong support from the Blue Cross and Blue Shield of Minnesota Foundation, the Minnesota Department of Human Services, and the Minnesota Department of Health.

In Massachusetts, the Massachusetts Department of Public Health took the lead with assistance from the Massachusetts Public Health Association, the Blue Cross Blue Shield of Massachusetts Foundation.

Both states produced important legislation, mainly through the advocacy efforts of the states' CHW associations. In Massachusetts, the process took the form of two separate legislative

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steps. The first recognized the CHW workforce and officially commissioned a report to the legislature, and the second took up occupational regulation of the field.

Massachusetts advocates also took advantage of a window of opportunity when the Legislature was considering statewide healthcare reform in 2006. In Minnesota, development of an educational pathway was an early priority; in Massachusetts, there were three recognized CHW training centers in the state already established when the policy initiative began.

What Massachusetts Did

Massachusetts followed a similar, but not identical, path to state policy change and has produced some wide-ranging results. It has:

- Created a statewide CHW association
- Created a state office of CHWs in the Massachusetts Department of Public Health
- Established a policy mandate for state contractors to employ CHWs
- Secured significant language on CHWs in a 2006 state health care reform bill that:
- Gave CHWs a role on the state Public Health Council
- Mandated a report to legislature on CHW policy
- Passed a bill creating CHW credentialing board
- Demonstrated the value of CHWs through enrollment activity following passage of the reform bill

The 2006 Massachusetts Health Care Reform Act was the first major policy achievement concerning CHWs, and in many ways, it was a pivotal one. Implementation of reform in Massachusetts required a massive enrollment effort that allowed CHWs to demonstrate concrete results. The report to the legislature mandated by the bill became a major symbol and a tool leading to the introduction of credentialing legislation, which was passed in 2010. This latter bill creates a credentialing board to recommend how CHWs should be credentialed.

The Massachusetts initiative was spurred by funding from HRSA in 2000, which produced three major results: the beginnings of a statewide CHW association, the production of a survey report that found CHWs to be essential to improving health, and the creation of an amendment to state contracting policies with requirements for CHW training and supervision.

Following these early achievements, the Massachusetts Department of Public Health, the new Massachusetts Association of Community Health Workers, and the Massachusetts Public Health Association formed an organized partnership, which received substantial and visible support from the Blue Cross Blue Shield of Massachusetts Foundation.

Health Care Reform Act Mandate

Convene statewide advisory council to investigate:

- Use and funding of CHWs
- Role in increasing access to health care
- Role in eliminating health disparities

Make recommendations for a “sustainable CHW program” – report to Legislature.

Certification recommendations introduced as new bill in 2009, passed in August 2010.

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Let's look in more detail at the first Massachusetts legislation concerning CHWs, Section 110 of the 2006 Massachusetts Health Care Reform Act.

Among other provisions, this section mandated that the state convene an advisory council to investigate the use and funding of CHWs in Massachusetts and their roles in increasing access to health care and eliminating health disparities. The council was then to make recommendations for policies leading to a sustainable CHW workforce, including provisions for training, certification, and financing.

The advisory council completed its study in 2009 and reported its findings and recommendations to the legislature in January 2010.

Between the study's completion and its presentation to the legislature, the state's CHW leaders began drafting legislation that would implement the council's recommendations on certification of CHWs.

The Massachusetts CHW Advisory Council initially included 14 agencies named in the original legislation; others were later invited. The council consisted of 30 organizations and agencies, including the Massachusetts Department of Public Health, the state Medicaid agency, the insurance "connector" agency charged with key elements of insurance coverage expansion in the state, and the state Department of Labor. The organizations responsible for the three existing CHW core training programs in the state were also represented, along with the state Primary Care Office, the Massachusetts Hospital Association, and the Association of Health Plans.

Massachusetts leaders acknowledge that not all interest groups were initially receptive to participating in the initiative. The hospitals and health insurers were initially not sure why they needed to be involved. Strong leadership from the state health department was crucial in securing their participation.

Lessons Learned in Massachusetts Lessons learned in Massachusetts include:

- Key stakeholders must be involved, but MDPH was indispensable as convener and funder
- Infrastructure: Office of CHWs located in MDPH health care workforce division
- Legislation had practical and symbolic value
- CHWs need support and education to get involved in policy; legislation is not always their top priority
- Awareness campaign still needed

Leaders argue that the state health department's role in this process as convener was crucial to their long-term success.

Massachusetts is one of the first states to have an actual office of CHWs, located in the state health department's health care workforce division. As noted earlier, the state health department also used its clout as a prominent funder of health services to influence the inclusion of CHWs in the delivery of services and to encourage stakeholders to come to the table.

Legislation adopted in Massachusetts has had both practical and symbolic value. It has both helped to direct resources to actual policy change and attracted decision makers' attention to

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the fact that the inclusion of CHWs in legislation was a high priority for the state's political leaders.

In a sign of the times, one of the state's three CHW core training programs lost its funding in the same legislative session in which the CHW certification bill passed. Although development of the final certification policies and procedures will take several years to implement, the fact that they are under development will probably increase demand for CHW training. This outcome would demonstrate the interconnectedness of all areas of policy involving community health workers.

Leaders in Massachusetts came to recognize that CHWs as a group may need support and education to become involved in policy change. The state CHW association (called MACHW) had a very active executive director and a policy director involved in these policy initiatives.

And finally, as in Minnesota, Massachusetts leaders have concluded that an awareness campaign is a high priority. The advisory council report to the legislature recommended such a campaign.

Sustainability: This information retrieved from https://www.chlpi.org/wp-content/uploads/2014/01/Community-Health-Workers-in-MA-Progress-and-Recs-08.10.2016.pdf

In its 2009 report, the Advisory Council noted that it is vital to provide sustainable financing for CHW positions and made recommendations with respect to both public and private payers.

With respect to **public payers**, the Council recommended that Massachusetts's Medicaid program—MassHealth—convene a workgroup to explore the possibility of recognizing CHWs as billable MassHealth providers. The Council also recommended that MassHealth provide incentives for Medicaid Managed Care Organizations (MMCOs) and Primary Care Clinician (PCC) Plan providers to "hire CHWs for outreach efforts and/or [to] integrate CHWs into their care models and care teams," and that MassHealth encourage the use of CHWs in pay-for-performance programs.

With respect to **private payers**, the Advisory Council recommended that organizations such as hospitals, community health centers, managed care organizations, and commercial insurers be encouraged to incorporate CHWs into healthcare teams and programs.

Finally, although the Council acknowledged the need for more sustainable sources of funding, it recommended that **public and private grant money** continue to be targeted and expanded to support the integration of CHWs into care systems.

While Massachusetts has made some progress in expanding financing for CHWs since the publication of the Advisory Council report, many of these recommendations remain highly relevant today and may be more likely to gain traction as Massachusetts implements its credentialing system. The following section summarizes the current status of public and private funding for CHW services and provides recommendations regarding how decision-makers can expand funding for CHW services moving forward.

In general, most CHW programs in Massachusetts continue to be funded by **short-term grants**. Until more sustainable funding streams are established, public and private grants remain an

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important source of support for CHW services. Therefore, public and private decision-makers should continue to target grant funding towards programs working to integrate CHWs into chronic and infectious disease care systems in Massachusetts.

Massachusetts has made some progress in increasing coverage of CHW services in its **public health insurance** system. However, coverage is currently limited to a few targeted programs and payers, leaving significant room for expansion. Recent state and federal policy reforms present a number of opportunities to provide greater coverage of CHW services in the MassHealth program.

Very little evidence of reimbursement for CHW services by **private insurers** in Massachusetts. As with MMCOs, some private insurers report employing or contracting with CHWs at the plan level or providing grants that support CHWs. Some private payers report that they would be more comfortable providing coverage of CHW services once the statewide credentialing system is in place. Therefore, state decision-makers should prioritize reviewing and approving the current draft regulations. Policymakers should also continue to drive expanded coverage of CHW services by public payers, as such changes can create momentum for similar reforms by private payers (especially those operating both MassHealth and commercial plans).

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Appendix F

Minnesota Online Review Notes

Where would you describe…

Thanks to outstanding partnership, along with valuable funder support over the past decade, Minnesota is recognized for key CHW field-building achievements. Our efforts are all about achieving health equity; improving health care quality, cultural competence and cost-effectiveness; and building individual and community capacity for better health (Minnesota Community Health Worker Alliance website, 2013. Retrieved from http://mnchwalliance.org/about-us/history/)

"As a best practice for tackling health disparities, CHWs are an essential component of Minnesota's health reform strategies," emphasizes Julie Ralston Aoki, JD, board president of the Minnesota CHW Alliance. "We see exciting opportunities for CHWs to make a difference in new structures such as health care homes, accountable care organizations, and our state's health insurance exchange ..." (Cleary, J. 2012. Community Health Workers: Bridging barriers to care. Minnesota Health Care News (10)11. Retrieved from http://s472440476.onlinehome.us/wp-content/uploads/2012/12/HealthCareNews.pdf

"Our state is the first in the U.S. to develop and implement a statewide, competency-based CHW curriculum based in higher education,"

Much has been accomplished in Minnesota over the last decade to train, support and provide sustainable funding for community health workers. A broad-based group of public and private agencies, and dedicated leaders — including CHWs themselves — is responsible for these accomplishments (Patrick Geraghty Board Chair Blue Cross and Blue Shield of Minnesota Foundation) From Community

Health workers in Minnesota: Bridging barriers, expanding access, improving health, 2010. Retrieved from http://s472440476.onlinehome.us/wp-content/uploads/2012/12/CHWsMNbcbs.pdf

Pathway

Different parts of the process call for more prominent roles for certain kinds of stakeholders. For example, if state legislation is involved, legislators often want to hear from people directly affected, such as patients, clients, employers, and CHWs themselves, rather than researchers and executive branch officials. The list includes:

- Potential employers and their associations
- Third-party payers, including the state
- Workforce development agencies, including education provider organizations
- CHWs themselves
- Community leaders and interest groups
- Other professional associations
- Key legislators and staff

Stages of Stakeholder Development:

- Awareness
- Understanding
- Interest
- Perceived benefits

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- Commitment
- Participation
- Leadership

The process in Minnesota and Massachusetts involved identifying stakeholders and moving them along a continuum of development from awareness to understanding, interest, perceived benefits, commitment, participation, and, finally, leadership. Some stakeholders may leap ahead in the process, but most will start at an early stage, such as awareness, and they must be cultivated at that stage before they can be asked to move to the next. For example, an employer who has never heard of CHWs may not be ready to take a leadership role in advocating for a policy change that might affect their organization in ways they don't understand.

Experience suggests that the greatest hurdle is in persuading stakeholders to sign on to an initiative after they have acknowledged credibility of the claimed benefits of CHWs. Anyone involved in processes of change has experienced a reaction such as, "That all sounds very good, but I'm really busy right now," or "…, but this is not among my top priorities."

In each state, a core stakeholder group was organized at the beginning of the process. This group was responsible for collecting CHW workforce data, obtaining funding to commission basic workforce surveys, or both. This basic background data was summarized in a brief report and then used by the core stakeholder group to recruit champions at higher levels in the public and private sectors into a larger, second-stage stakeholder group.

In parallel to the initial data collection effort, the core stakeholder group devoted early attention to cultivating participation from CHWs, including the statewide CHW network or association. This activity began earlier in the process in Massachusetts than in Minnesota, although individual CHWs were involved in the initiative from the beginning in Minnesota.

Stages of the policy change process common to Minnesota and Massachusetts also include:

- Enlist pivotal leadership institutions
- Formal reports documenting CHW success and offering strategies for sustainability
- Establish educational pathways early in process
- Introduce major legislation and policy change after other pieces are in place

Once a larger stakeholder group was organized, one or more pivotal institutions in each state began to take a more visible leadership role. In Minnesota, this role was primarily played by the state college and university system, with strong support from the Blue Cross and Blue Shield of Minnesota Foundation, the Minnesota Department of Human Services, and the Minnesota Department of Health.

In Massachusetts, the Massachusetts Department of Public Health took the lead with assistance from the Massachusetts Public Health Association, the Blue Cross Blue Shield of Massachusetts Foundation.

Both states produced important legislation, mainly through the advocacy efforts of the states' CHW associations. In Massachusetts, the process took the form of two separate legislative steps. The first recognized the CHW workforce and officially commissioned a report to the legislature, and the second took up occupational regulation of the field.

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Massachusetts advocates also took advantage of a window of opportunity when the Legislature was considering statewide healthcare reform in 2006. In Minnesota, development of an educational pathway was an early priority; in Massachusetts, there were three recognized CHW training centers in the state already established when the policy initiative began.

What Minnesota Did Minnesota:

- Formed broad-based partnership including CHWs and other major stakeholders
- Developed standard, competency-based CHW curriculum
- Created CHW peer network for ongoing education and peer support
- Defined CHW scope of practice
- Used HEIP's Policy Council to lead policy change process

Minnesota's initiative was created by the Healthcare Education- Industry Partnership, which is led by officials of the Minnesota State Colleges and Universities system and now part of HealthForce Minnesota. The Healthcare Education-Industry Partnership's CHW Policy Council led the effort for adoption of all of the initiative's products. The council included all of the major stakeholder groups that might be affected by policy change.

In the early stages, after the background research studies were published, the initiative produced a statement of the scope of practice for the CHW and drafted a standard CHW curriculum to be implemented by community colleges and other post- secondary schools.

Its third major accomplishment, which has had ripple effects around the country, was a Medicaid State Plan Amendment authorizing Medicaid reimbursement for CHW services. This move required authorizing legislation, submission to CMS of the State Plan Amendment proposal, and, after approval by CMS, the publication of regulations for implementation.

The 2007 legislation that led to Medicaid reimbursement for CHWs was quite simple. It expanded the list of services authorized under Medicaid to include services provided by a CHW who has earned a certificate from an approved curriculum, and it stipulated that CHWs must work under the supervision of an enrolled provider.

As often happens with such measures, the language of the original bill became embedded in an omnibus appropriation bill. The most significant point of the legislative process, however, may be the fact that fiscal note to this measure predicted that it would lead to a modest reduction in Medicaid spending.

With this authorization, the state Medicaid agency within the Minnesota Department of Human Services filed a proposed state plan amendment with CMS in September 2007. The amendment was approved in December 2007.

As noted earlier, the enabling legislation for Medicaid reimbursement was considered budget neutral. This conclusion could not have been made without the active leadership of the Minnesota Department of Human Services, which acted as a champion within the state government.

Minnesota is one of a number of states in which tribal governments play a significant role in health care. The Indian Health Service funds perhaps the largest single CHW program in the country, the Community Health Representative Program. Administration of Community Health Representatives differs in structure and style from one tribal government to another.

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Leaders in Minnesota elected to focus CHW training in community colleges, believing that earning academic credits was important for CHWs. Priorities may differ in other states. Nonetheless, community colleges are accustomed to recruiting students in open enrollment for occupation-related education. However, they also assist students in finding jobs after graduation, and some colleges were not prepared to offer the CHW program until leaders could document a more viable job market. This may well be true elsewhere.

And finally, Minnesota has included in its current priorities a plan to conduct an awareness campaign for the CHW as an occupation. In hindsight, Minnesota leaders believe that such a campaign might have been valuable earlier in the process.

Sustainability

According to the Blue Cross and Blue Shield of Minnesota Foundation, 2010) Retrieved from http://s472440476.onlinehome.us/wp-content/uploads/2012/12/CHWsMNbcbs.pdf

Workforce development and job creation

- Formation of the Minnesota CHW Alliance, formerly the Minnesota CHW Policy Council, a workforce development partnership
- Creation of new jobs for community health workers
- Growing understanding among health care providers that CHWs are important members of a multidisciplinary team and can enhance services for diverse clients

Research and legislation for sustainable financing

- Research on outcomes, cost effectiveness and sustainability
- Passage of Minnesota legislation authorizing Medical Assistance payment for community health workers

Awareness and public support

- Creation and use of tools and strategies to build awareness and support, including a public television program and DVD, communications, convenings and other activities
- A growing appreciation for the role community health workers play in increasing access to health care coverage, improving the quality and cost effectiveness of care, enhancing health and increasing the diversity of the health care workforce.

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Appendix G

SIM States Broad Thematic Analysis Results for Part One

Question 1: How would you describe what you have accomplished with CHWs in your state?

Overarching Themes	CT	ME	MA	MN	OR	TX
Formalization of the CHW Role **Sub-themes** → **Training** → **CHW Governing Organizations**	√ Sub-themes: Training and Governing Organizations	√ Sub-themes: Training Only	√ Sub-themes: Training and Governing Organizations	√ Sub-themes: Training and Governing Organizations	√ Sub-themes: Training and Governing Organizations	
State-Level Governance **Sub-theme** → **Legislation**	√ Sub-theme: Legislation	√ Sub-theme: Legislation	√ Sub-theme: Legislation		√ Sub-theme: Legislation	√ Sub-theme: Legislation
Stakeholder Engagement	√		√	√	√	√
Funding, financing, payment	√	√		√	√	

Question 2: How would you describe the pathway to get where you are?

Overarching Themes	CT	ME	MA	MN	OR	TX
Formalization of the CHW Role **Sub-themes** → **Creating Awareness of Role**	√	√ Sub-theme: Creating Awareness of Role	√ Sub-theme: Creating Awareness of Role	√	√	√ Sub-theme: Creating Awareness of Role
State-Level Governance **Sub-theme** → **Legislation**	√ Sub-theme: Legislation		√ Sub-theme: Legislation	√ Sub-theme: Legislation	√ Sub-theme: Legislation	√ Sub-theme: Legislation
Stakeholder Engagement **Sub-themes** → **Buy-In** → **Multiple Stakeholder Representation**	√ Sub-themes: Buy-In Multiple Stakeholder Representation	√ Sub-themes: Buy-In Multiple Stakeholder Representation	√ Sub-themes: Buy-In Multiple Stakeholder Representation	√ Sub-themes: Buy-In Multiple Stakeholder Representation	√ Sub-themes: Buy-In Multiple Stakeholder Representation	√ Sub-themes: Buy-In Multiple Stakeholder Representation

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Funding, financing → **State Support** → **ROI Research** → **Grant**	√ Sub-themes: State Support ROI Research	√ Sub-themes: State Support ROI Research	√ Sub-themes: State Support Grant ROI Research	√ Sub-themes: State Support ROI Research	√ Sub-theme: State Support	√ Sub-themes: State Support ROI Research

Question 3: Where has the political muscle come from?

Overarching Themes	CT	ME	MA	MN	OR	TX
Formalization of the CHW Role				√	√	√
State-Level Governance **Sub-theme** → **Legislation** → **State Agency Involvement**	√ Sub-themes: Legislation State Agency Involvement	√ Sub-theme: State Agency Involvement	√ Sub-themes: Legislation State Agency Involvement	√ Sub-themes: Legislation State Agency Involvement	√ Sub-themes: Legislation State Agency Involvement	√ Sub-theme: State Agency Involvement
Stakeholder Engagement	√		√	√	√	√
Funding, financing → **State Support** → **ROI Research**	√ Sub-themes: State Support ROI Research	√ Sub-themes: State Support ROI Research	√ Sub-themes: State Support ROI Research	√ Sub-themes: State Support ROI Research	√ Sub-theme: State Support	√ Sub-themes: State Support ROI Research

Question 4: What steps are you taking now to sustain the CHW workforce in your state?

Overarching Themes	CT	ME	MA	MN	OR	TX
Formalization of the CHW Role				√	√	√
State-Level Governance **Sub-theme** → **Legislation**	√ Sub-theme: Legislation			√ Sub-theme: Legislation	√ Sub-theme: Legislation	√ Sub-theme: Legislation
Stakeholder Engagement		√	√	√		
Funding, financing → **ROI Research** → **Medicaid**	√ Sub-themes: ROI Research Medicaid		√ Sub-theme: Medicaid	√ Sub-themes: ROI Research Medicaid	√ Sub-theme: Medicaid	

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Appendix H

SIM States Descriptive Analysis Results for Part Two

Descriptive	CT	ME	MA	MN	OR	TX
State legislation	2017- SB 126 defines CHW roles and responsibilities and directs a CHW credentialing feasibility study.	No legislation directly related to CHWs In 2011 – Proposed registry of CNAs and Direct Care Workers (CHWs could be included as a Direct Care Worker). Has not gone into effect yet.	2006- Health Care Reform Act: Examine CHW workforce and recommend strategies for sustainability 2007 - representation on Public Health Council 2010-Board of Certification Chapter 224 of Acts of 2012 - Formal role within primary care team and on (ACO) advisory bodies.	2007 - Medicaid reimburse for certain services by certified CHWs	2011- HB 3650 education and training requirements and CCOs provide access to Traditional Health Workers. 2013- HB 3407 Traditional Health Worker Commission oversees CHWs 2015- HB 2024 training and certification re: oral disease prevention services	1999 - HB 1864 Study, recommend education programs. 2001- SB 1051 Statewide training, certification program. Paid CHWs must be certified; unpaid CHWs may apply for certification. 2001 - SB 751 Use certified CHWs when possible for outreach and education for Medicaid enrollees. 2011 - HB 2610 Advisory committee study, recommend funding, reimbursement, maximizing access to CHWs.
Designated state agency, workforce	Dept. of Public Health To be finalized	Dept. of Health & Maine CDC (migrant health)	Dept. of Public Health, Office of CHWs	Dept. of Health & Dept. of HHS (Medicaid)	Oregon Health Authority, Office of Equity and Inclusion	Dept. of State Health Services
Training course, curriculum	In flux: Agency for Health Ed. Centers (since 2002, ½ cost, ½ hours, flexible) OR Community colleges (160	40-hr curriculum from Inst. for Public Health Innovation provided by Maine CDC-Mobile Health Program. Additional trainings by public health	80-hr. core curriculum in board-approved program offered by community orgs., local health dept., U. school of public health, and community colleges.	Core curriculum offered through community colleges, other post-secondary schools. 14 credit hours, includes a capstone internship.	State-approved, 80-hr training programs based on core competencies Movement now is more cultural-appropriate curricula.	160 hours – 20 hours x 8 core competencies. 40 different training centers: community colleges and academic institutions, AHECs, FQHCs,

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	hrs. + internship) Ideal: develop one standardized curriculum	dept. and employers. Based on core competency, skills, roles cross-walk.	Address 10 core competencies.	Majority of the curriculum relates to core competencies		CBOs, and more. Great variability and some flexibility to demonstrate core competencies.
Certification requirement	Studying feasibility of certification program Draft: Voluntary certification program	No. In development: State registry of CNAs and DCWs (will include CHWs)	As of 2017, voluntary with grandparenting period.	No, Unless billable to Medicaid	Encouraged, not required. Only certified CHWs participate in Health Homes.	Only for compensation.
Certification process	Proposed: Complete approved program, pass competency-based assessment Will grandparent current CHWs	State registry: background check, high school, foreign credentials, 18 yrs.	Application: work experience OR training + experience, 18 yrs., "good moral character," fee, passport photo, references. 2 yrs., CEUs required.	Application: completion of curriculum.	Application: completion of state-approved program, + background check. 3-years. 20 hrs. of CEU's Registry of certified CHWs.	Application: completion of approved program OR 6 years (1000 hrs.) experience Texas resident, 18 years. 2 yrs., CEUs
Designated state agency, certification	Proposed: Dept. of Public Health	Dept. of Licensing and Regulatory Services	MDPH, Board of Certification of CHWs	Dept. of Health	Traditional Health Worker Commission.	Dept. of State Health Services, Community Health Improvement Section, Family and Community Health Services Division.
Required skill set	Proposed: 11 core competencies from *Foundations for CHWs* textbook.	Did not want pre-reqs to be a barrier. Based on needs of SIM pilot projects	10 core competencies, Standards of Conduct	Core competencies developed through curriculum.	Developed through training. Additional skills for clinical setting. In community, knowing the community is key.	8 core competencies developed through training.
Policy – **mandatory reporting**	No state policies. CHW Association Code of	No		Employer-based	Oregon Administrative Rule for CHWs, mandatory	Embedded in training re: safety, ethics, advocacy

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	Ethics, and employer-based				reporting (abuse, etc.). Some employer-based	Rules revised every 4 years – will be surveying employers
Policy – **CHW safety**	No state policies. CHW Association Code of Ethics, and employer-based	No		Employer-based	Oregon Administrative Rule for CHWs, Safety-training, ethics, Some employer-based	Embedded in training re: safety, ethics, advocacy Rules revised every 4 years – will be surveying employers
Prevention Vs. Disease Mgmt.	In development: 10 Roles to define scope of practice for CHWs – most are prevention	Mostly around SDOH, but depends on setting.	Mostly preventive services	Both	Prevention in community, Disease mgmt. in clinical setting.	Both
PCMH integration	Advanced networks & FQHCs required to develop CHW capabilities and incorporate CHWs into primary care team	Explicitly listed as potential team members on Community Care Teams for practices in Maine's Health Homes program.	ACOs can pay for CHWs as part of multidisciplinary care teams.	Role on PCMH care teams in "Health Care Homes" as part of ACA.	Clinical setting – Integrated into health care team. Organization: (Care Oregon) employs CHWs on care team.	New MCO care delivery model is team-based care.
Potential employers: **salary**	Employer-based	Not discussed.		Most full-time, paid hourly, with benefits. Varies by factors typical to other professions.	All certified CHWs paid. Employer-based	In review
Potential employers: **liability**	Employer-based (HIPPA also)	Probably covered by umbrella policy in large social service agencies. Concern in medical community.		Employer-based	Liability falls on individual for ethical issues (remove state certification). Mostly through employer.	No state model.
Potential employers: **clinical placement**	Employer-based	Maine's Health Homes program includes		Employer-based	Integrated into the healthcare team.	Employed by community-based organizations,

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		CHWs on Community Care Teams				clinics and hospitals.
Potential employers: **supervision**	Employer-based	No health professional supervisor required.		Supervision doctor, dentist, advanced practice nurse, mental health professional, public health nurse or approved health professional	Supervision training used by CHW Association. Add on to help supervisors understand CHWs	Vary by employer
Vary, urban vs. rural?	Varies more by population needs					
Payment options	Currently: time-limited, program-specific grants. Exploring: Shared savings with advance payments, primary care bundles with advanced payments, global payments.	Still trying to figure this out CCTs in Maine's Health Homes program reimbursed through Medicaid. All part of the value-based payments discussion.	Grants, transformation funds; federal, state, local govts; health plans; private, non-profit funding. Medicaid incentive payments, ACOs,	MHCP reimburse "care coordination and patient education services provided by a CHW"	PCPCHs must include CHWs for some core services and CCOs required to include "non-traditional healthcare workers" like CHWs on care teams. Medicaid reimbursement. Small push for private insurers to pay for CHWs to save $$. Mostly grants and contracts.	Medicaid contracts with MCOs which allows CHWs. Multiple quality improvement projects and waiver funds. Block grant for training.
Payer requirements	Early discussions with networks, payers.	Still trying to figure this out		Completion of approved curriculum. MHCP-enrolled. Supervised by a MHCP-enrolled provider. Services ordered by a provider.	Medicaid requires certification and supervision by health professional.	Certification

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Appendix T

Goal 4 Telling the Story of Community Health Workers (CHWs) in Idaho

Telling the Story of Community Health Workers (CHWs) in Idaho

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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Community Health Workers (CHWs) serve Idaho's rural, frontier, and medically underserved communities as part of the Virtual Patient-Centered Medical Home (PCMH). CHWs are members of the PCMH team who act as a bridge between individuals and health and social services in the community. The number of trained CHWs in Idaho has been steadily growing due to the Statewide Healthcare Innovation Plan (SHIP). As stakeholders consider sustainability of CHWs beyond SHIP, it is valuable to look at progress. The purpose of this project is to tell the story of CHWs in Idaho.

Methods

A research associate (RA) with the State-level Evaluation Team (SET) spoke with nine individuals involved with Idaho's CHW initiative. Three of the individuals are CHWs, three are supervisory CHWs, two are clinic administrators who supervise CHWs, and one is a physician. Responses reflect their different roles and unique perspectives. Depending on the role of the individual, the RA asked questions similar to the following:

1. Describe in your own words the important elements of the CHW.
2. What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?
3. What unique contributions are CHWs able to make to address those challenges and provide better healthcare?
4. What might a day in the life of a CHW look like?
5. What might a patient interaction look like?
6. What would the patient helped the most say about CHWs?
7. What would your healthcare team (or supervisor) say about CHWs?
8. Can you provide an example:
    - Patient
    - Your interaction w/ patient
    - Your contribution to healthcare team
    - Action by healthcare team
    - Outcome
9. Do you have additional examples to provide?
10. How would you describe the community in which you work?
11. How would you describe the organization in which you work?
12. Are CHWs paid?
    - If yes, please describe. Do you know the funding source?
13. Do CHWs have a formal role on a healthcare team?
    - If yes, please describe.
14. What other roles participate in the healthcare team?
15. How frequently does CHW meet with the healthcare team?
16. What is the title of the CHW's direct supervisor?
17. How frequently does CHW meet with direct supervisor?
18. Describe CHW education, training, development.
19. Describe the oversight (supervision) CHWs receive.
20. Describe the access CHWs have to patient information (records).

The first section of this report summarizes responses to the questions in the context of four themes. The themes are:

1. Impact of CHWs on patient engagement
2. Impact of CHWs on social determinants of health
3. Impact of CHWs on PCMH team

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4. Impact of CHWs on health outcomes

Following the summarized responses, Appendix A includes all responses by question. Appendix B includes all responses by individual.

Impact of CHWs on Patient Engagement

To tell the story of CHWs in Idaho a research associate (RA) with the State-level Evaluation Team (SET) spoke with nine individuals involved in some way with the CHW initiative. While the individuals answered similar questions, the responses reflect different roles and unique perspectives.

Without exception, every individual described different ways in which CHWs affect patients and the ways in which patients engage in their healthcare. One clinic administrator identified patient engagement in health care as *the* important element of the CHW role. Community Health Workers engage patients in preventive screenings, chronic disease management, health-promoting behaviors, and accessing healthcare.

Preventive screenings

One way in which CHWs engage patients is by getting them to participate in preventive screenings, and the CHWs spoke with great familiarity about preventive screenings. One CHW mentioned holding health screenings at the food pantry in the community, and one particular patient participates every time—checking blood pressure, etc. The CHW went on to say "preventive care is a huge deal, and we're seeing increased visits and screenings." One supervisory CHW said, "we offer free health screenings in the community." Her team of CHWs has teamed up with a CHIBA counselor and held free health screenings at senior locations. She then enters results of screenings.

Types of screenings mentioned most frequently were A1C, blood pressure, and questionnaire screening forms. Other screenings include FIT tests for colon cancer, and BMI. A supervisory CHW stated, "we screen all our patients with a screening form." A CHW described the questionnaire she uses as very in-depth; with questions regarding background, education, abuse, stress, triggers, and more.

Chronic disease management

Another example of engaging patients is chronic disease management, and nearly all individuals provided examples. One supervisory CHW explained that her team of CHWs regularly offer or promote free CDSMP classes (chronic disease self-management program) in the remote community in which they live. The team is planning to add classes in chronic pain self-management.

A clinic administrator shared that CHWs call and remind patients to check weight – then report details to nurse for follow-up, or remind patient to go to community resources, such as the foodbank, if their weight has fallen. She gave another example of CHWs calling one particular patient each Friday to remind her to refill her weekly medication cassette. With the reminder and the refill, the patient avoids running out of medication over the weekend and needing to go to the ER.

Another clinic administrator explained that chronic disease management is the focus of CHWs in certain clinics. Often, the role for the CHWs is more about helping patients identify transportation options, daycare for children, scheduling options, etc. to be able to attend disease management classes.

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One CHW described how she helped one seemingly non-compliant diabetes patient. The CHW put up signs around her house and texted reminders to check blood sugar and take medications in the morning and evening. She helped the patient enroll in diabetes classes and even attended them with her; the patient completed all classes. Finally, the CHW brought in a pharmacy student to do a medication assessment and learned the patient was doubling up on some. The patient is now regarded as compliant.

One CHW has been trained to record what medication patients are taking, why and how they're taking the medications and whether or not they know where to go to get refills. She passes this information along to the health care team.

The physician described how the CHW program at his clinic started with one promotor(a) reaching out to migrant farm workers to help with different aspects of disease management. This included helping them with insulin, discussing management challenges, walk through treatment plans, etc.

Health-promoting behaviors

Another way in which CHWs engage patients is by helping them adopt health-promoting behaviors. One CHW offered an example in simply challenging a patient to limit her Pepsi to one small can per day. Other CHWs described helping patients to make lifestyle changes, such as smoking cessation. Another described how he connects patients to community resources, such as the foodbank which teaches how to shop and how to eat well on a low income.

The supervisory CHW described how her team of CHWs in a remote community often organize regular events such as community walks to engage people in physical activity. The walks, called "walk the prairie," are part of a promotional walking passport completed by community members. Some individuals are so empowered that if they have to miss one of the organized walks, they take the initiative to walk on their own to complete the passport.

One of the clinic administrators listed a host of health promoting activities CHWs organize for community members. Activities include things like Fit and Fall classes, weekly walks, music and memory classes, and diabetes prevention classes. Sometimes, the CHWs have to convince and drive the community members to the events, but usually the community members will become engaged and take the initiative for themselves.

A clinic administrator explained that disease prevention might be the focus of CHWs in certain clinics. They physician described how CHWs might bring nutritionists with them on home visits to teach patients how to prepare healthy foods.

Accessing health care

Finally, engaging patients is also helping them to access health care. One CHW put it this way, "We're seeing more visits." Most frequently, individuals cited examples of helping community members get set up with, or meet for the first time, a primary care provider. The physician explained that CHWs are able to convince patients to "come to the clinic" for labs, screenings, etc.

One CHW provided multiple stories of helping patients access dental care, or dental care for their children, sometimes for the first time in their life. She described, "I review the resources page; patient stops me at dental and says, "I need that, and so do my kids." The CHW continued, "within a month or two the patient would have dental help and be able to eat solid

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food, able to get nutrition." A supervisory CHW described noticing a child at Head Start who had rotting teeth. The CHW was able to get dental care for this child.

Some CHWs described helping patients access mental health care. One CHW explained, "I talk with a patient about social factors or life in general. The patient gets to talking and I mention the resource page for mental health and counseling services. The patient is interested in counseling, so the nurse writes a referral for counseling. The patient goes to the scheduled appointment to discuss problems they've been having. The patient receives accurate care and begins to address life issues outside of just physical health."

One clinic administrator provided an explanation of access to health care this may not be obvious. She describes her remote community in which patients have to drive over an hour each way to access the free health care clinic they need for prescription medication. The team of CHWs in this community is able to make home visits that fulfill the requirement of providers to have monthly contact with patients in order to dispense medication. CHWs in this community can do that visit and make that connection. In this sense, CHWs are the "arm from clinic to community," the administrator said.

Some CHWs help patients sign up for a health insurance plan. With health insurance, patients are more able to access health care. Access may also include seeing a specialty care provider.

Self-advocacy. An aspect of access includes the patients advocating for themselves, and CHWs seem to have a role in that. For example, a CHW shared how he may communicate something to the provider that the patient doesn't feel comfortable communicating, or he may help the patient explain a little better. He described this as "empowering" the patient to understand better what the provider's talking about or put into words what they're trying to explain. Essentially, this allows the patient to interact with the provider in a way that impacts their medical care. The CHW explained, "our patient population can be afraid of the provider—intimidated. I teach the patient, "you can advocate for yourself, you can speak up for yourself, and you can say these things."

A clinic administrator shared that patients can be uncomfortable relaying important, but personal, information to the doctor. The CHW can help patients understand why and how they need to share this information so the doctor is better able to treat the patient.

Spanish translation. Another important aspect of access is language translation. A number of CHWs described how they help Spanish-speaking patients who previously relied on family members to translate. CHWs can provide the interpretation with knowledge of medical terminology.

All individuals with which the RA spoke provided examples of CHWs engaging patients in their health care. A clinic administrator summarized the unique role of CHWs this way: "a significant number of residents in our population do not have health insurance. They don't want to pay for 'little things.' It is a challenge to get these patients to engage in their health—getting them interested in being healthier. CHWs can reach this non-insured population."

Impact of CHWs on Social Determinants of Health

Of the nine individuals throughout Idaho with which the RA spoke, nearly all described unique ways in which CHWs help address the social determinants of health (SDOH) for the patients with which they work. Three of them stated that "social factors" are the kinds of problems physicians do not have the time to discuss with patients, but recognize as important and rely on

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CHWs to address. A supervisory CHW stated, “The SDOH are huge for our patients. Do they have enough food on a daily basis? Do they have transportation to appointments? Can they afford their medications? Can they afford their utilities? If they can’t afford to pay bills, it’s going to be a lot harder for them to pay for their prescriptions, or whatever they need.”

CHWs described helping patients get food stamps, go to the foodbank, or learn how to shop on low-income. The supervisory CHW explained, “CHW helps patient meet basic needs, so they can be concerned about health. If they don’t have enough to eat on a daily basis, why should they be concerned about how what they eat affects their blood pressure, their glucose levels, or anything like that?”

CHWs described helping patients learn about financial options, health insurance and other resources to access and pay for healthcare, even solving medical debt problems. They described helping patients overcome tremendous barriers related to transportation to and from medical appointments. Or health education classes. They told of helping patients who don’t speak English by providing translation during appointments in the clinic.

CHWs also explained how they have been able to help individuals overcome SDOH indirectly related to health and healthcare, such as gaining employment or education, managing family responsibilities, feeling safe where they live, and having necessities for living. One CHW described helping a patient in Emmett get wood for her woodstove in the cold winter, when she had run out.

Both clinic administrators described the ways in which *where* the patients the live are often a SDOH. One identified the remote geographic location of their community as a barrier to access that CHWs can alleviate. Another identified the conditions of the home as being a determinant that CHWs are able to identify and either address or relay back to the healthcare team.

In some conversations, individuals described in broad terms how CHWs inform patients of available community resources and social services to address SDOH.

Impact of CHWs on PCMH team

All of the CHWs, supervisory CHWs, clinic administrators and the physician explained unique ways in which CHWs are integrated into, and contribute to, the PCMH team. In some ways, the CHW consolidates the work of the team, in other ways the CHW expands the work of the team, and often the CHW serves as the bridge between patients and the PCMH team.

Consolidation

Community Health Workers address non-medical, social determinants of health with patients, freeing up providers to devote appointments to direct healthcare. A clinic administrator and multiple CHWs recognized that the time to deal with the SDOH that impact complex medical issues is a real challenge faced by providers; clinicians know they can hand this kind of work to the CHW and also know the needs will be addressed. Multiple CHWs explained that CHWs in their organization meet with patients immediately following their appointment with a provider to explore and discuss SDOH. They enter this information into the patients’ electronic health records for care coordination. Another CHW explained she learns about and identifies ways to address SDOH when meeting with patients in their homes. Related to this, some of the CHWs described how their knowledge of resources is what often helps patients access the healthcare provided by their clinic, such as medical care, dental care, and behavioral health care. A clinic administrator explained CHWs are able to link with case managers for patients who have an extra need.

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A clinic administrator described how the CHW in her organization is the “eyes in the home” who relays what she sees back to the team, or intervenes in simple matters like fall risks. The CHW stated she does a house visit nearly every day. She often brings pharmacy students to conduct medication assessments. She described a situation in which a medication assessment brought to light that a patient was doubling up on medications; it is possible no one else ever would have caught that. She described another situation in which a home visit helped her to see why a patient was non-compliant with diabetes management; the patient was overwhelmed by caring for her great grandson. Sometimes, the clinic staff just ask her to go check on the patient, because she can see what is going on in the home. They physician stated the CHW is often able to identify if the patient is adhering to the medical regiment; if not, the CHW is able to find out the barriers to adherence.

Expansion

Nearly all the CHWs, supervisory CHWs, and the physician indicated CHWs are the arm that extends the reach of healthcare out into their communities. They meet with patients “where they are” through free screenings, outreach, health fairs, informational events, community networks and more. A clinic administrator explained, when necessary this reach out into the community often leads to pulling patients into the clinic for care, such as when a free screening uncovers undiagnosed diabetes. One supervisory CHW stated, “we go in, we look, we listen, we assess, and then we try to engage by what we observe.’ Another stated, “As a CHW you have a little bit more freedom to do stuff like that, whereas you don’t have freedom to do that as a provider.” The physician defined the role of promotor(a)s as reaching out to migrant farm workers who are very reluctant to come to the clinic.

In remote areas, CHWs expand not only the reach, but also the access to healthcare into the communities. A supervisory CHW explained many patients are required to have monthly contact with their provider for medications. The CHWs in her organization are able to meet with the patients in their homes, on behalf of PCMH, and save patients the costly 1-hour (each way) drive to meet with a provider.

Bridge

According to a clinic administrator, CHWs are often the conduit to building trust between the patient and the entire healthcare team. According to one CHW, some of the nurses in her clinic had been working with patients for years, yet the patients still did not trust them. She goes into their homes, sits with them, and helps them develop strategies to overcome the barriers to complying with their health plan. The CHW stated that patients ask her to go to appointments with them, just to be there so “we’re all on the same page.” She checks in with them later to see how they are doing.

Another CHW stated he comes from many of the same experiences patients struggle with, so he can empathize and offer compassion. From this shared perspective, he can convince many patients to do things the team may not otherwise be able to. In the case of migrant farm workers, the physician described how promotor(a)s share their language, their culture; they are able to convince migrant farm workers to come to the clinic for labs, screenings, etc.

A clinic administrator provided a related example of CHWs as the bridge between patients and the PCMH team. Many clinic employees live outside the community, and they are tuned more into the medical world, so they may forget about the patient world. Community Health Workers have their pulse on the community; they can reach patients clinic staff may not know about. Furthermore, she stated CHWs are able to reach the population of patients who just doesn’t like doctors.

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Multiple CHWs described how, in appointments, the CHW helps patients communicate things to the provider they are uncomfortable saying. They help them understand a diagnosis or jargon that goes over their head. They follow up individually with materials and resources based on the health literacy needs of the patient.

Impact of CHWs on health outcomes

All individuals demonstrated positive impact that CHWs have on patient engagement, nearly all acknowledged positive impact on social determinants of health, and all were able to describe positive impact on the PCMH team. Some were able to demonstrate a direct, yet powerful, impact on health outcomes, while others shared indirect impact.

Direct Impact

One supervisory CHW described how free preventive screenings in the community led to the diagnosis of diabetes for one individual. The team of CHWs connected the woman to her healthcare provider, showed her how to enroll in free CDSMP classes, and helped her adopt new healthy behaviors. As a result, this community member was able to bring her A1C below the pre-diabetic range. She said the woman, “burst into tears. She found a weight loss program that worked for her.”

The same supervisory CHW describe an uninsured community member who learned about her high A1C levels at a free community screening. The CHW connected a benefits counselor to this woman who helped her access affordable healthcare. She worked with her physician, took medication and enrolled in CDSMP classes and lowered her A1C level to 7. The anecdotes were echoed by the administrator at the clinic. The two provided multiple stories of patients learning of their chronic disease through a free community screening, accessing healthcare and making lifestyle changes that resulted in positive health outcomes.

Another clinic administrator told of the CHW being able to see and report malfunctioning medical equipment in the homes of patients. Based on this information, the provider can recommend new equipment and help the patient get the equipment they need to stay healthy and out of the hospital. Finally, one CHW told of a patient who, after accessing dental care, was able to eat solid food, able to get nutrition.

Indirect Impact

A clinic administrator summarized impact on health outcomes broadly: “The patient is empowered – that’s what we want. When the patient is empowered, they will change their behavior.” One CHW explained how she was able to engage a patient to comply with her healthcare plan. Others said they were able to engage patients to make lifestyle changes, such as smoking cessation, but did not discuss outcomes.

Multiple CHWs described outcomes, such as addressing issues beyond physical health. One CHW explained that engaging a patient resulted in greatly improved mental health. One outcome is that providers are seeing patients coming in the doors more frequently, which leads to increases in health for the patients, a CHW said.

Summary of Responses

In summary, all nine individuals involved with CHWs in Idaho described different ways in which CHWs affect patient engagement in healthcare. Community Health Workers engage patients in preventive screenings, chronic disease management, health-promoting behaviors, and accessing healthcare. Nearly all described ways in which CHWs help address the social determinants of health (SDOH)—the kinds of problems physicians recognize as important and

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rely on CHWs to address. All explained ways in which CHWs contribute uniquely to the PCMH team, by both consolidating and expanding the work of the team, and by serving as the bridge between patients and the PCMH team. Some were able to demonstrate a direct, yet powerful, impact on health outcomes, while others shared indirect impact.

One CHW summarized the impact of CHWs on the ROI for clinics and communities: “We’re seeing increased visits and screenings. We’re getting patients in the door. If we as CHWs can be proactive and go out into the community and share with them the importance of preventative care, then we’ll not only see a lower cost at [our organization], because those people are getting continued care, but we’ll see a decrease in cost in communities in general. I strongly believe the more we see Idaho start to adopt Community Health Workers into their program, the more that we’re going to see a lowered cost for communities and a lower burden of care for communities.”- CHW, Region 4

The physician summarized the impact of CHWS at multiple stages of patient care: “Community health workers work magic—literally and figuratively. They help identify things I haven’t even thought of. I know patients aren’t getting better, but I don’t know why. The CHW is able to find out why and then to find ways to solve the problem. I’ve seen CHWs turn around their health.” - Physician, Region 4

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Appendix A: Responses by question for Question 1-20, along with responses to "opportunity" questions which were asked in certain discussions.

QUESTION 1: Describe in your own words the important elements of the CHW.
Responses by Community Health Workers

- The biggest thing is connecting our clients with services
  - Special services, or being set up with a provider, specialty clinic
  - Just kind of acting as that middle man to get them connected.

- Making the patient feel heard, listening is important
- Knowing the resources lists well enough to offer more resources
- Being a champion of the patient and giving them an outlet for questions and concerns
- No time constraints with CHWs
- SDOH factors
- Know the resources in Treasure Valley
- Creating Relationships
- Engaging with the community
- Provide smiles to people when they're going through hard times and receive bad news
- Liaison between the patient and the clinic

Responses by Supervisory Community Health Workers

- Someone patient can relate to; "on their level;" can empathize and understand.
- Sometimes patient can feel like the provider is talking over their head. They may not understand what's being said; CHW can get on their level and help them understand.
- Doctor is super busy and has only a certain amount of time with the patient. The CHW can have more time and get to know the patient. Take the time to understand the struggles the patient is going through.
- We encourage individual health in order to build healthy communities.
- We encompass all of the people in our communities. They do not have to be a patient of St. Mary's Hospital; we are there to serve the community.
- We try to be the bridge to health care by being present in the communities.
- We go in; we look; we listen; we assess; and then we try to engage by what we observe.
- In our value-based system, the goal is to keep people healthy
- Provide education "where the patients are."
- CHWs serve as the liaison, increase access to patients' getting primary care
- CHWs are knowledgeable and relatable, consistent with the community
- Provide a warm hand

Responses by Clinic Administrators and Physician

- Meet patients' needs for free testing, etc.
  - Free events provide free screenings, A1C, FIT tests for colon cancer, BMI, phq 9, blood pressure
  - Share info with provider. If no provider, then CHW link patient to a PCP
- Engage patients to help them get healthy
  - Weekly walks, fit and fall classes, music and memory classes, chronic disease self-mgmt program, diabetes prevention classes
- Arm from clinic into community to provide services to try to engage patients in their health
  - Fulfill the requirement of providers to have monthly contact with patients in order to dispense medication. CHWs can do that visit and make that connection.
  - Link with case managers for patients who have an extra need

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  - Call and remind patients to check weight – then report details to nurse for follow-up. Or remind them to go to food bank.
- Ability to connect with the patient. Meet the patient "where they are." Go to their homes.
  - Patients trust the CHW and by extension the healthcare team; CHW can engage patients in healthcare
- With a complex patient population (co-morbidities, balancing myriad issues), the clinical work is very time intensive
  - clinicians know they can hand the SDOH kind of work to the CHW
  - The CHW allows us more time to see / touch more patients, work to top of education and licensure
- Our FQHC started with one promotor(a) reaching out to migrant farm workers.
  - The individual would go to the farms, fields and dairies to meet with migrant farm workers. Even go to their homes. Help with insulin, talk through challenges with managing diabetes at home.
  - The migrant farm workers were very reluctant to come to the clinic, as many were undocumented. The CHW spoke their language, understood their culture, and helped meet their medical needs. Sometimes, CHW was able to convince them to come to the clinic for labs, screenings, etc.
  - We hired another to be CHW lead – he has organized CHW team.
  - We added two more to assist patients in signing up for a health insurance plan.
- Currently, we have about 6 CHWs to meet patients' needs
  - Help with access to health insurance and healthcare
  - Help with language and transportation to appointments
  - Nutritionists accompany CHWs on home visits to teach how to prepare healthy foods
  - Work to address SDOH is some of the most valuable work CHWs do
- Our EMR includes an area for providers to make a referral to CHW around a SDOH. The CHW follows up with patient until the issue is cleared.
  - Housing, transportation, ACA insurance plans, make appts., language barriers, etc.

<u>QUESTION #2:</u> What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?
Responses by Community Health Workers

- Compliancy - A lot of times the patients go to the doctor's office, they have an appt., and then they go back home and they just don't follow though
- Medication assessment - It's incredible the amount of poly-pharmacy going on. The pharmacists don't talk to each other; the doctors don't talk to each other. So many side effects they don't understand
- Individually, needs of Spanish-speaking patients
- Not much time for providers to listen to social factors- this makes sure those are still addressed. Sometimes just as important as physical problems
- Accessibility
  - Providers care about patients deeply, but can't "meet people where they're at"
  - Time is scarce

Responses by Supervisory Community Health Workers

- SDOH are huge. Do patients have enough food on a daily basis, do they have transportation to appts., can they afford medications, utilities? If they can't afford to pay bills, it's going to be hard to pay for prescriptions, or whatever they need.

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- We are so rural, and just trying to reach people is hard. A free clinic serves low-income residents in three rural counties. The drive can be over 100 miles, and the cost of travel is a real barrier. But they have to be seen to get medication.
- The time a provider is able to spend in the office with somebody is short.
- Health literacy.
  - When a patient is in the examination room, they receive a diagnosis in jargon that goes over their head

Responses by Clinic Administrators and Physician

- Significant population does not have insurance
  - Does not want to pay for "little things." It would be better to catch issues before they become "big things."
- Getting patients to engage in their health; getting them interested in being healthier.
- In our clinic, many employees live in other communities. Tuned into the medical world, so they may forget about the patient world.
- Time to deal with the SDOH that impact complex medical issues of a complex patient population
- Eyes in the home. Patient may say one thing to the physician or care team, but that may not be what's really going on in the home.
  - When the CHW goes into the patient's home, they can report the in-home conditions to the healthcare team. This is extremely valuable to providers
- Getting to patients' living environment.
- CHW can identify if patient is adhering to the medical regiment and, if not, find out the barriers to adherence. Barriers tend to be SDOH-related - $ for visits, access to care, can't take time off work, need health insurance.

QUESTION #3: What unique contributions are CHWs able to make to address those challenges?

Responses by Community Health Workers

- Compliancy - Almost all of my patients, I've gone to almost all of their pcp appts. with them. They want me there with them, so we're all on the same page, I'll check up with them a week later, just to see how things are going
- Medication assessment
  - I was trained to do a medication assessment; so I kind of do a data collection of what a patient is taking, why they're taking it, how are they taking it; do they know where to go to get refills.
  - And I take this information back to our pharmacist here, and she'll type up the notes and give it to the doctor.
  - We just recently started having ISU 4th year pharmacy students go out with me, which is huge.
  - When I have rapport with a patient, I'll ask if it's okay for a pharmacy student to come just to go over your medications with you (as it's beyond my scope). They'll sit down with the patient for an hour, and I'll sit there too and they'll just completely go over all the medication.
- Trust with clients - Some of these nurses have been working with these patients for years and they still don't have a lot of trust in them.
  - I believe 100% it's the fact that I go into their homes. I sit down with them. I tell them, I'm an advocate for you; I'm not here because your doctor wants me here; I'm not here as a clinical person; I'm just here to see what can I do to help you make the most of this situation?

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- Recognize the SDOH that just get in the way of these patients, and just helping them navigate that.
  - Something as simple as transportation, or helping them get food stamps
  - I just don't judge. Not of these patients woke up and decided to be poor or sick. I'm just here to help them.
- Not much time for providers to listen to social factors- this makes sure those are still addressed. Sometimes just as important as physical problems
  - Lifestyle changes (tobacco cessation), dental work (dental free clinics)
  - Language translation – Spanish
- CHWs can meet patients "where they are" and outside the clinic
  - At health screenings, and outreach
  - I can meet with patients individually; I can help convince them to see a provider
- Practical things – being bilingual, diligent and discerning
- I can go out into the community to hold health screenings (food pantry)
- Perspective of the patient, experience, empathy, compassionate

Responses by Supervisory Community Health Workers

- After a patient is seen by a nurse, then by a doctor, the CHW goes in. We screen all our patients with a screening form (addressing SDOHs). The CHW uses the form to talk with patient about community resources, social services that can help address the needs.
- We try to have CHWs in those rural communities.
- We partner with the free clinic. By setting up a referral, we can go and visit the patient and save that (low-income) patient a trip to get their medication.
- We offer free health screenings in the community; we have information and resources; we make referrals; we assess and get ideas for needs we can help meet.
- We offer free classes and resources in the communities - beyond the office visit. For example, we are able to offer the CDSMP – chronic disease self-management program. We're going to add chronic pain self-management program (we're getting trained for that). One CHW is a DPP instructor.
- We hold regular community walks and engage people in physical activity.
- We have 1-on-1 visits.
- CHWs help to create and can provide patient materials, literature
- CHWs walk each patient through diagnosis, information, materials and resources
- Diet and nutrition. Based on Maslow's Hierarchy of Needs, for patients to be concerned with their quality of life, they have to know their basic needs are met. So, making sure they have enough food and water on a daily basis, or they have a place to stay, they have security and safety, they have a place to go home to. CHW helps them meet basic needs, so they can be concerned about health. If they don't have enough to eat on a daily basis, why should they be concerned about how what they eat affects their blood pressure, their glucose levels, or anything like that?

Responses by Clinic Administrators and Physician

- Can reach non-insured population through free screenings or individual visits in their own area – bank, grocery store, county fair, high school games, library, restaurant – in a non-threatening way. No finances. No intimidation. Make the initial contact with people who would not come in.
  - At screening, if levels are elevated, CHW let them know the findings are out of range. No medical advice, but provide educational material, and encourage patient to see doctor.
- Can reach population who just doesn't like doctors, will never go see a doctor, but may be willing to attend a free screening

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  - At free screening, patient more likely to get checked.
  - Success story: wife suspected for some time that her husband was becoming diabetic, but he made every excuse not to go to the doctor. Typical farmer: spring work, gotta put the hay up, get ready for harvest, I'm fine. But stopped by a free screening; saw the CHW who we already knew. Got the A1C test. Value was so high – 13! Got his attention: "I gotta get a game plan, don't I?" Would not go to an appointment, got the service.
- CHW has their pulse on the community – at the grocery store, at the ball games
  - Hear what people are actually doing and saying; more aware of what people don't know about medical things;
  - Do a better job of bridging the gap; a long-arm extension of us; put the information out where people can't ignore it anymore.
- CHW is able to intervene and address in-home problems in real time (simple things like fall risk presented by many rugs in the home, or placing reminders on the refrigerator)
- Initiate a plan with the patient to begin immediately addressing interventions around SDOH
- CHW cannot do medication reconciliation, but can relay information back to the health-care team about amount of different medications, or if/how patient is taking medication.
- CHWs have built community partnerships,
- CHWs go to patients homes to walk through treatment plan(s) with them.
- Help patients overcome barriers by connecting them to community resource, such as women's shelters, Medicaid, health insurance

<u>QUESTION #4:</u> What might a day in the life of a CHW look like?
Responses by Community Health Workers

- I'm probably out doing a house visit every day.
  - About a 2-hour appt. I have a long questionnaire that takes awhile
- I have meetings here
- I have a lot of documentation. I have to document everything I talk about.
- A lot of calling around; if a patient needs help with, say housing. I have a patient with glaucoma, so I'm helping him complete an application.
- Arrive around same time as patients, begin processing intake forms that patients fill out when they get there, begin entering responses into AthenaNet,
- go see patient with pertinent resources after providers are done or during a break in patient care,
- come back to grab any additional resources patient may express interest in, dismiss patient (provider dependent),
- go back and enter discussion notes and finish logging appointment details; also helped to fill out mental health and counseling request forms with the patient when applicable
- Chuckle – no typical day
- Answer patient questions through email, returning calls, etc.
- Doing outreach is a core aspect of my job
  - Resource for community
  - Stocking up on medical and outreach kits
  - Heading out to a partner location to interact with people – listen to learn what their barriers are, and seek solutions that our organization can participate in to address
- Community meetings - PTA's, community school programs, finding and developing partnerships with organizations that connect with our mission

Responses by Supervisory Community Health Workers

- CHWs are here during our clinic hours to work with patients.
- Nurses see the patients first, then the doctor, then CHW.

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- All patients complete a screening form. If form has red flags, CHW goes in to see patient.
  - Could be any SDOH – somebody dropped out of middle school and wants to get a GED. CHW connects them to resources in the community so they can finish that schooling.
  - Maybe they don't know where to go for food or don't know what kind of food to eat. One patient diagnosed with hypertension had access to food, but wasn't eating enough because he didn't know what he could and couldn't eat. We plugged him into a class through Idaho Foodbank that teaches people how to shop and eat on a low-income. That kind of stuff.
- On Monday morning I held a CDSMP program
- Tues-Thurs – we teamed up with a CHIBA counselor and held free health screenings at three senior sites.
- Tuesday morning plan and prepare for an upcoming event
- Wednesday evening we have CHW training
- Thursday I also trained a new CHW who is hosting an event next week.
- Today an interview, a presentation, data entry for a health screening.

Responses by Clinic Administrators and Physician

- Do so many different things at different times.

<u>QUESTION #5:</u> What might a patient interaction look like?

Responses by Community Health Workers

- Two-hour initial interaction
- Toward the goal of helping patient get a social service, or do a medication assessment, or help patient get a PCP
- I go into their house. I usually try to find something we can talk about, because they're all really proud of their homes. So we usually just chat, and if there's family members there, I get to know about them
- Then I go into my role (I don't know if your care manager explained my role to you), so I'll go a little more in-depth about what my role is. Explain what a [CHW] is. And then I seek approval to ask some questions
- A long questionnaire
  - Very in depth - goes into background, education, abuse, stress, triggers on PHQ 9,
- Opens so many doors
- Sometimes they'll ask me to come back over
  - I may bring a pharmacist with me,
  - Do a follow-up (food stamps, or other SDOH, help find a PCP), or check-in
  - Afterwards, I'll submit referrals
- Sometimes nurses ask me to go check on the patient – they're already dialed into services
- Very much patient dependent
  - Some patients are more reserved and just say thank you for the resources you hand them
  - Others want to tell you about their lives, ask questions, and really participate in the process
  - Often by asking people to elaborate more on the responses from the intake forms there is an opportunity to discover further need for additional resources (ex, food need vs dental needs)
- Mostly out in the community
  - Resource events – BSU, schools, services our organization provides
  - Personal time with people about their issues and connect to resources in our organization

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- Help to meet SDOH needs – food, etc.

Responses by Supervisory Community Health Workers

- Every patient fills out the form
- List of resources on the computers; CHW prints the resources and takes into the patient interaction.
- CHW sees every new patient and introduces themselves. Goes into it as a conversation. Not a lot of people understand what a CHW is. We explain what a CHW is.
    - If the patient wonders "why did I fill out that form?" We explain "these are things that might not affect you medically but might affect your health in other ways. We help you with that kind of stuff."
    - "You said you don't have enough food. What does that look like for you?"
    - CHW is there (has the time) to listen, to understand. Maybe say, "I see these resources didn't work for you, so we're gonna see if we can find something that works better for you."
    - CHWs let them know that since they volunteer, they're just here for that shift. So they let the patients know that if anything comes up, they can just call in to the clinic. I've had patients call in – one patient called in last winter, "I'm stuck in Emmett and my only source of heat I have (last winter) is a wood burning stove." But she ran out of wood, so how is she going to heat their house? So I did some research and got her connected to some different things out in Emmett that might help her keep her house heated.
    - CHW supervisor jumps in when the needs are beyond the CHW. CHW supervisor here full-time; has the time to go look beyond what can be looked for in that short session.
- Conversation casual. Let patient ask the questions; I try to listen more and offer resources
- Transitioning into 1-on-1's in patients' home, kind of like a mini-screening. We do A1C's; ask a set of assessment questions; complete a demographic form that we use at screenings.
- A home visit could be lengthy- an hour. In an aging community patients may be lonely, so they want to visit too. The initial visit could be the longest and then follow-up visits may be shorter.

<u>QUESTION #6:</u> What would the patient helped the most say about CHWs?
Responses by Community Health Workers

- That I care – I want to see the happy in their life – I don't judge
- I'm proactive. I get things done
- I listened and personalized resources for given situations. Not only did I give pertinent resource pages, I highlight resources that are more likely to help specific situations.
- Genuinely care
- Do my best to help with their situation
- Understand what their situation is like – I can connect to them
- Patients have asked for supervisor number to say THANK YOU for being available, accessible, there to help
- HOPE! I did experience what they're going through: parents diligence, hard work, school, rise above is possible, betters days ahead

Responses by Supervisory Community Health Workers

- They're being cared for beyond just what's going on medically. Beyond, "your blood pressure levels are good," "Your A1C is fine," "you're not dealing with depression, it's not showing up on the form."

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- Going beyond to say, “okay, these numbers are good, but how is your quality of life?” “do you feel safe at home?” Asking the “beyond” questions, and “what’s important to you?”
- They’re not going to say to a doctor – “I dropped out of high school a long time ago, and I want to go back. But I don’t know if that’s possible.” But with a CHW, they can talk about stuff like that. They can say, “I dropped out, and I kinda want to go back, but I don’t know if I can.” And the CHW can say something like, “here’s some different resources.” The fact that they’re even considering is huge, but then we encourage them to pursuit; that it’s even possible.
- We listen and we care and we’re compassionate. We want to help get them what they need, or get them headed in that direction.
- Thank you for offering events in the community that helped me get out of the pre-diabetic range. I soaked it up like a sponge.

Responses by Clinic Administrators and Physician

- Very thankful he was able to meet with CHW in his own home, in his own area. Not having to drive an hour to get what he needs from the clinic saves him time and money. So excited it was even an option. He understood the value and the need behind the visit, he was just excited he didn’t have to make drive an hour to get it.
- Husband was so excited somebody was able to reach out and help his wife. In his mind this was something that was going to prolong her life and keep her around for him.
- Anybody who has interacted with CHWs – it’s all been positive.

QUESTION #7: What would the healthcare team (or supervisor) say about CHWs?

Responses by Community Health Workers

- The same as patients
- I always ask questions if I need clarification
- I offer to help with tasks (like arranging transportation)
- I’m a team player – I like to help out where I can
- I do care about the population I work with
- Patient care always my top priority. I strive for a positive work environment with an engaged staff and patient centered care. Every patient is an individual and completely new from anything we’ve seen before.
- Echo what patients say
- Always ready to try something new – flexible
- Keep up with job that is ever evolving

Responses by Supervisory Community Health Workers

- They know the other needs are being addressed.
- Since CHWs complete referral forms (i.e. to counseling) with the patient, counselors know exactly what they’re needed for.
- Relieves pressure from the providers, so provider can go on to see another patient. It frees up time for them. CHWs address things the providers care about, but don’t have time to address in a normal clinical setting. Now there’s somebody to do that.
- I’m trying. I’m passionate about my role as a CHW. I’m caring and compassionate. We’re building a new program, and there are so many (good) challenges. I’m trying to help create this important job.
- We’re transitioning into a care team. Snake River Community Clinic has had some really good reviews about how we’re helping patients. They’re very thankful about how we’re helping their patients

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- Providers still need to learn more about CHWs, although they are understanding more. We have more work to educate the health care team.

Responses by Clinic Administrators and Physician

- Still some confusion about what the CHW does. Partly because it's a new model, a new way.
- Have seen the benefit the CHWs were able to offer the screening, the FIT test, providing the education
- Compassionate, patient advocate, patient facing
- Built important community partnerships
- Work has been invaluable. CHW can take the SDOH work, so nurses can focus on what they need to focus on.
- CHW is the conduit to building trust between patient and entire healthcare team
- CHWs work magic – literally and figuratively.
- Help identify things I haven't even thought of. I know patients aren't getting better, but I don't know why.
- CHW is able to find out why and then to find ways to solve the problem.
- I've seen CHW turn around their health.

QUESTIONS #8 AND #9: Can You Provide Examples?

Responses by Community Health Workers

- 63 year old legal guardian of 4 year old great grandson; inside home is great grandson's mother who has a newborn and doesn't do any work or help with the 4-year old; I kept calling patient; took forever for her to allow me to come into her house; timid/weary of healthcare; non-compliant checking blood sugars; unmanaged diabetes; forgetful because she's watching 4-year old;
  - Initial 2-hour house visit; she invited me back next week to meet great grandson; I returned, met him – he's a handful, still in diapers
  - I've met with patient about 10 times; I got her to agree to have a pharmacy student come in and do a medication check; I put up signs around the house (fridge, mirror) to remind her to check blood sugar and take medications.
  - I talked with her about early Headstart for great-grandson; I took her to the office; we got him enrolled; she just found out he was accepted; he'll be going in the afternoons (that's huge); we applied to have bus pick him up;
  - Got her set up with a counselor; going with her next week to meet her PCP
  - This is going to be huge for her to have the afternoons to herself
  - Until I started working with patient, nurse didn't know she was non-compliant because she was too busy taking care of great grandson
  - Now compliant; mental health has improved greatly
- Multiple patients
  - Talk about social factors or life in general. As patient talks, I mention the resource page for mental health and counseling services. Patient interested in counseling or therapy.
  - Nurse write a referral for counseling with (United Methodist)
  - Patient goes to scheduled appt. to discuss problems they've been having
  - Patients receives accurate care and begins to address life issues beyond physical health.
- 26-year-old female just moved from Oregon needed health insurance, didn't know Idaho.
  - We're certified enrollment counselors; spent a few hours helping her sign up for a plan
  - Also helped with housing, healthcare options,

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  - Able to provide affordable healthcare in our organization: medical, dental, behavioral with sliding fees
  - Warm hand off to receptionist; sometimes can talk to a provider right then
  - Saw this patient recently – she has a job and is still a regular patient at our organization
- I volunteer at one of the food pantries. Mentally challenged man. Talks with me.
  - Every time I see him, we catch up, we talk, I can do small medical checks like blood pressure, etc. Personal relationship
  - He now promotes health screenings with others at the food pantry
  - Get out as a resource in the community – resources are out there!
- High user in ED; abused by ex-boyfriend. Home in Nampa. Poor. Taking care of 17-year old son who just got released from prison and recently diagnosed with schizophrenia; living in a tiny room and sharing a bed with her son.
  - Non-compliant checking blood sugar. Out of control diabetes – 400 level blood sugar. Vision going; slowly deteriorating
  - I kept asking, "what if I set up diabetes classes?" Finally agreed. I met her at her house. She followed me to clinic. We went to appt., and completed the diabetes classes together.
  - For 1 week I texted her morning and night reminding her to check her blood sugar.
  - Pharmacy student came with me to do a medication review – she was doubling up on medications. Nobody would have ever caught that.
  - I don't want to coddle the patients – they just need extra support.
  - Trust! She held my hand during the whole appt.
  - Her vice: One Pepsi every day; we brainstormed, "a smaller can of Pepsi today"
- Many patients
  - I review resource pages, such as tobacco cessation, childcare, transportation, dental, and more. Patients stop me at dental and say "I need that, and so do my kids."
  - I help schedule patient for a dentist appointment- either in our dental clinic or dentist from resource page
  - Patient sees or takes children to dentist, sometimes for the first time in their lives.
  - Within a month or two the patient would have dental help - Able to eat solid food, able to get nutrition.

Responses by Supervisory Community Health Workers

- CHW may communicate something to provider that patient doesn't feel comfortable communicating. Maybe help patient explain better or help them advocate for themselves.
- Empower patient; understand what provider's talking about; put into words what they're trying to explain.
- Help patient interact with provider in a way that impacts their medical care.
- Our patient population can be afraid of provider; intimidated. Teaching patient – you can advocate for yourself, you can speak up for yourself, and you can say these things, explain the situation.
- One patient came to our very first community health screening. During an A1C test, she learned her numbers were very high. After that she saw her doctor and was trying to bring her A1C down. We connected her to CDSMP offered by *Area Agency on Aging and Community Action.* She participated in the classes. She attended every event we were offering or promoting. She participated in our "walk the prairie" community walks and completed a promotional walking passport. When she could not attend one walk, she used her passport to handwrite activities that she completed on her own at home. She had notes that she learned from the CDSMP class she took.

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We saw her everywhere. She came to the screenings to get monitored. This August, her A1C level was out of the pre-diabetic range. She burst into tears. She found a weight loss program that worked for her.

- At a recent health fair with a local hospital one individual in line was in desperate need of health care
  - CHW referred and scheduled person to a local urgent care clinic, then followed up later.
- One CHW working with a local Head Start program noticed a child with rotting teeth.
- CHW was able to get dental care for this child
  One CHW speaks Spanish helps patients who usually bring in family members to interpret.
  - CHW can provide the interpreting / medical terminology for the patient.
- One patient diagnosed with hypertension had access to food, but wasn't eating enough because he didn't know what he could and couldn't eat. We plugged him into a class through Idaho Foodbank that teaches people how to shop and eat on a low-income.
- Last winter a patient called: "I'm stuck in Emmett and my only source of heat is a wood stove. But I ran out of wood." I did some research and connected her to resources in Emmett that might help with heating.
- One patient came to a free community screening. She didn't want results sent to her doctor because she didn't have insurance at the time (husband just lost his job). Her A1C numbers were over 11 – very diabetic, and she didn't know it. We talked. I encouraged her to give the A1C numbers to her doctor. She agreed. I asked a benefits counselor to contact her.
  - I later called her, and she indicated she had been in to see her physician.
  - Next time I saw her walking in town, she was all smiles. "I've been to the doctor; I'm on medication; my A1C is down to 7." She is now taking our CDSMP class that we're offering to self-manage her diabetes.
- Impacting the behavior and engagement of patients.
  - It's really empowering to a person who has a screening and gets a poor result and CHWs can say, "Here we offer this class – we can help you manage your diabetes. We can connect you to these resources; we can help you with insurance. Would you like insurance benefits counselor to call you?"
  - When they're at the health screening table, they don't leave the table hopeless; they leave with information. They may take the information and come back when they're ready to make changes. But the CHW is available to help.

Responses by Clinic Administrators and Physician

- One patient has been able to meet with CHW in his own home. Doesn't have to drive an hour to get what he needs from the clinic saves him time and money.
- CHW known in the community. 80-year old gentleman approached CHW in the grocery store. "Can you help me? It would help my wife to get a little exercise, but she's not going to listen to me; she doesn't want to hear anything I have to say about exercise. I know you're doing those Fit and Fall classes. Could you just talk to her? Let her know what you're doing?"
  - CHW waited for the right time, then struck up conversation. Wife agreed, but didn't want to go alone. CHW picked her up on the way to the class.
  - Now patient is attending weekly Fit and Fall classes. CHW took the time to talk with her; picked her up. Not coming from husband. Connection. Patient engaged.
- Patients with DME- durable medical equipment (wheelchair, nebulizer, etc.), but the equipment is not functioning correctly in the home.
  - CHW goes to the home and can see that the equipment is not functioning correctly – it might be the cause of a problem a patient is experiencing or lead to decline in health status/result in hospital admission

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  - CHW reports the malfunctioning equipment to supervisor – "this is WHY the patient is reporting a problem, or isn't using the equipment"
  - Provider has greater understanding and can submit clinical documentation and recommendation for new equipment
  - Patient gets equipment they need
- In Garden City, Canyon County, migrant farm workers CHWs do community health screenings
- Patient had a newborn, but no safe car seat. CHW helped her acquire a new car seat
- Patient employed full time prior to an accident preventing him from work; had difficulty asking for assistance
  - CHW worked with him through email, phone, and office visits 1-2x weekly February through May.
  - Helped patient arrange payment plan to IRS
  - Helped patient receive St. Luke's financial assistance on the balance after insurance payment
  - Helped patient access St. Alphonsus financial aid to cover emergency room charges
- With the help and advocacy of the CHW, patient saved over $7,000 of estimated medical expenses from his accident
  Patient sought assistance with medical bills. CHW learned that the patient was also seeking employment but needed help to create CV. Patient had not worked in the U.S., but had a lot of professional work experience.
  - CHW helped edit and modify the CV to fit American resume styles.
  - Resume helped patient apply for jobs and acquire employment.
- One gal signed up for a screening just to help the event be successful. Her results revealed she had some serious health issues. She made real lifelong changes. Had she not gone to the screening, she would not have been diagnosed at the time she was.
- One patient had weekly med cassettes. Would always forget to pick up on Friday, so would be out of meds on Saturday and go to ER. CHW started calling patient on Friday to remind them to get medication before the weekend. ER visits declined, just by that weekly CHW contact.
  - Patients not comfortable relaying important, but personal information to the doctor
  - Patients trust the CHW and will share the important, personal information
  - CHW can help patient understand why and how they need to share information with provider
  - Provider is better able to treat patient
  - Patient is empowered. THAT's what we want. When the patient is empowered, they will change their behavior.

<u>QUESTION #10:</u> How would you describe the community in which you work?

- 75% Urban underserved + 25% Rural
- Language barriers – Spanish speaking, Migrant farm workers , Tribal communities
- Refugee communities, Urban – Garden City
- Frontier, because of where we are and away from services;
- Rural for sure, communities of 400 people, a long way from services

<u>QUESTION #11:</u> How would you describe the organization in which you work?

- Large healthcare system
  - We work with Medicare / Medicaid patients. They have to have both.

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  - Patients are at risk for a social service, or need a medication assessment, or need help getting a PCP
  - Within contract of our care managers here.
  - Post discharge
- Community health clinic
  - Patients are 200% or more below the poverty line.
  - CHWs are volunteers who work with patients at the clinic during clinic hours.
- Private, non-profit. Clinics all hospital-based clinics.
- 8 Family Practice Clinics.

QUESTION #12: Are CHWs paid?

- Federal grant – 18 month
- Strictly volunteer Community health coordinator funded through United Way grant. Clinic funded through grants as well.
- Yes. Initially were funded through unique grants. Now CHWs are included in our organization budget
- Paid by the hour. Started as a part-time, seasonal staff member paid by a grant.
- Paid with organization budget
- Reimbursed as an enrollment counselor
- Yes – a HRSA grant. Seeking additional grant funding for the future. Perhaps a private, foundation grant. Paid by the hour of $13 - $16, based on experience.
- Salary is based on a variety of factors (education, experience, and required skills for position)
- Funding sources include external and internal grants or some state funded iniatives (in Oregon)
  - Not currently reimbursed
  - We do not have a billing code for CHW work
  - We're moving in the direction of proving that CHW work is paying for itself over time
- Started with AmeriCorps volunteers
  - Today, paid salary as part of the organization budget
  - Probably not covered by payers

QUESTION #13: Do CHWs have a formal role on a healthcare team?

- Yes! Marketing to all clinics in the healthcare system; I'm completely recognized.
- Yes! See patients after the health care provider and work with social services and community resources.
- Not a formal role on the healthcare team - Docs have to know the CHW
  - The 7 CHWs are integrated into PCMH at the 16 service locations of our organization. But they are not permanently on site at each clinic location.
- No formal role at this point. Our goal is for CHWs to have a formal role of interactions, home visits, provide progress notes, and share valuable insights with team.
- Next steps / new role for the future is for CHW to check in with patients discharged from hospital.
- CHWs integrated differently in clinics/care team locations throughout a large health care system.
  - Our large healthcare organization has recently formed a CHW taskforce
  - One person to lead the taskforce + different groups who work with CHWs
  - Unique role for CHW depending on patient population and needs of each specific clinic or location
  - Standardization throughout the organization (work, training, policies, etc.)

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- Integrated into PCMH
  - We have 8 different clinics.
  - CHWs are integrated into our medical team for complex patients (along with behavioral health, social workers, dietician, clinical pharmacist)
    - Team goes clinic to clinic to serve complex patients.
    - Team helps patients understand and implement medical plan
    - Helps patients understand meal planning
    - Sometimes goes to patients' home
  - Providers can refer patients to CHWs through EMR referral system

QUESTION #14: What other roles participate in the healthcare team?

- Two full-time physicians, social worker, nurse, pharmacist
- PCP, nurses, referrals as needed (counselor, dentist)
- Physician/NP; Nurse/MA; RN case manager; Beh Health Specialist; Specialties

QUESTION #15: How frequently does CHW meet with the healthcare team?

- Twice a week.
- Not a lot of formal meetings; interact daily. Community health coordinator meets with medical director daily
- More than monthly
- Mostly, they feel comfortable contacting me personally if they have a question
- Proactive relationship
- After every home visit, CHWs follow-up with case managers. Progress notes or report sent to provider.
- After each screening event, CHW's send results to PCP (if patient gives permission to do so).

QUESTION #16: What is the title of CHW direct supervisor?

- Clinical team manager
- CHW – Community Health Coordinator – Programs Director
- CHWs report to the Manager of Outreach and Communications who reports to COO, in the administration hub
  - Help with messaging
  - Can be sent out for additional support
- Practice manager. There is also a lead CHW who is the direct contact.
- CHWs report directly to a clinician - RN or Social Worker. The clinical supervisor recognizes when a higher level of care is necessary for a patient.

QUESTION #17: How frequently does CHW meet with most direct supervisor?

- See her every day; meet formally every two weeks
- Community Health Coordinator talks with Programs director daily; meet formally every two weeks
- Lead CHW meets formally with Practice Managers (2) monthly.
- Lead CHW has monthly meetings with all CHWs.

QUESTION #18: Describe CHW education, training, development.

- Undergraduate degree
- National Community Health Coordinator Training

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- SHIP ISU CHW training class
- QPR gatekeeper suicide training
- Weeklong MI clinical training
- Health system training
- As a team, we're doing a weeklong health coach training
- Volunteers – no specific requirements for education and training
- Volunteer coordinator looks for qualities like empathy, listening skills, people skills
- Encourage training with ISU CHW course – 4 of 7 are going through right now.
- Other 3 CHWs could not make the time commitment for the ISU CHW course
- Tend to be pre-med, pre-PA college students – almost half
- See one, do one, teach one - In house 3 shadowing sessions prior to working with patients
- Encourage community trainings like behavioral health, etc.
- Not a medical background
- Extensive knowledge of the community
- Organization has "trained me up"
    - Support in-service training, development, conferences, education, etc.
    - Organization pays for the cost of trainings, invest into CHW program
- Regarding required skill set from CHWs?
    - Embedded in the community, trusted, able to work with patients in the community, community relations skills
    - Going forward, our organization would like to have a Spanish-speaking CHW who understands that culture
- Does your organization require certain education, training, development?
    - We can train CHWs up
    - We recognize the CHW "Pathways" model as effective in providing a procedure for intervening around defined SDOH with the patient
- Hard part is proving ROI for CHWs ** See below
    - Organization believes in the value of CHWs to serve the whole person
    - Org sees how CHWs fit the missing puzzle piece for patients
- We consider anyone along the full spectrum of less developed to most developed.
- After hiring we require the ISU course
- We provide professional development, such as attending the monthly IPCA meetings, or West Coast CHW conference
- We promote additional specialized trainings and continuing education, such as mental health, diabetes, as it arises.
- Certain skill set?
    - Self-motivated. Ability to get out-and-about with little oversight.
    - Care and concern
    - Many of our CHWs were previously volunteers
- All are currently enrolled in SHIP ISU course
- Public Health Dept. conducted 1-day training
- Some attended Spokane CDSMP training
- Some attend different conference (motivational interviewing, etc).
- Ongoing development
- Require skill set from CHWs?
    - Different skills for different CHWs: MA, BA, language
    - Don't know what education, training, development is required in the organization

<u>QUESTION #19:</u> Describe the oversight (supervision) CHWs receive.

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- Everything I do has to go back to a point of clinical contact
- Supervisor wants to make sure I have good communication with referring individual
- My supervisor signs off on discharge patient
- Oversight by community health coordinator; CHC reviews patient record prior to patient visit
- Team mentality in our dept.
- Meet w/ supervisor weekly to discuss my goals, my ideas for programs and initiatives
- Meet as an outreach team weekly to discuss events and opportunities
- Meet as an outreach department weekly
- Communication is key; system of open door, accessible – supervisor and CEO (open to hear our ideas)
- CHWs report to the CHW Program Coordinator (me) who reports to the COO
- Everybody knows, communicates, shares, etc.
- We use a Tracking Worksheet
- Develop goals and objectives
- We're watching – we'll address issues that arise
- If not meeting expectations, or if provide wrong information, then lead CHW has conversation with CHW
- Expectations include paperwork and reporting
- Reports directly to clinician – RN or social worker
    - Direct oversight
- Answer to lead CHW
    - Integrated Medical Team is under the Medical Director

<u>QUESTION #20:</u> Describe the access CHWs have to patient information (records).

- No access to EMR. I type up all notes and email to nurse or document/talk with nurses here directly.
- Yes access. Enter data into medical chart-community connector appointment-deficient knowledge of community services-an order for a community referral – what patient receives.
- Full access to EHRs – see patient charts for scheduling, etc.
- Full access to EHR.
- Access to EHR is helpful at Mobile Health Unit
- CHWs can access patient chart when necessary to check for follow-up, etc.
- Yes. CHWs have access to patient records.
- As an employee, CHW has access.
- Exact policy in development. Drawing from Oregon's model.
- Full access to EMR in order to access patient referrals to CHW

<u>OPPORTUNITY QUESTION:</u> Organization's policies regarding mandatory reporting.

- Required to report child abuse, suicidal, homicidal
- When we get a referral to do a 1-on-1, the referral goes to the CHW. The CHW visits with patient using a pathway questionnaire that includes questions about food, heat, power, medication, elder abuse, child abuse, medications, smoke detector, safety concerns, feeling depressed, pets, etc. CHW sends report with information from the pathway questionnaire to referring provider. Any concerns included in the report. We also connect patients to resources, if we see concerns (no food, no heat, etc.).
- Not sure… abuse by kids, etc.
    - CHWs share safety concern,
    - Progress notes to provider who made the referral will include concerns (like smoking in home with oxygen tank, or didn't know about foodbank, but I saw food or nutrition concerns)

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  - Not licensed, not a nurse or a medical provider, no obligated to report, don't know we have addressed those concerns. Social worker would be compelled to report. Knowing our CHW's they would be talking with me or other administrator (we're both nurses).
- Don't know about organization's mandatory policies
  - Reporting of child abuse is required by law.
  - CHW doesn't diagnose anything, so no mandatory reporting.

<u>OPPORTUNITY QUESTION:</u> Organization's policies regarding liability

- Covered by the clinic's liability policy
- CHWs are covered by the organizational liability umbrella policy.
- Blanket policy by hospital liability
  - Policies and protocol in place – no medical advice, no medical background, not trained, not licensed, not certified – don't give medical advice.
- Much easier to operationalize liability when CHW is a paid employee of the organization
  - First line of liability is the up line clinical supervisor
  - In the process of developing comprehensive policies
- In development. Drawing from Oregon's model
- Covered by organization's liability policy

<u>OPPORTUNITY QUESTION:</u> Organization's policies regarding HIPPA

  - Same policies, access and guidelines for HIPPA, confidentiality, privacy as clinicians
    - Everything behind lock and key, computers always locked
    - Very conscientious at events – viewable only by CHWs
    - Need the trust with the community

<u>OPPORTUNITY QUESTION:</u> Organization's policies regarding CHW safety

- For safety purposes, CHWs work in pairs when out in the community
- Follow proper lab safety instructions
- We need to get something set up for CHWs to call a number. Right now, if CHWs have concerns they bring to supervisor.
- Partner (Public Health Department) did a training for CHW's. They put a policy in place.
  - Clinic evaluates whether there is a concern to make a home visit to patient – won't refer
    - If clinic makes referral, they talk with the patient
    - If patient agrees to a home visit – a list of do's and don'ts for day of visit (dogs, alcohol,) what we do for you, what we expect of you.
  - CHW - If they know and feel comfortable going to home of person, that's fine
    - If they don't know person, or don't feel comfortable going to home – arrange a safe place to meet (coffee shop, library, area deemed safe for both). Patient may not want CHW in their home. Conversation they can have – both agree home is okay.
    - If doing a home visit
      - Recorded on calendar – everyone knows where and when
      - Check in with another CHW or with someone at clinic or family member – somebody always knows where, arrival, plan to be there, time of completion, when should be home.
- Don't know

<u>OPPORTUNITY QUESTION:</u> Prevention versus some level of chronic disease management?

- Depends on individual
- CHW – coordinator mostly disease management
  - Other CHWs work in promotional, awareness, community events.

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- Make sure you hire someone is who compassionate.
- Tied into a good system of support.
- Depends on patient population, clinic and community needs. CHW in one clinic may focus on prevention, while CHW in another clinic may help patients manage disease.
  - One of our sticking points right now is how CHW best helps patient manage disease. As a non-licensed person, CHW can't educate patient about disease. If the patient trusts the CHW, they will listen and follow advice. The CHW can help patient get to educational classes about diabetes (so work may be around identifying transportation options to the classes, daycare for children, scheduling, etc.)
- Providers want / need a real life patient scenario.
  - This is the patient
  - This is how a CHW can help you help your patient
  - This is how to refer the patient to CHW
  - Examples of patient successes, etc.
- Depends entirely on needs of the patient and needs of the day.

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APPENDIX B: RESPONSES BY INDIVIDUAL

Community Health Worker: Emily

Background:

- We work with Medicare / Medicaid patients. They have to have both.
- Patients are at risk for a social service, or need a medication assessment, or need help getting a PCP
- Within contract of our care managers here.
- Post discharge

Describe in your own words the important elements of your job as a CHW.

- The biggest thing is connecting our clients with services
  - Special services, or being set up with a provider, specialty clinic
  - Just kind of acting as that middle man to get them connected.

What challenges faced by healthcare providers in your organization are you uniquely able to address?

- **Compliancy**
  - A lot of times the patients go to the doctor's office, they have an appt., and then they go back home and they just don't follow though
  - Almost all of my patients, I've gone to almost all of their pcp appts. with them. They want me there with them, so we're all on the same page, I'll check up with them a week later, just to see how things are going,
- **Medication assessment**
  - One of my roles I was trained on was to do a medication assessment; so I kind of do a data collection of what a patient is taking, why they're taking it, how are they taking it; do they know where to go to get refills.
  - And I take this information back to our pharmacist here, and she'll type up the notes and give it to the doctor.
  - We just recently started having ISU 4th year pharmacy students go out with me, which is huge.
  - When I have rapport with a patient, I'll ask if it's okay for a pharmacy student to come just to go over your medications with you (as it's beyond my scope). They'll sit down with the patient for an hour, and I'll sit there too and they'll just completely go over all the medication. It's incredible the amount of poly-pharmacy going on. The pharmacists don't talk to each other; the doctors don't talk to each other. So many side effects they don't understand

What unique contributions are you able to make to address those challenges and provide better healthcare?

- **Trust with clients**
  - Some of these nurses have been working with these patients for years and they still don't have a lot of trust in them.
  - I believe 100% it's the fact that I go into their homes. I sit down with them. I tell them, I'm an advocate for you; I'm not here because your doctor wants me here; I'm not here as a clinical person; I'm just here to see what can I do to help you make the most of this situation?
- **Recognize the SDOH** that just get in the way of these patients, and just helping them navigate that.
  - Something as simple as transportation, or helping them get food stamps
  - I just don't judge. Not of these patients woke up and decided to be poor or sick. I'm just here to help them.

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What might a day in your life as a CHW look like?

- I'm probably out doing a house visit every day.
    - About a 2-hour appt. I have a long questionnaire that takes awhile
- I have meetings here
- I have a lot of documentation. I have to document everything I talk about.
- A lot of calling around; if a patient needs help with, say housing. I have a patient with glaucoma, so I'm helping him complete an application.

What might a patient interaction look like?

- Two-hour initial interaction
- Toward the goal of helping patient get a social service, or do a medication assessment, or help patient get a PCP
- I go into their house. I usually try to find something we can talk about, because they're all really proud of their homes. So we usually just chat, and if there's family members there, I get to know about them
- Then I go into my role (I don't know if your care manager explained my role to you), so I'll go a little more in-depth about what my role is. Explain what a [CHW] is. And then I seek approval to ask some questions
- A long questionnaire
    - Very in depth - goes into background, education, abuse, stress, triggers on PHQ 9,
- Opens so many doors

Sometimes they'll ask me to come back over

- I may bring a pharmacist with me,
- Do a follow-up (food stamps, or other SDOH, help find a PCP), or check-in
- Afterwards, I'll submit referrals

Sometimes nurses just ask me to go check on the patient – they' re already dialed in to services

What would the patient you helped the most say about you?

- That I care – I want to see the happy in their life – I don't judge
- I'm proactive. I get things done

What would your healthcare team (or supervisor) say about you?

- The same as patients
- I always ask questions if I need clarification
- I offer to help with tasks (like arranging transportation)
- I'm a team player – I like to help out where I can
- I do care about the population I work with

Can you provide an example:

- 63 years old; legal guardian of 4 year old great grandson; inside house is great grandson's mom who has a newborn baby and doesn't want to do any work or help with the 4-year old; I kept calling patient; took forever for her to allow me to come into her house; timid/weary of healthcare; non-compliant checking blood sugars; unmanaged diabetes; forgetful because she's watching the 4-year old;
- Initial 2-hour house visit; she invited me back next week to meet great grandson; I returned, met 4-year old great grandson – he's a handful, still in diaper
- I've met with patient about 10 times; I got her to agree to have a pharmacy student come in and do a huge medication check with her; I put up signs around the house (fridge, mirror) to remind her to check blood sugar and take medications in the morning.

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- I talked with her about early Headstart for her 4-year old great-grandson; I took her to the office; we got him enrolled; she just found out he was accepted; he'll be going in the afternoons (that's huge); we applied for him to have bus pick him up;
- Got her set up with a counselor; going with her next week to meet her PCP
- This is going to be huge for her to have the afternoons to herself
- Until I started working with this patient, the nurse didn't know she was non-compliant with diabetes mgmt. because she was too busy taking care of great grandson
- Now compliant; mental health has improved greatly

Do you have additional examples to provide?

- High user in ED; abused by ex-boyfriend. Home in Nampa. Poor. Taking care of 17-year old son who just got released from prison and recently diagnosed with schizophrenia; living in a tiny room and sharing a bed with her son.
- Non-compliant checking blood sugar. Out of control diabetes – 400 level blood sugar. Vision going out; slowly deteriorating
- I kept asking, "what if I set up diabetes classes for you?" Finally agreed to go. I met her at her house. She followed me to the clinic. We went to appt. together. Did all the diabetes education training together.
- For a week. I texted her every morning and every night reminding her to check her blood sugar.
- Pharmacy student came with me to do a medication review – she was doubling up on medications. Nobody would have ever caught that.
- I don't want to coddle the patients – they just need extra support.
- Trust! She held my hand during the whole appt.
- Her vice: One Pepsi every day; we brainstormed, "what if you have a smaller can of Pepsi today?"

How would you describe the community in which you work as a CHW?

75% Urban underserved

25% Rural

How would you describe the organization in which you work as a CHW? Large healthcare system

Are you paid as a CHW? Federal grant – 18-month

As a CHW, do you have a formal role on a healthcare team?

Yes! Marketing to all clinics in the healthcare system; I'm completely recognized.

What other roles participate in the healthcare team?

Two full-time physicians, social worker, nurse, pharmacist

How frequently do you meet with the healthcare team? Twice a week.

What is the title of your direct supervisor? Clinical team manager

How frequently do you meet with your most direct supervisor? See her every day; meet formally every two weeks

Describe your education, training, development as a CHW.

- Undergraduate degree

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- National Community Health Coordinator Training
- SHIP ISU CHW training class
- QPR gatekeeper suicide training
- Weeklong MI clinical training
- Health system training
- As a team, we're doing a weeklong health coach training

Describe the oversight (supervision) you receive as a CHW.

Everything I do has to go back to a point of clinical contact
Supervisor wants to make sure I have good communication with referring individual
My supervisor signs off on discharge patient

Describe the access you have to patient information (records). No access to EMR. I type up all notes and email to nurse or document/talk with nurses here directly.

Anything else??? Difficult for me to speak to a direct medical outcome. I just deal with the social barriers for the nurses.

Community Health Worker: Sierra

Describe in your own words the important elements of your job as a CHW.

- Making the patient feel heard, listening is important
- Knowing the resources lists well enough to offer more resources
- Being a champion of the patient and giving them an outlet for questions and concerns
- No time constraints with CHWs
- SDOH factors
- Know the resources in Treasure Valley

What challenges faced by healthcare providers in your organization are you uniquely able to address?

- Individually, needs of Spanish-speaking patients
- Not much time for providers to listen to social factors- this makes sure those are still addressed. Sometimes just as important as physical problems

What unique contributions are you able to make to address those challenges and provide better healthcare?

- Not much time for providers to listen to social factors- this makes sure those are still addressed. Sometimes just as important as physical problems
    - Lifestyle changes (tobacco cessation), dental work (dental free clinics)
    - Language translation - Spanish

What might a day in your life as a CHW look like?

- Arrive around same time as patients, begin processing intake forms that patients fill out when they get there, begin entering responses into AthenaNet,
- go see patient with pertinent resources after providers are done or during a break in patient care,
- come back to grab any additional resources patient may express interest in, dismiss patient (provider dependent),
- go back and enter discussion notes and finish logging appointment details; also helped to fill out mental health and counseling request forms with the patient when applicable

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What might a patient interaction look like?

- Very much patient dependent
  - Some patients are more reserved and just say thank you for the resources you hand them
  - Others want to tell you about their lives, ask questions, and really participate in the process
  - Often by asking people to elaborate more on the responses from the intake forms there is an opportunity to discover further need for additional resources (ex, food need vs dental needs)

What would the patient you helped the most say about you?

- I listened and personalized resources for given situations. Not only did I give pertinent resource pages, I would highlight resources that were more likely to help them address specific situations.

What would your healthcare team (or supervisor) say about you?

- Patient care always my top priority. I strive for a positive work environment with an engaged staff and patient centered care. Every patient is an individual and completely new from anything we've seen before.

Can you provide an example:

- Multiple patients
- Talk about social factors or life in general. Patient gets to talking and I mention the resource page for mental health and counseling services. Patient interested in counseling or therapy.
- Nurse write a referral for counseling with (United Methodist)
- Patient goes to scheduled appt. to discuss problems they've been having
- Patients receives accurate care and begins to address life issues outside of just physical health.

Do you have additional examples to provide?

- Many patients
- I review resource pages, such as tobacco cessation, childcare, transportation, dental, and more. Patients stop me at dental and say "I need that, and so do my kids."
- I help schedule patient for a dentist appointment- either in our dental clinic or dentist from resource page
- Patient sees or takes children to dentist, sometimes for the first time in their lives.
- Within a month or two the patient would have dental help - Able to eat solid food, able to get nutrition.

Community Health Worker: Laramie

Describe in your own words the important elements of the CHW role.

- Creating Relationships
- Engaging with the community
- Provide smiles to people when they're going through hard times and receive bad news
- Liaison between the patient and the clinic

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What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?

- Accessibility
  - Providers care about patients deeply, but can't "meet people where they're at"
  - Time is scarce

What unique contributions are CHWs able to make to address those challenges and provide better healthcare?

- CHWs can meet patients "where they are" and outside the clinic
- At health screenings, and outreach
- I can meet with patients individually; I can help convince them to see a provider
- Practical things – being bilingual, diligent and discerning
- I can go out into the community to hold health screenings (food pantry)
- Perspective of the patient, experience, empathy, compassionate

What might a day in your life as a CHW look like?

- Chuckle – no typical day
- Answer patient questions through email, returning calls, etc.
- Doing outreach is a core aspect of my job
  - Resource for community
  - Stocking up on medical and outreach kits
  - Heading out to a partner location to interact with people – listen to learn what their barriers are, and seek solutions that our organization can participate in to address
- Community meetings - PTA's, community school programs, finding and developing partnerships with organizations that connect with our mission

What might a patient interaction look like?

- Mostly out in the community
  - Resource events – BSU, schools, services our organization provides
  - Personal time with people about their issues and connect to resources in our organization
  - Help to meet SDOH needs – food, etc.

What would the patient you helped the most say about you?

- Genuinely care
- Do my best to help with their situation
- Understand what their situation is like – I can connect to them
- Patients have asked for supervisor number to say THANK YOU for being available, accessible, being there to help
- HOPE! I did experience what they're going through: parents diligence, hard work, school, rise above is possible, betters days ahead

What would your healthcare team (or supervisor) say about you?

- Echo what patients say
- Always ready to try something new – flexible
- Keep up with job that is ever evolving

Can you provide an example:

- Patient – 26 year old female just moved here from Oregon. She needed health insurance, didn't know Idaho. Came to us.
- We're certified as enrollment counselors; spent a few hours helping her sign up for a health insurance plan

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  - Also helped with housing, healthcare options,
- Your contribution to healthcare team
  - Understanding our financial programs are valuable
- Action by healthcare team
  - Able to provide affordable healthcare in our organization: medical, dental, behavioral with sliding fees
  - Warm hand offs to receptionist; sometimes can talk to a provider right then;
- Saw this patient recently – she has a job and is still a regular patient at our organization
- Do you have additional examples to provide?
  - Volunteer at one of the food pantries. Mentally challenged. Talks with me.
  - Every time I see him, we catch up, we talk, I can do small medical checks like blood pressure, etc. Personal relationship
  - He now promotes health screenings with others at the food pantry
  - Get out as a resource in the community – resources are out there!

Background –answered by supervisor during an earlier interview
- Paid by the hour. Started as a part-time, seasonal staff member paid by a grant.
- How paid with organization budget
- Reimbursed as an enrollment counselor

How frequently do you meet with the healthcare team?
- More than monthly
- Mostly, they feel comfortable contacting me personally if they have a question
- Proactive relationship

Describe your education, training, development as a CHW.
- Not a medical background
- Extensive knowledge of the community
- Organization has "trained me up"
  - Support in-service training, development, conferences, education, etc.
  - Organization pays for the cost of trainings, invest into CHW program
- Hard part is proving ROI for CHWs ** See below
  - Organization believes in the value of CHWs to serve the whole person
  - Org sees how CHWs fit the missing puzzle piece for patients

Demonstrating ROI for CHWs
- All about tracking
- Hired a CHW Program Coordinator
  - To better track patients
  - How affecting patients' chart – increases in health, coming in doors more frequently
  - Are seeing a rise that we hadn't been tracking before
  - Great to see an org be able to see where CHWs can fill a need
    - Data tracking
    - All about team work to cover all of the gaps – data tracking has been huge to see the programs are working
  - Relatively new to know $$ yet – see Cristina Foud
- Preventive care is a huge deal
  - We're seeing increased visits and screenings – we're getting patients in the door

  "If we as CHWs can be proactive and go out into the community and share with them the importance of preventative care, then we'll not only see a lower cost at [our organization], because those people are getting continued care, but we'll see a decrease

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in cost in communities in general. I strongly believe the more we see Idaho start to adopt Community Health Workers into their program, the more that we're going to see a lowered cost for communities and a lower burden of care for communities."- CHW, Region 4

The oversight (supervision) you receive as a CHW

- Team mentality in our dept.
- Meet w/ supervisor weekly to discuss my goals, my ideas for programs and initiatives
- Meet as an outreach team weekly to discuss events and opportunities
- Meet as an outreach department weekly
- Communication is key; system of open door, accessible – supervisor and CEO (open to hear our ideas)

Access you have to patient information (records)

- Full access to EHRs – see patient charts for scheduling, etc.

Liability

- Covered by the clinic's liability policy
- HIPPA
  - Same policies, access and guidelines for HIPPA, confidentiality, privacy as clinicians
    - Everything behind lock and key
    - Computers always locked
    - Very conscientious at events – viewable only by CHWs
    - Need the trust with the community

Anything else?

- CHW Association in Idaho
  - CHWs in Treasure Valley know each other; we share community partners, resources, connections,
  - CHW Association in Idaho seeks to address the difficulty of defining CHW, given the differences and similarities among CHWs
  - CHWs have been in Idaho for quite some time, but the past few years have brought increased interest in CHWs
  - We have until July to get CHW Association up and running
  - Will be nice to have an accreditation to show value of CHWs, validate CHWs are an integral part of healthcare team

Supervisory Community Health Worker: Johnny

Clinic:

Clinic patients are 200% or more below the poverty line.
Clinic CHWs are volunteers who work with patients at the clinic during clinic hours.

Describe in your own words the important elements of your job as a CHW.

- Someone the patient can relate to; more "on their level;" someone who can empathize and understand what they're going through.
- Not all the time, but sometimes in the doctor/patient relationship the patient can feel like the provider is talking over their head. They may not understand what's being said; the CHW can get on their level and talk with them in layman's terms; help them understand what's being said.

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- The doctor's super busy and has only a certain amount of time with the patient. The CHW can have more time with and get to know the patient. Take the time to understand the struggles the patient is going through.

What challenges faced by healthcare providers in your organization are you uniquely able to address?

- The Social Determinants of Health are huge for our patients. Do they have enough food on a daily basis, do they have transportation to appts., can they afford their medications, can they afford the utilities? If they can't afford to pay bills, it's going to be a lot harder for them to pay for their prescriptions, or whatever they need.

What unique contributions are you able to make to address those challenges and provide better healthcare?

- After a patient is seen by a nurse, then by a doctor, the CHW goes in. We screen all our patients with a screening form (addressing SDOHs). The CHW uses the form to talk with patient about community resources, social services that can help address the needs.

Can you make the link between the SDOH and healthcare?

- Diet and nutrition – that's a huge one. Based on Maslow's Hierarchy of Needs, for patients to be concerned with their quality of life, they have to know their basic needs are met. So, making sure they have enough food and water on a daily basis, or they have a place to stay, they have security and safety, they have a place to go home to. CHW helps them meet basic needs, so they can be concerned about health. If they don't have enough to eat on a daily basis, why should they be concerned about how what they eat affects their blood pressure, their glucose levels, or anything like that?

What might a day / shift in your life as a CHW look like?

- CHWs are here during our clinic hours to work with patients.
- Nurses see the patients first, then the doctor, then CHW.
- All patients complete a screening form. If form has stuff they're triggered for, then the CHW goes in to see that patient.
    - Could be any SDOH – somebody isn't satisfied with their education level; maybe dropped out of middle school and want to get their GED. CHW can connect them to resources in the community so they can finish that schooling.
    - Maybe they don't know where to go for food or they know where, but don't know what kind of food to eat. One patient was diagnosed with hypertension had access to food, but wasn't eating enough because he didn't know what he could and couldn't eat. We plugged him into a class through Idaho Foodbank that teaches people how to shop and eat on a low-income. That kind of stuff.

What might a patient interaction look like?

- Every patient fills out the form
- List of resources on the computers; CHW prints the resources and takes into the patient interaction.
- CHW sees every new patient and introduces themselves. Goes into it as a conversation.
    - It's a new concept; not a lot of people in Idaho understand what a CHW is. We explain what a CHW is.
    - If the patient wonders "why did I fill out that form?" We explain "these are things that might not affect you medically but might affect your health in other ways. We help you with that kind of stuff."

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- "You said on this form you don't have enough food. What does that look like for you?"
- CHW is there (has the time) to listen, to understand. Maybe say, "I see these resources didn't work for you, so we're gonna see if we can find something that works better for you."
- CHWs let them know that since they volunteer, they're just here for that shift. So they let the patients know that if anything comes up, they can just call in to the clinic. I've had patients call in – one patient called in last winter, "I'm stuck in Emmett and my only source of heat I have (last winter) is a wood burning stove." But she ran out of wood, so how is she going to heat their house? So I did some research and got her connected to some different things out in Emmett that might help her keep her house heated.
- CHW supervisor jumps in when the needs are beyond the CHW. CHW supervisor here full-time; has the time to go look beyond what can be looked for in that short session.

What would the patient you helped the most say about you?

- They're being cared for beyond just what's going on medically. Beyond, "your blood pressure levels are good," "Your A1C is fine," "you're not dealing with depression, it's not showing up on the form."
- Going beyond to say, "okay, these numbers are good, but how is your quality of life?" "do you feel safe at home?" Asking the "beyond" questions, and "what's important to you?"
- They're not going to say to a doctor – "I dropped out of high school a long time ago, and I want to go back. But I don't know if that's possible." But with a CHW, they can talk about stuff like that. They can say, "I dropped out, and I kinda want to go back, but I don't know if I can." And the CHW can say something like, "here's some different resources." The fact that they're even considering is huge, but then we encourage them to pursueit; that it's even possible.

What would your healthcare team (or supervisor) say about you?

- They know the other needs are being addressed.
- Since CHWs complete referral forms (i.e. to counseling) with the patient, counselors know exactly what they're needed for.
- Relieves pressure from the providers, so provider can go on to see another patient. It frees up time for them. CHWs address things the providers care about, but don't have time to address in a normal clinical setting. Now there's somebody to do that.

An example:

- A CHW may communicate something to the provider that the patient doesn't feel comfortable communicating. Maybe help the patient explain a little better, or help them advocate for themselves.
- Empower patient; understand what provider's talking about; put into words what they're trying to explain.
- Help patient interact with the provider in a way that impacts their medical care.
- Our patient population can be afraid of the provider; intimidated. Teaching the patient – you can advocate for yourself, you can speak up for yourself, and you can say these things, explain the situation.

Additional examples:

- One CHW speaks Spanish helps Spanish-speaking patients who usually bring in family members to interpret.
- CHW can provide the interpreting / medical terminology for the patient.
- Another: One patient diagnosed with hypertension had access to food, but wasn't eating enough because he didn't know what he could and couldn't eat. We plugged him into a

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class through Idaho Foodbank that teaches people how to shop and eat on a low-income.

- Another: Last winter a patient called: "I'm stuck in Emmett and my only source of heat is a wood stove. But I ran out of wood." So how is she going to heat her house? I did some research and connected her to some different things out in Emmett that might help her keep her house heated.

How would you describe the community in which you work as a CHW?

Language barriers – Spanish speaking

Migrant farm workers

Tribal communities

Refugee communities

Urban – Garden City

How would you describe the organization in which you work as a CHW? Community health clinic

Are you paid as a CHW? Strictly volunteer Community health coordinator funded through United Way grant. Clinic funded through grants as well.

As a CHW, do you have a formal role on a healthcare team?

Yes! See patients after the health care provider and work with social services and community resources

What other roles participate in the healthcare team?

PCP, nurses, referrals as needed (counselor, dentist)

How frequently do you meet with the healthcare team? Not a lot of formal meetings; interact daily. Community health coordinator meets with medical director daily

What is the title of your direct supervisor? CHW – Community Health Coordinator – Programs Director

How frequently do you meet with your most direct supervisor? Community Health Coordinator talks with Programs director daily; meet formally every two weeks

Describe your education, training, development as a CHW.

- Volunteers – no specific requirements for education and training
- Volunteer coordinator looks for qualities like empathy, listening skills, people skills
- Encourage training with ISU CHW course – 4 of 7 are going through right now.
- Other 3 CHWs could not make the time commitment for the ISU CHW course
- Tend to be pre-med, pre-PA college students – almost half
- See one, do one, teach one - In house 3 shadowing sessions prior to working with patients
- Encourage community trainings like behavioral health, etc.

Describe the oversight (supervision) you receive as a CHW.

Oversight by community health coordinator; CHC reviews patient record prior to patient visit

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Describe the access you have to patient information (records). Yes access. Enter data into medical chart – community connector appointment - deficient knowledge of community services – an order for a community referral – what patient receives.

Anything else? I go out into the community (foodbanks, etc.) and work with the clients there. If clients do not have a medical home, I encourage them to come to our clinic. As a CHW you have a little bit more freedom to do stuff like that, whereas you don't have freedom to do that as a provider.

Supervisory Community Health Worker: Leah

Describe in your own words the important elements of your job as a CHW.

- We encourage individual health in order to build healthy communities.
- We're unique in that we encompass all of the people in our communities. They do not have to be a patient of St. Mary's Hospital; we are there to serve the community.
- We try to be the bridge to health care by being present in the communities.
- We go in; we look; we listen; we assess; and then we try to engage by what we observe.

What challenges faced by healthcare providers in your organization are you uniquely able to address?

- We are so rural, and just trying to reach people is hard. As one example, a free clinic serves low-income residents in three rural counties. The drive can be over 100 miles for some of them, and the cost of travel is a real barrier to them. But they have to be seen to get medication.
- The time a provider is able to spend in the office with somebody is short.

What unique contributions are you able to make to address those challenges and provide better healthcare?

- We try to have CHWs in those rural communities.
- We partner with the free clinic. By setting up a referral, we can go and visit the patient and save that (low-income) patient a trip to get their medication.
- We offer free health screenings in the community; we have information and resources; we make referrals; we assess and get ideas for needs we can help meet.
- We offer free classes and resources in the communities - beyond the office visit. For example, we are able to offer the CDSMP – chronic disease self-management program. We're going to add chronic pain self-management program (we're getting trained for that). One CHW is a DPP instructor.
- We hold regular community walks and engage people in physical activity.
- We have 1-on-1 visits.

What might a ~~day~~ week in your life as a CHW look like?

- On Monday morning I held a CDSMP program
- Tues-Thurs – we teamed up with a CHIBA counselor and held free health screenings at three senior sites.
- Tuesday morning plan and prepare for an upcoming event
- Wednesday evening we have CHW training
- Thursday I also trained a new CHW who is hosting an event next week.
- Today an interview, a presentation, data entry for a health screening.

What might a patient interaction look like?

- Conversation casual. Let patient ask the questions; I try to listen more and offer resources

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- Transitioning into the 1-on-1's: when we go to a patient's home, it's kind of like a mini-screening. We do A1C's; ask a set of assessment questions; complete a demographic form that we use at screenings.
- A home visit could be lengthy- an hour. In an aging community patients may be lonely, so they want to visit too. The initial visit could be the longest and then follow-up visits may be shorter.

What would the patient you helped the most say about you?

- We listen and we care and we're compassionate. We want to help get them what they need, or get them headed in that direction.
- Thank you for offering events in the community that helped me get out of the pre-diabetic range. I soaked it up like a sponge.

What would your healthcare team (or supervisor) say about you?

- I'm trying. I'm passionate about my role as a CHW. I'm caring and compassionate. We're building a new program, and there are so many (good) challenges. I'm trying to help create this important job.
- We're transitioning into a care team. Snake River Community Clinic has had some really good reviews about how we're helping patients. They're very thankful about how we're helping their patients

Can you provide an example:

- One patient came to our very first community health screening. During an A1C test, she learned her numbers were very high. After that she saw her doctor and was trying to bring her A1C down. We connected her to CDSMP offered by *Area Agency on Aging and Community Action.* She participated in the classes. She attended every event we were offering or promoting. She participated in our "walk the prairie" community walks and completed a promotional walking passport. When she could not attend one walk, she used her passport to handwrite activities that she completed on her own at home. She had notes that she learned from the CDSMP class she took.

  We saw her everywhere. She came to the screenings to get monitored. This August, her A1C level was out of the pre-diabetic range. She burst into tears. She found a weight loss program that worked for her.

Do you have additional examples to provide?

- One patient came to a free community screening. She didn't want results sent to her doctor because she didn't have insurance at the time (husband just lost his job). Her A1C numbers were over 11 – she was very diabetic, and she didn't know it. We talked. I encouraged her to give the A1C numbers to her doctor. She agreed. I asked a benefits counselor to contact her.

  I later called her, and she indicated she had been in to see her physician.

  Next time I saw her walking in town, she was all smiles. "I've been to the doctor; I'm on medication; my A1C is down to 7." She is now taking our CDSMP class that we're offering to self-manage her diabetes.

  Impacting the behavior and engagement of patients. It's really empowering to a person who has a screening and gets a poor result and CHWs can say, "Here we offer this class – we can help you manage your diabetes. We can connect you to these resources; we can help you with insurance. Would you like insurance benefits counselor to call you?" When they're

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at the health screening table, they don't leave the table hopeless; they leave with information. They may take the information and come back when they're ready to make changes. But the CHW is available to help.

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QUESTIONS #10-20 - See notes from Sherry discussion
Expectations for mandatory reporting:

- We need to get something set up for CHWs to call a number. Right now, if CHWs have concerns they bring to supervisor.
- When we get a referral to do a 1-on-1, the referral goes to the CHW. The CHW visits with patient using a pathway questionnaire that includes questions about food, heat, power, medication, elder abuse, child abuse, medications, smoke detector, safety concerns, feeling depressed, pets, etc. The CHW then sends progress report with all information from the pathway questionnaire back to the referring provider. Any concerns would be included in the progress report. We also connect patients to resources, if we see concerns (no food, no heat, etc.).

Supervisory Community Health Worker: Kyle

Describe in your own words the important elements of the CHW role.

- In our value-based system, the goal is to keep people healthy
- Provide education "where the patients are."
- CHWs serve as the liaison, increase access to patients' getting primary care
- CHWs are knowledgeable and relatable, consistent with the community
- Provide a warm hand

What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?

- Health literacy.
  - When a patient is in the examination room, they receive a diagnosis in jargon that goes over their head

What unique contributions are CHWs able to make to address those challenges and provide better healthcare?

- CHWs help to create and can provide patient materials, literature
- CHWs walk each patient through the diagnosis, the information, the materials and resources

What would other members of the healthcare team say about Community Health Workers?

- Providers still need to learn more about CHWs, although they are understanding more. We have more work to educate the health care team.

Can you provide examples:

- At a recent health fair with a local hospital one individual in line was in desperate need of health care
  - CHW referred and scheduled person to a local urgent care clinic, then followed up later.
- One CHW working with a local Head Start program noticed a child with rotting teeth.
  - CHW was able to get dental care for this child

How are CHWs integrated into PCMH in your organization?

- The 7 CHWs are integrated into PCMH at the 16 service locations of our organization. But they are not permanently on site at each clinic location.
- CHWs report to the Manager of Outreach and Communications who reports to COO, in the administration hub
  - Help with messaging
  - Can be sent out for additional support

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- Not a formal role on the healthcare team
  - Docs have to know the CHW

Are CHWs in your organization paid?
- Yes. Initially were funded through unique grants. Now CHWs are included in our organization budget

How does your organization handle liability?
- CHWs are covered by the organizational liability umbrella policy.

Can you discuss if/how CHWs are reimbursed by payers?
- We haven't figured out how to bill; have not pursued this.

Does your organization require a certain skill set from CHWs?
- Self-motivated. Ability to get out-and-about with little oversight.
- Care and concern
- Many of our CHWs were previously volunteers

Does your organization require certain education, training, development?
- We consider anyone along the full spectrum of less developed to most developed.
- After hiring we require the ISU course
- We provide professional development, such as attending the monthly IPCA meetings, or West Coast CHW conference
- We promote additional specialized trainings and continuing education, such as mental health, diabetes, as it arises.

What oversight (supervision) does your organization provide?
- CHWs report to the CHW Program Coordinator (me) who reports to the COO
- Everybody knows, communicates, shares, etc.
- We use a Tracking Worksheet

What access do CHWs have to patient information (records)?
- Full access to EHR.
- Access to EHR is helpful at Mobile Health Unit
- CHWs can access patient chart when necessary to check for follow-up, etc.

What are your organization's policies regarding: mandatory reporting, safety of CHWs, etc.?
- Required to report child abuse, suicidal, homicidal
- For safety purposes, CHWs work in pairs when out in the community
- Follow proper lab safety instructions

What percent of CHW time is expected to be about prevention versus some level of chronic disease management?
- Depends on individual
- CHW – coordinator mostly disease management
- Other CHWs work in promotional, awareness, community events.

What else?
- Make sure you hire someone is who compassionate.
- Tied into a good system of support.

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Clinic Administrator: Sherry

- We've done a bunch of things over the last several years in reaching out to patients, and how can we engage patients and different things like that. Case management (RNs as case mgrs.).
- Working with partners to consider next steps – all agreed CHWs seemed the best next step.
- 8 community partners include a free clinic, public health department, office of rural health, hospital and clinics

Describe the important elements of the CHW.

- **Meet patients' needs** for free testing, etc.
  - Free events provide free screenings, A1C, FIT tests for colon cancer, BMI, phq 9, blood pressure
  - Share info with provider. If no provider, then CHW link patient to a PCP
- **Engage patients** to help them get healthy
  - Weekly walks, fit and fall classes, music and memory classes, chronic disease self-mgmt program, diabetes prevention classes
- **Arm from clinic into community** to provide services to try to engage patients in their health
  - Fulfill the requirement of providers to have monthly contact with patients in order to dispense medication. CHWs can do that visit and make that connection.
  - Link with case managers for patients who have an extra need
  - Call and remind patients to check weight – then report details to nurse for follow-up. Or remind them to go to food bank.

What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?

- **Significant population does not have insurance**
  - Does not want to pay for "little things." It would be better to catch issues before they become "big things."
- **Getting patients to engage** in their health; getting them interested in being healthier.
- **In our clinic, many employees live in other communities**. Tuned into the medical world, so they may forget about the patient world.

What unique contributions are CHWs able to make to address those challenges and provide better healthcare?

- **Can reach non-insured population** through free screenings or individual visits in their own area – bank, grocery store, county fair, high school games, library, restaurant – in a non-threatening way. No finances. No intimidation. Make the initial contact with people who would not come in.
  - At screening, if levels are elevated, CHW let them know the findings are out of range. No medical advice, but provide educational material, and encourage patient to see doctor.
- **Can reach population who just doesn't like doctors**, will never go see a doctor, but may be willing to attend a free screening
  - At free screening, patient more likely to get checked.
  - Success story: wife suspected for some time that her husband was becoming diabetic, but he made every excuse not to go to the doctor. Typical farmer: spring work, gotta put the hay up, get ready for harvest, I'm fine. But stopped by a free screening; saw the CHW who we already knew. Got the A1C test. Value was so high – 13! Got his attention: "I gotta get a game plan, don't I?" Would not go to an appointment, got the service.
- **CHW has their pulse on the community** – at the grocery store, at the ball games

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- Hear what people are actually doing and saying; more aware of what people don't know about medical things;
- Do a better job of bridging the gap; a long-arm extension of us; put the information out where people can't ignore it anymore.

What might a day in your life as a CHW look like?

- Do so many different things at different times.

What might a patient interaction look like?
What would the patient you helped the most say about you?

- Very thankful he was able to meet with CHW in his own home, in his own area. Not having to drive an hour to get what he needs from the clinic saves him time and money. So excited it was even an option. He understood the value and the need behind the visit, he was just excited he didn't have to make drive an hour to get it.
- Husband was so excited somebody was able to reach out and help his wife. In his mind this was something that was going to prolong her life and keep her around for him.
- Anybody who has interacted with CHWs – it's all been positive.

What would your healthcare team (or supervisor) say about you?

- Still some confusion about what the CHW does. Partly because it's a new model, a new way.
- Have seen the benefit the CHWs were able to offer the screening, the FIT test, providing the education,

Examples:

- One patient has been able to meet with CHW in his own home, in his own area. Not having to drive an hour to get what he needs from the clinic saves him time and money.
- CHW known in the community. 80-year old gentleman approached CHW in the grocery store. "Can you help me? It would help my wife to get a little exercise, but she's not going to listen to me; she doesn't want to hear anything I have to say about exercise. I know you're doing those Fit and Fall classes. Could you just talk to her? Let her know what you're doing?" CHW waited for the right time, then struck up conversation. Wife agreed, but didn't want to go alone. CHW picked her up on the way to the class. Now patient is attending weekly Fit and Fall classes. CHW took the time to talk with her; picked her up. Not coming from husband. Connection. Patient engaged.

Additional examples?

- One gal signed up for a screening just to help the event be successful. Her results revealed she had some serious health issues. She made real lifelong changes. Had she not gone to the screening, she would not have been diagnosed at the time she was.
- One patient had weekly med cassettes. Would always forget to pick up on Friday, so would be out of meds on Saturday and go to ER. CHW started calling patient on Friday to remind them to get medication before the weekend. ER visits declined, just by that weekly CHW contact.

How would you describe the community in which you work as a CHW?

Frontier, because of where we are and away from services;
Rural for sure, communities of 400 people, a long way from services

How would you describe the organization in which you work as a CHW?

Private, non-profit. Clinics all hospital-based clinics.
8 Family Practice Clinics.

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Are CHWs paid? Yes – a HRSA grant. Seeking additional grant funding for the future. Perhaps a private, foundation grant. Paid by the hour of $13 - $16, based on experience.

Do CHW have a formal role on a healthcare team?

No formal role at this point. Our goal is for CHWs to have a formal role of interactions, home visits, provide progress notes, and share valuable insights with team.
Next steps / new role for the future is for CHW to check in with patients discharged from hospital.

What other roles participate in the healthcare team?

Physician/NP; Nurse/MA; RN case manager; Beh Health
Specialist; Specialties

How frequently does CHW meet with the healthcare team?

After every home visit, CHWs follow-up with case managers. Progress notes or report sent to provider.

After each screening event, CHW's send results to PCP (if patient gives permission to do so).

What is the title of CHW direct supervisor?

Practice manager. There is also a lead CHW who is the direct contact.

How frequently do you meet with your most direct supervisor?

Lead CHW meets formally with Practice Managers (2) monthly.
Lead CHW has monthly meetings with all CHWs.

Describe your education, training, development as a CHW.

All are currently enrolled in SHIP ISU course
Public Health Dept. conducted 1-day training
Some attended Spokane CDSMP training
Some attend different conference (motivational interviewing, etc).
Ongoing development

Describe the oversight (supervision) you receive as a CHW.

Develop goals and objectives
We're watching – we'll address issues that arise
If not meeting expectations, or if provide wrong information, then lead CHW has conversation with CHW
Expectations include paperwork and reporting;

Describe the access you have to patient information (records). Yes. CHWs have access to patient records.

Safety Issues:

- Partner (Public Health Department) did a training for CHW's. They put a policy in place.
  - Clinic
    - first evaluates whether there is a concern to make a home visit to patient – won't refer

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        - If clinic makes referral, they talk with the patient
        - If patient agrees to a home visit – a list of dos' and don'ts for day of visit (dogs, alcohol,) what we do for you, what we expect of you.
    - CHW
        - If they know and feel comfortable going to home of person, that's fine
        - If they don't know person, or don't feel comfortable going to home – arrange a safe place to meet (coffee shop, library, area deemed safe for both sides). Patient may not want CHW in their home. Conversation they can have – both agree home is okay.
        - If doing a home visit
            - Recorded on calendar – everyone knows where and when
            - Check in with another CHW or with someone at clinic or family member – somebody always knows where, arrival, plan to be there, time of completion, when should be home.

Mandatory Reporting:

- Not sure… abuse by kids, etc.
- CHWs share safety concern,
- Progress notes to provider who made the referral will include concerns (like smoking in home with oxygen tank, or didn't know about foodbank, but I saw food or nutrition concerns)
- Not licensed, not a nurse or a medical provider, no obligated to report, don't know we have addressed those concerns. Social worker would be compelled to report. Knowing our CHW's they would be talking with me or other administrator (we're both nurses).

Liability

- Blanket policy by hospital liability
- Policies and protocol in place – no medical advice, no medical background, not trained, not licensed, not certified – don't give medical advice.

Clinic Administrator: Elizabeth

Describe in your own words the important elements of the CHW role.

- Ability to connect with the patient. Meet the patient "where they are." Go to their homes.
    - Patients trust the CHW and by extension the healthcare team; CHW can engage patients in healthcare
- With a complex patient population (co-morbidities, balancing myriad issues), the clinical work is very time intensive
    - clinicians know they can hand the SDOH kind of work to the CHW
    - The CHW allows us to have time to see / touch more patients, work to top of scope of education and licensure

What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?

- Time to deal with the SDOH that impact complex medical issues of a complex patient population
- Eyes in the home. Patient may say one thing to the physician or care team, but that may not be what's really going on in the home.
    - When the CHW goes into the patient's home, they can report the in-home conditions to the healthcare team. This is extremely valuable to providers

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What unique contributions are CHWs able to make to address those challenges and provide better healthcare?

- CHW is able to intervene and address in-home problems in real time (simple things like fall risk presented by many rugs in the home, or placing reminders on the refrigerator)
- Initiate a plan with the patient to begin immediately addressing interventions around SDOH
- CHW cannot do medication reconciliation, but can relay information back to the health-care team about amount of different medications, or if/how patient is taking medication.

What would other members of the healthcare team say about Community Health Workers?

- Compassionate, patient advocate, patient facing
- Built important community partnerships
- Work has been invaluable. CHW can take the SDOH work, so nurses can focus on what they need to focus on.
- CHW is the conduit to building trust between patient and entire healthcare team

An example:

- Patients with DME- durable medical equipment (wheelchair, nebulizer, etc.), but the equipment is not functioning correctly in the home.
- CHW goes to the home and can see that the equipment is not functioning correctly – it might be the cause of a problem a patient is experiencing or lead to decline in health status/result in hospital admission
- CHW reports the malfunctioning equipment to supervisor – "this is WHY the patient is reporting a problem, or isn't using the equipment"
- Provider has greater understanding and can submit clinical documentation and recommendation for new equipment
- Patient gets equipment they need

Another example:

- Patients not comfortable relaying important, but personal information to the doctor
- Patients trust the CHW and will share the important, personal information
- CHW can help patient understand why and how they need to share this information with the provider
- Provider is better able to treat patient
- Patient is empowered. THAT's what we want. When the patient is empowered, they will change their behavior.

How are CHWs integrated into PCMH in your organization? CHWs integrated differently in clinics/care team locations throughout a large health care system.

- Our large healthcare organization has recently formed a CHW taskforce
    - One person to lead the taskforce + different groups who work with CHWs
    - Unique role for CHW depending on patient population and needs of each specific clinic or location
    - Standardization throughout the organization (work, training, policies, etc.)

Do CHWs have a formal role on a healthcare team?

- CHWs report directly to a clinician - RN or Social Worker. The clinical supervisor recognizes when a higher level of care is necessary for a patient.

CHWs are paid

- Salary is based on a variety of factors (education, experience, and required skills for position)

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- Funding sources include external and internal grants or some state funded iniatives (in Oregon)

How does your organization handle liability?
- Much easier to operationalize liability when CHW is a paid employee of the organization
- First line of liability is the up line clinical supervisor
- In the process of developing comprehensive policies

Can you discuss if/how CHWs are reimbursed by payers?
- Not currently reimbursed
- We do not have a billing code for CHW work
- We're moving in the direction of proving that CHW work is paying for itself over time

Regarding required skill set from CHWs?
- Embedded in the community, trusted, able to work with patients in the community, community relations skills
- Going forward, our organization would like to have a Spanish-speaking CHW who understands that culture

Does your organization require certain education, training, development?
- We can train CHWs up
- We recognize the CHW "Pathways" model as effective in providing a procedure for intervening around defined SDOH with the patient

What oversight (supervision) does your organization provide?
- Reports directly to clinician – RN or social worker
- Direct oversight

What access do CHWs have to patient information (records)?
- As an employee, CHW has access.
- Exact policy in development. Drawing from Oregon's model.

What are your organization's policies regarding: mandatory reporting, safety of CHWs, etc.?
- In development. Drawing from Oregon's model.

What percent of CHW time is expected to be about prevention versus some level of chronic disease management?
- Depends on patient population, clinic and community needs. CHW in one clinic may focus on prevention, while CHW in another clinic may help patients manage disease.
- One of our sticking points right now is how CHW best helps patient manage disease. As a non-licensed person, CHW can't educate patient about disease. If the patient trusts the CHW, they will listen and follow advice. The CHW can help patient get to educational classes about diabetes (so work may be around identifying transportation options to the classes, daycare for children, scheduling, etc.)

Bonus: What I would say to providers around Idaho
- Providers want / need a real-life patient scenario.
    - This is the patient
    - This is how a CHW can help you help your patient
    - This is how to refer the patient to CHW
    - Examples of patient successes, etc.

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Physician: Dr. Rich

Describe in your own words the important elements of the CHW role.

- Our FQHC started with one promotor(a) reaching out to migrant farm workers.
  - The individual would go to the farms, fields and dairies to meet with migrant farm workers. Even go to their homes. Help with insulin, talk through challenges with managing diabetes at home.
  - The migrant farm workers were very reluctant to come to the clinic, as many were undocumented. The CHW spoke their language, understood their culture, and helped meet their medical needs. Sometimes, CHW was able to convince them to come to the clinic for labs, screenings, etc.
  - We hired another to be CHW lead – he has organized CHW team.
  - We added two more to assist patients in signing up for a health insurance plan.
- Currently, we have about 6 CHWs to meet patients' needs
  - Help with access to health insurance and healthcare
  - Help with language and transportation to appointments
  - Nutritionists accompany CHWs on home visits to teach how to prepare healthy foods
  - Work to address SDOH is some of the most valuable work CHWs do
- Our EMR includes an area for providers to make a referral to CHW around a SDOH. The CHW follows up with patient until the issue is cleared.
  - Housing, transportation, ACA insurance plans, make appts., language barriers, etc.

What challenges faced by healthcare providers in your organization are CHWs uniquely able to address?

- Getting to patients' living environment.
- CHW can identify if patient is adhering to the medical regiment and, if not, find out the barriers to adherence. Barriers tend to be SDOH-related - $ for visits, access to care, can't take time off work, need health insurance.

What unique contributions are CHWs able to make to address those challenges and provide better healthcare?

- CHWs have built community partnerships,
- CHWs go to patients' homes to walk through treatment plan(s) with them.
- Help patients overcome barriers by connecting them to community resource, such as women's shelters, Medicaid, health insurance

What would other members of the healthcare team say about Community Health Workers?

- CHWs work magic – literally and figuratively.
- Help identify things I haven't even thought of. I know patients aren't getting better, but I don't know why.
- CHW is able to find out why and then to find ways to solve the problem.
- I've seen CHW turn around their health.

Can you provide an example:

- Community: Garden City, or Canyon County migrant farm workers.
  - CHWs do community health screenings
- Patient had a newborn baby, but no safe car seat.
  - CHW helped her acquire a new car seat
- Patient employed full time prior to January 2017. He had an accident preventing him from any type of work and had a difficult time asking for assistance for himself.

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    - CHW worked with him through email, telephone, and office visits once or twice a week from February through May.
  - Assisted patient in arranging payment plan to IRS $3,800.00
  - Submitted and received approval for St. Luke's financial assistance on a balance of $1,800.00 which was the amount left after insurance payment, balance is now zero.
  - Submitted St. Alphonsus financial aid application to cover out of network emergency room charges when carrier refused to reprocess bill as in-network. After much documentation, assistance was approved and the balance of $1,251.00 is now zero.
  - With the help and advocacy of the CHW, this patient was able to save over $7,000.00 of estimated medical expenses he had incurred from his accident.
- Patient came to CHW for assistance with some medical bills. After spending some time with the patient, CHW learned that the patient was also seeking employment but needed help in creating a CV. Patient has never worked in the U.S., but had a lot of professional work experience.
  - CHW aided in editing and modifying the CV to fit American resume styles.
  - Patient was able to use this resume to apply for jobs and was able to acquire employment.

How are CHWs integrated into PCMH in your organization?
  - We have 8 different clinics.
  - CHWs are integrated into our medical team for complex patients (along with behavioral health, social workers, dietician, clinical pharmacist)
    - Team goes clinic to clinic to serve complex patients.
    - Team helps patients understand and implement medical plan
    - Helps patients understand meal planning
    - Sometimes goes to patients' home
  - Providers can refer patients to CHWs through EMR referral system

Are CHWs in your organization paid?
- Started with AmeriCorps volunteers
- Today, paid salary as part of the organization budget

How does your organization handle liability?
  - Covered by organization's liability policy

Can you discuss if/how CHWs are reimbursed by payers?
  - Probably not covered

Does your organization require a certain skill set from CHWs?
  - Different skills for different CHWs: MA, BA, language

Does your organization require certain education, training, development?
  - Don't know

What oversight (supervision) does your organization provide?
  - Answer to lead CHW
  - Integrated Medical Team is under the Medical Director

What access do CHWs have to patient information (records)?
- Full access to EMR in order to access patient referrals to CHW

What are your organization's policies regarding: mandatory reporting, safety of CHWs, etc.?
- Don't know

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- Reporting of child abuse is required by law.
- CHW doesn't diagnose anything, so no mandatory reporting.
- Policies regarding safety? Don't know

What percent of CHW time is expected to be about prevention versus some level of chronic disease management?

- Depends entirely on needs of the patient and needs of the day.

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Appendix U

Idaho Healthcare Coalition

Spring, 2017 Survey Report

Prepared for
Statewide Healthcare Innovation Plan (SHIP)
Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702
Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis

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The Idaho Healthcare Coalition was established in 2014 by Governor Otter to serve as the key governing body of Idaho's Statewide Healthcare Innovation Plan (SHIP). The SHIP is a blueprint to transform Idaho's healthcare system to a model focused on the Patient Centered Medical Home and clinical quality measures. Idaho's SHIP is a 4 year $40M State Innovation Model (SIM) Test Grant awarded by the Centers for Medicare and Medicaid Innovation (CMMI). Idaho is just one of many states and territories who have received a SIM grant from CMMI. Although each state operates with own unique landscape, a consistent and demonstrated success all states seem to share is the engagement of stakeholders, such as insurers, payers, hospitals, consumers, clinicians, and health care organizations (1).

The Idaho Healthcare Coalition (IHC) includes 45 governor-appointed individuals from all areas of the state who represent healthcare providers, public and private payers, policy makers, and community-based organizations. Many of the IHC members were part of an earlier effort, the Idaho Medical Home Collaborative, established by Governor Otter in 2010. Moreover, most will likely continue beyond the grant period, as the Governor extended the IHC to continue work on the SHIP until 2019 (2).

As key stakeholders, IHC members have unique perspectives regarding the history, progress so far, and future accomplishments of the SHIP grant. The SHIP State-level Evaluation Team sought to capture this feedback during the spring of 2017. The purpose of this report is to report and discuss key themes from the project.

Methods

In March 2017 researchers from the SHIP State-level Evaluation Team contacted nearly all members of the IHC by email to request their participation in a 30-minute, one-on-one, confidential interview. Five members were excluded, because they are engaged in separate projects. A total of 25 members participated in the interviews. The conversations were recorded for accuracy and transcribed for qualitative coding and analysis. Researchers asked six questions:

1. What is your history with the Idaho Medical Home initiative? (this question was skipped for those IHC members just joining the SHIP and related efforts.)
2. What professional lens or perspective would you say you bring to the Idaho Healthcare Coalition?
3. From your professional view what would you say are the key accomplishments of SHIP so far?
4. Again from your professional view what future accomplishments do you hope to see completed by the end of SHIP?
5. Do you foresee major barriers to these accomplishments, and if yes, are there actions the IHC could take to address these barriers?
6. Is there anything else you would like to share about SHIP?

Table 1 presents the response coding categories of SHIP accomplishments originally generated for the first six SHIP goals. These categories reflect a combination of the principles embedded in the goals and the course of conversations across the IHC meetings and workgroups. Additionally, based on review of the interview transcripts 6 codes were added for key accomplishments, 10 codes were generated for barriers, and 8 codes were generated for IHC actions.

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Each transcript was read and independently coded for each question by at least two members of the evaluation team. The codes were then compared and differences in coding discussed until consensus was reached. In most cases, differences in coding occurred because of inclusion of additional codes for a given question.

Table 1. Coding Categories for Current and Future SHIP Accomplishments

SHIP Goal	SHIP Accomplishments to Date	Future SHIP Accomplishments
Goal 1: Implementation of Patient Centered Medical Home	1a: implementation of PCMH with team-based care 1b: increase in patient engagement 1c: improvement in patient experience (from Triple Aim) 1d: implementation of PCMH with patient referrals to Medical Health Neighborhood	7a: stabilization of PCHM with improved reimbursement 7b: expansion of PCMH throughout the State 7c: educating public 7d: coordination of care
Goal 2: Implementation of clinic-based health information technology	2a: implementation of HIT at clinic 2b: use of HIT for registry development and/or population health management	8a: successful implementation of clinic's HIT
Goal 3: Regional Collaboratives	3a: establishment of RCs 3b: implementation of RC projects 3c: use of RCs to improve referrals in Medical Health Neighborhood	9a: stabilization of RCs as not for profit entities and ongoing 9b: stabilization of Idaho Healthcare Coalition 9c: streamline RC practices 9d: one vision of medical health neighborhood
Goal 4: Virtual Patient Centered Medical Home	4a: implementation of VPCMH by at least one element (Community Health Workers, telehealth and/or Community Health Emergency Medical services) 4b: use of VPCMH to improve patient referrals	10a: expansion of some aspect of VPCMH 10b: educated provider community
Goal 5: Statewide bidirectional HIT system	5a: implementation of bidirectional HIT system 5b: clinic use of bidirectional system to improve patient tracking and referrals	11a: comprehensive use of Statewide bidirectional HIT system
Goal 6: Payer alignment from volume to value	6a: agreement among payers as to how to convert from volume to value	12a: stable alignment of payments according to value
Other	13a: bringing people together 13b: population perspective	

The next section of this report provides a summary of the interview responses regarding history, current and future SHIP accomplishments, and barriers and IHC actions. The responses are organized according to frequency of interviewees' references to a specific code.

Responses

What is your history with the Idaho Medical Home Initiative?

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Of the 25 interview participants, nearly half (n=12) indicated they have been involved with the Idaho Medical Home Initiative since its inception. An additional 6 participants indicated they have some history, and 7 stated they have no history with the Idaho Medical Home Initiative.

According to the Idaho Office of Healthcare Policy Initiatives (3), the Idaho Medical Home Collaborative (IMHC) included 25 members. Of the 25 members listed on the IMHC membership list, only 9 are current members of the IHC. This suggests a discrepancy in membership identification. Respondents may have confused membership on the current IHC with membership on the original IMHC.

It appears that the original IMHC included healthcare providers, public and private payers, and policy makers. The profile of the current IHC membership seems to have expanded to include community-based organizations.

What professional lens or perspective would you say you bring to the Idaho Healthcare Coalition?
The profile of participants was generally similar to IHC membership. Of the 45 members currently serving on the IHC, 71% (n= 32) bring an administrative perspective. This includes public and private payers, policy makers, and community-based organizations. Of the 25 interview participants, 60% (n=15) indicated they bring an administrative perspective.

The remaining 29% (n=13) of the current IHC members bring a clinical perspective. This includes healthcare providers. Of the interview participants, 40% (n=10) indicated they bring a clinical perspective.

Some respondents indicated they bring both, administrative and clinical perspectives. To maintain confidentiality that number is not being reported, but it is true among the overall IHC membership as well. Table 2 presents the profile of current IHC members and interview participants.

Table 2. Profile of Interview Participants

	Current IHC membership	IHC interview participants
	N=45	N=25
Involved with Idaho Medical Home	n=9 listed on the IMHC membership list	n=12 identified as being involved since inception; n=6 identified as some involvement
Primarily clinical	29%(n=13)	40%(n=10)
Primarily administrative	71%(n=32)	60%(n=15)

What would you say are the key accomplishments of SHIP so far?
Of the 25 interview participants, 76% (n=19) provided a response related to Goal 1. By far the most common response under Goal 1 (n=18) related to “implementation of Patient Centered Medical Home with team-based care.” Additionally, 66% of participants (n=14) provided a response not related to a SHIP goal, but rather how the IHC governance. By far the most common response under governance (n=11) related to “bringing people together.” Forty percent of participants (n=10) provided a response related to Goal 3. The most common response (n=9) was “establishment of Regional Collaboratives.”

Of the participants, 28% (n=7) identified “agreement among payers as to how to convert from volume to value” as a key accomplishment. This relates to Goal 6. Twenty-four percent (n=6)

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provided a response related to Goal 2. Five of the responses included "implementation of HIT at the clinic." Some interview participants (n=3) provided responses related to Goal 4, such as, "implementation of virtual patient-centered medical home by at least on element (CHW's, telehealth, and/or CHEMS." Finally, one interview participant identified "implementation of bidirectional HIT system (Goal 5) as a key accomplishment.

Based on frequency of responses, it appears that IHC members collectively identified Goal 1 as a key accomplishment of SHIP so far. Another key accomplishment related not to a SHIP goal, but rather the way the IHC works as a governing body. Elements of Goals 3, 6, and 2 were identified by interview participants to a lesser degree. Table 3 presents the complete list of key SHIP accomplishments identified by IHC interview participants.

Table 3. Key SHIP Accomplishments to Date Identified by IHC Interview Participants

	%(n)	Categories	(n)
Goal 1: Implementation of Patient Centered Medical Home	76% (19)	implementation of PCMH with team-based care	18
		increase in patient engagement	1
		improvement in patient experience (from Triple Aim)	1
Other	66% (14)	bringing people together	11
		workgroups	2
		population perspective	2
		innovating healthcare	1
		working together	1
Goal 3: Regional Collaboratives	40% (10)	establishment of RCs	9
		use of RCs to improve referrals in Medical Health Neighborhood	1
Goal 6: Payer alignment from volume to value	28% (7)	agreement among payers as to how to convert from volume to value	
Goal 2: Implementation of clinic-based health information technology	24% (6)	implementation of HIT at clinic	5
		use of HIT registry development for population health	2
Goal 4: Virtual Patient Centered Medical Home	12% (3)	implementation of VPCMH by at least one element (Community Health Workers, telehealth and/or Community Health Emergency Medical services)	
Goal 5: Statewide bidirectional HIT system	4% (1)	implementation of bidirectional HIT system	

What future accomplishments do you hope to see completed by the end of the SHIP grant?

Of the 25 interview participants, 56% (n=14) provided a response related to Goal 1. By far the most common response under Goal 1 (n=10) related to "coordination of care." Additionally, 40% (n=10) identified "stable alignment of payments according to value" as a future accomplishment. This relates to Goal 6. And 32% of participants (n=8) provided a response related to Goal 3. The most common response (n=6) was "stabilization of Regional Collaboratives as not for profit entities and ongoing."

Twenty percent of participants (n=5) identified "comprehensive use of Statewide bidirectional HIT system" as a future accomplishment. This relates to Goal 5. Some interview participants (n=3) identified future accomplishments related to Goal 4; such as, "expansion of some aspect of VPCMH." Finally, one interview participant identified "successful implementation of clinic's HIT (Goal 2) as a future accomplishment.

Based on frequency of responses, it appears that IHC members collectively identified aspects of Goal 1 for future accomplishment of SHIP. Elements of Goals 3, 6, 2 and 4 were identified by

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interview participants to a lesser degree. Table 4 presents the complete list of future accomplishments by the end of the SHIP grant identified by interview participants.

Of note is the difference between what the interview participants were thought to initially talk about as seen in the codes and the issues actually raised in their discussions. Approximately half of the codes originally developed by the researchers (codes which reflect the principles embedded in the goals and conversations from IHC meetings and workgroups) were not discussed in the interviews. With a few exceptions, most participants identified just one aspect of each SHIP goal as key accomplishments. On the other hand, two-thirds of the participants identified accomplishments not seemingly related to SHIP goals and conversations.

Table 4. Future Accomplishments by the End of the SHIP Grant Identified by IHC Interview Participants

	%(n)	Categories	(n)
Goal 1: Implementation of Patient Centered Medical Home	56% (14)	coordination of care	10
		expansion of PCMH in state	5
		educated public	3
		stabilization of PCMH with improved reimbursement	1
Goal 6: Payer alignment from volume to value	40% (10)	stable alignment of payments according to value	
Goal 3: Regional Collaboratives	32% (8)	stabilization of RCs as ongoing not for profit	6
		stabilization of IHC	3
		streamline RC practices	2
		one vision of medical health neighborhood	1
Goal 5: Statewide bidirectional HIT system	20% (5)	comprehensive use of state bidirectional HIT system	
Goal 4: Virtual Patient Centered Medical Home	12% (3)	expansion of VPCMH	
Goal 2: Implementation of clinic-based health information technology	4% (1)	Successful implementation of clinic's HIT at clinic	

What major barriers do you foresee to the accomplishments you hope to see completed by the end of the SHIP grant?

Of the 25 interview participants, most identified multiple and varied barriers to future accomplishments. The top four categories of barriers identified by participants were payer-related (64%, n=16); resource or sustainability-related (48%, n=12); Idaho Health Data Exchange (32%, n=8); and Regional Collaboratives (24%, n=6).

Other categories of barriers identified by participants included physician-related (16%, n=4); hospital or clinic-related (16%, n=4); patient or community-related (12%, n=3); IHC-related (12%, n=3); legislative-related (12%, n=3); and CMS-related (8%, n=2). Table 5 presents the response coding categories generated based on review of the interview transcripts. The categories are presented in order of frequency.

Table 5. Barriers to Future Accomplishments

Barriers	%(n)
payer-related	64% (16)
limited resources & sustainable funding	48%(12)
IHDE-related	32%(8)
RC-related	24%(6)
physician-related	16%(4)
hospital or clinic-related	16%(4)

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patient and community-related	12%(3)
IHC-related	12%(3)
legislative	12%(3)
CMS	8%(2)

Are there actions the IHC could take to address these barriers?
Responses to this question also varied among the 25 interview participants. The top categories of actions suggested by participants were maintain commitment and contributions by IHC members (40%, n=10); educate providers and clinics (40%, n=10); and increase awareness (36%, n=9).

Other categories of actions suggested by participants included cultivate mentorship and leadership (24%, n=6); seek sources of sustainable funding (24%, n=6); convene payers (16%, n=4); influence state policy (12%, n=3); and build evidence of success (8%, n=2).

Table 6 presents the response coding categories generated for actions the IHC could take to address the barriers. The categories are presented in order of frequency.

Table 6. Recommended Actions by Interview Participants IHC Could Take to Address Barriers

Actions	%(n)
maintain commitment and contributions by IHC members	40% (10)
educate providers and clinics	40%(10)
increase awareness	36%(9)
cultivate mentorship and leadership	24%(6)
seek sources of sustainable funding	24%(6)
convene payers	16%(4)
influence state policy	12%(3)
build evidence of success	8%(2)

Discussion

As key stakeholders of the State Health Innovation Plan, members of the Idaho Healthcare Coalition have unique perspectives regarding the history, progress so far, and future accomplishments. The SHIP State-level Evaluation Team sought to capture this feedback through brief, one-on-one, confidential interviews.

Overall, the Idaho Healthcare Coalition itself emerged as one of the key accomplishments to date. With respect to the SHIP goals, principles related to Goal 1 (Patient Centered Medical Home), Goal 3 (Regional Collaboratives), and Goal 6 (payment alignment from volume to value) dominated the current and future accomplishments for the SHIP grant by IHC members. These key elements, critical to the future of healthcare in Idaho, are discussed below.

Patient Centered Medical Home
The Patient Centered Medical Home (PCMH) aims to perpetuate reform of the delivery of primary care services and payment mechanism. It is believed that the PCMH model strengthens the primary care system essential for delivering high value care (7). The IHC's endorsement of

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implementation of the PCMH model throughout the state echoes national recognition of the importance of State-level innovation with primary care.

Results from interviews suggest that IHC members perceive great strides in implementation of PCMH in Idaho. Moving forward, continued progress in this area should focus on coordination of care and expanding the PCMH model throughout the state. Myriad barriers related to physicians, clinics and hospitals, as well as the patients and communities they serve, will need to be addressed, and IHC members have put forth recommendations for continued coalition development and external education and advocacy. Furthermore, a recently released white paper by Idaho Medicaid (8) lays out a framework that advances highly coordinated patient-centered care. The proposal features incentives for primary care providers that "will integrate and expand upon the PCMH activities currently administered through Medicaid's Healthy Connections program and the Idaho SHIP program…" (p. 2).

Payment Alignment from Volume to Value

Similarly, the IHC's recognition of the need for payment reform and the involvement of payers in that reform movement parallels nationwide attention being given to these issues. Recent analyses from the Catalyst for Payment Reform on Medicare payments underscores the complexity of the process of moving to value-based methodologies (9) and therefore the importance of IHC's efforts to engage payers in ongoing discussions of the issues.

In interviews some IHC members indicated that Idaho's SHIP has facilitated progress in this area, and they would like to see more regarding stable alignment of payments according to value. Payers were identified more than any other barrier to future SHIP accomplishments, but IHC members were less clear on recommendations beyond "convene payers." The white paper mentioned above demonstrates a willingness by Idaho's Medicaid to drive continued progress in this area. The proposed changes to the Healthy Connections program operationalize value through payment incentives and formulas that include nationally established quality metrics.

Regional Collaboratives

The SHIP Regional Collaboratives (RCs) build on the Idaho Public Health Districts as independent agencies ensuring essential public health services to all counties in the State. The RCs facilitate the development of medical neighborhoods within their District in part through a regional stakeholder advisory collaborative group. Given that RCs are a core element of strengthening connections between and among medical/health neighbors, it is not surprising that one of the key SHIP accomplishments to date is "establishment of RCs."

Successful RCs have mobilized a cross section of members and improved patient referrals within some medical neighborhoods. Of note is the observation that one of the future accomplishments by the end of the SHIP grant is, "stabilization of RCs as ongoing not-for-entities." Continued conversation about the ongoing role of the Regional Collaboratives at the end of the SHIP funding will take place at the June 2017 Regional Collaborative Summit.

The future role of RCs is further explored by the white paper, which builds on their success and suggests an evolved role as community based advisory group for health outcome improvement coalitions.

Idaho Healthcare Coalition

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Healthcare clinicians and administrators throughout Idaho have been engaged in transformation before the SHIP initiative, during the planning process, and throughout implementation. That stakeholder engagement emerged as an accomplishment of Idaho's SHIP is consistent with the experience of myriad states undergoing healthcare reform, such as Delaware (4), Nevada (5) and others (1).

The importance of this accomplishment cannot be overstated. In a study of states working toward value-based payment reform, Conrad, Grembowski, Hernandez, Lau, and Marcus-Smith (6) concluded that to succeed in a context of shifting market conditions and priorities, multi-stakeholder coalitions can be a widely respected "honest broker" that can convene and maintain commitment among entities that may otherwise have competing interests, such as payers, providers, and purchasers.

Summary

Idaho's SHIP has engaged clinical and administrative stakeholders throughout the state who are committed to transforming healthcare and health for Idahoans. As a result of the SHIP grant, key accomplishments – most notably in the areas of the Patient Centered Medical Home, payment reform and Regional Collaboratives – have been achieved. With less than two years remaining in the grant, IHC members have identified future accomplishments to work toward. A strong IHC is well-positioned to overcome barriers and continue progress. With stakeholder commitment strategies can be implemented to cultivate mentors and leaders and create sustainability for the future beyond the SHIP grant.

Concurrent to this IHC Spring, 2017 Survey, Idaho Medicaid drafted a framework for Idaho Medicaid's effort to develop a provider based accountable care model. The white paper shares the key features of Idaho's SHIP discussed here, and it reflects a willingness of Idaho Medicaid to operationalize some of the most complex goals and drive efforts to achieve them. In the future Idaho's healthcare system may serve as a model for the Patient Centered Medical Home, value-based payment reform, and regional governance.

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Appendix V

The Value of Community Health Emergency Medical Services (CHEMS) in the State of Idaho

Prepared for
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Office of Healthcare Policy Initiatives
Idaho Department of Health and Welfare
450 W. State Street
Boise, ID 83702

Prepared by
Idaho SHIP State-level Evaluation Team
October 2018
By: Jayne Josephsen, EdD, RN, CCCTM, CHPN, CHSE, Boise State University
Scott Metlen, Associate Professor, Business Department Head,
College of Business and Economics, University of Idaho

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Preface

The use of Community Health Emergency Medical Service (CHEMS) programs is an innovative addition to our health care system and one that offers many positives to patient centered care and quality outcome initiatives. Since CHEMS is a fairly new development in health care delivery there has been some hesitancy on the part of payers and the health care community at large to fully integrate this avenue of care delivery. Coupled with hesitancy on the part of payers and organizations, the CHEMS agencies themselves have struggled with operationalizing and communicating the extensive value of the program to other members of the health care system. This white paper was envisioned as a way to bridge these gaps in understanding, to bring awareness of the value of CHEMS in Idaho, and to further explore what needs to be done for a CHEMS program to be successful.

This White Paper reviews and explores pertinent CHEMS related information and concepts, addressing the need to provide data that substantiates the value of CHEMS programs to a variety of payers in Idaho. It is anticipated that by examining and outlining the value of CHEMS, creation of ongoing payment mechanisms and structures will be initiated. Additionally, it is felt that it is crucial to investigate how CHEMS programs can assist in the transition from fee for service to value-based payment structures, as well as contribute to cost savings and affect quality patient outcomes. Lastly, the CHEMS program in Idaho, as well as many other parts of the nation, have struggled with defining data for collection and how to capture this data in a meaningful way. As stated in the Idaho Statewide Health Care Innovation State-Level Final Evaluation Report 12/10/2018, effective care coordination efforts rely on good communication between levels of care and providers (Scotten, Manos, Malicoat, & Paolo, 2014). Data capture and sharing is critical so that the program's positive outcomes are documented and available to members of the medical neighborhood and payers. In addition, information from other providers has to be made available to the CHEMS programs so patients are selected that are best suited for this type of care. The goal of this White Paper is to summarize and clarify these essential elements of CHEMS, supporting the development of stable and sustainable financial backing, and promoting the integration and growth of CHEMS programs and initiatives in Idaho.

Disclaimer

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Introduction

The current health care system is undergoing a transformation to meet the needs of our communities and populations, while endeavoring to manage costs, increase quality, value and outcomes in health care. The Statewide Healthcare Innovation Plan (SHIP) is a statewide initiative that strives to transform healthcare delivery in Idaho, with a focus on patient centered care and value-based outcomes. A large part of this initiative was the development and implementation of the Patient Centered Medical Home (PCMH) model of primary care delivery throughout the state. Community Health Emergency Medical Services (CHEMS) is one avenue of innovative healthcare delivery that has been part of the SHIP initiative, specifically to meet goal four, improving rural patients' access to PCMHs by developing virtual PCMHs. Additionally, the use of CHEMS in the PCMH model contributed to integration of the PCMH into their medical neighborhood, which is the partnership between clinical organizations and community resources to enhance health and patient centered care delivery. See Appendix A for an example of an Idaho CHEMS/Community partnership plan.

Many organizations and programs related to emergency medical services (EMS) often refer to a CHEMS program as mobile integrated healthcare community paramedicine or MIH-CP. These programs may involve the use of paramedics, emergency medical technicians (EMT), or other roles and providers that serve the public via a paramedicine framework, a combination of public health, public safety, and health care services (EMS.gov, n.d.). Throughout this paper the reader may see either CHEMS, EMS, MIH-CP, MIH (mobile integrated healthcare), or just CP (community paramedicine/paramedic) used to describe the literature and findings that support the value of CP's that includes the use of paramedics, EMT's, or other roles and disciplines, depending on the needs and resources of the community

The change in acronym and description is based in the fact that the use of CHEMS or other similar programs leads to a mobile, community based, integrated healthcare delivery system (Choi, Blumberg, & Williams, 2016). The National Association of Emergency Medical Technicians has defined mobile integrated healthcare (MIH) as the "…provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment in a coordinated manner with physicians, hospitals, and other providers" (as quoted in *Promoting Innovation in Emergency Medical Services*, 2016, p. 38). MIH programs have seen the need for a flexible and proactive approach to care that allows for use of CP's in an expanded role. The pairing of the concepts of MIH and CP allows for the strategic placement and use of emergency medical service providers in extended roles and capacities to meet the needs of community members while decreasing costs and improving outcomes (Nolan, Nolan, & Sinha, 2018).

The integration of MIH-CP programs supports many current policy recommendations, one being the Triple Aim developed by the Institute of Medicine. The Triple Aim calls for improving the quality and experience of care, improving the health of populations, and reducing per capita costs of healthcare (The Institute for Healthcare Improvement, 2018). With this goal of changing the focus of healthcare from a fee for service with an acute care orientation, to goals of health promotion and prevention, there is an increasing need to be innovative in seeking avenues to meet these objectives. One approach is employment of CP's to meet these needs by providing care to patients that could be attended to more appropriately outside of the acute care setting (Abrashkin et al., 2016).

Community paramedicine programs can provide a significant benefit to the primary healthcare team through provision of a variety of services including health education, promotion, and prevention interventions. Employment of MIH programs can increase access to care, enhance

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transition of care experiences, address social determinants of health, and assist with integration of resources in the medical neighborhood (Ashton, Duffie, & Millar, 2017). CP providers are in a unique position and can contribute to the health of their patients and communities as they are often the provider that is most often in the patients home due to frequent 911 calls. This access gives CP's a compelling perspective regarding patient needs related to their health and supports the value of MIH programs in meeting patient needs in the context of their life experience, needs, and values. (*Promoting Innovation in Emergency Medical Services*, 2016).

History of MIH-CP/CHEMS

The call for MIH-CP programs in our communities and as an adjunctive service to healthcare provision is not new. As early as 1996 the U.S. Department of Transportation EMS agenda called for MIH programs utilizing EMS personnel to augment primary care, such as preventative care, community health clinics, and outpatient management for patients with chronic conditions. Partnering this EMS agenda, in 1997 the Multiple Option Decision Point Model was introduced, which allowed EMS personnel to respond with alternative transport and destination options (*Promoting Innovation in Emergency Medical Services*, 2016). In 2004 the U.S. Department of Health and Human Services called for CP programs to work specifically with rural populations to meet their unique needs. In 2012 the Joint Committee on Rural Emergency Care called for CP's to receive increased training in primary and preventative care. Furthermore, in 2012 the National Association of State EMS Officials formally defined community paramedicine as "an emerging healthcare delivery model that increases access to basic services through the use of specialty trained emergency medical service…providers in an expanded role" (as quoted in Choi et al., 2016, p. 362). As is shown, MIH-CP has been identified as a significant and valuable contribution to the menu of healthcare services available to our communities.

History of MIH-CP/CHEMS in Idaho

CP's in Idaho have had legislative backing. House Bill 153 was passed in 2015 supporting the delivery of community health emergency medical services in the State of Idaho. The community emergency medical technician, community health emergency medical services and community paramedic are also defined in Statute 56 Section 56-1012 (Legislature of the State of Idaho, 2015; 2018). With the state support of MIH-CP programs through legislation, and funding and direction provided from the SHIP initiative, several counties have already implemented versions of MIH-CP in their communities; including Ada, Bonner, Canyon, Payette, Shoshone, and Valley counties to name a few. These local MIH-CP programs have provided for patient safety through medication reconciliations and fall prevention interventions and improving the link between patients and their primary care providers; mitigating potentially dire health issues by bringing these to the attention of the primary provider in a timely manner. These Idaho programs have focused upon addressing social determinants of health issues through connection of patients to community resources and providing post-acute care support for those with chronic health conditions such as congestive heart failure. Arguably, the most important aspect of local MIH-CP programs in Idaho relates to addressing access to care issues in this rural and frontier state and supporting the virtual PCMH model of care.

The Value of MIH-CP/CHEMS

MIH programs address a myriad of challenges in our current healthcare system. As we transition from a crisis acute care focused system to a more preventative and health promotion framework of care delivery it is essential that we meet our patients in the context of their lives. This scenario means being able to deliver care in patients' homes or virtually. The use of MIH allows for an extension of primary care into these venues, as well as providing for reinforcement of patient education related to self-management and health promotion. The future foundation of

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health care is based on increased quality of life, addressing social determinants of health, and integrating patient values into healthcare delivery (Shi & Singh, 2019). MIH-CP programs support these values and are a foundational component to transformative healthcare.

Rural Initiatives

MIH programs are well suited for rural areas and can meet their unique needs. Rural areas often have health care issues related to distance, transportation difficulties, and lack of healthcare providers. Beyond these geographic issues rural areas also typically have decreased health outcomes when compared to their urban counterparts (Olson & Anderson, 2018). Utilizing CP's can provide an alternative avenue for primary and preventative health care to be delivered and/or augmented. A key feature of some rural areas is the critical access hospital, which have limitations on beds and length of stay, usually requiring discharge within 96 hours of admission. Use of CP's to provide interventions and follow up post discharge could increase community linkages and meet population health needs, specifically those with chronic diseases (Steeps, Wilfong, Hubble, & Bercher, 2017). By providing home visits and wellness checks as well as other services CP's can promote quality patient outcomes while the patient retains the ability to stay in their home setting and communities. The key to effective deployment of a MIH-CP program in a rural area is stakeholder engagement, such as the critical access hospital and primary care providers, to develop a framework of interventions CP's can perform to support their communities' health (Bigham, Kennedy, Drennan, & Morrison, 2013; Mowry, 2005; Olson & Anderson, 2018).

Potential Program Deliverables

A MIH-CP framework can contribute to a comprehensive approach to patient centered care while supporting quality and cost initiatives. Per Choi et al. (2016, p. 361) CP can address "wellness, prevention, care for the chronically ill, post discharge care, social support networks, and increasing medical compliance for the local population". This is no small deliverable, but one that CP's are equipped to provide through licensure, community standing, and the CP framework of healthcare, including public health and safety. Evidence supports that with some additional training EMS personnel can provide MIH-CP services that can address common medical issues and treatments, such as health assessment, depression screenings, home safety checks, point of care (POC) testing, medication inventory and review, and connection of patients with community resources (e.g. transportation, food banks, etc.) (Bigham et al., 2013; Patterson, Coulthard, Garberson, Wingrove, & Larson, 2016). In fact, scope of practice for paramedics has already increased in some areas of the nation to address acute care needs. There now is a call by several EMS organizations to also include health education, promotion and prevention competencies into that scope of practice so that local and community needs are met (Bigham et al., 2013).

Many current MIH-CP programs already have initiatives to improve chronic disease management, reducing Emergency Department (ED) visits, reducing hospital readmissions, improving patient satisfaction, and reducing falls in the elderly (Choi et al., 2016; Patterson et al., 2016). These are appropriate issues for CP's to address, as many 911 calls are related to chronic disease exacerbations and management of falls (Agarwal, et.al., 2017). Some CP programs have multiple dimensions of integration and not only address the items described above but also provide a 911 triage nurse to assess appropriate response to the call, providing alternative responses to the traditional ambulance run and transporting the patient to alternative destinations besides the ED if applicable (Zavadsky, 2018). According to Steeps et al. (2017) EMS professionals overwhelmingly support CP programs and are willing to participate in needed additional training and education, as they value the role of the CP's in their communities

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and believe their unique perspective is an important contribution to delivering integrated and quality healthcare.

MIH-CP/CHEMS as a Solution

Incorporation of CP's is a vital part of integrated healthcare in Idaho and necessary to pursue and continue beyond SHIP. There are numerous studies that have shown that use of MIH-CP programs contributes to quality patient outcomes and cost savings. See below for a description of selected programs and studies that show that CP's are a fundamental part of patient centered, holistic, and integrated care in the burgeoning value-based healthcare system structure.

1. Texas
   One of the most well-known MIH-CP programs is that of MedStar in North Central Texas. MedStar's has several initiatives, two are described here. One of the most prominent of Med Star's programs focuses on readmission prevention and participates in a shared savings program for funding with local health systems related to costs saved through decreased readmission rates. The Med Star program has been shown to affect a cost savings of $21,647 in charge avoidance and $5536 per patient enrolled in the MedStar readmission reduction program. Specifically, in Congestive Heart Failure participants there was a readmission rate of 16.3% compared to the national rate of 23% (Choi et al., 2016, p.362).

   Moreover, MedStar has partnered with a local hospice agency to address unnecessary revocation of hospice due to transportation to the ED and potential admission to the hospital. In this model patients at high risk of revoking their hospice care plan due to ED visits were referred to MedStar and if one of those patients called 911, MedStar would send out a hospice trained CP to assess if a visit to the ED was warranted or if the patient needed symptom management with medication in the home or other interventions. The CP would then contact the hospice nurse and would remain in the home until the hospice nurse arrived. This program resulted in a 54% reduction in hospice revocation and a savings of $1075 per enrolled patient (*Promoting Innovation in Emergency Medical Services*, 2016, p. 67).

2. Nevada
   REMSA's (Regional Emergency Medical Services Authority) community health program in northern Nevada included a nurse health line that patients could access and receive assessment, triage, and referral to appropriate services. Their community paramedics also had the ability to conduct advanced assessments, divert patients to alternate care venues besides the ED, and to conduct POC testing. These activities improved transitions in care from the acute care setting and resulted in reported high levels of patient satisfaction, enhanced community partner linkages in their region, and achieved an 84% ROI (return on investment) (REMSA, 2017).

3. Michigan
   A grant funded MHI-CP program in suburban Detroit used a combination of CP's and telemedicine to assess the health condition of those with chronic illness. The focus of this program was on residents of long-term care facilities, as often after hours' resident health issues are addressed with a 911 call and transport to the ED for assessment and treatment. But, in this program a CP would make a visit to the resident at the long-term care facility and then connect with an ED provider either by phone or video and

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determine if the patient needed to be transported to the ED or if the condition could be addressed in the facility with CP support. This way of assessing and addressing patient's needs reduced costs as the cost of the CP visit was nominal in comparison to the cost of an ED visit and contributed to resident satisfaction and quality of life, as trips to the ED can be very fatiguing and stressful for this population (Greene, 2014).

4. North Carolina
   Another urban MIH-CP program coordinated in home care to prevent exacerbations of chronic illnesses. The EMS provider stratified patients on their frequency of using the 911 service over the past year. Services were delivered to those patients who used 911 greater than or equal to four times in the past year. Twice weekly home visits, health education and coaching, routine health screenings, medication management, home safety assessment, and patient engagement and goal setting were provided to the participants by the CP. The results of this program were increased participant quality of life self-ratings, reduced ED use, and fewer inpatient admissions. Additionally, participants reported increased mobility, self-care, and decreased pain and discomfort (Nejtek, Aryal, Talari, Wang, & O'Neill, 2017).

5. Ontario, Canada
   An MHI-CP program in Ontario, Canada provided health risk assessments related to diabetes, coronary vascular disease, and other health factors. Once the assessment was completed the CP provided the participant with an individualized action plan focusing on health risk reduction and health promotion and education. The CP would also communicate the results to the participant's primary care provider. The yearlong program resulted in a 25% decrease in 911 calls, decreased blood pressures of participants at a clinically significant level by the fifth CP visit, a 15% decrease from high to moderate risk on the CANRISK diabetes assessment, and an average cost savings of $32,520 per every 20 avoided 911 calls (Agarwal et al., 2017).

Market Drivers

There are several market drivers that affect the use of MIH-CP programs and their ability to provide essential healthcare services to their communities. Issues such as the regulatory environment, introduction of value-based reimbursement models, and billing and coding practices all contribute to the need for integration of MIH-CP into our healthcare delivery system as well as creating challenges to that integration (Cleverley & Cleverley, 2018). Additionally, national trends such as the increase in the aging population, and this populations' high use of healthcare, contribute to the need to evaluate how market drivers can be addressed so that barriers to integration of MIH-CP into healthcare delivery are alleviated.

Reimbursement for Transport to Alternative Destinations

Historically, the mission of EMS providers has been limited to emergency care and transportation. In fact, current payment policies from private and public insurance providers discourage the diversion of 911 transports to venues other than the ED, as billing policies require transport to the ED for reimbursement. Multiple agencies including the Institute of Medicine and the American College of Emergency Physicians have recommended that this billing policy be adjusted so the EMS can transport the patient to the most appropriate level of care to meet their needs, whether it is an urgent care center, a mental health crisis center, or another venue (Morganti, Alpert, Margolis, Wasserman, & Kellermann, 2014).

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It is estimated that 30% to 50% of patients that are transported to the ED go for non-emergent issues, costing an estimated $750 billion per year (Bigham et al., 2013; Nejtek et al., 2017). It has also been estimated that between 7% and 34% of Medicare patients and between 11% and 61% of all other patients might have been able to be managed safely at home or in another setting other than the ED. This is not only an issue of cost, but also appropriate resource utilization, reduction of potential iatrogenic issues, and enhanced patient centered care and experience (Abrashkin et al., 2016; Morganti et al., 2014). The value and ability of MIH-CP programs in addressing these contemporary health system issues cannot be understated.

Reimbursement for Treatment

Currently, there is also a call for reimbursement for EMS providers to be able to bill for treatment that does not include transportation. A typical visit with a CP can address a plethora of issues such as assessment, minor treatments, health education and promotion, connection with community resources, referrals, etc. (Snooks et al., 2017). The average cost of an adult ED visit in 2014 was $1533 (Consumer Health Ratings, 2018). A MIH-CP program can make a house call or provide for an alternative destination for fraction of that cost. The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse has established reimbursement rates between $164 and $211 for an EMS service depending on if the issue is treated in the home or the patient encounter results in transportation to an alternative destination other than the ED. North Carolina estimates a savings of between $845,385.13 and $1,175,678.44 for their Medicaid population alone by enabling MIH-CP in the state and avoiding unnecessary ED visits/transports (North Carolina Department of Health and Human Services, 2017, p. 37). If the CP can provide the needed service in the home without transport to the ED or transport to an appropriate venue, there is potential for sustainable and continued health care cost savings.

The Elderly Population

It is estimated that two-thirds of older adults have one or more chronic conditions, which may cause symptoms like unstable mobility and cognitive impairments (Gong & Hu, 2018). Many in this population are also homebound or have difficulty leaving their home, having compromised access to healthcare (Abrashkin et al., 2016). The elderly population is estimated to account for more than a third of all EMS calls with high rates of non-transportation (Agarwal et al., 2017). Many of the 911 calls for this population are related to falls. Evidence has shown that alternative interventions such as referral of the patient to a community-based fall prevention program or other community services can effectively reduce future falls, improve patient outcomes, and decrease costs (Cox, Roggenkamp, Bernard, & Smith, 2018; Snooks et al. 2017). MIH-CP can provide this high 911 and ED use population with a more integrated approach to health care that addresses their unique needs, while extending the arm of the primary provider into the home and addressing post-discharge/transitional care needs with home visits and home safety assessments (Abrashkin et al., 2016). Integration of CP's as part of the healthcare team and system can result in cost savings for all involved in the health care management of the elderly population.

Hospital Admission/Readmissions

The Affordable Care Act section 3025 added the hospital readmissions reduction program, in which the Centers for Medicare and Medicaid Services (CMS) reduces payments to hospitals with excess readmissions to link payment with quality of care (CMS, 2018). Penalties are given for 30-day readmissions for a variety of diagnoses. There have been a range of MIH-CP programs implemented to address this market driver. One specific program partnered CP's with pharmacists and clinicians to provide support for congestive heart failure patients with a high

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risk of readmission. A CP performed home visits, physical assessments, health education, and some in home medication administration. The program showed a 44% decrease in 30-day readmission rates over an 18-month period (Boykin, Wright, Stevens, & Gardner, 2018). With the average Medicare covered hospital admission estimated at $12,200 in 2012, it is evident that the use of CP programs can provide a valued cost savings related readmission initiative (Abrashkin et al., 2016).

Funding Options for Sustainability

Value based payment structures are founded on a framework of coordinated care delivery and interconnectedness. Incentivizing and rewarding providers and systems that work together to improve quality, outcomes, and control costs. Value based payment systems are already being implemented under various alternative payment models that promote accountability and encourages investment in quality and effective care. Unfortunately, a study by Patterson et al. (2016) found that most MIH-CP programs (58.1%) are funded through absorbing the cost of the program out of the tax-based funds provided to the EMS service (p. 147). This is untenable, as EMS programs are tax funded to provide “emergency” services and CP services are benefiting providers, health systems, and communities in the form of cost savings from decreased ED visits and readmissions as well as preventative health initiatives.

This current source of funding for MIH-CP programs does not promote an integrated and value-based healthcare system. Payment models used by public and private payers should include MIH-CP services as part of their resource utilization, cost management, and quality outcomes initiatives, contributing to meeting value-based goals of care. It has been shown that the use of CP programs provides cost saving in relation to ED use and readmissions, there is also some preliminary connection with preventable health issues. Public and private payers cannot ignore this innovative alternative to care provision and still meet the call for patient centered and value-based care.

A key to patient centered care and value-based reimbursement is patient satisfaction, which is an aspect of the Triple Aim. Utilization of MIH programs can assist in health care systems and providers in meeting this outcome. In a study by Brydges, Denton, & Agarwal (2016) it was found that patients receiving CP services felt that the CP could be trusted, and they communicated respect and care for the patient. The patients also felt secure in the knowledge that if there was an emergent condition the CP would identify and act as well as provide care for them in a preventative and health promotion capacity. These results support the use of CP’s, as they can promote patient centered care and meet the Triple Aim goals of patient satisfaction, lower costs, and better outcome. Thus, potentially increasing reimbursement rates to providers and health care systems. This example shows the value of CP programs to providers and systems and these same providers and systems can contribute to the sustainability of MIH programs through a variety of shared savings programs, including bundled payment programs. In addition, payers can add CP programs to their accountable care organization (ACO) models and telehealth services. If a health maintenance organization (HMO) model is being used the CP program can also be included as a way to control costs (Cleverley, & Cleverley, 2018).

Call to Action/Recommendations for Idaho CHEMS Programs

It is evident that MIH-CP programs can make a significant impact on a community’s health as well as addressing all aspects of the Triple Aim. CP programs have been shown to improve quality of life and patient satisfaction scores, as well as decreasing inappropriate use of the ED and decreasing readmission rates. In addition, MIH-CP programs have been used to meet people where they live and assess their health care needs in the context of their daily lives,

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providing health promotion and education activities that have been shown to have a positive effect on risk factors such as blood pressure and diabetes. A robust MIH-CP system of programs and care is essential to the state of Idaho for continued healthcare transformation as well as to meet the unique needs of our large rural and frontier populations. For this to occur there are several areas that need to be addressed, with each stakeholder in our healthcare system having an essential part to perform. Continued integration of community paramedicine in Idaho will take a cohesive and joint effort by all parties. The following are recommendations that ideally would support and enhance the operationalization and implementation of MIH-CP in Idaho.

Recommendation One: Transition from CHEMS to MIH-CP

Several EMS organizations have defined community paramedicine and have adopted the MIH-CP designation for these types of programs. Specifically, a panel for the National Association of EMS Physicians in 2014 integrated the concepts of mobile integrated healthcare and community paramedicine (Choi et al., 2016, p. 362). This unified definition of community paramedicine communicates the central part that CP's can provide in our current health care system; that calls for cohesive and coordinated patient care. Furthermore, the MIH designation speaks to one of the most attractive features of CP programs, their mobility and ability to meet the patient in the context of their lives in a proactive manner (*Promoting Innovation in Emergency Medical Services*, 2016). The use of the acronym CHEMS has the potential to continue to focus upon the emergent aspects of EMS programs, rather than connecting that community paramedicine provides a foundational service of public safety and health and is a crucial component of the PCMH transformation, as well as health care reform overall. The MIH-CP designation communicates to all stakeholders (payers, providers, and patients alike) that community paramedicine is an essential aspect of integrated and patient centered health care.

Recommendation Two: Outcomes Development and Measurement

Idaho based CHEMS/MIH-CP programs should seek to partner with local Universities, Community and Public Health Programs, Providers, and Payers to assist in measurement of outcomes and results of CP interventions (REMSA, 2017). The outcomes and results measurement should be based upon the MIH-CP toolkit available at http://www.naemt.org/initiatives/mih-cp/mih-cp-program-toolkit under "MIH Measures Workbook". Local stakeholders such as health care systems, primary care providers, home health/hospice agencies, long term care facilities, and public, private and self-funded insurance representatives should meet to determine locally relevant outcome measures that MIH-CP agencies should track and report (Staffan, Swayze & Zavadsky, 2017).

Recommendation Three: Training Offerings

Currently Idaho State University has been providing training for the CHEMS providers under SHIP. It is recommended that the current CP programs in Idaho continue to partner with community stakeholders such as Universities, community colleges, health systems, and providers to create a locally relevant framework of CP training/modules and scope of practice to meet the needs of the community (Bigham et al., 2013). It has been suggested the MIH-CP training programs include training in diagnostic and triage skills, chronic disease pathophysiology, psychomotor assessment, community resources, communication, and cultural competency skills. Additional skills might include social determinants of health, scope of practice, obtaining a medical history, lab values, pharmacology, documentation, physical assessment related to non-emergent situations, and making appropriate referrals to providers and resources (Choi et al., 2016; Swayze & Jensen 2016) Additionally, those CP's who will be providing these services might benefit from training on patient engagement, activation, and

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motivational interviewing. These evidence-based suggested training topics should be cross checked with the current curriculum offered through Idaho State University as well as applicability to community resources and needs.

Recommendation Four: Partnership with Community Healthcare Providers

Partnerships with hospital systems and community providers should continue to be developed by CP programs, centering upon post discharge patient disposition. The partnership between the Ada County Paramedics and Saint Alphonsus Regional Medical Center is an example of such a program. Focusing on this population would be appropriate, as many patients are not eligible for home health post discharge due to lack of home bound status but could benefit from a few follow up home visits to ensure medication adherence and follow up care, as well as to assess the home environment. The CP is in a key position to provide this service and is a key alternative health care provision option to address this gap in patient care services. Partnering with the Providers to determine who would benefit from CP services is critical. Partnering with payers to develop codes that will allow payment for these services is just as critical.

To expand the patient list of those most in need of CP services, partnerships with home health and hospice agencies should also be solicited to assist in coordinating care and providing notification of 911 calls. The CP program could also provide back up support for local home health and hospice agencies after hours and on weekends. These actions could contribute to shared savings related to prevention of revocation of hospice enrollment due to ED visits and preventable hospital admissions. The shared savings could theoretically come from the hospice per diem rate for a hospice patient or from a bundled payment shared savings program from home health agencies involved in bundled payment partnerships.

Recommendation Five: Addressing Financial Barriers

Expanding and changing payment codes for what activities performed by whom and at what price should be redone to facilitate CP payments that would fund such programs. For instance, payers in Idaho should separate payment for treatment by the CP from transportation to the ED. If these are two separate billing codes/procedures then patients who do not need transportation to the ED might still receive care and referrals they need without overtaxing the ED system or being inappropriately transported to the ED, thus leading to cost savings (Choi et al., 2016). Additionally, CP programs in Idaho should continue to pursue partnerships with local clinics, health systems, private payers, and Medicaid to engage in shared savings programs, bundled payment programs for specified populations, or other versions of being a partner in an accountable care organization. These partnerships will lead to a more sustainable funding platform while providing needed services to improve access to care and quality initiatives such as patient satisfaction, clinical quality measures, and overall population health outcomes (Choi et al., 2016)

Payers in the state of Idaho, private and public, should continue to examine their reimbursement of telehealth services in partnership with MIH-CP programs to determine if CP's could be added to the list of eligible providers as many services the CP could provide would be in the patient's home, a qualified patient location for service reimbursement under several plans (Telehealth Council, 2018). In conjunction with the primary care provider or clinical designee the CP could provide a telehealth service for codes related to transitional care management at 7 and 14 days' post discharge or under the general transition care management codes (*Promoting Innovation in Emergency Medical Services*, 2016)

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Recommendation Six: Addressing Legal Barriers

MIH-CP programs should engage state legislators, promoting inclusion of MIH-CP services in the overarching healthcare innovation models and payment structures in the state. This process has begun with HB 153, Section 4, 56-1013, which identifies community health emergency medical services as an authorized act in the state of Idaho and provides some liability protection (Legislature of the State of Idaho, 2015). This inclusion needs continual championing by state legislators and stakeholders, advocating for a more comprehensive incorporation of MIH-CP services into healthcare. An initial key to MIH-CP integration would be inclusion of CP's as a provider that can be reimbursed under state Medicaid rules. Additionally, CP's should be encouraged to practice to their full scope of practice without legal or regulatory barriers. Thus, it is recommended that the state of Idaho department of health and welfare and state legislators review and modify or update legislation and regulatory frameworks as needed to embrace the need for innovative forms of health care delivery in Idaho like MIH-CP programs. A good model to follow is what is detailed in the white paper produced by REMSA, REMSA 2017

Recommendation Seven: Addressing Data Exchange Barriers

As is feasible, the MIH-CP programs in Idaho should be integrated into the states medical data exchange program (IHDE), for ease of data reporting related to outcomes as well as to improve communication between providers and improve transitions in care (Choi et al., 2016; *Promoting Innovation in Emergency Medical Services*, 2016). Furthermore, CP personnel, primary providers, and health systems should review the HIPPA guidelines and permitted disclosures of patient information so that information can be shared in a useful way that meets patient needs but also protects patient privacy. For example, if a MIH-CP program is contracted with a hospital for post discharge follow up they may fall under meaningful use guidelines that allow for sharing of patient information for the purpose of the program. Ultimately, CP provide a wide array of services to patients including assessment and referrals. The CP needs to be able to share necessary patient information with other healthcare providers to meet identified patient needs. Agencies in partnership with MIH-CP programs need to define trajectories of information exchange as well as any safeguards or consents that might be needed to facilitate patient care (Jensen, 2016).

Conclusion

Value based payment models focusing on patient outcomes are a foundational aspect of our changing health care system. This concentration on outcomes demands change in traditional care delivery practices. Essential to our transforming health care system is the implementation of patient centered care, patient engagement, and a focus on patient satisfaction. The use of MIH-CP programs has shown that they can significantly contribute to the value of health care through providing safe and appropriate care that increases patient satisfaction and promotes positive health outcomes (Staffan et al., 2017). In addition, the use of MIH-CP programs has also demonstrated they can contribute to overall direct cost savings, such as decreasing 911 calls, and readmissions, as well as affecting indirect costs such as improving quality of life and decreasing heath risk factors such as high blood pressure (Nejek, Aryal, Talari, Wang, & O'Neill, 2017).

Not only can growth of the MIH-CP programs address issues such as social determinants of health and access to care, CP programs promote public safety and the health of our communities by providing prevention and health promotion interventions in the context of the patients' lives, values, and abilities. Ultimately, the value adds of CP programs are increasing patient and provider satisfaction, improving patient outcomes, and contributing to the management of health care resources and cost containment. This opportunity for healthcare

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cost savings in various capacities (readmissions, ED visits, hospice revocation) and improved patient outcomes demands the development, expansion, funding, and integration of current CP programs as a vital component of the system of care in the state of Idaho.

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

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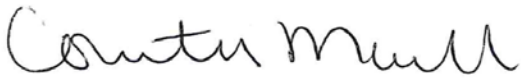
Appendix A
CHEMS/Community Partnership Example

CHEMS- Blackfoot Medical Center

As part of Blackfoot Medical's efforts to provide better care of the community we teamed up with Blackfoot Fire in their CHEMS program. February 27th 2018 Kevin Gray from Blackfoot Fire came to a provider meeting and we presented the program. Providers decided to move forward and we launched the program March 1st, 2018.



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Current Status: *Pending* **PolicyStat ID:** *4999658*

Mountain View Hospital

Origination:	*N/A*
Last Approved:	*N/A*
Last Revised:	*N/A*
Next Review:	*2 years after approval*
Owner:	*Courtney Marshall: Supervisor*
Policy Area:	*Performance Improvement (PI)*
References:	

CHEMS process - Blackfoot Medical Center

Policy: CHEMS program

Purpose: To provide better discharge care for the community.

Definition: CHEMS- Community Health Emergency Medical Services

Process: Upon discharge the provider will determine if the patient is a good candidate for the CHEMS program. Once approved by the provider the clinical staff will complete a CHEMS transfer of care form and fax it to Blackfoot Fire with the patient's demographic sheet. Clear doctor orders will be completed on the form instructing Blackfoot Fire of proper care to the patient. All forms must have a discharge diagnosis, allergy sheet, and medication sheet attached. Blackfoot Fire will then follow up with the patient at time indicated by the provider and will report findings and care back to the provider through phone call and faxing chart notes. Notes will need to be scanned in the patients chart.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Courtney Marshall: Supervisor	05/2018

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BMC ...at
Mountain View Hospital
Getting you back to what you Love

P: 208-785-2600
F: 208-785-1762

Patient Name _____
Date of Discharge _____
Provider _____
Caregiver _____

Diagnosis: _____

Doctor Orders/Special Instructions: _____

Attached:

Demographics	
Medication list	
Allergies	

Staff faxing form: _____

Fax form to: 208-785-8604
Attn: CHEMS Patient Info

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- CHEMS services at the Paramedic level

License number **7603** has been renewed effective **05/29/2018** through **06/30/2019**, to provide the services listed above. Rules governing Idaho EMS agency licensing are published in IDAPA 16.01.03 "Emergency Medical Services Agency Licensing Requirements".

Additional license types or modifications to your existing license types including geographic response areas may require an application. Questions regarding agency licensing can be directed to Jathan Nalls at (208)334-4000 or email emsagencylicensure@dhw.idaho.gov. Thank you for your commitment to providing quality EMS to your community.

Sincerely,

Wayne Denny, Bureau Chief

cc: Agency Medical Director

2

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Courtney Marshall

From:	Kevin Gray <firechief@cityofblackfoot.org>
Sent:	Tuesday, May 29, 2018 11:44 AM
To:	Courtney Marshall
Subject:	FW: Agency License Renewed; Blackfoot Fire Department
Attachments:	Agency License Certificate.pdf

Courtney
Here is the info that the state sent me. Kevin

Fire Chief Kevin R. Gray
Blackoot Fire Department

CONFIDENTIALITY NOTICE: The information contained in this electronic message and any attachments are confidential and intended only for the use of the intended recipient(s), and may contain information that is privileged and/or exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information, or use of the information contained herein (including any reliance thereon), is strictly prohibited. If you received this communication in error, please notify us immediately and destroy the material in its entirety, whether in electronic or hard copy format. All personal messages express views solely of the sender, which are not to be attributed to The City of Blackfoot. Thank you.

From: EMSAgcyLicensure@dhw.idaho.gov [mailto:EMSAgcyLicensure@dhw.idaho.gov]
Sent: Tuesday, May 29, 2018 11:43 AM
To: Kevin Gray
Subject: Agency License Renewed; Blackfoot Fire Department

Blackfoot Fire Department

Dear Blackfoot Fire Department Administrator,

Thank you for renewing your Idaho EMS agency license. We have completed the review of the renewal application and inspection findings. The information provided indicates that your agency meets the requirements for Idaho agency licensure. Your license authorizes you to provide only those services listed below within the described geographic response area and according to the staffing and deployment plans submitted in the application.

- Prehospital Transport services at the Paramedic level

- Transfer services at the Paramedic level

- Standby services at the Paramedic level

1

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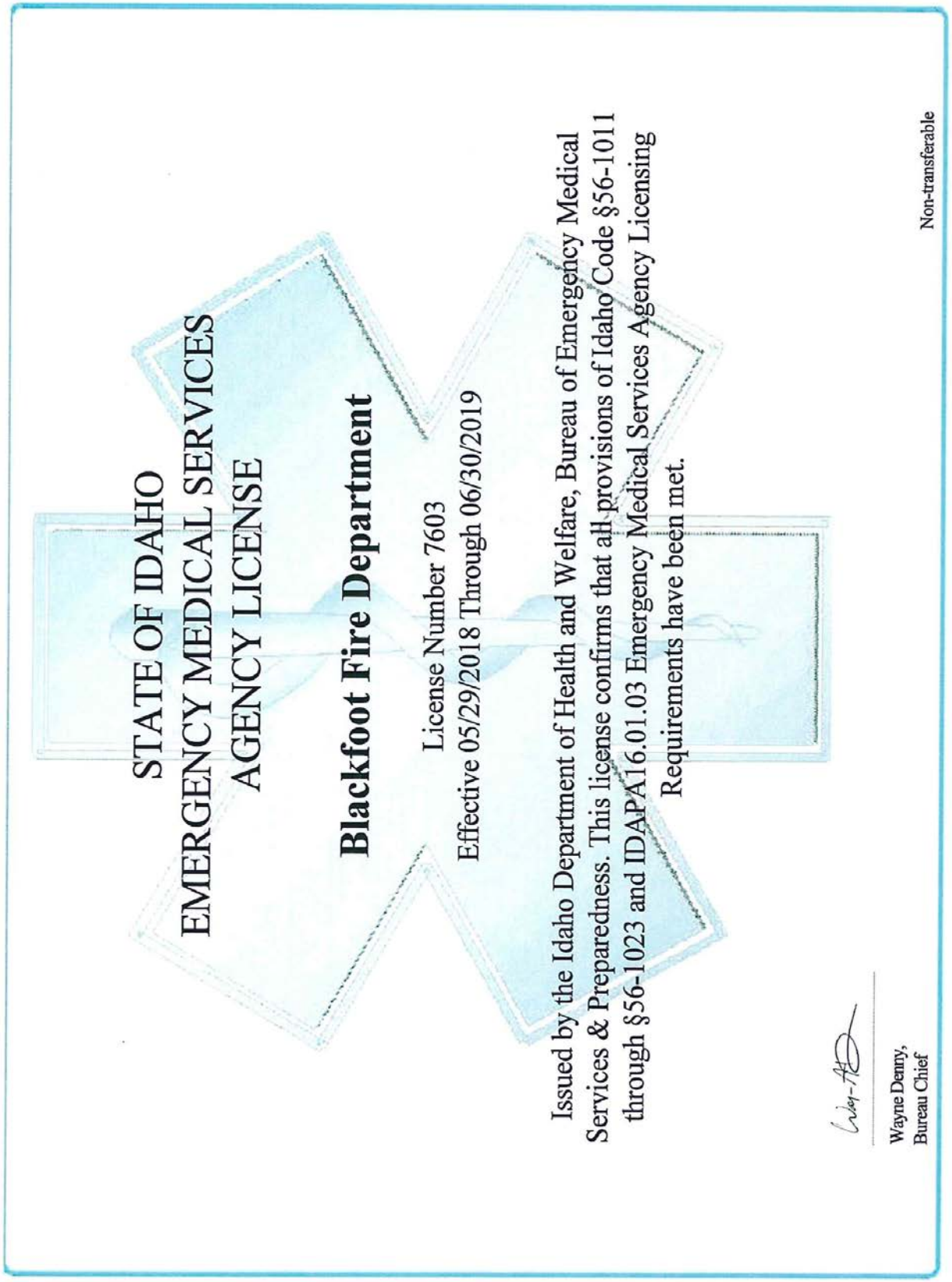

STATE OF IDAHO
EMERGENCY MEDICAL SERVICES
AGENCY LICENSE

Blackfoot Fire Department

License Number 7603
Effective 05/29/2018 Through 06/30/2019

Issued by the Idaho Department of Health and Welfare, Bureau of Emergency Medical Services & Preparedness. This license confirms that all provisions of Idaho Code §56-1011 through §56-1023 and IDAPA16.01.03 Emergency Medical Services Agency Licensing Requirements have been met.

Wayne Denny,
Bureau Chief

Non-transferable

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Appendix W

State Led Evaluation Synopsis by Goal

Goal 1: Transform primary care practices across the State into Patient-Centered Medical Homes.

Patient Centeredness: Patient-centeredness was assessed using seven open ended questions inquiring about primary care services received in the past year, patients' expectation of patient and primary care healthcare team's responsibilities for patient care, patient's plans to change their health behavior in the next 6 months and role of their clinic in those changes, and barriers to better self-care. These questions address the Centers for Medicare and Medicaid's Quality Priority Domain: Strengthen Person and Family Engagement as Partners in their Care and two of the meaningful measures areas within this domain. These two areas are 1) patient's experience with care and 2) care is personalized and aligned with patient goals.

Seventy percent of patients overall reported receiving at least one basic primary medical service in the past year. Management of chronic conditions (46%) and regular checkups (43%) were the most frequently reported of these services within this group of patients. Forty-three percent overall reported receiving at least one element of PCMH services with reciprocal listening (31%) and care coordination (31%) the most frequently cited. A combined subset of 22% of these patients reported receiving both types of care.

Overall, 68% of patients defined responsibility for their own health as a personal responsibility, 54% defined their responsibility as following MD and healthcare team's directions, and as a combined subset, 36% of patients defined responsibility as encompassing both aspects.

In total, 78% of all patients named at least one element of PCMH services as something they felt their healthcare team was responsible for, as compared to 43% of these same patients listing at least one basic medical service as a healthcare team responsibility. Within the PCMH domain, communication was by far the most frequent aspect of care sought (55% wished to have a healthcare team that listened to the patients' concerns and 35% wished the healthcare team would make sure the patient understood recommendations for care) Within the basic medical service domain, the most frequently occurring element patients expected was an informed and accurate differential diagnosis from their provider (60%) and prescribing of correct medications (27%). A combined subset of 28% of these patients expected to receive both types of care.

Improvements in exercise and diet were the most frequently cited changes planned for the next 6 months (41% and 31% respectively). Within these two groups saying they were going to change diet or exercise, 21% also stated they had a responsibility exercise and 20% stated they had a responsibility to eat properly.

Overall, 38% of participants affirmed that their healthcare team was doing everything needed and doing a good job. Another 32% could not state any additional role for their healthcare team. One hundred and forty-eight interviewees had specific additional services they would like to receive. Specific additional services listed by 148 interviewees has as the top three new services were 1. Hopes for further explanation and communication with their healthcare team (32%) 2. Counseling on nutrition (18%) and Care coordination (18%).

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Of the 20 specific barriers to better self-care named by the interviewees, the top three were finances (15%), health issues (12%) and personal motivational issues (12%). An additional 29% stated that nothing prevented them from taking better care of their health.

Sixty-one percent of the interviewees defined access as being able to see a physician and/or healthcare team when needed. Eighty-four percent of the patients reported being able to easily schedule an appointment with a doctor when they needed one. Most patients also had reliable transportation (89%), ready access to primary care in the past 6 months (88%), ready access to dental care (60%) and had insurance coverage (57%). In contrast, 44% of patients had specialty referrals available, and 33% reported access to behavioral health.

PCMH Clinic Transformation: Windshield surveys were completed to provide a snapshot of the SHIP PCMH clinics and surrounding environment. As a group, the 106 clinics surveyed were in communities with green spaces, had adequate and easily accessible parking, and their buildings were well maintained. As a group, 46% did not have sidewalks leading to the facility and 60% did not have bus stops visible in the immediate vicinity.

In-person or phone interviews with PCMH clinic staff at 127 clinics were structured and coded to inquire as to the clinics' successes and priorities for the six NCQA (National Committee for Quality Assurance) PCMH Standards. The PCMH Portal Notes used over the course of the 3 PCMH clinic cohorts to record and track transformation plans, progress and concerns/interest were also coded for content using these same six NCQA PCMH standards.

Forty percent of participating clinics for which information was available had been enrolled in Idaho Medicaid's Healthy Connections, and 42% of these clinics were at a level 2 to level 3 level of NCQA PCMH recognition. Neither of these background variables were associated with reported successes or future priorities and interests in the PCMH model.

Reported successes converged between clinic staff interviews and PCMH portal notes for the top two issues cited in either source. Access and continuity of care and care coordination were the two most frequently occurring accomplishments (averages of 50% and 45% respectively). Both NCQA Standards remained relatively constant in importance for priorities and future interests.

A divergence in perceived success between the two sources was seen for Quality Improvement, although looking forward, Quality Improvement was a top priority (average of 71%).

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

The challenges encountered in the assemblage of clinically valid data from Electronic Health Record systems is one of the key lessons learned from the SHIP Goals related to health information technology and healthcare workforce training. Foundational skills for health information technology use and implementation include computer and information literacy defined as the ability to manage, analyze, interpret and integrate data for purposes of clinic transformation and tracking patient outcomes.

A follow-up effort post SHIP will be development of learning modules on CQM data definition, data capture, data aggregation, data validation and data reporting. Interactive exercises will be developed to illustrate how analyses of data gaps can be used to correct inaccurate measures.

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Examples of issues known to occur and to be remediable once identified include placement of information in the wrong location in the EHR, clinicians failing to record procedures, and differing definitions of laboratory values. Particular attention will be given to the training and support needs of staff in rural and independent primary care practices.

These modules will be offered through the public University System. Badges will be designed to attest to the learner's capacity for the completion of the specific steps necessary for successful submission of accurate data to an external audience(s). This effort will address the needs of workforce development and training and contribute to the overall development and growth of a value-based patient centered system of care in Idaho.

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

The seven Idaho Public Health Districts provided a geographical and organizational framework for formation of the seven SHIP Regional Collaboratives (RC). As shown in Figure 2, the RCs are conceptualized to provide a third level of support for the primary care clinic and their patients. A specific objective of the RCs was to identify resources for patient support often previously unknown to the primary health care clinic, thus expanding capacities of the medical health neighborhood. Efforts were made to establish initial partnerships with clinics and other community entities which had the capacity to address certain social determinants of health beyond the reach of the primary health clinic. Interviews with Regional Collaborative members attest to the success of the RCs in raising awareness of resources within a community's medical health neighborhood. Summaries of these interviews are available in Appendix O and P.

A corroborating set of evidence on the value of the Regional Collaboratives is seen in the coded notes from the monthly SHIP Public Health District Manager reports on RC activities. Four of the five 2017 NCQA PCMH content areas appear in the top ten most frequently occurring activities. The PCMH content area of Access to Care was cited much less frequently. Five of the seven SHIP Goals also appear in the ten most frequently occurring activities with the Goal 1 Coaching/PCMH Transformation, by far, the most commonly reported across the seven Regions.

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

Idaho is a large state (11th largest geographically in the nation) with 44 counties and most Idahoans dispersed widely throughout 19 rural (43%) and 16 frontier (36%) counties. Travel in many areas of the State requires driving through narrow, mountainous roads. The entire State has longstanding challenges with shortages in almost all categories of healthcare professionals. The combination of these factors calls for unique solutions for the delivery of primary healthcare to citizens living outside the State's 9 urban counties. The three components of the virtual PCMH (Community Health Workers, Community Health Emergency Medical Services and Telehealth) are designed to provide such solutions for far flung, small, rural communities.

The first component, Community Health Workers (CHW), draws on the strength of training and deploying local residents to address community healthcare needs. CHWs can help patients navigate the healthcare system, arrange for referrals, and follow-up with support with self-care for chronic health issues. The status of CHWs in Idaho is addressed with Appendices R, S, and T.

The second component, Community Health Emergency Medical services (CHEMs) builds on the training and licensure of paramedic units to provide specific medical and support services

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more broadly in the communities they serve. For example, expansion of the role of CHEMs with home visits and medication check-ins may help chronically ill patients better adjust after a hospital discharge. Agreements executed with community partners may offer alternative locations for transport for non-emergency conditions rather than taking the patient to the Emergency Department for what will be deemed an unnecessary ambulance ride. The SHIP experience with CHEMs was recorded with interviews with CHEMs staff and are summarized in Appendix R and Appendix V.

SHIP's telehealth efforts were supported by technical assistance and consultation with experts in the area. As of May 2018, a submission has been made to the Health Quality Planning Commission (HQPC) with a request for review of telehealth reimbursement, scope of practice and related issues (Appendix M). The HQPC was established by Idaho State Legislative Statute in 2006 to "...promote improved quality of care and improved health outcomes through investment in health information technology and in patient safety and quality initiatives in the state of Idaho" (https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch10/sect56-1054/).

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

A range of efforts initiated under SHIP provide opportunities for case studies of alignment of payment to transform from volume to value. Among those efforts amendable to such analyses is the Community Health Emergency Medical Services. Traditional Emergency Medical Services seek to change their business model from a fee-for-service transport system to a value-based system, with value defined in many ways for patients, providers and payers. Appendix V summarizes the evidence on outcomes of CHEMs demonstrations and reviews issues for Idaho in expanding CHEMs. Appendix Q provides additional background information on the Idaho CHEMS model.

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Appendix X (Table 3)

Frequencies of Summary Variables from Patient Interviews by Rural, Metropolitan and Frontier Counties

	Rural County	Urban County	Frontier County
Definition of responsibility for own health	Number (percent)	Number (percent)	Number (percent)
Responsibility for own health is with individual person	170 (65)	553 (71)	57 (66)
Responsibility for own health means following MD and healthcare team's directions	142 (54)	431 (56)	48 (56)
Responsibility for own health is with individual person and following MD and healthcare team's directions[2]	87 (32)	288 (37)	31 (36)
Has your healthcare team helped you in the past year?	Number (percent)	Number (percent)	Number (percent)
Patient Centered Medical Home Care received in past year	111 (42)	343 (43)	43 (50) p=.012
Basic Medical Care received in past year	171 (65)	601 (76)	56 (65)
Both PCMH and basic medical care received in past year[2]	57 (22)	212 (27)	29 (34)
Responsibilities of healthcare team in helping patient take care of their own health?	Number (percent)	Number (percent)	Number (percent)
Healthcare Team has responsibility to provide PCMH care	205 (78)	623 (81)	66 (77) p=.006
Healthcare Team has responsibility to provide basic medical care	105 (40)	331 (43)	51 (59)
Healthcare Team has responsibility to provide PCMH care and basic medical care[2]	66 (25)	226 (29)	33 (38)
Things patient should be doing but need more information or help to take more responsibility for own health?	Number (percent)	Number (percent)	Number (percent)
Additional help from clinic	110 (42)	366 (47)	35 (41)
Health is personal responsibility	77 (29)	252 (33)	22 (26)
No additional help because clinic is doing everything possible	106 (41)	322 (42)	43 (50)
Financial assistance	7 (2)	18 (2)	5 (6)
No additional help needed	50 (19)	143 (18)	14 (16)
Any changes planned in next 6 months?	Number (percent)	Number (percent)	Number (percent)
No changes-keep everything the same	50 (19)	132 (17)	14 (16)
Changes related to medical care	37	137	16

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	(14)	(18)	(19)
Changes in specific behaviors (exercise and diet)	129 (49)	419 (54)	47 (55)
Changes in general self-care	54 (21)	172 (22)	16 (19)
Can healthcare team help with planned changes in next 6 months?	Number (percent)	Number (percent)	Number (percent)
No additional help needed	84 (32)	258 (33)	17 (19)
Healthcare team already doing everything they can to help	96 (37)	284 (37)	40 (46)
Patient responsible for health	13 (5)	60 (8)	3 (3)
Suggested new services	40 (15)	153 (20)	21 (24)
Things keeping patient from taking care of themselves as much as they would like?	Number (percent)	Number (percent)	Number (percent)
Personal motivation	21 (8)	102 (13)	10 (12)
Limits in resources	44 (17)	136 (18)	22 (26)
Family/work	78 (30)	227 (29)	17 (20)
Health issues	32 (12)	128 (17)	18 (21)
No issues prevent taking care of own health	76 (29)	233 (30)	20 (23)
Total Number of Patients (1143)	262 (23)	795 (70)	86 (7)
Number of Counties (24)	12	7	5

TABLE 3 Frequencies of Summary Variables from Patient Interviews by Rural, Metropolitan and Frontier Counties[1]

1. file:///C:/Users/wsolomon/Downloads/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf
2. Combined patient group citing both PCMH and basic medical services. Includes MD talked about diet.

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Appendix Y (Table 4)

Frequencies of Summary Variables from Patient Interviews by Clinic Type

	Community Health Center	Privately Owned	Hospital Owned	Rural Health Center
Definition of responsibility for own health	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Responsibility for own health is with individual person	374 (49)	192 (25)	137 (24)	11 (79)
Responsibility for own health means following MD and healthcare team's directions	315 (52)	156 (26)	131 (22)	3 (21) p=.051
Responsibility for own health is with individual person and following MD and healthcare team's directions[1]	199 (36)	104 (38)	94 (38)	3 (21)
Has your healthcare team helped you in the past year?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Patient Centered Medical Home Care received in past year	228 (41)	130 (48)	122 (49)	1 -
Basic Medical Care received in past year	390 (70)	193 (71)	189 (76)	5 (36)
Both PCMH and basic medical care received in past year[1]	127 (23)	81 (30)	79 (32)	3 (21)
Responsibilities of healthcare team in helping patient take care of their own health?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Healthcare Team has responsibility to provide PCMH care	450 (80)	213 (78)	203 (82)	8 (57)
Healthcare Team has responsibility to provide basic medical care	234 (42)	136 (50)	97 (39)	4 (29)
Healthcare Team has responsibility to provide PCMH care and basic medical care[1]	163 (29)	85 (31)	64 (26)	3 (21)
Things patient should be doing but need more information or help to take more responsibility for own health?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Additional help from clinic	259 (46)	101 (37)	136 (57)	4 (29)
Health is personal responsibility	178 (32)	90 (33)	77 (31)	2 (14)
No additional help because clinic is doing everything possible	71 (13)	45 (17)	6 (2)	3 (21)
Financial assistance	17 (3)	2 -	11 (4)	0
No additional help needed	82 (15)	65 (24)	46 (19)	4 (29)
Any changes planned in next 6 months?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
No changes-keep everything the same	93 (16)	59 (22)	37 (15)	0

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Changes related to medical care	94 (17)	53 (19)	38 (15)	0
Changes in specific behaviors (exercise and diet)	322 (58)	116 (43)	136 (55)	7 (50)
Changes in general self-care	103 (18)	73 (27)	60 (24)	3 (21) p=.034
Can healthcare team help with planned changes in next 6 months?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
No additional help needed	179 (32)	85 (31)	81 (33)	2 (14)
Healthcare team already doing everything they can to help	201 (36)	116 (43)	89 (36)	5 (36)
Patient responsible for health	31 (6)	20 (7)	22 (9)	3 (21)
Suggested new services	120 (21)	47 (17)	42 (17)	0
Things keeping patient from taking care of themselves as much as they would like?	Number (percent)	Number (percent)	Number (percent)	Number (percent)
Personal motivation	74 (13)	32 (12)	27 (11)	0
Limits in resources	11 (20)	45 (17)	40 (16)	2 (14)
Family/work	157 (28)	76 (28)	76 (31)	3 (21)
Health issues	83 (15)	36 (13)	49 (20)	5 (3)
No issues prevent taking care of own health	155 (28)	89 (33)	73 (29)	3 (21) p=.032
Total Number of Patients	615 (54)	238 (21)	248 (22)	14 (1)
Total Number of Clinics (89)[2]	46	26	15	2

TABLE 4 Frequencies of Summary Variables from Patient Interviews by Clinic Type

1. Combined patient group citing both PCMH and basic medical services. Includes MD talked about diet.
2. Free clinic (1 clinic: 11 patients) and “other” clinic (2 clinics: 17 patients) are not included.

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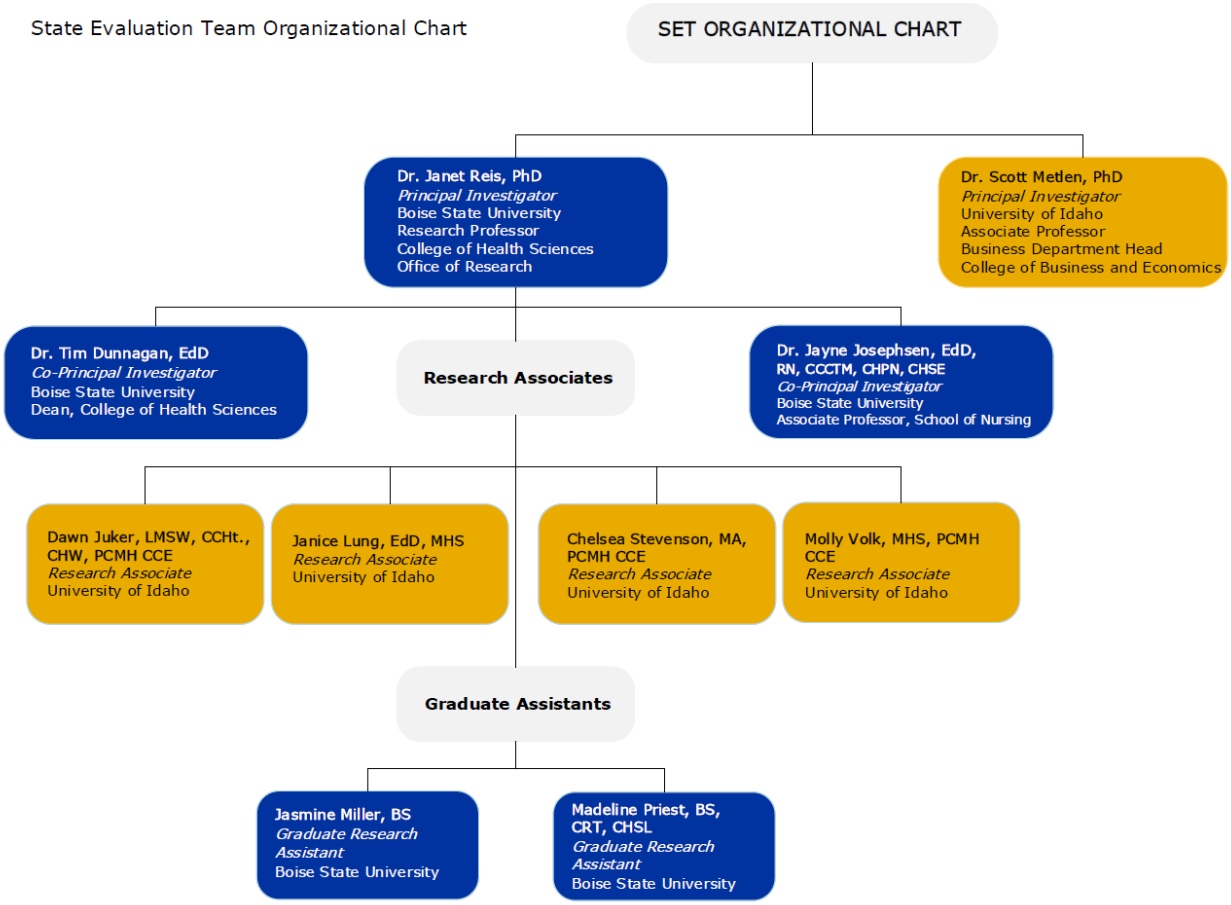
Figure 4. State Evaluation Team Organizational Chart



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Statewide Healthcare Innovation Plan

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

Appendices

SHIP State Level Evaluation Supplemental Materials

SHIP STATE LEVEL EVALUATION FACT SHEET

Number of patients interviewed

- 1143 patients
- 74% female
- Average age 43 years
- Of the 1,143 patients interviewed; 70% of patients came from urban counties, 23% from rural counties and 7% from frontier counties

Number of clinics interviewed

- 92 clinics from the three cohorts participated in patient interviews
- 127 clinics from the three cohorts participated in the clinic interviews
- 25% (23) are in rural counties
- 65% (60) are in urban counties
- 10% (9) are in frontier counties

Top 3 things patients want from their primary care team

1. Listen to Patient Concerns: 43.6% (498) patient responses

2. Confirm that Patient Understands Care: 28.2% (322) patient responses

3. Schedule Follow-Up Appointment and Care Coordination: 15.5% (177) patient responses

Top 3 things clinics want to work on in the future

1. Performance Measures and Quality Improvement

2. Care Coordination and Care Transitions

3. Care Management and Support

Note: The final state level evaluation report will be available after January 31, 2019. For questions, please contact JanetReis@boisestate.edu or ann.watkins@dhw.idaho.gov

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

What was learned from Goals 2 & 5 Use Cases?

- Establishment of connectivity of 92% (152) SHIP clinics by January 31, 2019
- Use cases is Public Health Districts 6 and 7 underscored the importance of small, rural clinic staff being knowledgeable in measure knowledge and EHR knowledge domains
    - Majority of staff had beginner's understanding of Excel, data management, and clinical quality measures

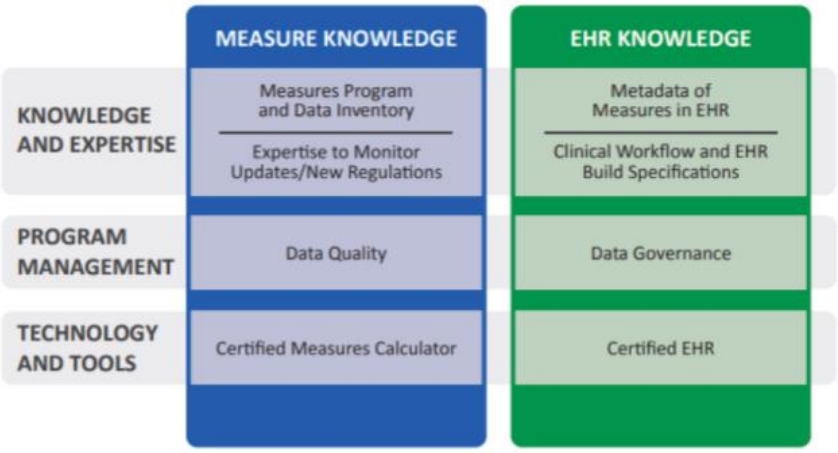
How can clinics use this information to improve their practice and engagement with patients?

1. Improve Data Entry
    - Understanding the necessity of correct placement of information in Electronic Health Record (EHR) and using correct type of information
    - Clinic staff responsibilities in workflow for patient care
    - The recording of those responsibilities in an EHR as appropriate
    - The generation of a clinical quality measure from the accumulated, specified codes for that measure
2. Define Measures and Measure Specification
    - Understanding the necessity of matching clinical workflow for a measure with the official measure specification and the EHR measure version reporting capability used by a clinic.

How is information used for curriculum development?

- Module Development
    - Specific to clinical staff to provide them with an interactive way to further understand role within data validation and data capturing
- A core of learning and skill development with clinic staff and BSU health science graduate students
- Understand the necessity of correct placement of information in EHR records and using correct type of information
- Understand the necessity of matching clinic definition of measure with measure specification and measure definition available in version of EHR
- To measure knowledge and EHR knowledge domains

Example:



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Idaho SHIP Clinic Transformation

Patients + Providers = Better health, Better value

Prepared for
Idaho SHIP PCMH Clinics

Prepared by
Idaho SHIP State-level Evaluation Team
Contact: Dr. Janet Reis
janetreis@boisestate.edu
January, 2019

Disclaimer: The project described was supported by Grant Number CMS-1G1-14-001 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies. The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor

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

Look What We Accomplished!

Through Idaho's Statewide Healthcare Innovation Plan (SHIP) 163 primary care practices, just like yours, have transformed into Patient-Centered Medical Homes (PCMH). As of January 31, 2019, 88 clinics have achieved national PCMH recognition as well. It has not been easy, but it has been worth it, and we celebrate your success.

Researchers with the State-Level Evaluation Team (SET) sought to capture and tell the story of PCMH transformation in Idaho. This is what we did:

- We interviewed PCMH clinic staff from 126 clinics spanning the three cohorts. We spoke with individuals either in person or by phone.
- We analyzed PCMH Portal Notes of clinics in each of the three cohorts.
- We conducted windshield surveys to get a snapshot of the clinics and surrounding environment.
- We recorded panel discussions among members of the healthcare team. We posted the recordings on the SHIP website in order to share the "lived" experience of transformation.
- We spoke with 1,143 of your patients from 92 clinics. Based on your recommendations, program participation, or random selection, we interviewed individuals either in person, by phone, or completion of a written questionnaire.

As a result of our work, the SET gained valuable insights about how the experience made a difference to you. We also learned about your patients and what they need to achieve better health. The purpose of this report is to share statewide themes and recommend broad strategies to support your continued efforts to advance healthcare in Idaho. We hope this will be valuable to you, your clinic staff and patients! In this report we'll highlight three key topics:

1. What we heard from you
2. What we heard from your patients
3. SET recommendations going forward

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

What we heard from you

It's all about patient care, and the PCMH model translates to better patient care

Your clinics strive to provide patient-centered care where the focus is on the best thing for the patient at the time. Your patients appreciate PCMH in the practice and in the care, they receive.

- *"PCMH allows me to provide better care for patients with complex needs."*
- *"When a clinic transforms to PCMH, all the patients in the clinic benefit."*
- *"It's a chance to get back to what we say we want from medicine."*

PCMH is a team sport

Patients are better served by team-based care, and an integrated care team results in more points of contact which lead to improved outcomes. Team members enjoy working in a team; it's more efficient and makes more tools available.

- *"The people on our team want to be more engaged clinically."*
- *"Through the resources we now have we're able to manage a difficult patient's care without me having to see him all the time."*
- *"We're getting better at providing proactive care around specific diagnoses."*

PCMH transformation is a journey, not a destination

Clinics must determine the pros and cons of becoming PCMH accredited. Transformation involves a heavy lift, both financially and organizationally. A lot of it is about learning the systems and tools that work best for the clinic and developing better systems of communication. It's a continual effort.

It requires redefinitions of staff roles and redirection of certain workflows. Restructuring of the work environment occurs for professionals involved in direct patient care and their administrative support teams. The experience and challenges of transformation vary greatly and depend on individuals' roles.

Data and documentation are critical

PCMH requires a greater degree of focus and attention to data.

- *"We have to be able to measure things to improve them, so you have to continually look at the data and you have to react to it."*

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The payment systems haven't caught up with transformation efforts

The payers want to pay for value, and its coming. But many of you repeatedly acknowledged the challenges of heading toward a value-based payment model while still existing in a fee-for-service world.

— *"Sometimes it feels like rafting down a fast-moving river with your legs in two different rafts."*

PCMH has a positive impact on clinics and patients

You are already seeing short-term benefits of PCMH. Your most stated response was greater access and better continuity of care. You also identified pre-visit planning, seeing gaps in care, and addressing environmental factors.

Your journey continues

As your journey of PCMH transformation continues, most of you reported that your first priority for the coming year is continual development in the areas of quality improvement and performance measures. You are also prioritizing care coordination and care transitions, as well as care management and support.

There seems to be a collective need for continued support, specifically in the form of mentoring from other clinics. Our clinics in frontier counties desire help with patient-centered access and continuity of care. Our rural clinics seek help with templates for policies and procedures, and EHR affinity groups.

We also heard you identify a need for assistance with health technology. You told us that you feel there are so many programs to report to, it becomes a balance between providing better care or providing better reports.

— *"We want to be able to provide the most beneficial care to patients, without it being too cumbersome in terms of documentation."*

— *"We seem to be navigating how to implement and document processes while providing efficient services."*

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What we heard from your patients

Most patients accept responsibility for their role in creating better health

Most of the patients we talked to believe they are personally responsible for their own health. Responsibility looks different to different people. For example, some may define their responsibility as following the directions of the healthcare team.

Circumstances matter

We talked to many people who will never get better due to circumstances beyond their control. We talked with others who will only get better when circumstances beyond their control are addressed, such as co-morbidities, homelessness, socioeconomic status, employment, etc. Still others experience barriers that can be overcome with time or effort. All of these circumstances must be recognized when working with the whole person.

Patients we spoke with identified 23 specific barriers to better self-care. The most frequently stated barriers were finances, health issues, and personal motivation.

Patients value the patient-centered care they receive from their healthcare team

Although they may not know the technical terms, patients desire the foundations of PCMH. For the most part, they value the patient-center care they receive.

- *"Whenever I have any questions they always can answer it."*
- *"I think that I've been given a lot of needed information from my clinic and everyone has been really helpful."*
- *"They are very engaged in my health. When I have questions, they call me back, and they're very good at making sure that they relay information to me in a way that I can understand."*

Patients want more from their healthcare team

Communication was by far the most frequent aspect that patients want. This ranged from listening to concerns, confirming the patient understands recommendations, and providing further explanation when necessary.

- *"Listen, listen, listen. They really need to listen to what you say, what you are concerned about. If they don't know the answer, look something up and get back in touch with you."*
- *"I think they need to make sure that they're really paying attention to what the patient is saying. I like to be heard."*

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— *"Making sure that I understand and am heard."*

Patients indicated they would benefit by counseling on nutrition.

— *"I think it is the healthcare team's responsibility to be able to educate the patient on how to prevent and take care of their health."*

Patients told us they value care coordination.

Patients want access to care

They want to be able to schedule an appointment with a healthcare team when they need one, at a location that is accessible to them. They want their care to be coordinated in a way that does not require them to repeat their story along their journey to health. They appreciate when their provider and healthcare team know who they are before they enter the exam room. Patients want to be listened to by providers and staff who care about them.

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SET recommendations going forward

Acknowledge the momentum and gains in PCMH transformation

The Goal 1 of the SHIP program was an amazing endeavor to get multiple stakeholders to the discussion table and to create an environment ripe for transformation. I think Goal 1 of SHIP provided a launch pad for PCMH transformation in Idaho. It encouraged clinics to begin the PCMH journey and connected them to resources, technical assistance, and other PCMH clinics.

Ongoing role of RCs and expanding role of medical health neighborhood

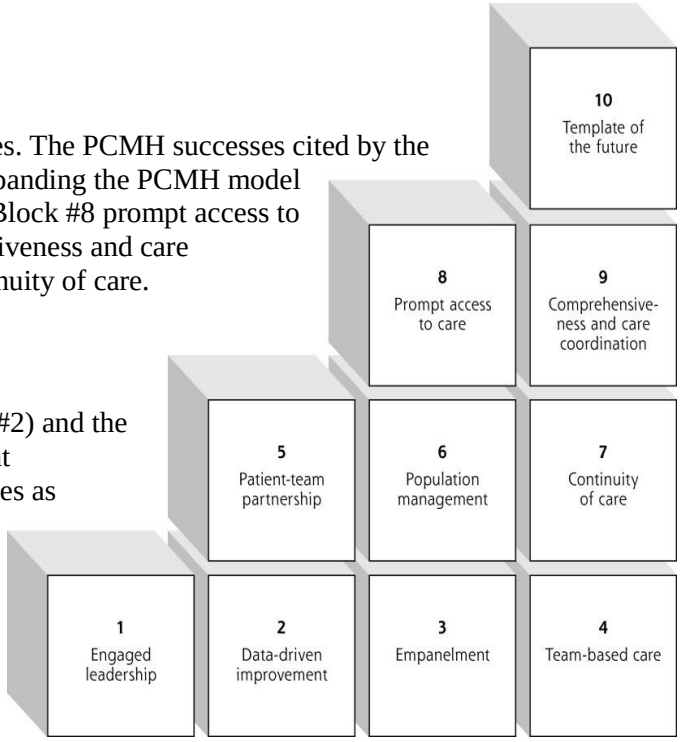
Primary care clinics are not positioned to deal with the barriers alone, they need the partnerships across the community to address the barriers and make sure the PCMH can function. Partnerships provide additional sources of what patients want: listening, etc. CHWs could help here too as could CHEMS staff. Breaking out of the silos.

Expand PCMH services

There is room to expand on PCMH services. The PCMH successes cited by the clinics offer a possible continuation of expanding the PCMH model for clinic functions. These were Building Block #8 prompt access to care and, Building Blocks #9, comprehensiveness and care coordination and Building Block #7, continuity of care.

Data-driven improvement

The Bodenheimer model (Building Block #2) and the related function of Population Management (Building Block #6) appeared multiple times as recognized key PCMH functions and frequently encountered challenges.
Of central concern was a basic capacity to generate timely and accurate clinical data from the Electronic Health Records. Because of problems with data quality, as one example, capacity was limited for the risk stratification analyses necessary for effective population management (Building Block #6).



Building Block #2: Ten Building Blocks for the Patient Centered Medical Home
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Clinic's challenges in data generation, particularly for rural, independent clinics, recommends that training modules be developed for mid-level clinic staff in data capture, data aggregation, data validation and data reporting.

The responses of patients to a question on what prevented them from taking care of themselves as well as what they would like to underscore the necessity of differentiating among the social determinants health that may be feasibly addressed by a clinic, and determinants requiring support from a broader medical health neighborhood. This question reverts to the role of some version of a Regional Collaborative Organization with capacity to identify and connect resources for primary care providers and their patients.

Patients' feedback on their interest in exercise and nutrition offer an example of collaboration at the clinic and community level within the PCMH and medical health neighborhood paradigms. Primary care clinics could build on patients' interest in the patient team partnership using Motivational Interviewing or similar techniques to assess patient's readiness to change for specific health behaviors. Patients in turn could be referred to options for food and for exercise offered through community partnerships with ongoing follow-up from their healthcare team. The Idaho SHIP leaves in place an interconnected, patient-centered system for such initiatives central to improvement of individual health.

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SHIP MILESTONES 2018-2019

Highlights from our final year

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

53 Clinics were selected to participate in PCMH Cohort 3

163 Clinics are now participating in SHIP

- 98% of the 166 Clinics enrolled in SHIP continue to be engaged in PCMH transformation
- Adoption of PCMH model of care is a journey that requires significant work to build PCMH capacity.
- Adoption of the PCMH model has also been accelerated statewide with provision of transformation support at the regional level though national experts

- Idaho's Largest Commercial Insurers participated in the model test
- Payers are evolving payment models from paying for volume of services to paying for improved health outcomes
- Department of Health and Welfare Idaho Medicaid Healthy Connections was a leader in payment reform.

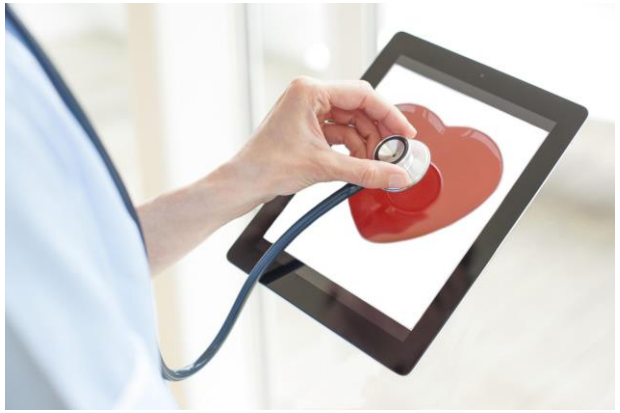
Value-based payment coupled with PCMH care delivery models have bent the cost curve in Idaho

Financial analysis conducted indicates that Idaho's healthcare system costs have been reduced by at least $93 million over three years

new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care, and outcomes rater than volume of service.

Clinics continue to evolve their business models and adapt new strategies to adjust to the changing landscape of payment reform initiatives

INNOVATIVE WORKFORCE DEVELOPMENT STRATEGIES IMPLEMENTED TO ADDRESS THE STATE'S CRITICAL HEALTH PROFESSIONAL WORKFORCE SHORTAGES



Establishing Community Health Emergency Medical Services (CHEMS) programs and 13 Telehealth grants to expand medical services in rural and underserved communities

and

Training of 107 Community Health Workers (CHWs)

- Idaho's plan included significant investment to connect PCMHs to the IHDE
- Enhance care coordination though improved sharing of patient information among providers.
- Resources were invested in the Health Information Exchange (HIE) infrastructure
- The health information technology environment in Idaho continues to shift with increased health record conversations at the practice level that require changes in workflows and policies

PROJECT

ECHO

- Project ECHO launched a multi-point video conference on opioid addiction and treatment to conduct virtual clinics with community providers, particularly those in geographically isolated areas lacking access to specialists.

Summary of the Patient Interviews of the State-Level Evaluation of the Statewide Healthcare Innovation Plan (SHIP)

University of Idaho and Boise State University

Patient-Centeredness

- Need to understand patient's own perspectives on what constitutes patient centered care as compared to fee for service episodic care. What are patients willing and able to do with their healthcare team in a patient centered medical home?

- Patient's definition of patient-centeredness is DIFFERENT from patient satisfaction with care as measured in CAHPS: Consumer Assessment of Healthcare – Providers and Systems

1187

Road map for value based change from In-person patient interviews

"Alone we can do so little, together we can do so much." -- *Helen Keller*

1188

SHIP Goal 1

Patient-Centeredness was measured with 7 open ended questions for 1143 patients

- Patients' expectation of their own responsibilities for their personal health
- Care received from their healthcare team in the past year
- Patient's definition of primary care healthcare team's responsibilities for patient care
- Additional resources and/or help needed by patient to better take care of their health
- Patient's plans to change their health behavior in the next 6 months
- Role of their primary care healthcare team in helping with those changes
- Patient's own personal barriers to better self-care

1189

SHIP Goal 1

1. **Patients' expectation of their own responsibilities for their personal health**

   - Overall, 68% of patients defined responsibility for their own health as a personal responsibility not involving their healthcare team

   - Overall, 54% defined their responsibility as following MD and healthcare team's directions

   - A combined subset, 36% of patients defined responsibility as encompassing both personal <u>and</u> following MD and healthcare team's directions

1190

SHIP Goal 1

2. Care received from healthcare team in past year

- Overall 70% of patients reported receiving at least one basic primary care medical service in the past year. Management of chronic conditions (46%) and regular checkups (43%) were the most frequently reported of these Services

- Overall 43% reported receiving at least one element of PCMH Services. Reciprocal listening (31%) and care coordination (31%) were the most frequently cited

- A combined subset of 22% of these patients reported receiving both PCMH and Basic primary care

1191

SHIP Goal 1

3. Patient's definition of primary care healthcare team's responsibilities for patient care

- Overall, 78% of all patients named at least one element of PCMH services verses basic care as something they felt their healthcare team was responsible for providing. ***Communication was by far the most frequent aspect of care sought (55% wished to have a healthcare team that listened to the patients' concerns and 35% wished the healthcare team would make sure the patient understood recommendations for care).***
- Overall, 43% of all patients listed at least one basic medical service as a healthcare team responsibility ***The most frequently occurring element patients expected was an informed and accurate differential diagnosis from their provider (60%) and prescribing of correct medications (27%).***
- A combined subset of 28% of these patients expected to receive <u>both</u> PCMH <u>and</u> Basic primary care

1192

SHIP Goal 1

4. Additional resources and/or help needed by patient to better take care of their health

- One hundred and forty-eight interviewees had specific additional services they would like to receive.

The top three new services were:

1. Increased explanation of care recommendations and more communication with their healthcare team (32%)
2. Counseling on nutrition (18%)
3. Care coordination (18%)

1193

SHIP Goal 1

5. Patient's plans to change their health behavior in the next 6 months

Most frequently cited changes planned for the next 6 months:

- Improvements in exercise (41%)
- Diet (31%)
- Within these two groups saying they were going to change diet or exercise, 21% also stated they had a responsibility to exercise and 20% stated they had a responsibility to eat properly

1194

SHIP Goal 1

6. Role of their primary care healthcare team in helping with those changes

- Overall, 38% of participants affirmed that their healthcare team was doing everything needed and doing a good job

- Overall, 32% could not state any additional role for their healthcare team

1195

Clinical Implications for Patient-Healthcare Team Partnership

- Many Patients both seek and expect a PCMH model for their primary healthcare
- Patients have clear boundaries for what additional services they want from their healthcare team
- Expansion of the primary healthcare team's role in assisting patients with planned changes in health behavior will require a proactive approach. Patients' endorsement of a PCMH model offers a bridge for that partnership expansion

1196

SHIP Goal 1

7. Patient's own personal barriers to better self-care

- Of the 20 specific barriers to better self-care, the top three were:
  1. finances (15%)
  2. health issues (12%)
  3. personal motivational issues (12%)

- An additional 29% stated that nothing prevented them from taking better care of their health

1197

Clinical Implications for Patient-Healthcare Team Partnership

- Patients contend with many and varied challenges to taking care of their health
- Patients' endorsement of a PCMH model offers a bridge to broader communication with their healthcare team about obtaining additional resources to improve patients' health
- Primary healthcare clinics cannot alone address patients' many and varied challenges to taking care of their health: broader community partnerships are necessary

1198

SHIP Goal 1

Patient's Access to care: 1143 patients were asked about access to healthcare services

- Overall 61% of patients defined access as being able to see a physician and/or healthcare team when needed
- Overall 84% of patients reported being able to easily schedule an appointment with a doctor when they needed one
- Overall 89% had reliable transportation, 88% had ready access to primary care in the past 6 months, 60% had ready access to dental care, and 57% had insurance coverage
- In contrast, 44% of patients had specialty referrals available, and 33% reported access to behavioral health

1199

SHIP Goal 1

Feedback to SHIP PCMH Clinics

- Each clinic received a summary report on the patient interviews highlighting areas where patients sought collaboration with their healthcare team

- Clinics were able to incorporate these summaries as an element of patient engagement into development of their NCQA PCMH applications

1200

Clinical Implications for Patient-Healthcare Team Partnership

Patient Feedback from Idaho's SHIP evaluation attests to the potential of achieving value based primary care through a patient-centered approach which supports a collaborative patient-healthcare team partnership focused on realistic behavioral change and care coordination.

1201

State Level Evaluation Patient Centered Medical Home Discussion Panel Quotes

Karl Watts, MD
St. Alphonsus

- "PCMHs form the foundation of this bigger project of population health. All the processes and all the work to make a population as healthy as you can and proactively working with those patients to prevent disease processes and issues in the future"

Amber Villelli
Kaniksu Health Services

- "Our patients are starting to really consider us their home and looking to us to help them manage other services they might use."

Kelly McGrath, MD
Clearwater Valley Health Clinic

- "I'm going to be much more effective with an integrated care plan and care team. Particularly if we can move into the community and have a medical neighborhood further out."

Michael Ryan
Bingham Memorial Hospital

- "Transforming to a PCMH is something that's going to push and drive the core of the patient experience we provide across the entire organization."

Angela Beauchaine, MD
Primary Health Medical Group

- "One of the great things about the value-based payment that I've seen is it's allowed us to continue to have care coordinators that really help us to manage patients and meet our quality goals. "

Rachel Stephenson
Saltzer Medical Group

- "Becoming a PCMH allowed us to maintain a competitiveness within our community and it coincided with the payment models we were already a part of."

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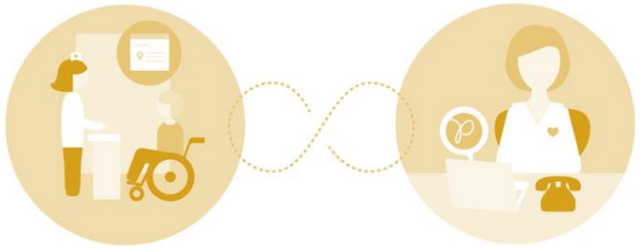
SUCCESSES OF SHIP REGIONAL COLLABORATIVES

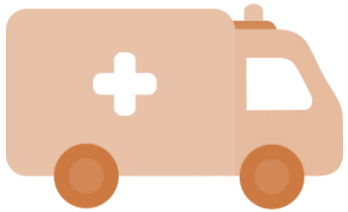
Excerpts from the State Level Evaluation



Care Coordination Network
Connecting hospitals, emergency departments, primary health, behavioral health, oral health, and specialty care.

Healthy Minds Partnership
School-partnered behavioral health service delivering traditional behavioral health therapy to students to reduce access issues such as transportation issues.

Suicide Prevention Partnership
Partnership with primary health care clinics to deliver suicide prevention trainings and toolkits to clinics and encourage them to screen patients.



Trauma Response Network
School-partnered workgroup teaching schools how to utilize resources in times of crisis.

Idaho Integrated Behavioral Health Network Conference
Building partnerships to expand mental health awareness in various health systems and health districts through training, networking, and outreach.

Referral Resource for Caregivers
Creation of a referral resource provided by clinic care teams to identify community resources and connect patients and caregivers to services they need.

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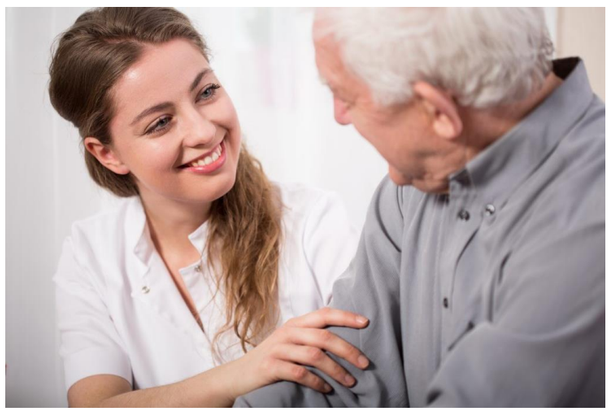
STATE LEVEL EVALUATION SUCCESSES OF COMMUNITY HEALTH WORKERS IN IDAHO

Statewide Healthcare Innovation Plan
Improved health, improved healthcare, and lower cost for all Idahoans



Community health worker's meet the needs of Idaho communities by promoting access to services, providing health education, supporting care delivery, and promoting advocacy.

Patient Centered Medical Home (PCMH)

- Enhance care coordination.
- The "bridge" between the patient and medical team.
- Meet with patients after their appointments to explore and discuss SDOH.
- Go into patient homes and assess fall-risks and medications.
- The "arm" that extends the reach of healthcare into their communities.

Social Determinants of Health (SDOH)

- Transportation assistance to and from appointments, social activities, grocery stores.
- A resource for food, food stamps, food banks, education on what to eat and how to shop.
- Assist with financial problems and obtaining insurance.
- Translate for non-English speaking patients
- The "informer" of community resources and social services for patients.

Health Outcomes

- Improve clinical outcomes.
- Detect malfunctioning medical equipment and assisting with replacing equipment.
- Decrease medical costs.
- Reduce avoidable hospitalization and readmissions.
- Empower patients.

Patient Engagement

- Provide preventative screenings.
- Assist with chronic disease management.
- Promote healthy behaviors.
- Improve access to healthcare.
- Improve patient experience and engagement.

Sometimes a patient feels like the provider is talking over their head. CHW's can get on their level and help them understand.
-CHW Supervisor

"We go in; we look; we listen; we assess; and then we try to engage by what we observe"
-CHW

One women was non compliant with her diabetes management. I kept asking her "what if I set up diabetes classes for you?" She finally agreed to go so I met her at her house and we went to the appointment together. We did all of the diabetes training together.
-CHW

COMMUNITY HEALTH WORKERS

CHW's see patients after the health care provider and work with social services and community resources.
-CHW Supervisor

CHW's can reach non-insured population through free screenings or individuals visits in their own area.
-CHW supervisor

80-year old gentleman approached CHW in the grocery store. He asked for help getting his aging wife to exercise. "She doesn't listen to me. I know you're doing those Fit and Fall classes. Could you talk to her." The CHW talked to the wife and she agreed to attend. The CHW picked her up on the way to the class. The wife is now attending weekly Fit and Fall classes.
-CHW Supervisor

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State Level Evaluation Telling the Story of Community Health EMS (CHEMS) in Idaho

Statewide Healthcare Innovation Plan

WHO:

Donnelly Rural Fire Department
Idaho Falls Fire Department
Ada County Paramedics
Canyon Country Ambulance District
Payette County Paramedics
Sandpoint Primary Care Physician

WHAT:

CHEMS personnel are healthcare providers who receive additional education, work in a medical health neighborhood, and assist the primary care team to implement a patient care plan.

BENEFITS

- Medication/Diet Reconciliation
- Fall Prevention
- Referral for Mental Health Patients
- Companionship to Isolated Homebound Person
- Appropriate Use of Health Equipment
- Referral to Other Community Resources
- Access to Primary Care Screenings
- Post Hospital Re-admission Prevention
- Referral to Specialized Care

CHALLENGES

Legal:
"a lot more legal work than we were used to." - Ada County

"Maintaining confidentiality in compliance with HIPAA can be a challenge." - Idaho Falls

"The legal team is already busy"
- Hospital Administrators

Allocation of time:
"There is not a CHEMS repository of protocols; no standardized algorithms. Each CHEMS agency is developing their own." - Canyon County

"We're spending 2 hours with a patient and 30 minutes faxing notes. Data entry seems over the top."
- Payette County

"We need another person to get all of this stuff done."
- Shoshone County

Establishing Partnerships:
"We have to continually remind nurses we cannot go above our scope of practice." - Donnelly

"MD's forget to make referrals; they just don't understand CHEMS is an opportunity to see patients in their home." - Sandpoint Physician

Data Reporting:
"Data must prove cost benefit." - Donnelly

"We receive no funding from an outside source. Stakeholders who could support CHEMS say to us, 'show us it works.' We need to find a way to gather that data and communicate it." -Payette County

"The EMS data tracking system is great for 911, but not CHEMS" -Ada County

MOTIVATION FOR CHEMS EXPANSION

ACCESS:
"We want to provide primary access to health care for residents that live in a remote community 45 minutes away from Idaho Falls."
- Idaho Falls Fire Department

MISSION:
"We knew CHEMS was a concept we believed in. When we started with CHEMS, we started with the mission and then figured out how to pay for it.
- Ada County Paramedics

NEED:
"The ability to provide resources to patients who may feel that they have been left alone."
- Payette County Paramedics

PATIENT CENTERED MEDICAL HOME:
"Individuals are not getting the care that they need in certain aspects. CHEMS contributes to a healthy population. As a member of the team I attended the healthcare coalition meetings and really pushed the CHEMS effort. This is what our community needs."
- Donnelly Rural Fire Department

ALREADY THERE:
"We're already in the homes, so let's provide access to primary care. We're already in the homes, so let's expand who we are. We're already in the homes, so let's meet the needs of patient's that are not being met. We're already in the homes, so let's contribute to team-based care."
- All CHEMS Individuals

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

Statewide Healthcare Innovation Plan

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

Idaho Telehealth 101

In May of 2018, the Department of Health and Welfare partnered with the Idaho Healthcare Coalition to work with 8 Idaho clinics and 1 CHEMs agency to support new telehealth programs that improve care, increase access to care, expand system capacity, and achieve efficiencies in health care delivery.

To build clinics capacity, knowledge, and expertise to develop and implement their own telehealth programs, six webinars were created to cover:

- Demand Analysis
- Readiness Self-Assessment
- Telehealth Billing and Coding
- Equipment Selection
- Program Development
- Evaluation and Monitoring

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

Telehealth Program Grantees

- Coeur d'Alene Pediatrics
- Teton Valley Health Services - Driggs Health Clinic
- Family Medicine Residency of Idaho
- Latah Community Health - CHAS
- Payette County Paramedics
- Sandpoint Family Health Center
- Shoshone Family Medical Center
- Southfork Medical Clinic
- Terry Reilly Health Services

Elements for Idaho Telehealth Program Development

- External Stakeholder Engagement Can Get Complicated
- Provider Driven Patient Recruitment and Engagement Does Not Guarantee Patient Participation
- Vendor Selection and Relationship Development Support Sustainability
- Model Development and Team Leadership Support are Critical First Steps
- Payment for Telehealth Services Remains a Barrier

State Level Evaluation
University of Idaho Project Echo;
Real Patient Case Studies, Real Patient Results

In early 2018, the University of Idaho received start-up funding from the Statewide Healthcare Innovation Plan SIM grant to integrate Project ECHO (Extension for Community Healthcare Outcomes). The intervention is intended to revolutionize medical education and increase workforce capacity to provide best practice specialty care and reduce health disparities.

Through twice monthly seminars and other resources ECHO, primary care doctors, and clinicians across Idaho can share knowledge through use of video conferencing to connect virtual clinics with community providers. Since 80% of Idaho's communities are considered rural, this is especially beneficial for these clinics to increase their ability to provide excellent specialist care to patients in their own communities.

In October of 2018, The University of Idaho was awarded $374,919 in funding by the Substance Abuse and Mental Health Services Administration. This funding is set to be distributed over a three-year period to offer behavioral health training programs for healthcare professionals in Idaho. A pilot behavioral health ECHO program launched in the fall where 53 healthcare professionals such as physicians, nurse practitioners, and pharmacists are enrolled in training. These individuals represent 37 clinics across 24 communities.

This pilot aims to increase providers ability to better recognize the signs and symptoms of mental disorders and practice de-escalation techniques, provide primary care providers education about various community resources available for patients and establish a referral system in order to direct patients to the necessary resources. By using videoconferencing, ECHO Behavioral Health expects to train at least 200 providers over a three-year period.

In addition to the Behavioral Health Program, Project ECHO also began a videoconference series surrounding opioid addition in Idaho. Allowing healthcare providers to learn best practices for treating patients with chronic pain or opioid use disorder, connect with peers from around the state to discuss what really works, and get feedback on difficult patient cases from a panel of specialists.

https://www.uidaho.edu/academics/wwami/echo

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

Statewide Healthcare Innovation Plan

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

All Goals

Appendices

2019 Facts, Figures and Trends

Facts, Figures and Trends 2018-2019

IDAHO DEPARTMENT OF HEALTH & WELFARE

1249

A Message from Director Dave Jeppesen

Welcome to an annual snapshot of the work the Idaho Department of Health and Welfare did in SFY 2018 to promote and protect the health and safety of all Idahoans.

This report illustrates the work this agency does in all eight of its divisions as well as the tremendous impact we have on the lives of all Idahoans. We work with struggling families to make sure they have a safe place to raise their children. We assist people in crisis – whether that's a mental or physical health crisis, or the need for public assistance.

The Behavioral Health community crisis centers continue to assist thousands of Idahoans who suffer from a behavioral health crisis. Idaho had four operating crisis centers in SFY 2018, in Idaho Falls, Coeur d'Alene, Twin Falls, and Boise. Additional crisis centers are being implemented in regions 3 and 6 and at hospitals throughout region 2 as part of an innovative collaboration to meet rural needs. Learn more on page 19.

The Youth Empowerment Services (YES) project has made significant progress in 2018, moving from a lawsuit (Jeff D. v Otter) toward a new system of care for children with Serious Emotional Disturbance (SED). A phased rollout began in January 2018, with full implementation of the transformed children's mental health system of care targeted for mid-2019. Once the new system is fully operational, it will be monitored for three more years to ensure sustainability. Learn more on page 26.

Child and Family Services (CFS) finalized planning for a Three-Year Transformation Project that launched in July 2018. This project's goal is to modernize business practices to allow CFS staff to focus on protecting children and supporting families, rather than unnecessary work and documentation. Learn more on page 40.

The Healthy Connections Value Care Program in Medicaid supports the department's strategic objective to transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs. Starting in 2019, Medicaid will offer financial incentives to providers who control their health care costs and achieve benchmarks related to patient care. Learn more on page 90.

The Division of Public Health was awarded 5-year accreditation status on June 6, 2017, through the national Public Health Accreditation Board (PHAB). IDHW is one of 31 state public health departments to be accredited and has been featured on PHAB's "Accreditation Works" news report. Learn more on page 105.

Introduction

We have organized the information and data in this handbook to give you an overview of services we provide, numbers of people we serve, and how appropriations are spent. This guide is not intended to be a comprehensive report about the Idaho Department of Health and Welfare, but it should answer many frequently asked questions.

The first few pages of this report provide the big picture, describing the agency's overall budget and major spending categories. Following this overview, we give a brief description of each division and statistical information for many of our programs and services. When possible, we provide historical perspective. The handbook is color-coded by division for easy reference.

To provide the health and human services described throughout this handbook, we diligently follow a Strategic Plan, which details strategic initiatives designed to address gaps in delivering on our key goals:

Goal 1: Improve the health status of Idahoans.

Goal 2: Increase the safety and self-sufficiency of individuals and families.

Goal 3: Enhance the delivery of health and human services.

The department is designed to help families in crisis and to give a hand to vulnerable children and adults who cannot solve their problems alone. Our programs are integrated to provide the basics of food, healthcare, job training, and cash assistance to get families back on their feet so they can become self-reliant members of Idaho communities. Staff in all our divisions depend on each other to do their jobs as they help families solve their problems so we can promote and build a healthier Idaho.

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Our Organization

The Department of Health and Welfare (DHW) serves under the leadership of Idaho Gov. Brad Little. Our director oversees all department operations and is advised by an 11-member State Board of Health and Welfare appointed by the governor.

DHW deals with complex social, economic, and health issues. To do that effectively, our agency is organized into eight divisions: Medicaid, Family and Community Services, Behavioral Health, Welfare (Self-Reliance), Public Health, Licensing and Certification, Operational Services, and Information and Technology. Each division provides services or partners with other agencies and groups to help people in our communities. For example, the Division of Family and Community Services will provide direct services for child protection, but it may partner with community providers or agencies to help people with developmental disabilities.

Each of our public service divisions run multiple individual programs. The Division of Public Health, for instance, includes such diverse programs as Immunizations, Epidemiology, Food Protection, Laboratory Services, Vital Records, Health Statistics, and oversight of Emergency Medical Services and Preparedness.

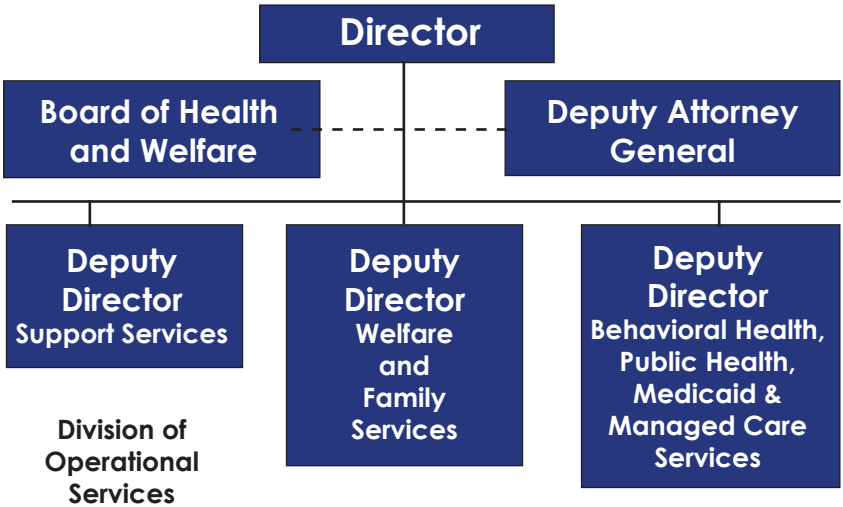
Many people turn to DHW for help with a crisis in their lives, such as a job loss or a mental health crisis. Along with meeting these needs, DHW programs also focus on protecting the health and safety of Idaho residents. The Division of Licensing and Certification licenses assisted living facilities and skilled nursing facilities, among others. The EMS and Preparedness bureau certifies emergency response personnel such as EMTs and paramedics. The Criminal History Unit provides background checks for people working with vulnerable children and adults, such as in daycares or nursing homes.

One of the guiding principles of all DHW programs is to collect and use performance data so we can ensure we maximize state funding and provide the best services possible. Many of these performance measures are available in this publication. By constantly measuring and collecting performance data, DHW programs are held accountable for continued improvement.

Funding for DHW programs is often a combination of state and federal funds. For example, the federal government pays about 70 percent of each medical claim for service provided to Idaho residents in the Medicaid program. In SFY 2019, the federal government will contribute about 62.5 percent of DHW's total appropriation.

On the following pages you will find more information about our diverse organization and the amazing work our dedicated employees perform to protect the health and safety of Idaho citizens.

Organizational Chart



Division of Operational Services

Division of Information and Technology

Division of Licensing and Certification

Financial Services

Audits & Investigations

Public Information and Communications

Division of Welfare

Division of Family and Community Services

- Southwest Idaho Treatment Center

Division of Medicaid

Division of Behavioral Health

- State Hospital South
- State Hospital North

Division of Public Health

Office of Healthcare Policy

Strategic Plan

Strategic Plan Overview 2019-2023

Governor's Priorities:
Enhancing Economic Opportunity • Empowering Idahoans • Promoting Responsible Government

OUR MISSION
Promote and protect the health and safety of Idahoans.

OUR VISION
Provide leadership for a sustainable, integrated health and human services system.

OUR VALUES
Integrity, high quality customer service, and compassion are the foundation for all Department activities. A focus on these values will lead to success.

OUR STRATEGIC GOAL
Ensure the delivery of services that promote healthier, safer, self-sufficient Idahoans.

STRATEGIC OBJECTIVES	STRATEGIC INITIATIVES
Objective 1: **Transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs**	• Advance Idaho's healthcare delivery system to enable Idahoans to live healthier lives, to improve healthcare services, and to reduce the cost of healthcare • Control Medicaid costs by financially rewarding providers and organizations that deliver measurably better care to our participants • Improve the children's mental health system in Idaho for children with serious emotional and behavioral disorders
Objective 2: **Protect children and vulnerable adults**	• Ensure children who have experienced abuse or neglect have safe, permanent homes • Develop and implement effective residential care for adult Idahoans with severe, chronic mental illness
Objective 3: **Promote stable and healthy Idahoans through medical coverage, program access, support services, and policy**	• Reduce suicide attempts and deaths in Idaho by collaborating with multi-sector stakeholders • Improve access to residential care settings for residents with Alzheimer's or dementia • Reduce opioid addiction and overdose deaths in Idaho • Provide job training and education to low-income adults receiving state assistance, to help them gain stable, full time employment and eventually move to self-sufficiency
Support System Strategic Initiatives	• Empower Idahoans to make informed decisions to improve their lives by connecting them to community services through the "Live Better Idaho" website • Deliver services to our customers in a safe environment by providing employees with tools and resources for preventing or responding to potentially violent situations • Protect our network and sensitive data by enhancing cybersecurity; and improve the efficiency of department operations by integrating information systems

IDAHO DEPARTMENT OF HEALTH & WELFARE

Read the entire strategic plan at https://healthandwelfare.idaho.gov/AboutUs/StrategicPlan/tabid/134/Default.aspx

Office of the Director

Dave Jeppesen, Director, (208) 334-5500

The Office of the Director oversees and sets the vision for the entire department, working with the Governor's office and the Idaho Legislature to provide policy direction for services and programs that are effective and economically sound.

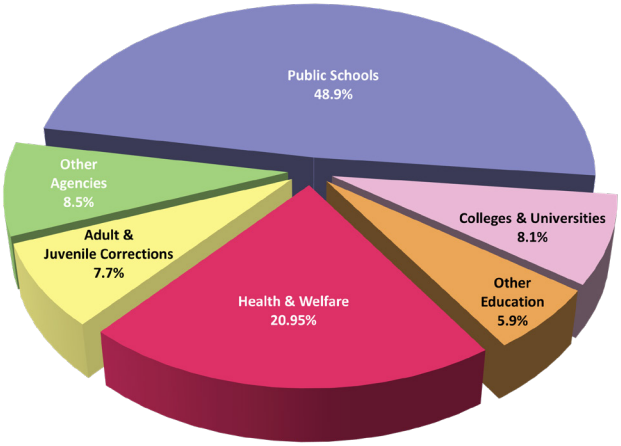
The Director's Office sets a high standard for customer service and ensures implementation of DHW's Strategic Plan.

The office relies on the Executive Leadership Team to help formulate policy. The executive team is comprised of members of the Director's Office, division administrators, regional directors, and administrators of State Hospital South, State Hospital North, and Southwest Idaho Treatment Center. The Director's Office includes:

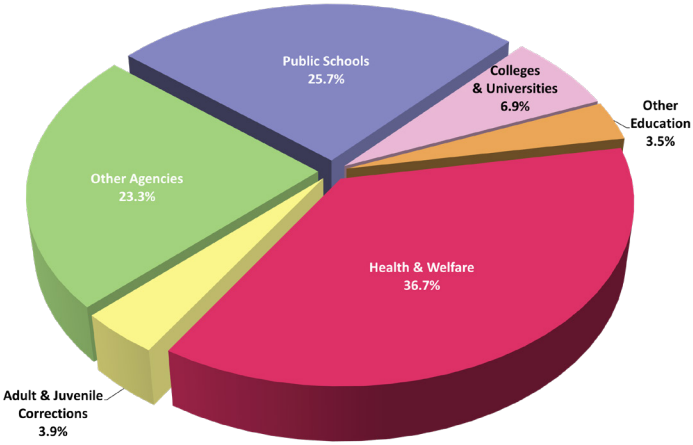
- The director.
- A deputy director responsible for Behavioral Health, Medicaid and Managed Care Services, Public Health, and Office of Healthcare Policy Initiatives. (Lisa Hettinger, (208) 334-5500)
- A deputy director responsible for Family and Community Services, Welfare, and the regional directors. (Lori Wolff, (208) 334-5500)
- A deputy director responsible for Support Services, Information and Technology, and Licensing and Certification. (David Taylor, (208) 334-5500)

Total State SFY 2019 Appropriations

State General Fund Appropriations for all State Agencies



Total Appropriations for all State Agencies



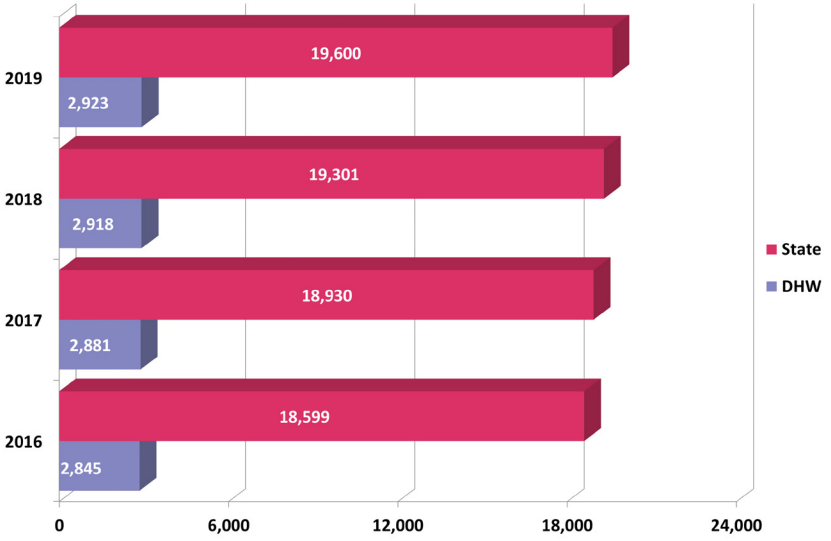
SFY 2019 Financial Data Summary

In Millions

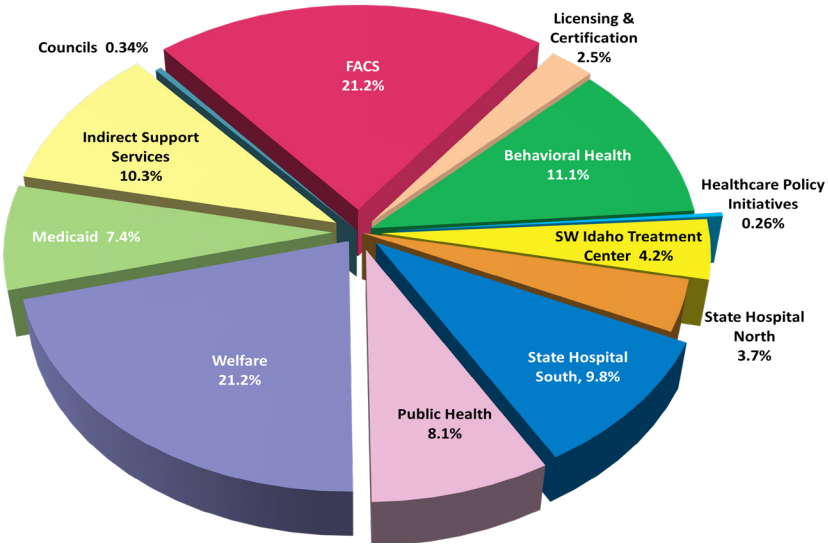
Functional Area	General	%Total	Total	%Total
Public Schools	$1,785.27	48.9%	$2,140.62	25.7%
Colleges, Universities	295.76	8.1%	576.79	6.9%
Other Education	214.31	5.9%	290.00	3.5%
Health & Welfare	765.24	20.9%	3,053.28	36.7%
Adult & Juvenile Corrections	282.51	7.7%	327.76	3.9%
All Other Agencies	309.64	8.5%	1,936.07	23.3%
Total	**$3,652.72**	**100.0%**	**$8,324.51**	**100.0%**

Appropriated Full-Time Positions

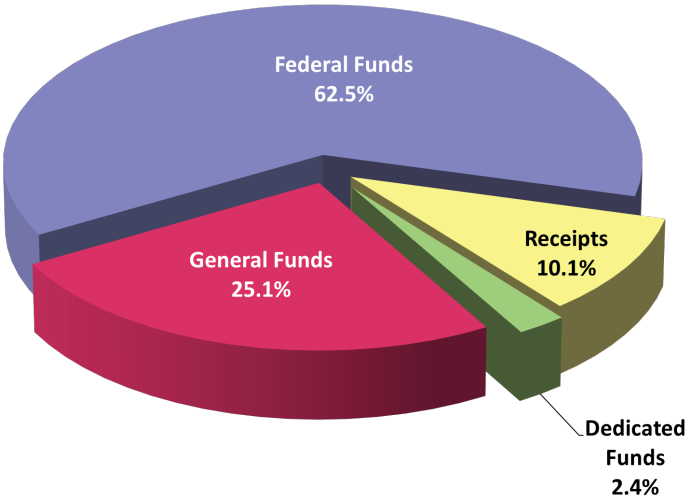
The use of Full-Time Positions (FTP) is a method of counting state agency positions when different amounts of time or hours of work are involved. The department's workforce has remained steady over the last four years, with the state's overall workforce increasing 10.9 percent.



SFY 2019 FTP Distribution - Department of Health & Welfare



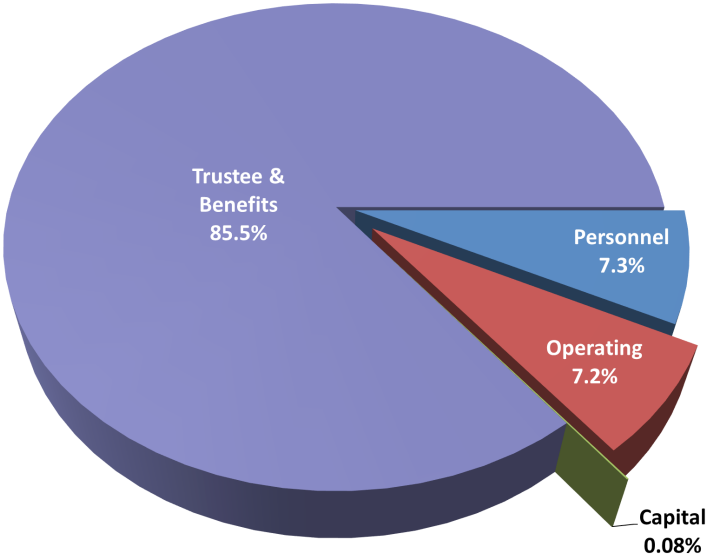
SFY 2019 DHW Appropriation Fund Source



Financial Data Summary

Fund Source		Amount
General Funds		$ 765.2 Million
Federal Funds		1,907.1 Million
Receipts		307.9 Million
Dedicated Funds		
Access to Health Insurance	$ 0	
Domestic Violence	520,800	
Cancer Control	344,200	
Central Tumor Registry	120,000	
Liquor Control	650,000	
State Hospital South Endowment	5,061,800	
State Hospital North Endowment	1,549,500	
Prevention of Minors' Access to Tobacco	43,800	
Millennium Fund	2,866,700	
EMS	2,894,200	
EMS Grants	1,400,000	
Hospital, Nursing Home, ICF/ID Assessment Funds	30,000,000	
Immunization Assessment Fund	18,970,000	
Time Sensitive Emergency Fund	426,000	
Technology Infrastructure Fund	8,222,200	
Total Dedicated Funds		$73.1 Million
Total		**$3,053.3 Million**

SFY 2019 DHW Appropriation by Expenditure Category

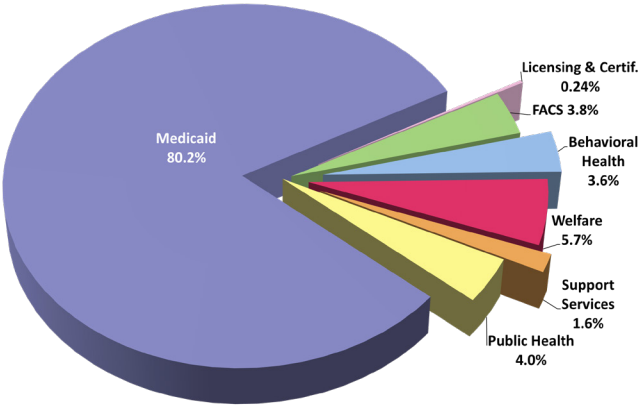


Financial Data Summary

By Object	Amount
Trustee and Benefits	$2,609.2 Million
Personnel Costs	223.0 Million
Operating Expenditures	218.7 Million
Capital	2.4 Million
Total	$3,053.3 Million

- The appropriation for benefits to Idaho citizens increased $163.4 million from SFY 2018 appropriation levels, while personnel costs, operating and capital expenses increased by $29.1 million.
- Payments for services to Idaho citizens make up 85.5 percent of DHW's budget. These are cash payments to participants, vendors providing services, government agencies, nonprofits, hospitals, etc.
- The department purchases services or products from 11,538 companies, agencies or contractors, and more than 41,482 active Medicaid service providers.

Original SFY 2019 DHW Appropriation



By Division	FTP	General	Total
Welfare/ Self-Reliance	**619.50**	**$ 43,445,400**	**$ 175,037,800**
Medicaid			
Low-income children/			
working age adults		182,089,800	731,165,100
Individuals w/Disabilities		217,736,500	1,051,186,300
Dual Eligible		170,904,400	588,094,800
Administration	216.00	14,490,700	79,004,300
Total Medicaid	**216.00**	**$ 585,221,400**	**$ 2,449,450,500**
Licensing & Certification	**71.90**	**$ 1,964,000**	**$ 7,321,500**
Family and Community Services			
Child Welfare	404.80	12,121,900	46,834,000
Foster/Assistance Payments		11,338,200	30,091,500
Service Integration	35.00	736,500	6,067,500
Developmental Disabilities	180.96	11,013,500	21,852,200
SW Idaho Treatment Center	123.75	2,603,200	10,930,900
Total FACS	**744.51**	**$ 37,813,300**	**$ 115,776,100**
Behavioral Health			
Adult Mental Health	210.56	33,771,600	38,350,600
Children's Mental Health	97.67	8,300,600	14,786,700
Substance Abuse	16.00	2,733,200	17,206,300
Community Hospitalization		3,069,000	3,069,000
State Hospital South	285.25	12,193,700	26,181,200
State Hospital North	107.10	7,857,400	9,565,400
Total Behavioral Health	**716.58**	**$ 67,925,500**	**$ 109,159,200**
Public Health			
Physical Health	151.18	5,142,100	102,570,100
EMS & Preparedness	42.84	277,400	11,997,500
Suicide Prevention	4.00	1,233,200	1,323,200
Laboratory Services	39.00	2,259,900	4,896,500
Total Health	**237.02**	**$ 8,912,600**	**$ 120,787,300**
Support Services	**299.60**	**$ 19,508,700**	**$ 48,720,200**
Healthcare Policy	**7.60**	**$ 251,500**	**$ 17,945,400**
Councils	**10.00**	**$ 195,700**	**$ 9,082,000**
Department Totals	**2,922.71**	**$ 765,238,100**	**$ 3,053,280,000**

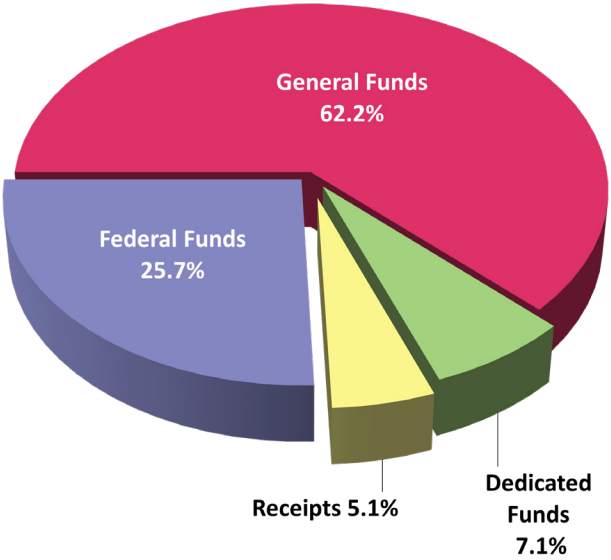
Division of Behavioral Health

Ross Edmunds, Administrator, (208) 334-6997

The Division of Behavioral Health helps children, adults, and families address and manage personal challenges resulting from mental illnesses and/or substance use disorders. The division recognizes that many people suffer from both a mental illness and substance use disorder and is integrating services for these co-occurring disorders to improve outcomes.

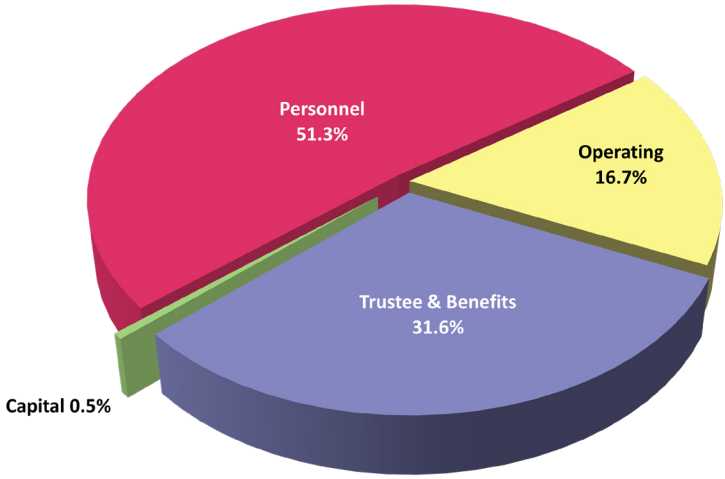
The division includes Children's Mental Health Services, Adult Mental Health Services, Substance Use Disorders Program, and the Idaho Tobacco Project. The division also administers the state's two psychiatric hospitals, State Hospital North and State Hospital South, for people who have been court-ordered into the state's custody.

Behavioral Health SFY 2019 Funding Sources

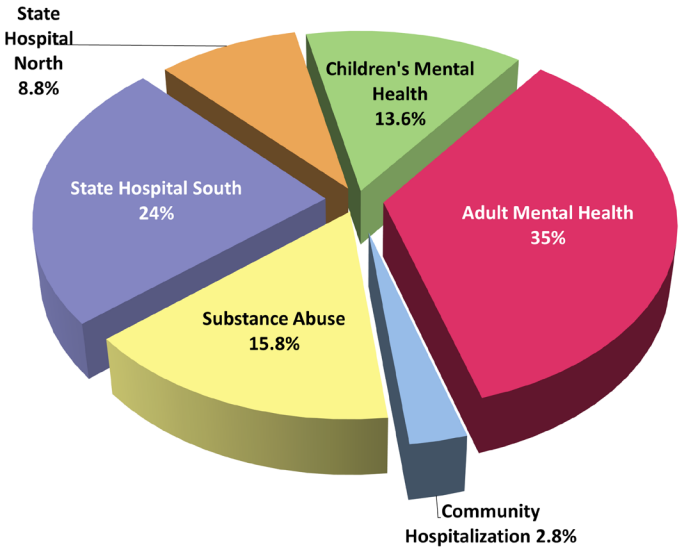


Authorized FTP: 716.58; Original Appropriation for SFY 2019: General Funds $67.9 million, Total Funds $109.2 million; 3.6% of Health and Welfare funding.

Behavioral Health SFY 2019 Expenditure Categories



Behavioral Health SFY 2019 Appropriation by Program



SFY 2018 Program Highlights

Recovery Community Centers
The division has entered into a contract with Recovery Idaho that provides social support services for individuals with Opioid Use Disorder through Idaho's nine Recovery Community Centers located throughout the state. Services provided under this contract include support groups, recreational activities, and recovery coaching. The recovery centers are also tasked with meeting individuals in hospital emergency departments who have overdosed on opioids to help them access treatment and recovery support services that will help them achieve a life of sobriety. The final component of this contract is for the centers to make this similar type of connection with individuals who have been discharged from a local jail. In the first year of this contract, the Recovery Community Centers provided more than 5,000 recovery support opportunities for individuals seeking assistance from them.

Partnerships with Public Health Districts
The Division of Behavioral Health continues to contract with each of the seven public health districts for administrative assistance and support for the regionally-based Behavioral Health Boards (BHBs). These partnerships have created a venue in which local boards identify community strengths and needs and work collaboratively to capitalize on the strengths while addressing the needs of the local communities. This collaborative approach has resulted in the funding and support of a variety of activities, including community events that promote behavioral health awareness, scholarships for conferences and training, transitional housing needs for individuals with co-occurring disorders, as well as providing recovery coaching services. In addition to working collaboratively with the BHBs, the division and the Division of Public Health have partnered in the area of "prescriber education" in light of the opioid epidemic. Through a contract with DHW, the health districts are educating prescribers on best and safest practices for opioid prescriptions. Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose.

Felony probation and parole population
The division entered into a contract with the Community Health Center Network of Idaho (CHCNI), the umbrella organization for the Federally Qualified Health Care (FQHC) clinic network. The purpose of this contract is to provide mental health services for Idaho's felony parole and probation population. All regions have at least one FQHC providing these services. We continue to work with CHCNI to increase the number of FQHCs participating in the contract to improve access to services.

The following mental health services are provided under this contract:

psychiatric diagnostic evaluation, mental health treatment planning, pharmacological evaluation, pharmacological management, individual counseling, group counseling, family counseling, and care coordination.

By providing these services, we anticipate probation and parole clients will be more successful in their reintegration into the community and less likely to re-offend and face subsequent reincarceration. Data collected from CHCNI will be cross-referenced with Idaho Department of Correction data to determine impacts to the recidivism rates for this population because of these services.

Homes with Adult Residential Treatment (HART)
The Division of Behavioral Health budgeted $2 million to continue the safe and stable housing supplemental payments to assisted living facilities that provide care for adults with serious and persistent mental illnesses as well as to pilot the Homes with Adult Residential Treatment (HART) model.

Supplemental Safe and Stable payments were continued to support approximately 35 assisted living facilities with the provision of critical residential services. The HART demonstration project was initiated to pilot an intensive, treatment-oriented, residential living program for individuals with a serious and persistent mental illness. Contracts have been implemented with four HART facilities across the state.

The HART provides a safe and therapeutic homelike environment that includes meals, living space, assistance with daily living, and clinical treatment services. Each HART provider is required to be an Optum-approved Idaho Behavioral Health Plan provider and able to deliver an array of treatment services including assessment, treatment planning, psychotherapy, community/peer supports, Community Based Rehabilitation Services (CBRS), group therapy, case management, and medication services. It is hoped the HART model will allow for the provision of clinical treatment interventions to better address behavioral health-related issues that have not been able to be addressed without evicting the resident or escalating the resident to a crisis or emergency facility. The division will gather outcome data to determine whether the HART model is a more effective approach to the care of Idahoans with serious and persistent mental illness.

Psychiatric Hospitalization/High Risk Adult Unit
The Department of Health and Welfare was appropriated funding to construct a new adolescent state psychiatric hospital in the Treasure Valley. The adolescent hospital is expected to be complete in July 2020. There are a couple primary reasons for this project: 1) Over 70% of the adolescents who go to the state hospital are from the Treasure Valley; and 2) The state needs to free up space at State Hospital South in Blackfoot for a high-risk unit. In addition to the funding for the construction of the adolescent hospital, the Legislature appropriated funding to remodel and retrofit the current adolescent hospital at State Hospital South so it can be used

to care for a higher-risk, more violent adult population.

Overall, this will not increase the number of adolescent beds in the state, but it will add adult psychiatric beds to the state system. These beds are highly needed and will match the needs of the more acute, dangerous, and violent population DHW is trying to serve today.

Adult Mental Health Transformation
The adult mental health system in Idaho has improved significantly in the past five years. There are far more services, programs, and resources than in the past. However, these enhancements to the current system of care continue to struggle with meeting the needs of a growing population with increases in the diagnosis of mental illness in Idaho.

The department contracted with the Western Interstate Commission for Higher Education (WICHE) to update and make recommendations to a decade-old gap and resource analysis that WICHE completed under commission from the Legislature. The updated report explains the progress made since the original report in 2008. However, there is still a need for more effective use of the current resources provided for mental health care in Idaho as well as for additional resources. It is clear there needs to be a strategic path forward in Idaho, with broad stakeholder input. The department is leading the collaborative WICHE Steering Committee to ensure the entire system has input on the strategic path forward.

Behavioral Health Crisis Centers
The Behavioral Health community crisis centers continue to meet the needs of thousands of Idahoans who suffer from a behavioral health crisis. Idaho currently has four crisis centers, operating in Idaho Falls, Coeur d'Alene, Twin Falls, and Boise. Additional crisis centers are being implemented in regions 3 and 6, and at hospitals throughout region 2 as part of an innovative collaboration to meet rural needs.

The crisis centers continue to see a wide variety of patients with very challenging needs. They have been highly effective in reducing unnecessary hospitalization and incarceration. As each of the centers have opened their doors, they have quickly become a significant and important part of each communities' continuum of care and services for people suffering from a behavioral health crisis.

The primary challenge with the crisis center model for each community is the requirement for each center to submit a plan to become 50 percent self-sustaining. The plan is due to the state by the end of the center's second year of operation. As of this writing, the centers in Idaho Falls and Coeur d'Alene have reached the full two years and submitted their plans. The plan for Twin Falls will be presented to the 2019 Idaho Legislature as intent language indicates.

The Behavioral Health Crisis Center of Eastern Idaho in Idaho Falls opened in December 2014. The Northern Idaho Crisis Center in Coeur d'Alene opened in December 2015. The Crisis Center of South Central Idaho in Twin Falls opened in October 2016. The Pathways Community Crisis Center in Boise opened in December 2017. The crisis centers in Regions 2, 3, and 6 are expected to open in early 2019.

Behavioral Health Crisis Center of Eastern Idaho				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Crisis center visits	735	1,950	2,481	2,439
Clients served (unduplicated)	377	689	707	824
Average length of stay (hours)	11.51	16.66	19.28	21.67
Diagnosis type				
• **Substance use only**	82	157	362	275
• **No significant mental health or substance use**	22	37	63	49
• **Mental health only**	264	876	814	764
• **Mental health and substance use**	298	835	1,224	1,289
• **Inadequate information**	34	19	10	29

Northern Idaho Crisis Center				
		SFY 2016	**SFY 2017**	**SFY 2018**
Crisis center visits		615	1,118	1,621
Clients served (unduplicated)		414	699	999
Average length of stay (hours)		7.05	7.56	8.46
Diagnosis type				
• **Substance use only**		25	54	87
• **No significant mental health or substance use**		29	17	77
• **Mental health only**		214	543	760
• **Mental health and substance use**		146	288	533
• **Inadequate information**		72	45	63

Behavioral Health Crisis Center of South Central Idaho			
		SFY 2017	FY 2018
Crisis center visits		1,031	2,104
Clients served (unduplicated)		297	527
Average length of stay (hours)		19.60	19.88
Diagnosis type			
• Substance use only		126	175
• No significant mental health or substance use		18	7
• Mental health only		240	429
• Mental health and substance use		528	1460
• Inadequate information		32	14

Pathways Behavioral Health Community Crisis Center			
			FY 2018
Crisis center visits			742
Clients served (unduplicated)			469
Average length of stay (hours)			11.89
Diagnosis type			
• Substance use only			50
• No significant mental health or substance use			16
• Mental health only			302
• Mental health and substance use			235
• Inadequate information			87

NOTE: Pathways Behavioral Health Community Crisis Center opened in December 2017 in Boise, resulting in only a partial year of data.

Children's Mental Health Services

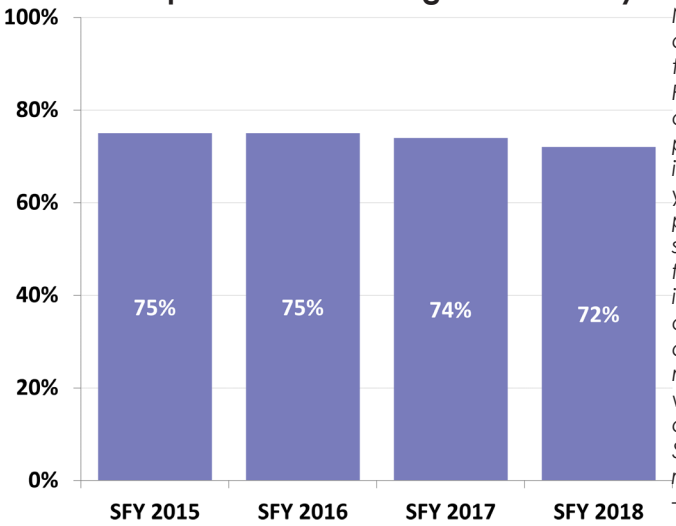
The Children's Mental Health program is a partner in the development of a community-based system of care for children with a serious emotional disturbance (SED) and their families. The program provides crisis intervention, case management, and other supports that increase the capacity for children with SED and their families to live, work, learn, and participate fully in their communities. Most treatment services are delivered by private sector providers in the community through referrals from regional behavioral health centers operated by the Division of Behavioral Health.

Parents and family members play an essential role in developing a system of care. They are involved at all levels of development, including the making of policies, administrative rules, and laws, as well as their own service plans. Without family member involvement and the support to sustain their involvement, the system of care would be unable to achieve positive outcomes for children and their families.

Functional Assessment Tool

The Child and Adolescent Needs and Strengths (CANS) is Idaho's new tool for measuring the functional impairment of children and youth seeking to participate in the Youth Empowerment Services (YES) system of care. It replaces the division's Child and Adolescent Functional Assessment Scale (CAFAS) as the eligibility and outcome measure for children and youth. Both the CANS and the CAFAS are backed by extensive research supporting their validity and sensitivity to measure change and progress. The division's regional behavioral health centers used the CAFAS for the first half of SFY 2018 before transitioning to the CANS.

Improved Functioning Measured by CAFAS



NOTE: 72 percent of youth receiving two or more CAFAS scores have demonstrated improved functioning during the past year. Of those, 94 percent demonstrated meaningful and reliable improvement with a score change of 20 points or more. CAFAS use was discontinued on Dec. 31, 2017. SFY 2018 data represents 7/1/2017 – 12/31/2017.

Collecting data on the most common CANS treatment needs and useful strengths can inform the system of the direction that will best support those it is serving. Identifying the most prevalent system-wide needs could indicate the addition of services and supports to address these needs should be explored, or help determine which evidence-based practices may be a valuable investment. Strengths describe the assets of the child or youth and family that can be used in treatment planning to support and advance healthy development. As staff begins to collect more CANS data, they will be able to monitor statewide outcomes progress by analyzing needs and strengths from reassessment and discharge CANS.

The following figures show the most prevalent actionable needs and useful strengths of the 1,084 youth who were administered an initial Children's Mental Health CANS between January and June 2018.

Strengths		
	Number of CANS with strengths identified	Percentage of total
Legal permanency	1027	95%
Relationship permanence	967	89%
Family	873	81%
Cultural identity	860	79%
Talents / interests	777	72%
Needs		
	Number of CANS with needs identified	Percentage of total
Family	701	65%
Emotional/Physical Regulation	699	64%
Anger Control	682	63%
Oppositional Behavior	640	59%
Impulsivity	630	58%

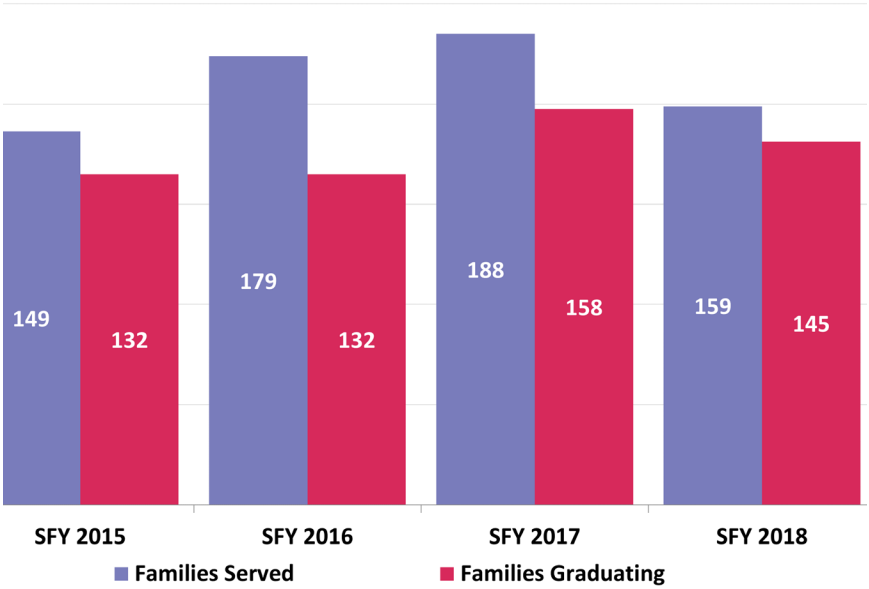
NOTE: Data is system wide and includes CANS assessments completed between Jan. 1, 2018, and June 30, 2018, by the Division of Behavioral Health, community providers, and independent assessor agencies.

Parenting with Love and Limits

The Children's Mental Health program continues to provide Parenting with Love and Limits (PLL) statewide. This evidence-based program is effective in treating youth with disruptive behaviors and emotional disorders. The annual evaluation continues to demonstrate positive outcomes that are consistent with national PLL programs.

Idaho's program showed improvement in functioning and reduced the amount of time a youth and his or her family receives services from the Children's Mental Health program. Thirty-one percent of families have their cases closed within three months of completing PLL services, compared to an average length of service of 12 months for families who do not participate in PLL.

Youth receiving Parenting with Love and Limits showed significant reductions in negative behaviors as measured by an instrument called the Child Behavior Checklist. A multi-year evaluation indicates negative behaviors declined in the areas of aggression, rule breaking, conduct disorder, oppositional defiant behaviors, externalizing behaviors, and internalizing behaviors. Of the 159 new families served, 145 families graduated. Since its start in 2008, PLL has served a total of 1,701 families in all seven regions statewide.



Respite Care

As a result of the Youth Empowerment Services (YES) project, in January 2018 agency respite became a Medicaid 1915(i) service available through the Idaho Behavioral Health Plan (IBHP) to Medicaid-eligible members who meet SED qualifications. In an effort to maintain an effective respite system that meets the needs of all Idaho families that have children with SED, the division has continued to issue vouchers through regional behavioral centers for respite services that are provided by a member of the family's natural support. This allows the family caregiver to hire someone from their natural support system who is familiar with the family and may already be equipped to handle the specific situation. Respite is available to all qualified children and youth who are residents of Idaho, under the age of 18, and are voluntarily seeking this service. Respite services can be furnished in the child or youth's home, another home, a foster family home, or another community-based setting.

Behavioral Health and Juvenile Justice

The division continues to work with county juvenile justice, magistrate courts, the Idaho Department of Juvenile Corrections, and parents in situations involving youth with mental health issues and the courts. Idaho Code Section 20-511A of the Juvenile Corrections Act allows the court to order mental health assessments and plans of treatment if a youth under court jurisdiction is diagnosed with a serious emotional disturbance.

Children Receiving Mental Health Services

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Total Children Served	2,554	2,487	2,320	2,332	2,394
Court-ordered 20-511A	600	583	603	509	466
Parenting with Love and Limits	187	149	179	188	159
Case Management	1,494	1,464	1,411	1,360	1,292
Alternate Care	38	46	65	52	47

Youth Empowerment Services

More detailed information, including a glossary, fact sheets, and work updates, is available on the website devoted to this work: www.yes.idaho.gov.

The Youth Empowerment Services (YES) project has made significant progress in 2018, moving from a lawsuit (Jeff D. v Otter) toward a new system of care for children with Serious Emotional Disturbance (SED). The phased rollout began in January 2018, with full implementation of the transformed children's mental health system targeted for mid-2019. Once the new system is fully operational, it will then be monitored for an additional three years to ensure sustainability.

This project is a collaborative effort among Department of Health and Welfare, Department of Education, Department of Juvenile Corrections, and parents, providers, and other community stakeholders. The framework for the project, as described in the court-approved Idaho Implementation Plan, identifies the strategies and tasks being used in developing the services and supports outlined in the Jeff D. Settlement Agreement.

Of greatest significance is the change in the approach to service delivery for children, youth, and their families. The YES system of care relies on a model of service delivery in which all child-serving systems operate in a coordinated manner to support parents and caretakers as the main drivers of the care and treatment they are seeking. Families will receive information, education, coaching, and other supports so they will be able to effectively navigate the system and participate in the decision points along the way.

This system of care approach has demonstrated across the country that collaborative coordinated care, driven by the youth who use it and their families, results in greater positive outcomes for the youth than those systems that do not operate in a coordinated, family driven manner.

The following are accomplishments related to the Youth Empowerment Services project for SFY 2018:

- An annual progress report detailing each of the implementation plan objectives was completed and submitted to the district court and plaintiff's counsel as per the settlement agreement in May 2018. It is available on the YES website: yes.idaho.gov.
- Children with SED whose families' income amounts up to 300% of the Federal Poverty Level (FPL) are now eligible for Medicaid.
- A contract was developed with Liberty Healthcare to administer independent assessments and determine eligibility for YES services. The Independent Assessment process was initiated on Jan. 1, 2018.
- A person-centered service planning process was designed for Med-

icaid participants. Division of Behavioral Health staff were trained in person-centered service planning.

- Collaborative workgroups focused on the various objectives outlined in the implementation plan continue to meet on a regular basis to accomplish the work. Stakeholder interest remains high and participation in the workgroups is good. Expert consultants continue to offer technical assistance for the implementation of the improved system of care.
- The Interagency Governance Team (IGT) operates as an advisory body for the implementation efforts. This 17-member team includes representatives from the three agency partners, parents, youth, advocates, and providers. The team is currently chaired by a provider member.
- The cross-system Quality Management, Improvement and Accountability (QMIA) Council published its sixth quarterly QMIA report in July 2018. The QMIA reports are available on the YES website.
- The Idaho CANS web-based tool was implemented across Idaho. All applicable Optum Network providers are anticipated to be delivering services to children once they are certified and trained in the CANS by July 2019.
- CANS training to Optum network providers began in April of 2018. Providers who were certified and met the CANS/ICANS training and setup requirements could begin billing for the CANS effective July 1, 2018.
- Staff from Liberty Healthcare, Optum Healthcare, the Division of Behavioral Health, Division of Family and Community Services, and the Department of Juvenile Corrections have been certified and trained in the CANS.
- The ICANS website (icans.dhw.idaho.gov) was launched in March 2018 to meet the needs of agency staff and providers using the ICANS/CANS. Resources and user guides as well as information on available training are on the ICANS website and are referenced on the YES website.
- The YES website continues to be updated and includes collaborative materials and references for each of the audiences identified: parents, youth, providers, and community. The "YES 101," provides an overview of the YES System of Care and is being used in outreach efforts. An electronic version is available on the YES website. The website serves as a public access site for project implementation, reports, fact sheets, training, and other communications.
- Ongoing training and outreach to families and community stakeholder groups is being conducted.

Adult Mental Health Services

The needs of Idaho adults who have a mental health diagnosis are diverse and complex. The division works to ensure that programs and services, including community-based supports, outpatient services, and inpatient hospitalization services are available to eligible Idaho residents. The division determines eligibility for adult mental health services through screening and assessment. Adult mental health services may be accessed through the division either through an application for services or through a court order for services.

The provision of state-funded mental health treatment to Idaho residents is distributed between seven community-based regional behavioral health centers serving all 44 counties in the state. Each regional behavioral health center is staffed with a variety of licensed treatment professionals (psychiatrists, nurse practitioners, social workers, clinicians, peer support specialists, and other mental health workers). Each center offers crisis services and ongoing mental health services.

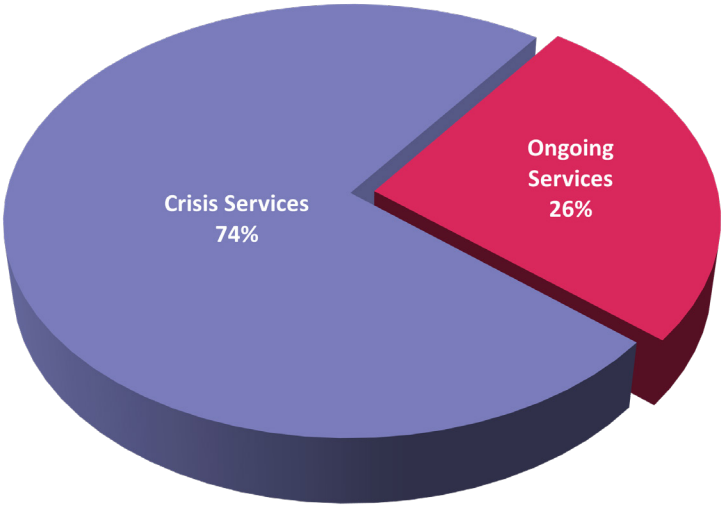
Crisis Intervention

Crisis intervention services are provided statewide through the adult mental health crisis units. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning. Crisis units provide phone and consultation services 24 hours a day, seven days a week.

Crisis units also screen all adults who are being petitioned for court-ordered commitment. The court-ordered commitment process is followed when the court determines that someone is likely to injure themselves or others. People who are placed under commitment may be treated in a community or state hospital, or they may receive intensive community-based care for acute needs.

During SFY 2018, 74 percent of the participants receiving services from the division received crisis services. The remaining 26 percent received ongoing mental health treatment. The primary goal of ongoing mental health services is to promote recovery and improve the quality of life for Idaho adults with mental health diagnoses.

Adults receiving Mental Health Services SFY 2018



Adults Served

The division's regional behavioral health centers provide services to adults determined eligible through a voluntary application process. Eligibility includes service to those who are:

1. Experiencing psychiatric crisis.
2. Receiving treatment by court order.
3. Diagnosed with a serious mental illness (SMI) or a serious and persistent mental illness (SPMI) with no other resources available to meet their needs.

The division's regional behavioral health centers also provide court-ordered evaluation, treatment recommendations, and other necessary treatment provisions for individuals being sentenced under Idaho Code 19-2524, 18-211/ 212, 66-329, and/or Mental Health Court. Adults referred through Mental Health Court receive Assertive Community Treatment (ACT) services. ACT staff is integrally involved in collaborative mental health court meetings.

Eligible individuals can also receive case management services through regional behavioral health centers. Case managers use person-centered planning to identify mental health needs. Once treatment needs are identified, case managers link the participant to available community resources, coordinate referrals, advocate for the participant, and monitor service effectiveness and participant satisfaction. Short and long-term, non-intensive services are available on a limited basis.

Supportive Services

Community support services are available on a limited basis. These services include outreach, medication monitoring, skill-building services, community-based rehabilitation services, benefits assistance, and housing support.

Assertive Community Treatment (ACT)

ACT services provide a full array of community-based services as an alternative to hospitalization for adults with serious and persistent mental illnesses who have the most intense service needs. ACT services are provided by a team of professional staff, certified peer support specialists, and recovery coaches.

Services include individualized treatment planning, crisis intervention, peer support services, community-based rehabilitation services, medication management, case management, individual and group therapy, co-occurring treatment, and coordination of other community support services.

Co-occurring Mental Health & Substance Use Disorders Services

According to the National Survey on Drug Use and Health, in 2016 an estimated 43.3 percent of adults with a substance use disorder within the past year also had a co-occurring mental illness. The division's regional behavioral health centers provide integrated treatment for those diagnosed with co-occurring mental health and substance use disorders. If regional behavioral health centers are unable to provide a full range of co-occurring treatment for participants, they may refer to or collaborate with a private agency to provide additional services.

Adult Mental Health Services

	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adults Served	13,503	13,940	14,358	13,122
Supportive Services (meds, housing and employment)	1,713	2,031	2,107	2,107
Assertive Community Treatment	560	587	573	585
Co-occurring Services	1,777	1,914	2,114	2,097

State Hospital South

Jim Price, Administrator, (208) 785-8402

State Hospital South (SHS) was established in 1886 in Blackfoot, Idaho. The hospital is currently licensed by the state to serve 90 adult patients, 16 adolescent patients, and 29 residents in the Syringa Chalet skilled nursing home. The hospital is accredited by the Joint Commission, which is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting established performance standards.

Adult patients are referred to the hospital by the regional behavioral health centers after civil or competency restoration commitment from the legal system. Civilly committed patients have been found to be a danger to themselves, a danger to others, or gravely disabled. Competency restoration patients have been found unfit to proceed in the criminal justice system due to mental defect. Restoration patients require the need to modify treatment plans more frequently, and the legal reporting requirements for these patients require considerably more psychologist time for testing and writing reports than for the hospital's patients who are civil commitments.

Patients with increased aggression, substance use disorders, and criminal thinking and behavior require additional staff to maintain safety, and they often require a single room as well as the use of more seclusion and restraints. The requirement for single rooms affects the hospital's occupancy rate and waiting list.

This past year, to manage the risk of elopements from the facility, the hospital extended the height of the fencing that encloses the outside courtyards and added fencing around exterior doors located at the ends of the adult unit hallways. To improve patient safety, alterations were made to patient bathroom doors, and the hospital added padding to seclusion/safe area rooms. Security cameras were also installed in common areas to promote staff and patient safety.

Patient-centered treatment for all the hospital residents is provided by an interdisciplinary team of benefits specialists, dental professionals, dieticians, nursing staff, psychiatric, and general practice physicians, physician assistants, physical therapists, psychologists and counselors, recreational therapists, social workers, treatment coordinators, and other support staff. The hospital has a peer specialist who promotes recovery by offering hope and encouragement to patients as well as modeling personal success in managing a mental health disorder. During treatment, patients are assisted by a multidisciplinary team in developing a personalized Wellness Recovery Action Plan for when they return to community living.

The Idaho Division of Veterans Services is pursuing plans to develop an Idaho State Veterans Cemetery near the hospital's cemetery. Construc-

tion of the new cemetery could begin in 2019.

During the 2017 legislative session, the Idaho Legislature supported a plan to build a new adolescent hospital in the Treasure Valley. That project is moving forward, with construction expected to be completed in July 2020. The space once used for the adolescent unit at SHS will be converted to adult beds, expanding the facility's capacity with an additional 20 to 25 adult beds.

The 2018 Legislature approved a concurrent resolution permitting the Department of Health and Welfare to enter into an agreement with the Idaho State Building Authority to obtain financing for a new nursing home to be built on the hospital's campus. That project is moving forward quickly. Construction is expected to be completed by July 2020. Syringa Chalet, now 80 years old, will be demolished as part of that project. The new nursing home will expand the number of beds available to elderly residents with mental illnesses who require a skilled nursing level of care.

SHS Adult Inpatient Psychiatric Services				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Adults Patient Days	26,005	28,112	27,734	28,753
Admissions	547	640	582	575
Avg Daily Census	71	76.8	76	78.8
Median Length of Stay (Days)	30	32	34	35
Daily Occupancy Rate	79.2%	85.3%	84.4	87.5%
30-Day Readmission Rate	2.56%	3.75%	1.55%	1.57%
180-Day Readmission Rate	14.26%	15.16%	9.97%	13.04%
Cost/Patient Day	$600	$589	$636	$612

Syringa Skilled Nursing				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Patient Days	8,837	9,355	9,989	10,294
Admissions	14	17	16	8
Occupancy Rate	83.5%	88.1%	94.4%	97.3%
Cost/Patient Day	$621	$604	$623	$604

Adolescent Unit				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Patient Days	4,562	4,574	3,997	4,088
Admissions	149	131	116	124
Occupancy Rate	78.1%	78.1%	68.4%	70.0%
Median Length of Stay (Days)	29.0	31	29	31
30-Day Readmission Rate	2.7%	0%	0%	0%
180-Day Readmission Rate	8.1%	4.6%	7.8%	5.6%
Cost/Patient Day	$724	$747	$848	$837

State Hospital North

Todd Hurt, Administrative Director, (208) 476-4511

State Hospital North (SHN) in Orofino, Idaho, is a licensed 60-bed psychiatric hospital providing primarily involuntary inpatient treatment for adults in psychiatric crisis who are committed to the Department of Health and Welfare. State Hospital North collaborates with patients, their families, and the referring Regional Behavioral Health Centers to develop targeted goals and objectives for the individual's treatment episode while simultaneously focusing on critical supports and arrangements for follow-up care after discharge.

Hospitalization at State Hospital North is intended to be of a short to intermediate duration with the key objective of stabilizing presenting psychiatric symptoms and assisting patients to return to their communities in the shortest reasonable period of time. The length of stay for inpatient care is variable based on patient needs and prevailing best practices within the mental health field. The median length of stay for the recent year is about 44 days.

Admissions to State Hospital North are initiated by the local community and referred through the Regional Behavioral Health Centers. Treatment is individualized and is delivered by interdisciplinary treatment teams consisting of psychiatrists, nurse practitioners, medical doctors, licensed nurses, psychiatric technicians, master's level clinicians, psychosocial rehabilitation specialists, therapeutic recreation specialists, dietitians, and support personnel.

Employees at the hospital deliver many specialized services that include assessments and evaluations, medication management, individual and

group therapies, opportunities for community integration, involvement in recreational and educational activities, nutrition, fitness, and discharge planning. The facility uses the Recovery Approach in treatment, retains a trauma-informed culture, and promotes a therapeutic alignment with the person as we develop a self-directed care plan with key recovery goals.

SHN Adult Inpatient Psychiatric Services				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Adults Patient Days	16,834	18,026	17,644	18,070
Admissions	243	233	206	278
Avg Daily Census	46	49	48	44
Daily Occupancy Rate	77%	82%	81%	74%
Median Length of Stay (Days)	48	55	55	44
30-Day Readmission Rate	2.1%	<1% (.009%)	1.5%	< 1 %
180-Day Readmission Rate	13.6%	7.7%	6.3%	7.2 %
Cost Per Patient Day	$509	$492	$558	$619

Substance Use Disorders Program

The Substance Use Disorders (SUD) Program includes:

- Treatment and recovery support services, including Medication Assisted Treatment (MAT) for opioid use disorder.
- Management of the SUD provider network.
- Training for treatment staff.
- Behavioral health program approval.
- Tobacco inspections.

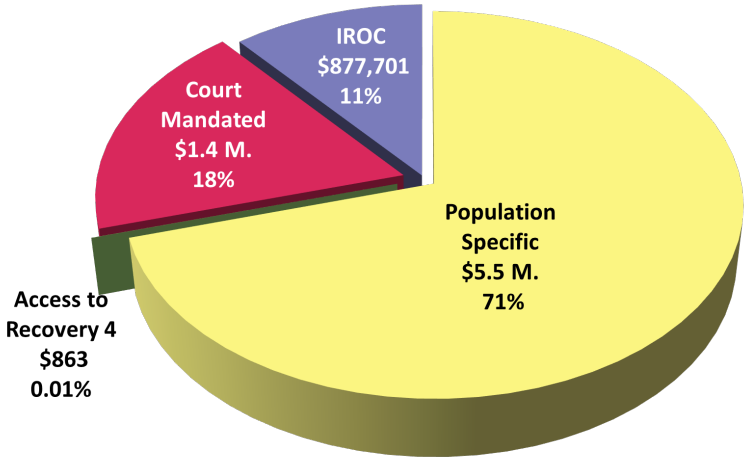
Services for SUDs are delivered through contracts with private and public agencies with a focus on best practices and evidence-based programs. The goal of treatment is to help participants live their lives in recovery. The division served 3,444 unduplicated Substance Use Disorder clients in SFY 2018.

Idaho currently has a provider network developed and managed by BPA Health. The network contains 78 state-approved treatment providers at 132 locations. Treatment services include, but are not limited to, detoxification, outpatient therapy, residential treatment and Medication Assisted Treatment (MAT).

The network also includes 26 stand-alone recovery support service providers at 65 locations. Recovery support services help people enter into and navigate systems of care, remove barriers to recovery, stay engaged in the recovery process, and live full lives in communities of their choice. Recovery support services include case management, family life skills, recovery coaching, safe and sober housing for adults, childcare, transportation, and drug testing. Specialized services are available for pregnant women, women with dependent children, and adolescents.

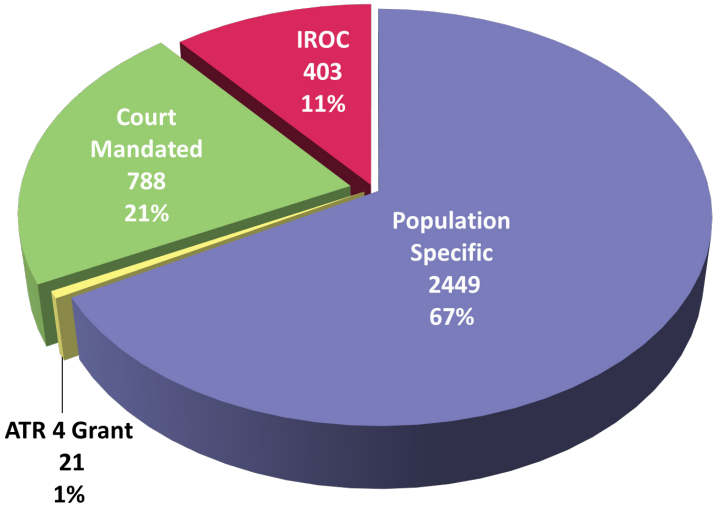
In 2017, Idaho received a $2 million federal grant to help fight the opioid epidemic. With that funding, the division created the IROC (Idaho's Response to the Opioid Crisis) program, serving Idahoans suffering from Opioid Use Disorder (OUD). That funding was renewed for another year in May 2018. From May 2017 to July 2018, the program provided treatment services to 729 individuals with OUD and provided recovery support services on nearly 9,000 occasions.

SFY 2018 Substance Use Disorders Expenditures by Priority Population



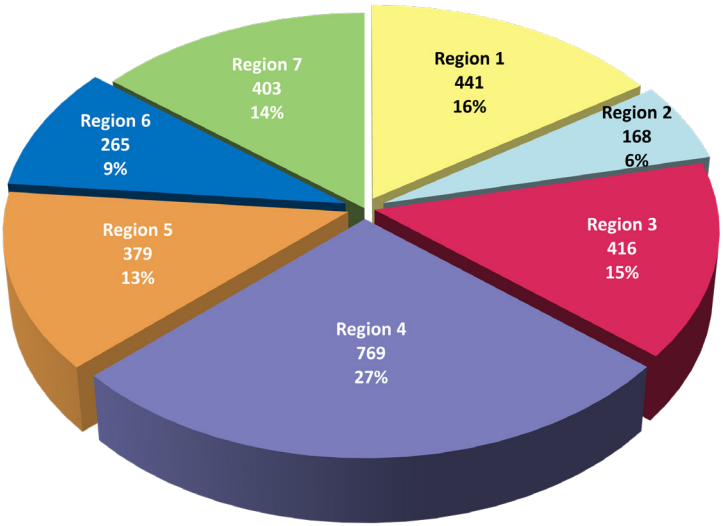
NOTE: Population Specific includes adolescents, adults, IV drug use, women with children, child protection, Idaho Youth Treatment Program clients, and patients at state hospitals.

SFY 2018 Substance Use Disorders Treatment by Priority Population



NOTE: The Idaho Department of Health and Welfare collaboratively funded treatment for some clients in the Population Specific priority populations. Participants may be served in more than one priority population.

SFY 2018 Substance Use Disorders Client Intakes by Region



The Idaho Tobacco Project

The Idaho Tobacco Project works with retailers to prevent youth access to tobacco products. The Tobacco Project provides retailers with educational materials, no-cost permits, and supports inspections to evaluate compliance with the state statute that prevents minors' access to tobacco. Educational materials include a monthly newsletter, a training CD, point-of-sale resources (posters near cash registers or in staff areas), and online training resources (preventthesale.com/Idaho) to help retailers educate their staff.

To encourage retailers to be vigilant against selling tobacco to minors, youth-purchase inspections are conducted annually at every retailer site where youth can legally enter. In 1998, the first year that statewide youth-purchase tobacco inspections were conducted, the violation rate was 56.2 percent. In 2017, the survey of inspections resulted in a violation rate of 8.54 percent. The chart below summarizes the outcome of the inspections conducted for the past five years.

Inspections					
	CY 2013	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2017**
Permittees	1,654	1,663	1,639	1,581	1,398
Inspections	1,976	1,798	1,768	1,755	1,709
Violations	154	135	157	118	146
Non-Compliance Rate	9.1%	7.51%	8.88%	6.72%	8.54%

Division of Family and Community Services

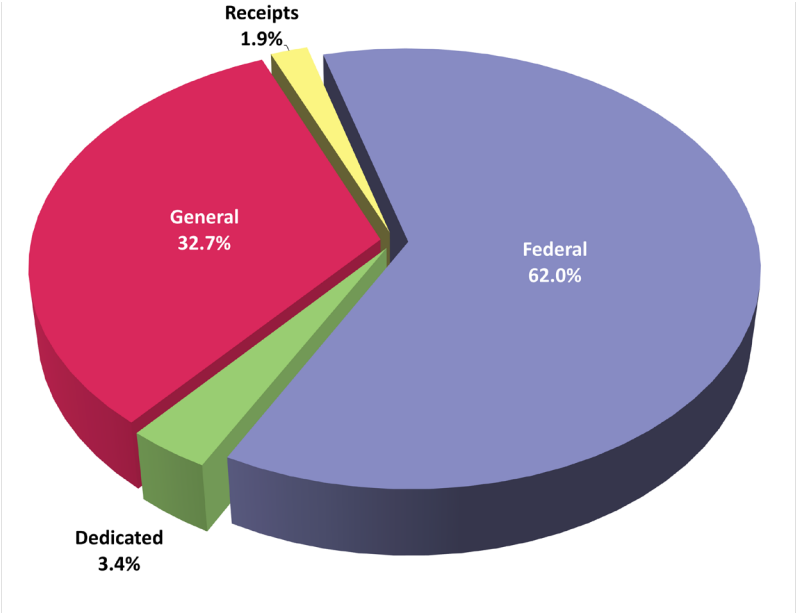
Miren Unsworth, Administrator, (208) 334-0641

The Division of Family and Community Services (FACS) directs many of the department's social and human service programs. These include child protection, adoption, foster care, developmental disabilities, and screening and early intervention for infants and toddlers with developmental delays or disabilities.

FACS also provides navigation services that connect individuals and families in crisis with services that help stabilize their lives. FACS programs work together to focus on the entire family, building on strengths while supporting and empowering them.

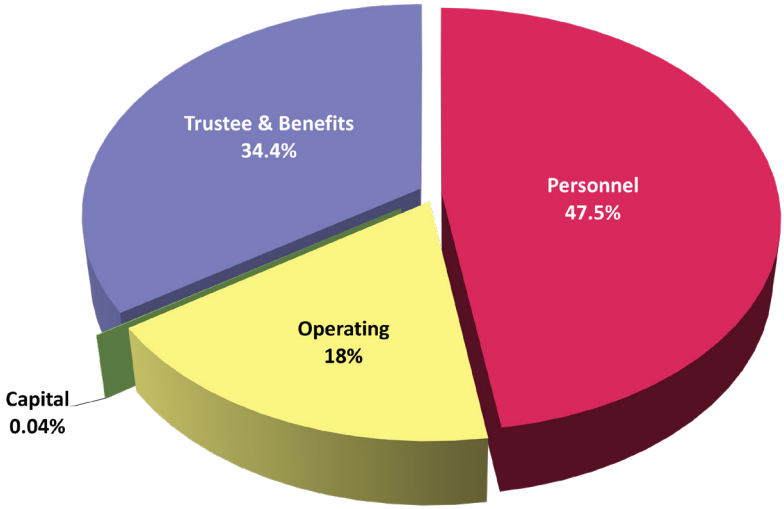
The division also administers Southwest Idaho Treatment Center. This facility provides residential care for people with developmental disabilities who face severe behavioral challenges or significant medical complications.

FACS SFY 2019 Funding Sources



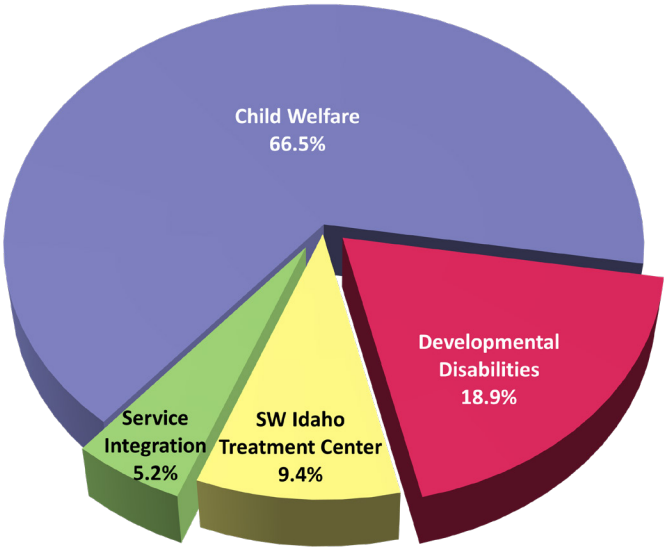
Authorized FTP: 744.51; Original Appropriation for SFY 2019: General Funds $37.8 million, Total Funds $115.8 million; 3.8% of Health and Welfare funding.

FACS SFY 2019 Expenditure Categories



Note: Personnel costs account for a greater share of expenditures in FACS because of the nature of community-based, client-focused services and 24/7 staffing levels required at Southwest Idaho Treatment Center.

FACS SFY 2019 Spending by Program



Note: Child Welfare includes Child Protection, Foster Care, and Adoption. Almost half of Child Welfare expenses are for Foster Care/Adoptive assistance payments to families and providers.

SFY 2018 FACS Division Highlights

During SFY 2018, Child and Family Services (CFS) finalized planning efforts for a Three-Year Transformation Project that launched in July 2018. This project is aimed at addressing long-standing pain points within the program. The goal of the project is to ensure Child and Family Services modernizes its business practices, allowing staff to focus on the critical goal of protecting children and supporting families while removing unnecessary work and documentation that currently takes up the majority of their time and effort.

The Three-Year Transformation Project involves:

1. Organizational Restructuring
A new bureau in FACS will focus on business design and process improvement, areas in CFS identified as pain points. These organizational changes are crucial to improving consistency in statewide practice and providing continuity of child protection services for families, children, and foster parents. This bureau will provide process engineering, training, implementation supports, and data gathering and reporting. Redesigning business practices and processes with a focus on decision-making will allow the program to better serve Idaho families, effectively use its resources, and create lasting improvements.

2. A Systemic Focus on Business Priorities
The current child welfare environment is reactive to many inputs and pressures, but often the efforts to change are singular. When reacting to each passing challenge or creating one-time solutions, long-term and sustainable solutions are not implemented. The transformation project is a deliberate staging of priorities over a three-year cycle to ensure improvements in all critical areas we have identified. These include:

- Improving the safety assessment process and timeliness of safety decisions.
- Improving in-home safety plans and prevention activities to keep children from coming into the state's care.
- Improving concurrent planning processes to make permanency placement decisions as quickly as possible.
- Improving the permanency placement process for children under the age of 3 years.
- Creating improved case management and workflow standards across the child welfare workload.
- Redesigning foster care recruitment and licensing processes, as well as training supports.
- Improving performance visibility and data accessibility across all units of work.
- Designing and implementing a new Child Welfare Automated System.

- Determining strategies and an implementation schedule to ensure compliance with the federal Family First Prevention Services Act.

3. Stabilizing Current Workforce
Turnover within the program continues to be a challenge in getting ahead of workload problems across the state. Although some regions have stability in their workforce, some do not. Trends show that we have better outcomes in areas where positions remain filled and we have longer tenure. Our goal during this project is to improve stability in our statewide workforce by investing in pay increases for social workers, reducing stress and overload in case assignment and workload, providing better tools and training to help staff be successful in their everyday work, and providing data and case management tools to improve decision-making and manage performance.

4. Aligning Business and Technology
FACS will replace its outdated Child Welfare Automated Information System. Idaho's 2018 Legislature approved $ 3.9 million in state general funds for the first year of this three-year plan to begin our efforts to implement a new Comprehensive Child Welfare Information System (CCWIS). CCWIS is a federal classification for a new generation of automated systems with improved case management functionality. FACS will contract with a technical integrator to configure and customize case management software on the Microsoft Dynamics Platform and a business engineering firm to define new business designs and streamline existing processes.

Service Integration

2-1-1 Idaho CareLine

The Idaho CareLine is a statewide, bilingual, toll-free information and referral service linking Idaho's residents to health and human services. 2-1-1 was created through a national initiative for an easy-to remember, three-digit phone number for the sole purpose of providing confidential access for callers to obtain local community health and human services information. In 2002, the Idaho CareLine was designated as the statewide 2-1-1 call center in Idaho.

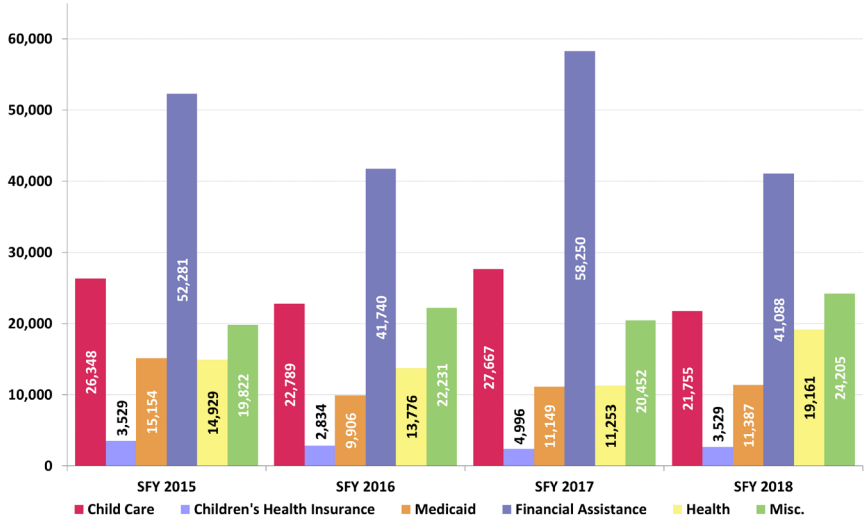
In SFY 2018, CareLine participated in 54 community outreach events and promoted various IDHW and community campaigns designed to increase the health, stability, and safety of Idahoans.

Idaho CareLine facilitated 98,362 information contacts during SFY 2018; however, staff provided 122,361 individual referrals. The variance between the two figures is a direct result of CareLine's software, which counts individual calls or contacts, rather than the number of referrals provided to

a customer during an individual call or contact. CareLine's referral database currently has 11,382 active services relating to 3,558 programs. This promoted various department and community campaigns designed to increase the health, stability, and safety of Idahoans.

CareLine's resources can be accessed by dialing 2-1-1 or 1-800-926- 2588. Agents assist callers 8 a.m. to 6 p.m. MST Monday through Friday. Resources also can be found by visiting www.211.idaho.gov; or by texting a zip code to CareLine at TXT211. Additional information can be found by visiting 2-1-1 on Facebook and Twitter. Emergency and crisis referral services are available after hours.

Number of Calls Received by Idaho CareLine



Resource and Service Navigation

Resource and Service Navigation identifies and develops resources to support struggling families so they can achieve long-term stability using customized service plans focused on family strengths and community supports. Navigators work with individuals, children, and families for up to 120 days to help them achieve their goals for long-term stability, well-being, and health and safety.

During SFY 2018, Navigation received 8,369 referrals. Navigation provided case management to 3,088 households, made up of 9,037 individuals. Of those, Navigation provided monetary assistance to 1,685 households, made up of 6,189 adults, children, and youth. Navigation provided career enhancement to 75 households, made up of 254 adults, children, and

youth. Navigation services distributed $1.3 million in emergency assistance and career enhancement support, while leveraging community funds on behalf of families in Idaho.

The past three years have shown a significant increase in Navigation's ability to leverage community funds. For every Navigation dollar spent, the community donated funds or provided in goods the amount of 33 cents in SFY 2015; 46 cents in SFY 2016; 38 cents in SFY 2017; and 44 cents in 2018. This demonstrates the program's continued efforts to focus on the health, safety, and stability of Idahoans, while also maintaining close and collaborative community ties.

In addition to Emergency Assistance and Career Enhancement, Navigation also received $60,000 from Casey Family Programs to serve Idaho KinCare families. More than 26,600 children in Idaho are being raised by relatives. Navigators served 98 KinCare households, made up of 321 family members. Navigators continued to work in communities across the state on behalf of about 10,000 kinship families for the Idaho KinCare Project. On July 20, 2018, through a proclamation from Gov. C.L. "Butch" Otter, Idaho celebrated its eighth annual Idaho KinCare Family Day.

Child and Family Services

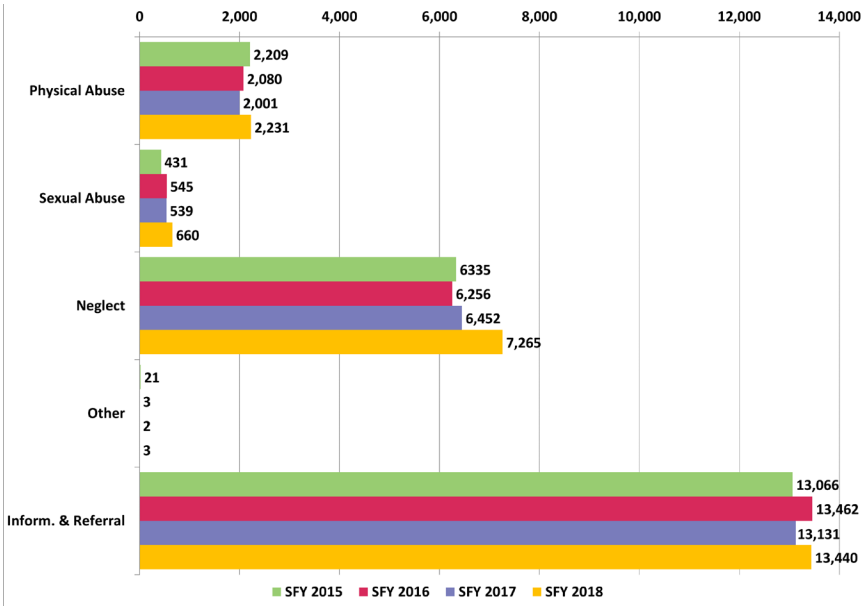
Child and Family Services (CFS) is responsible for child protection, foster care, adoption, independent living for youth transitioning from foster care to adulthood, and compliance with the Indian Child Welfare Act. The program also licenses families to care for foster children, monitors and assures compliance with the federal title IV-E foster care and adoption funding requirements, and manages the Interstate Compact on the Placement of Children.

Child Protection

Child and Family Services operates a Centralized Intake Unit to process all child protection referrals. The primary responsibility of this unit is to answer calls and document child welfare concerns from the public (called referrals), make priority determinations related to the referral, and assign safety assessments to field social workers based on the priority of the referral. Field social workers conduct safety assessments to determine if the child is safe. Social workers and families work together to ensure the child's safety can be maintained in their homes.

If the child's safety cannot be managed with the child at home, the child may be removed by law enforcement or a court order. When children are removed from their homes, social workers continue to work with the families to return the children to the home as soon as it is safe to do so.

Child Protection and Prevention Referrals



Note: In SFY 2018, there were 23,599 referrals from concerned citizens, slightly up from 22,125 in SFY 2017. Of these referrals, 10,159 were assigned for safety assessment. An additional 13,440 referrals were categorized as Information and Referral. These are circumstances that don't meet criteria for assignment of a safety assessment and are frequently referred to other programs or agencies.

Foster Care

Foster care is a critical component of the state's child welfare services. Resource families (foster, relative, and adoptive) provide care for children who have been abused, neglected, or abandoned, and who cannot be maintained safely in their own homes.

During SFY 2018, 2,936 children were served through the foster care program. In the same year, 1,241 children left foster care. Of these children, 66% were reunified with their parents/caregivers.

Whenever possible, relatives of foster children are considered as a placement resource and may be licensed as resource parents. Relatives can be important supports to the child, the child's parents, and the resource family.

Child and Family Services manages out-of-home placements to:

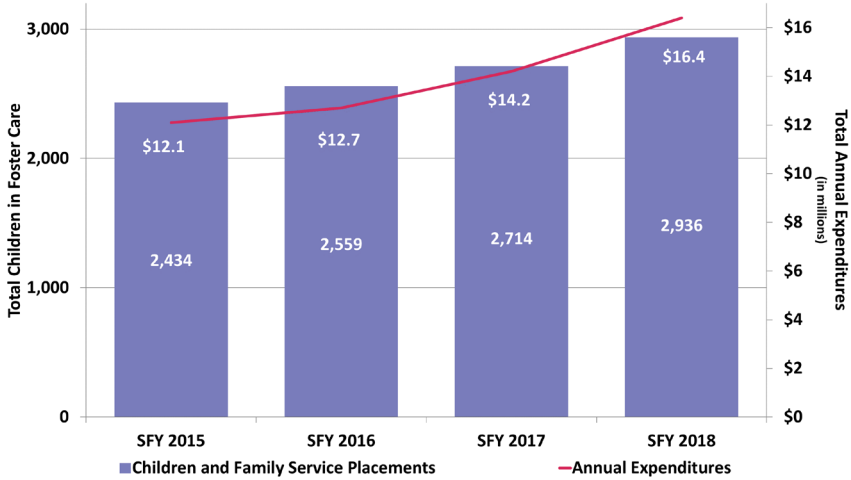
- Assure the child will be safe.
- Provide services to the family and the child to promote reunification

and reduce long-term negative effects of the separation.
- Allow for continued connection between the child, his or her family, and the community.

Knowledgeable and skilled resource families and other care providers are integral to providing quality services to children placed outside their family homes. Licensing processes and requirements are designed to assess the suitability of families to safely care for children.

Resource families work with children and their families with the goal of reunification as soon as the safety issues are resolved that required placement outside the home. When a child's family is unable to make changes that assure a child's safety, the resource family may become a permanent placement for a child.

Children Placed in Foster Care and Annual Expenses

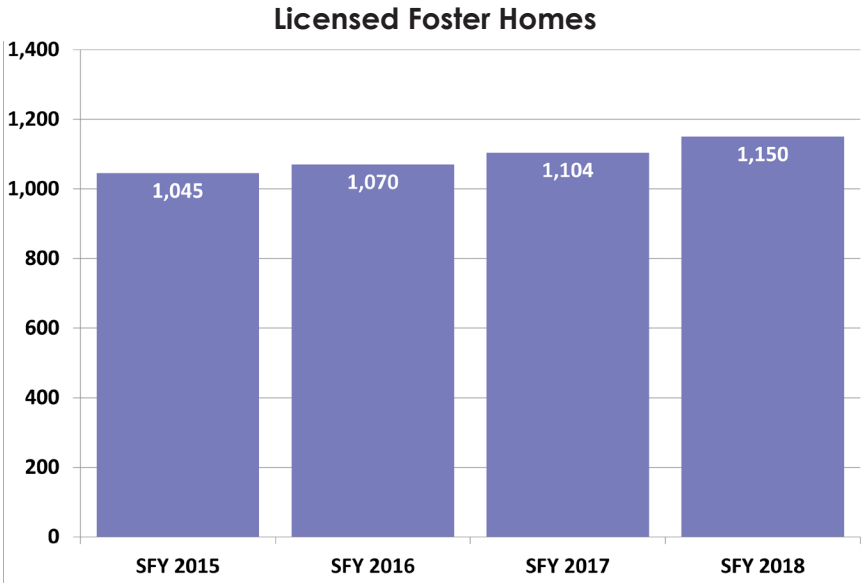


Note: This chart shows total number of children served annually. On June 30, 2018, there were 1,726 children in state care. On June 30, 2017, there were 1,597 children in care.

Treatment foster care is available to children who have complex needs that go beyond what general resource parents are able to provide. Treatment foster parents have additional training and experience that prepares them to care for children with significant specialized needs. Working in collaboration with a treatment team, these foster parents provide interventions specific to each child to develop skills and prepare them to be successful in less restrictive settings.

There is a critical need to recruit and retain resource families for all children in foster care. On June 30, 2018, there were a total of 1,150 licensed resource families. These include resource families in Idaho and resource

families out-of-state where children were placed through the Interstate Compact on the Placement of Children (ICPC). This is an increase of about 50 families since SFY 2017, but there is an ongoing need to recruit families who can provide care to sibling groups, adolescents, and those with emotional, behavioral, and special needs. Resource parents of Hispanic, African American, and Native American heritage also are needed. Foster care recruitment and retention is an area of concentrated focus with the CFS Three-Year Transformation Project.



Independent Living

Idaho's Independent Living Program assists foster youth in their transition to adult responsibilities. Supports and services for cultural and personal identity formation, supportive relationships and community connections, physical and mental health, life skills and personal needs, education, employment, housing, transition planning, and establishing permanent connections are funded through this program.

During SFY 2018, the Independent Living Program served 507 youth ages 14 to 21. This includes 62 youth who turned 18, the legal age of adulthood, while they were in foster care.

To help foster youth transition to adulthood and provide educational opportunities, the Education and Training Voucher Program provides up to $5,000 per year. The voucher is available to youth who have been in foster care after the age of 14 and have received a high school diploma or GED. A total of 23 youth participated in the program at colleges,

universities, technical schools, and other institutions of higher education during SFY 2018.

Older youth often experience barriers to success after leaving foster care. In partnership with the federal Administration for Children and Families, Idaho collects service and outcome information about and from youth for several years after they leave foster care through the National Youth in Transition Database. This helps determine the services that are successful in achieving positive outcomes.

Adoption

Child and Family Services provides adoption services for children in foster care whose parents' rights have been terminated by the court. In most cases, Idaho children adopted from foster care have special needs. These children may have physical, mental, emotional, or medical disabilities, or they may be part of a group of siblings who must stay together. Some children may be older but still need a permanent home through adoption.

The department's goal is to find a family who can best meet a child's needs within 24 months of when the child entered foster care. To help meet this goal, the department looks for relatives who are interested and able to adopt the child. When no relatives are available or if it has been determined that placement with a relative is not in the child's best interest, non-relative foster families often adopt.

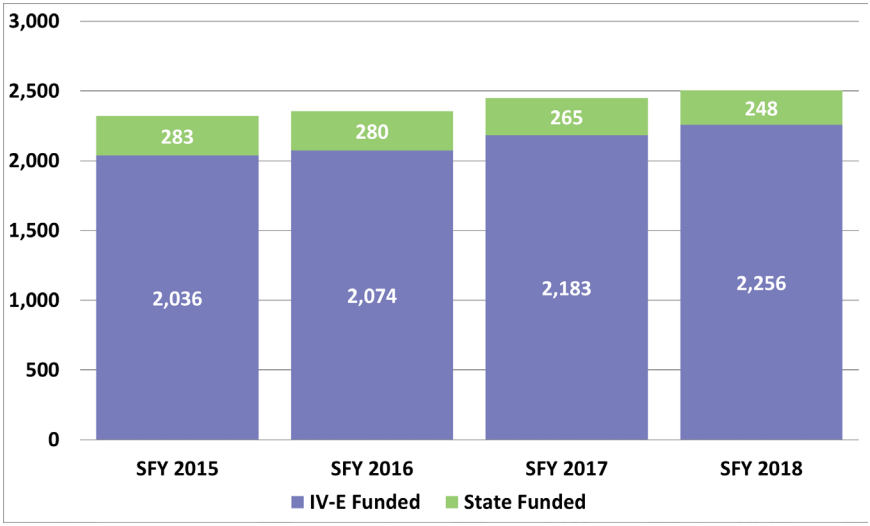
Families who adopt children with special needs are eligible to apply for federal or state adoption assistance benefits. These benefits help subsidize the expenses associated with finalizing an adoption and the cost of parenting a child who has special needs.

In SFY 2018, 257 children were adopted from foster care. At the state and local levels, the department and the courts work closely to improve monitoring and processes to reduce delays and help children have safe, caring, stable, and permanent families.

Adoptions Finalized			
SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
215	195	236	257

Average Monthly Adoption Assistance Payments			
SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
$359	$359	$363	$369

Children Receiving Adoption Subsidies



Developmental Disabilities Services

The Developmental Disabilities Program manages and delivers services for infants, children, and adults who have developmental disabilities. Through partnerships with community members, the program has service choices available for consumers and their families, allowing them to strive for self-direction and full participation in their communities.

Idaho Infant Toddler Program

The Idaho Infant Toddler Program (ITP) coordinates early intervention services for children with developmental delays or disabilities from birth to 3 years of age. The Infant Toddler Program partners with public agencies and private contractors and works closely with parents to enhance each child's developmental potential. Services are provided through a team approach with a primary professional coaching the family.

The four most frequently provided services are:

1. Speech and language therapy
2. Family education (special instruction)
3. Occupational therapy
4. Physical therapy

Services are delivered according to an Individualized Family Service Plan. Teams provide evidence-based services, including teaming, natural environment learning practices, and family coaching across the state. Teams build the capacity of families to promote children's learning. Family feed-

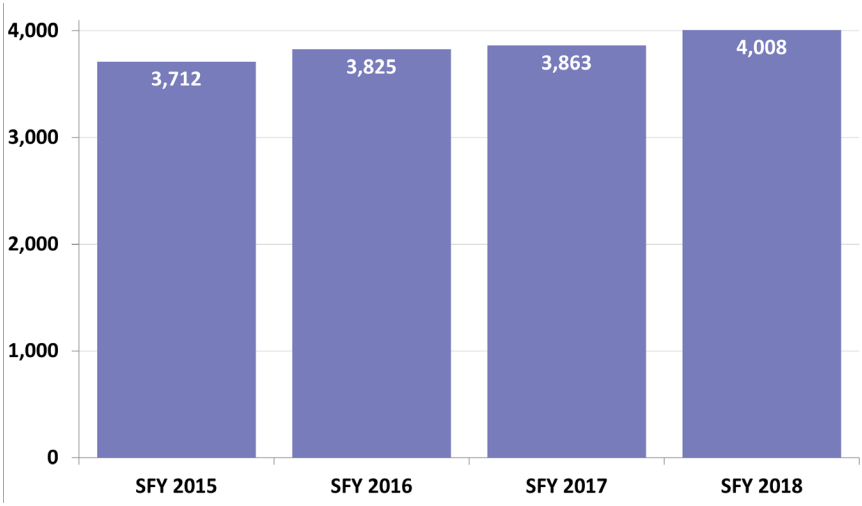
back about the team approach and coaching continues to be favorable and produce positive outcomes.

The Infant Toddler Program received the full SFY 2018 grant approval. It also received the highest federal rating of "Meets Requirements."

Children served by the program are referred for a variety of reasons, including diagnosable conditions that result in delays or disabilities. Nine percent of children referred for evaluation have been involved in substantiated cases of neglect or abuse. Twenty-six percent of children found eligible for services were born prematurely.

Efforts to identify children who have delays or disabilities through outreach and screening services are a program priority. In SFY 2018, the Infant Toddler Program received 4,210 referrals. Region-specific outreach strategies and online screening by parents has resulted in a steady increase in the number of referrals for five consecutive years. The increase in referrals provides the program with the opportunity to provide services to young children who need them the most. These early intervention services provide a life-long impact for children. During SFY 2018, the program served 4,088 children and their families.

Children Served in the Infant Toddler Program



Children's Developmental Disability Program

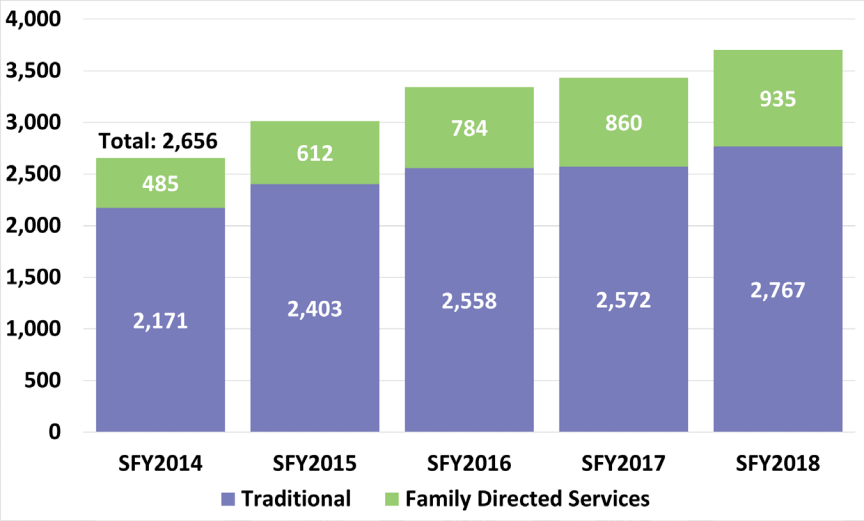
The Children's Developmental Disabilities Program oversees services for children with developmental disabilities up to age 18. Services are delivered through two pathways: traditional and family directed services. Traditional services are delivered by community providers using evi-

dence-based practices to meet the goals identified on a service plan written as part of the family-centered planning process. The family directed pathway allows parents to have a more hands-on and flexible approach in determining the types of services and supports their children receive. It also allows more control over who provides those services and supports.

The program continues to grow, with enrollment increasing to more than 3,700 children. Over 25% of these children receive services under the family directed program. A parent satisfaction survey in SFY 2018 indicated that 88% of parents and guardians are satisfied with the services their children are receiving.

The program continues to increase the quality of services by focusing on evidence-based practices, family centered planning, and ensuring services are delivered consistent with Home and Community Based Rules.

Traditional and Family Directed Services



Crisis Prevention and Court Services Team

The FACS Crisis Prevention and Court Services Team provides training, technical assistance, and consultation to families and agencies that support individuals with disabilities who are at risk of a community placement disruption because of a behavioral, mental health, or medical crisis. The team's priority is to help the person remain in their community. If that is not possible, the team helps to locate another community placement option that can meet the person's needs. As a last resort, a placement referral may be made to Southwest Idaho Treatment Center.

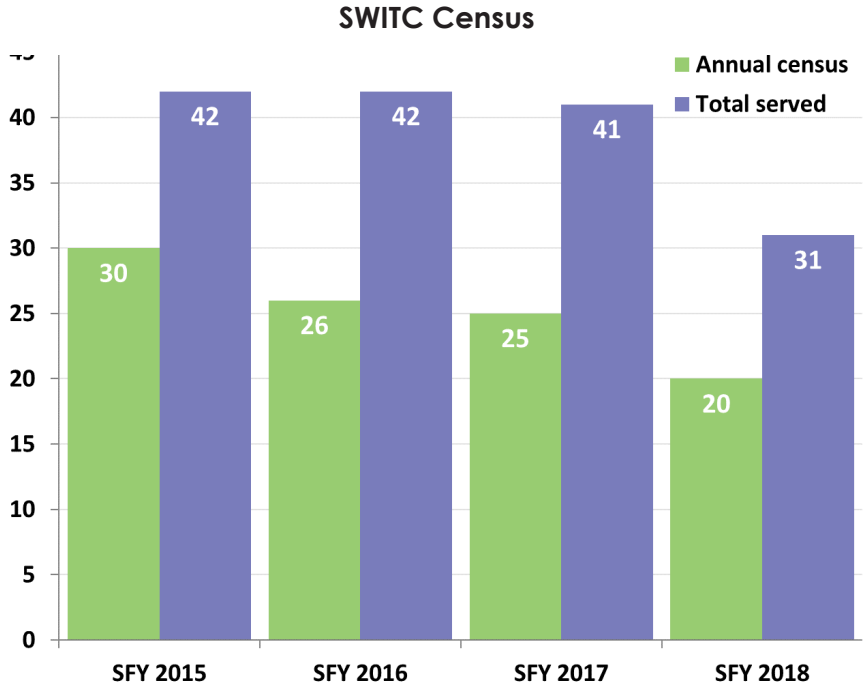
Southwest Idaho Treatment Center

Jamie Newton, Administrator, (208) 475-2434

The mission of SWITC, located in Nampa, is to provide services as a short-term therapeutic stabilization and transition center for clients, focused mostly on those who have been committed to the department because of criminal activity or severe behaviors. SWITC has become a stabilization center for individuals with intricate and challenging needs, with the goal of transitioning them to effective community placements for long-term services as quickly as possible.

The combined efforts of the Crisis Prevention and Court Services Team in maintaining community placements and SWITC in systematically supporting people as they move back into their communities has resulted in a continued decline in the number of clients at the center over the past decade to between 20 and 25.

The 2017 Idaho Legislature passed a bill allowing the creation of a secure treatment facility. Rules governing the Secure Treatment Facility for People with Intellectual Disabilities have been approved by the Board of Health and Welfare. A wing of SWITC is being refurbished to provide for secure services for up to four clients.



Annual census is a point-in-time count on June 30 each year. Total served is the total number of unique clients served during the year.

Council on Developmental Disabilities

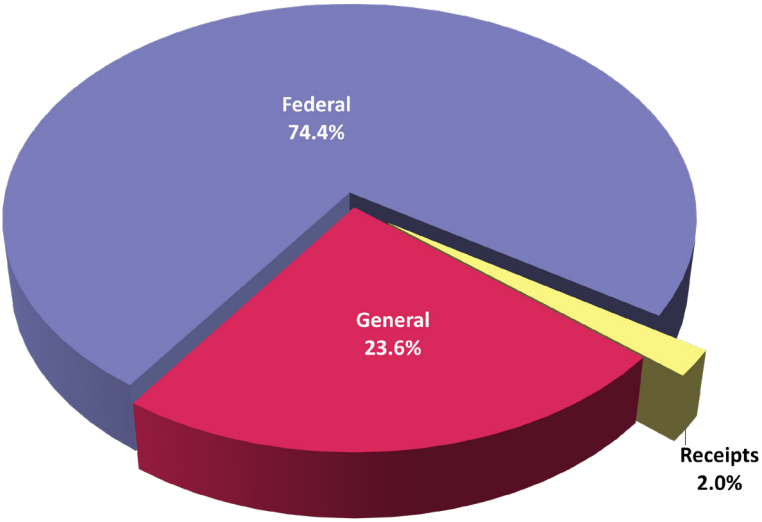
Christine Pisani, Executive Director, (208) 334-2178

The Idaho Council on Developmental Disabilities (ICDD) promotes a participant and family-centered system of comprehensive, coordinated community services by engaging in advocacy, capacity building, and systemic change activities. The council also works to build the capacity of communities to recognize the gifts and talents of all community members so that people with developmental disabilities are living meaningful and included lives. The work of the council is directed by 23 governor-appointed stakeholders, who determine the council's priorities.

Council Vision: All Idahoans participate as equal members of society and are empowered to reach their full potential as responsible and contributing members of their communities.

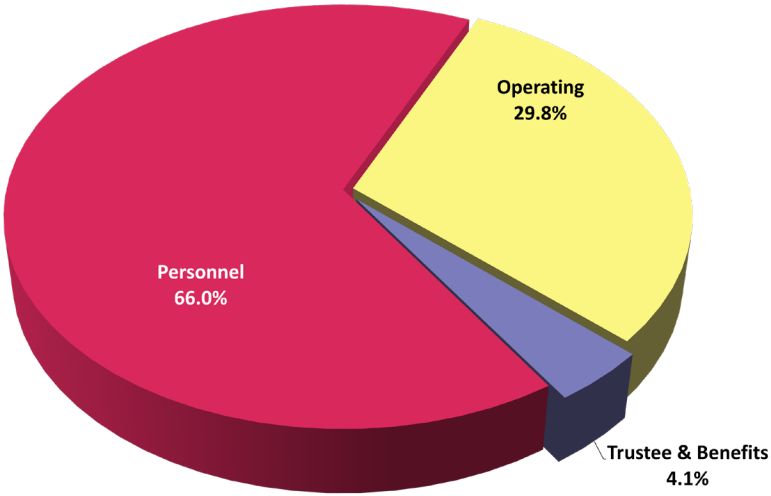
Council Mission: To promote the capacity of people with developmental disabilities and their families to determine, access, and direct services and support they choose, and to build communities' abilities to support those choices.

SFY 2019 Funding Sources



Funding is channeled through the DHW budget, but councils are independent and not administered by DHW. FTP: 6; General Funds $180,700; Total Funds $765,600.

SFY 2019 Expenditure Categories



Council Initiatives

The council has completed the second year of its (2017-2021) five-year plan. Many council projects are multi-year efforts involving systems change initiatives. A snapshot of council initiatives and outcomes for 2018 include:

Adults with intellectual/developmental disabilities experience improved quality in Home and Community Based Services. The Idaho Council on Developmental Disabilities continued to work collaboratively with the Department of Health and Welfare to facilitate Community NOW!, a statewide collaborative workgroup led by adults with intellectual and developmental disabilities (I/DD) and families who participate in Medicaid home and community-based services. The workgroup was created so adults with I/DD and their family members can lead discussions about their experiences with adult developmental disability services provided under Idaho's Medicaid DD Waiver program.

The workgroup was made possible through the shared resources of the department and the Idaho Council on Developmental Disabilities. Community NOW! meetings and discussions took place as part of implementation of the K.W. v. Armstrong settlement agreement. The workgroup brought together more than 60 people, including: adults with I/DD; family members who support and advocate for adults with I/DD; department managers and administrators; advocacy groups such as ICDD, Disability Rights Idaho, Medicaid service providers; and representatives from the

Idaho Attorney General's Office, the American Civil Liberties Union, and Human Services Research Institute.

Intentional work has been done this past year to address Recommendation #1 identified in the 2017 Community NOW! Report: **Establish a quality person-centered planning process based on best practices.**
Outcomes include:

- Stakeholders educated about proposed Idaho person-centered planning model
- An advisory committee of adults with I/DD and families is supported through the council to review and approve all proposals for a person-centered planning approach for the adults in the developmental disability service system.
- Self-advocates and council staff reviewed content and format of the new Department of Health and Welfare's My Choice Matters website and provided suggested language. This new website was created for adults in the DD program and will soon have audio availability in order to have text read to the reader. http://www.mychoicematters.idaho.gov/

People who experience intellectual or developmental disability with a co-occurring mental illness have access to mental health services from skilled service providers.

The council received updated information from the Independent Assessment Provider in March 2018. There are 4,510 adults on the Developmental Disability Waiver and 2,773 of those adults experience a co-occurring mental health diagnosis. The council invested $25,000 and collaborated with the Department of Health and Welfare to host two three-day workshops for mental health clinicians in 2018. Julie Brown, Ph.D., presented in Pocatello at Idaho State University in June and in Coeur d'Alene at North Idaho College in September.

The council supported a parent of an adult with dual diagnosis to speak to the mental health clinicians about the family's experience and lack of mental health services. The current council chair spoke to the clinicians about his experience as a person with a dual diagnosis, the lack of recognition of mental health diagnosis until later in life, and the impact that has had on him personally.

Outcomes Include:

- 81 clinicians received Skills System training to improve their ability to serve adults with a dual diagnosis (I/DD and mental health diagnosis)
- 97% who completed the survey after the training said they were planning to serve more people with a dual diagnosis.

Build the capacity of individuals and parents to lead, mentor, and advocate for others by increasing their leadership and advocacy skills.

In May 2018, 27 participants graduated from the council's leadership development program, Idaho Partners in Policymaking. The council has been providing this leadership development program since 1997, with over 200 graduates statewide.

Outcomes include:

- 14 adults with intellectual or developmental disabilities, and 13 parents, including five individuals from the Spanish-speaking community, graduated from this intensive eight month leadership program.

Learn more: https://icdd.idaho.gov/

Council on Domestic Violence and Victim Assistance

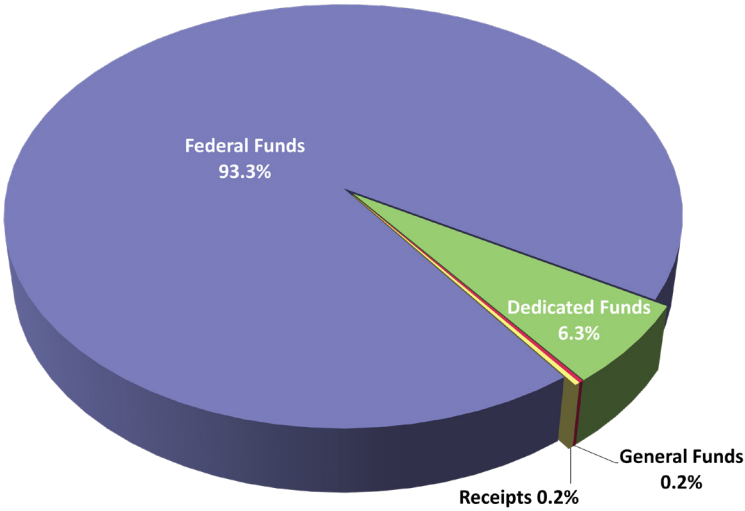
Nicole Fitzgerald, Executive Director, (208) 334-1540

The council was created in 1982 by the Idaho Legislature to promote assistance to victims of crime. The scope of the council includes:

- Administration of federal and state funding provided to programs that serve crime victims.
- Promoting legislation that impacts crime.
- Providing standards for domestic violence, sexual assault, and offender intervention programs.
- Training and public awareness about violence and victim assistance.

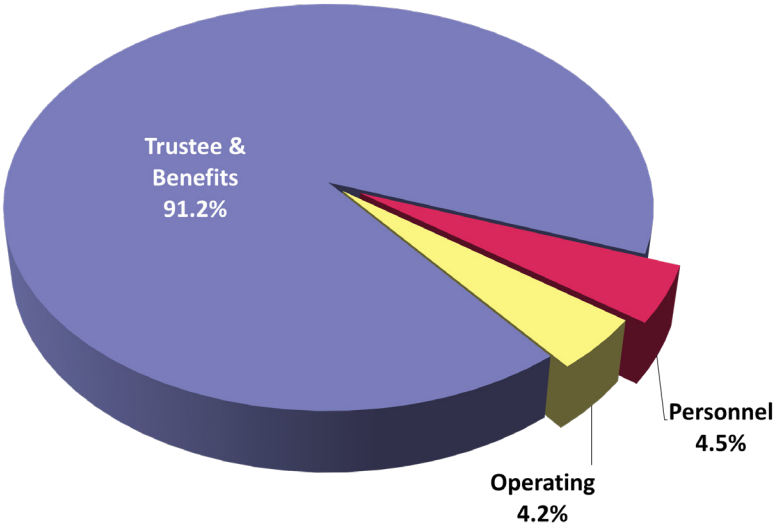
In addition, the council serves as a statutory advisory body for programs affecting victims of crime and acts as a coordinating agency for the state on victim assistance issues.

SFY 2019 Funding Sources



Funding is channeled through the DHW budget, but councils are independent and not administered by the department. FTP: 4; General Funds $15,000; Total Funds $8.3 million.

SFY 2019 Expenditure Categories



The council consists of seven members, one from each of the seven judicial districts in Idaho.

As a funding agency, the council administers a combination of federal and state resources. Primary funding sources include: the United States Department of Justice Office for Victims of Crime; the Victims of Crime Act; the Federal Family Violence and Prevention Grant; the Idaho State Domestic Violence Project; and the Idaho Perpetrator Fund.

The council funds 40 programs throughout the state that provide direct victim services, including crisis hotlines, shelters, medical and legal advocacy, juvenile services, counseling, support groups, and victim family assistance.

The council serves as the oversight for all state-approved offender intervention programs throughout the state.

The council also provides statewide training for service providers about crime victim issues, and provides additional resources including publications and educational materials.

For more information, visit https://icdv.idaho.gov/.

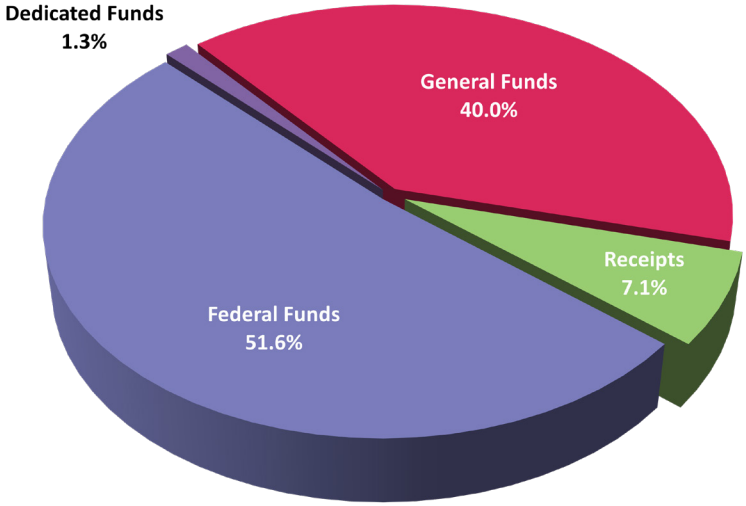
Indirect Support Services

Indirect Support Services provides the vision, management, and technical support for carrying out the department's mission. Indirect Support includes the Office of the Director (details on page 9), Legal Services, Financial Services, Operational Services, Information and Technology, Audits and Investigations, and Public Information and Communications.

The Office of the Director oversees the entire department, working with the Governor's office and the Idaho Legislature to effectively and economically provide policy direction for services and programs.

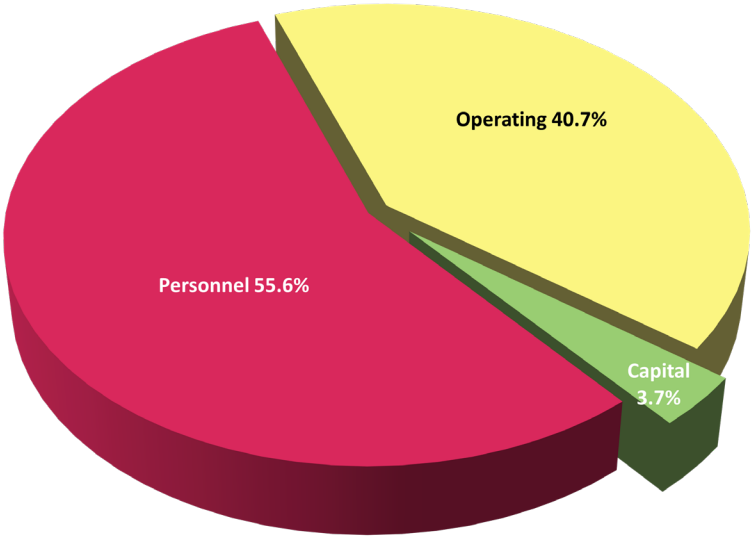
The staff of Legal Services, through the State Attorney General's office, represents and provides legal advice and litigation services. Financial Services provides administrative and financial support for the department. Information Technology provides automated and computer support for delivery of services, along with hardware, software, and networking support across the state. Audits and Investigations conducts internal audits and external fraud investigations for department benefit programs. Operational Services provides the human resource services to manage the department's workforce of 2,923 employees throughout the state, oversees the department's facilities, and administers the contracting and legislative rule-writing for the agency.

SFY 2019 Funding Sources

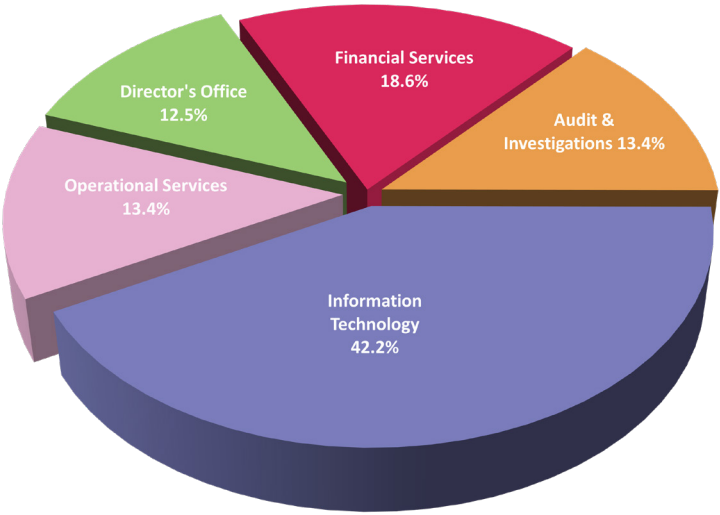


Authorized FTP: 299.6; Original SFY 2019 Appropriation: General Funds $19.5 million, Total Funds $48.7 million; 1.6% of Health and Welfare funding.

SFY 2019 Expenditure Categories



SFY 2019 Spending by Program



Support Services

David N. Taylor, Deputy Director, (208) 334-5500

Support Services provides administrative services to support the department's programs and goals. It manages the department's budget, cash flow, and physical assets; oversees accounting and financial reporting; provides fraud investigation services; and processes all payroll actions. Through cooperation with other divisions, Support Services provides guidance and support to ensure resources are managed responsibly.

Bureau of Financial Services

Financial Services consists of Financial Management; Financial Policy, Reporting and Reconciliation; Financial Systems Support; Accounts Payable; Revenue Operations; Grant Reporting; Cash Management; Employee Services; and Electronic Benefits.

Financial Management

Financial Management responsibilities include, but are not limited to:

- Operating a federally approved cost allocation plan that facilitates recovery of indirect costs incurred in support of federal programs.
- Managing four Random Moment Time Studies used to charge costs to federal grants that fund Self-Reliance programs, Child Welfare, Children's Mental Health, and Adult Mental Health.
- Preparing and submitting the department's annual budget request to the Division of Financial Management and Legislative Services Office.
- Distributing appropriated funding to more than 2,500 operating budgets within the department.
- Monitoring program expenditure trends to allocated funding.
- Preparing financial analysis and reporting for division and executive management.
- Monitoring established full-time equivalency positions.
- Researching and compiling historical expenditure and revenue information.

Financial Policy, Reporting & Reconciliation

Financial Policy, Reporting and Reconciliation (FPRR) is a critical oversight, monitoring, and control function supporting agency financial operations. FPRR responsibilities include, but are not limited to:

- DHW Comprehensive Annual Financial Report (CAFR)
- Financial reconciliation activities
- Financial policy
- Report development and analysis

- Training, documentation, and communication strategies for financial operations

Daily, monthly, quarterly, and annual financial reconciliations are performed in this unit. It is also responsible for reports and maintenance of Financial Services' data warehouse, and provides support for interagency systems, such as the P-Card. The priority for this unit is the methodical, continuous evaluation and intervention in financial operations to maintain compliance with GAAP/GASB standards and ensure adherence to applicable rules, laws, regulations and best practices.

Financial Systems Support

This unit supports the automated accounting systems used by DHW. It provides system support including design, testing, troubleshooting, monitoring program systems, interfaces, and help desk support for related accounting functions. The unit supports these systems:

- FISCAL: Primary accounting system including major modules for cost allocation, cash management, budgetary control, and management reporting, as well as coordination and reconciliations with the statewide STARS system.
- BARS: Primary accounts receivable, receipting, and collections system.
- TRUST: Client-level trust management and reporting system to account for funds held as fiduciary trustee.
- Navision: Front-end to DHW's budget, purchasing and vendor payment activities. Navision is also the primary fixed asset inventory and depreciation system of record.
- Contraxx: Electronic contract operation and management system.
- Payables Interfaces: Medicaid, child care, energy assistance, job services payment systems, and vendor management support.

Accounts Payable

This unit supports statewide DHW accounts payable activities, primarily through the Navision accounting system. This unit is responsible for:

- Vendor invoice audit/payments
- Vendor edits
- Warrant issues such as stop payments, forgery, cancellations, and re-issue
- Rotary fund payments
- Interagency payments
- Payables Help Desk phone support
- Navision research assistance
- Electronic Benefit Transfer (EBT) support
- Direct FISCAL entries (Trust payments, adjustments, CRU refunds)

- P-card filing / maintenance

Revenue Operations

This unit is responsible for department-wide billing, collection, recovery, and receipt posting activities. The Revenue Operations Unit pursues collection of outstanding debts, including DHW fee-for-service, third-party recovery, benefit overpayment, and any other monies receivable as negotiated through repayment agreements. Statewide billing and collection activities include, but are not limited to:

1. DHW's fee-for-service programs, including:
- Designated exams, Department of Correction's evaluations, court testimony billings.
- Medicaid's certified family home licensing fees.
- Criminal History Unit billing (including Adam Walsh background checks).
- Bureau of Laboratories and public health district services.
- Disability determination records requests.

2. Medical billing for services that are reimbursable through third-party insurers and/or Medicaid for:
- Developmental disabilities.
- Infant Toddler Program.
- Adult and children's mental health.

3. Overpayments, civil monetary penalties, and miscellaneous recoveries include:
- Provider and individual fraud (Welfare and Medicaid).
- Foster care overpayments.
- Educational stipend defaults.

4. Interagency billings.

5. Receipting and posting for all centrally processed receipts.

Grant Reporting

This unit ensures compliance with federal funding requirements by:
- Tracking reporting requirements and completing expenditure reports for more than 100 federal grants that fund DHW programs. The largest of these federal grants is Medicaid, for which the SFY 2018 expenditures were $1.46 billion.
- Managing the department's Medicaid School Based Services Program.

Cash Management

Cash Management ensures adequate cash is available for the department to meet its financial obligations, functioning as the financial liaison to human services programs by:

- Drawing federal funds from the U.S. Treasury to meet immediate cash needs of federally funded programs.
- Requesting state general and dedicated funds through the Office of the State Controller.

Employee Services

This unit handles all employee documents relating to insurance, compensation and payroll deductions, and provides consultation to field offices. It also:

- Operates the Payroll and Employee Information System (EIS) through the Idaho Paperless Online Payroll/Personnel System (IPOPS).
- Provides payroll and benefit support for regional, institutional, Central Office, and field personnel.
- Verifies online time entry for all staff to ensure accurate and timely employee compensation.
- Provides validation and entry of information for new hires, terminations, transfers, and payroll deductions such as health insurance and pension to ensure data integrity.
- Maintains and safeguards employee personnel records.

Electronic Benefit Transfer (EBT)

The Electronic Benefits Transfer unit is responsible for implementation, development, and daily operation of the Electronic Benefits Transfer (EBT), Direct Payment Card (DPC), and Electronic Payment System (EPS) activities. Although overall, electronic payments associated with the Child Support program and cash assistance programs have stayed relatively static with slight increases over the past year, there has been a steady decrease in electronic benefit payments associated with food stamp benefits.

After the recession, SFY 2012 saw the highest peak of disbursed food stamp benefits in the State's history, totaling $366 million. Since then, DHW has seen a steady decline in food stamp benefit payments year-over-year. In SFY 2018 food stamp payments totaled $209 million – down 13% when compared to the previous year, and down 20% compared to SFY 2016.

The EBT Group coordinates information and resources to meet the electronic payment needs of the department. Group members perform related contract monitoring activities; monitor federal, state and department laws, rules, and policies; assess governmental and industry changes for

impacts to services related to all types of electronic payments; and provide necessary and appropriate information to management regarding electronic payment capabilities and mandated requirements.

DHW contracts with Fidelity Information Services to set up and maintain accounts for food stamp benefits; cash assistance programs for the Temporary Assistance to Needy Families (TANF or TAFI) and Aid to the Aged, Blind, and Disabled (state supplement or AABD).

Participants access their food benefits with an EBT Quest Card. Participants receiving cash benefit payments have the option of accessing their cash on an EBT Quest Card, or receiving the funds by direct deposit into a personal bank account.

DHW has a separate contract with US BANK for Child Support clients who choose to have their payments go to a Direct Payment Card (DPC). Child support payments can be accessed with a US BANK ReliaCard, or they can be deposited directly into a personal bank account.

Electronic Payments Distributed

Bureau of Audits and Investigations

The Bureau of Audits and Investigations provides support to DHW's public assistance programs through the following units:

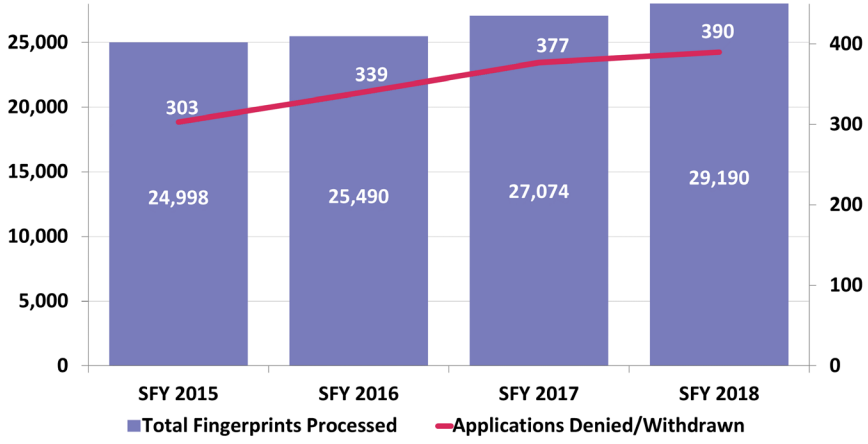
- Criminal History
- Internal Audit
- Fraud Analysis
- Medicaid Program Integrity
- Welfare Fraud Investigations

Criminal History Unit

The Criminal History Unit conducts department-required background checks. The background check is fingerprint-based and includes a search of national and state criminal databases and jurisdictions. It also includes checks of specific registries including National Sex Offender Registry, Medicaid and Medicare Excluded Provider listings; Child and Adult Protection registries; Idaho Nurse Assistant Registry; and Idaho driving records.

The department's background check is completed on people who work in over 40 programs to provide direct care for participants who are children or are disabled or elderly. Learn more at the Criminal History Unit's web site, https://chu.dhw.idaho.gov.

Criminal History Checks by Year



Fraud Analysis

This unit provides data analysis support for the Bureau of Audits and Investigations. Data mining is used to find hidden patterns of waste, fraud, and abuse in client eligibility data, benefit issuances, and provider billings and claims. Statistical analysis is then used to identify and prioritize cases for investigation.

Internal Audit

This unit provides independent appraisals of the department's various operations and systems of control. It helps the department accomplish its objectives by bringing a systematic, disciplined approach to evaluation, and it improves the effectiveness of risk management, control, and governance processes. Internal auditing assists department staff by furnishing them with analyses, appraisals, recommendations, counsel, information, and by promoting effective control at reasonable costs.

Internal Audit is also responsible for initiating a data governance program that will identify, classify and protect the department's sensitive data.

Internal Audit				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Audits completed	5	3	2	3
Audit recommendations made	11	13	2	16
External reports reviewed	63	60	83	93
Grant risk assessment	NA	NA	209	257

The Medicaid Program Integrity Unit

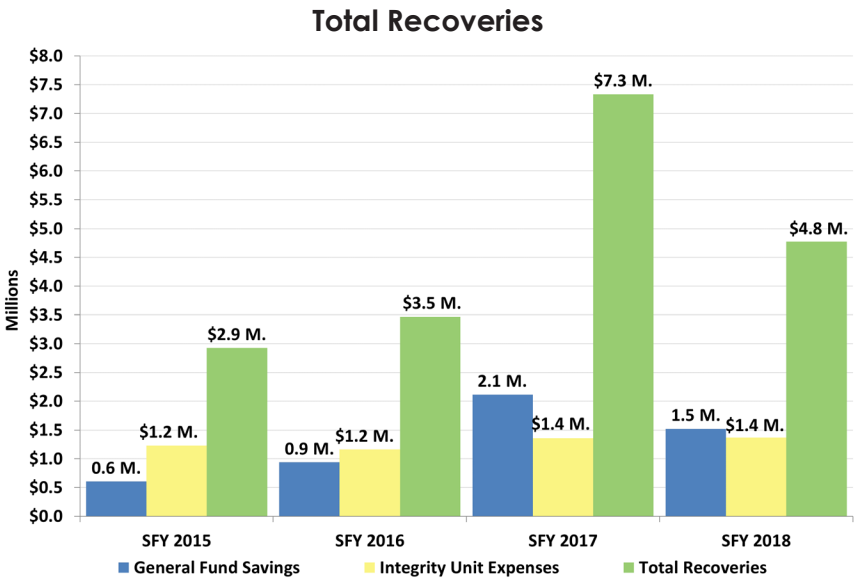
This unit investigates allegations of Medicaid fraud, waste, and abuse, and conducts federally mandated program reviews and investigations by reviewing provider billing practices and records.

Medicaid investigations are initiated from:

- Data mining and other proactive reviews
- Referrals from other agencies
- Provider self-reporting
- Provider, client, and anonymous complaints

Issues are resolved through:

- Education
- Policy recommendations
- Recoupment of overpayments
- Assessment of civil monetary penalties
- Termination of provider agreements
- Exclusion from the Medicaid program
- Referral for prosecution

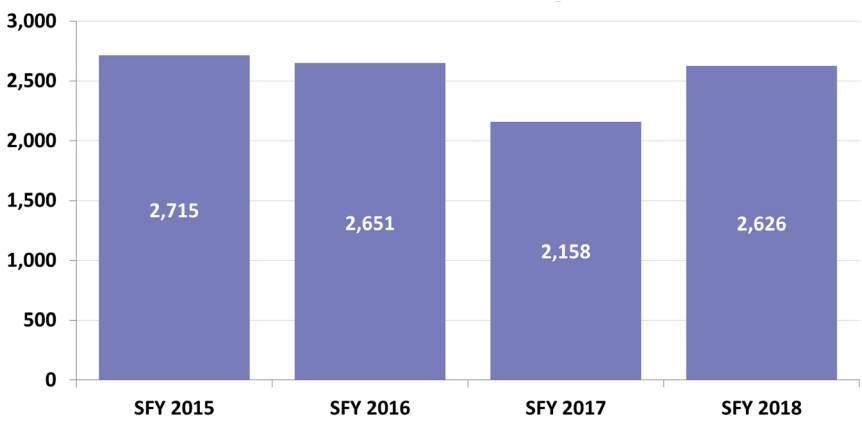


The Welfare Fraud Unit

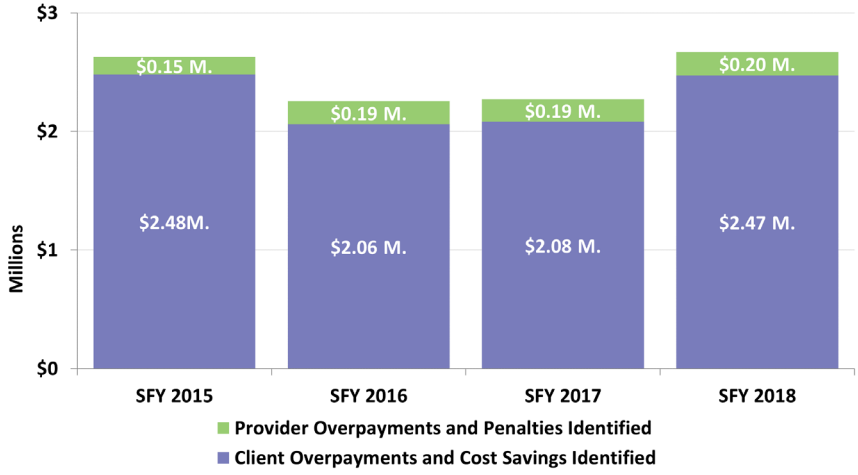
This unit investigates allegations of welfare program waste, abuse, and fraud that include Supplemental Nutrition Assistance program (Food Stamps), cash assistance, Medicaid, child care assistance, and others.

Investigators work with program staff, local law enforcement, Office of the Inspector General, and county prosecutors in every region of the state to investigate allegations. Each year the unit receives about 4,000 complaints from the public and 20,000 leads through data analysis.

Welfare Fraud Cases Investigated



Overpayments and cost savings



Division of Information and Technology

Michael R. Farley, Administrator, (208) 334-5625

The Information Technology Services Division (ITSD) provides office automation, information processing, and local and wide area networking, including unified communications and internet connectivity, for the department statewide. The division uses best practices and sound business processes to provide information technology solutions to improve the efficiency and effectiveness in providing services to the residents of Idaho. The division also provides leadership and direction in support of DHW's mission to promote and protect the health and safety of Idahoans.

The Information and Technology Services Division:

- Provides direction in policy, planning, budget, and acquisition of information resources related to all Information Technology (IT) projects, and to upgrades to hardware, software, telecommunications systems, and systems security.
- Oversees the review, analysis, evaluation, and documentation of IT systems in accordance with Idaho policies, rules, standards, and associated guidelines.
- Maintains all DHW IT resources, ensuring availability, backup, and disaster recovery for all systems.
- Secures IT resources to meet all state, federal, and local rules and policies to maintain client confidentiality and protect sensitive information.
- Oversees development, maintenance, and enhancement of application systems and programs for all computer services, local area networks, and data communications internally and with external stakeholders.
- Provides enterprise services to strategically align business processes and needs with IT solutions.
- Provides IT-related project management, support, and direction in the planning, development, implementation, and evaluation of large-scale IT Projects.
- Provides direction for development and management of department-wide information architecture standards.
- Participates in the Information Technology Leadership Council (ITLC) to provide guidance and solutions for statewide business decisions.
- Implements the state's Information Technology Authority (ITA) directives, strategic planning, and compliance.
- Collaborates with the Office of Information Technology Services (ITS) in statewide messaging, communications, video conferencing, networking, strategic planning, and ITA initiatives or directives.

The Information Technology Services Division provides reliable, timely, high-quality, innovative, flexible, cost-effective IT solutions, working with our business partners to identify and prioritize products and required ser-

vices. The division is divided into three distinct areas:

1. Operations.
2. Infrastructure.
3. Application Development and Support.

Bureau of IT Operations

The Bureau of IT Operations provides technical support services and coordinates resources to promote the efficient use of technology throughout the department. The bureau's functions include:

- **Statewide Technical Support:** Provides DHW staff with Level 1, 2, and 3 technical support services for all desktop and mobile computer-related issues, including hardware, software, and network connectivity. State-wide technicians work from a shared queue, which enables faster service to all our customers who can be supported remotely, freeing up local techs' time to support our customers with issues that require hands-on support.
- **Printer support:** The bureau is the primary point of contact for all network and multi-function printing services. Technicians work with Operational Services and local management staff to assure the most cost-efficient and effective selections are made for printing and faxing.
- **Service Management:** Responsible for design and maintenance of service desk support software used by many agency divisions.
- **Endpoint Management:** Responsible for design and maintenance of desktop and laptop images, security patching and software updates. Researches, evaluates, tests, and recommends technology to enhance technical productivity throughout the agency. Provides mobile device security management.
- **Technology training and development:** Introduces new products to DHW staff; offers training classes (both live and online); and maintains SharePoint knowledge sites for IT Technicians and DHW staff.
- **Enterprise Content Management:** works with other divisions to establish document management practices. Maintains software utilized in the process and provides training and support to divisions utilizing the software.

Bureau of IT Infrastructure

The Bureau of IT Infrastructure is responsible for designing, deploying, and maintaining network hardware and software infrastructure, system security procedures and practices, database security, system backup, and disaster recovery. The bureau also provides development and support for all agency business offices and associated partnerships, including the Office of Drug Policy, Community Action Agency, Health Data Exchange, and the Commission for the Deaf, Blind and Hard of Hearing. Finally, the bu-

reau is responsible for disaster recovery planning, and conducts exercises and testing of recoverability of technology.

The bureau's functions include:

- **Wide Area Network:** Provides wide area, local area, and wireless network design, deployment, and statewide support, as well as data telecommunications infrastructure support.
- **IT Security:** Responsible for user and data security management and standards; database and data warehouse security; enterprise antivirus/HIPS administration; remote access support (Secure Socket Layer Virtual Private Network); and firewall administration and support.
- **UCC:** Designs, deploys and supports unified communications including Voice over IP (VoIP), Fax over IP (FoIP), and video. Also provides support for data center facilities and associated computer systems, including power, cooling, and backup generator for emergencies.
- **Server Support:** Windows and CentOS Linux server build, deployment, and maintenance; server infrastructure and application delivery integration and automation; storage area network support; enterprise electronic messaging support; data backups and restoration; server virtualization; VM provisioning and support; and server security patching.
- **Security and Compliance Audit:** responsible for DHW and ITSD information policies and procedures to maintain compliance with state and federal rules, regulations and guidelines regarding Personally Identifiable Information (PII), Personal Health Information (PHI), the Health Insurance Portability and Accountability Act (HIPAA), the Internal Revenue Service (IRS), the Social Security Administration (SSA), the Office of Inspector General (OIG), FNS Food and Nutrition Services, and CMS Center for Medicaid Services. Also, provides computer forensics support and internal security posture assessments (vulnerability scanning).

Bureau of Application Development and Support

The primary responsibility of the Bureau of Application Development and Support is the design, development, operational maintenance, and support of all business applications, which provide necessary health and human services for the citizens of Idaho. The bureau provides the design and support for the applications necessary to accommodate the entire agency's eight extremely diverse divisions and the programs they administer.

The bureau is also responsible for ongoing enhancements of existing applications; development of new business applications; integration of commercial off-the-shelf products into the agency's application framework; development, maintenance, and support of databases; and creation

and maintenance of departmental reports for all software (middleware) necessary to support the movement of information between computing platforms.

The bureau's functions include:

- **Web Application Operation & Support group:** Responsible for the operation, maintenance, and support of web-based applications for the entire agency. The team supports over 150 applications, including custom-developed, commercial, and commercial off-the-shelf, as well as commercial off-the-shelf products that have been customized for specific business needs. The team is responsible for the day-to-day operations of each of the applications, in addition to all patching, upgrades, and other routine maintenance. All monitoring of server connections and services are part of the team's duties 24 hours per day, 7 days a week.
- **The Application Development group:** Responsible for gathering requirements, designing (including the architectural flow of the application), and coding the enhancement of existing applications; developing new business applications; and integrating commercial and commercial off-the-shelf applications into DHW's application framework.
    - Provides support for all applications and movement of information between computing platforms.
    - Provides software architectural design and design standards which enable, enhance, and sustain DHW's business objectives.
    - Promotes application delivery, including quality assurance application testing, system production support, time-period emulation qualification, and technical documentation. Previously, the group focused on the design, development, and support of the mainframe application; the group has now broadened their scope of work and skill set to include supporting and developing in Java, Natural, and other programming languages. The team continues to provide the ongoing enhancements and maintenance of the applications remaining on the mainframe system.
    - Provides leadership and guidance of complex integrated systems. Responsible for overseeing the applications that support the Welfare division for all benefits programs, including SNAP, TANF, Child Care, LIHEAP, Supportive Services, and Education & Training programs, and the entire Child Support Enforcement program application.
    - Provides research, design, and capacity planning for setting new systems and/or technology direction, and works with business partners to define system requirements for potential uses of technology and automation of process. The group works with all teams to design the most effective, efficient, and maintainable systems possible and incorporate microservices, reusable APIs, and other relevant technologies for ongoing sustainability.
- **The Business Analyst & Application Support team:** Provides DHW staff

with support for applications such as WISPr, Vital Statistics, Criminal History, Audits & Investigations, The Knowledge Center, VistA (Veterans Administration) Hospital Management System, and the e-Case file document management system, as well as many other ongoing enhancement and modernization efforts for various business-related applications.

- **The Production Services group:** Supports multi-platforms (Mainframe, Windows, Oracle and Linux) by working with cross functional teams and technology partners both inside and outside of the agency, such as banking partners, the federal government, and other state entities.
    - This group contributes to improving processes, increasing automation, and improving the daily interactions between the many platforms and applications.
    - The group develops scripts to execute automated processes, including defining requirements, testing, and documentation.
    - They work with senior IT resources in supporting testing and implementations of upgrades and new infrastructure technology, the various .NET and JAVA applications, mainframe systems, and data transmissions.
    - The group identifies processing areas needed for optimizations, and works with IT analysts in improving production and non-production processing.
    - They also monitor data transmissions and job processing per predefined requirements and communications.
    - They also support the production environment by applying a disciplined, logical, and comprehensive approach to problem resolution.
    - The group focuses on clear, concise communications for all internal and external interfaces.
- **The Enterprise Data Warehouse group:** Provides a common data repository, data warehouse design, operation, and maintenance for all business-essential and critical information, allowing secure and reliable access to this information for decision-making purposes.
- **The Database Administration (DBA) team:** Responsible for the installation, configuration, upgrade, and migration for all databases utilized by all the applications throughout the agency. The DBA team is responsible for the hardware, operating system, and database software. All upgrades, patching, and changes to the database are managed by this team. The DBA team also creates the structure, views, and, most importantly, the data quality and data integrity of the systems they support.
- **Enterprise architecture:** Designs, develops, and maintains an enterprise model framework, and develops enterprise standards and strategies. Creates and maintains architectural models of business processes, business units, information, technology, and their interrelationships.
- **Licensing and Procurement Management:** Specializes in IT contracts, software, and hardware licensing in partnership with DHW's senior buyers in purchasing, leading the process for the procurement of

computer software and hardware. Tracks all compliance of licensing and renewal dates for the agency.
- **SharePoint Administration and Support:** Oversees SharePoint upgrades and administration for the enterprise. It also conducts training and aids in SharePoint development for the agency's business units. They design, administer, maintain, and support SharePoint for all department users.
- **DHW External Websites and Social Media team:** In conjunction with the Public Information Office, this group oversees the agency's social media, public service campaign sites, and the external DHW website. The team designs, codes, and maintains all public facing sites, ensuring the content and information presented is relevant and timely.

ITSD Highlights

ITSD has completed multiple ongoing initiatives to support DHW's growing and evolving needs for information technology, while improving efficiency in automation with limited resources.

Technological Improvements
- Idaho Electronic Health Record (EHR) Incentive Management System. This system will provide users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard-compliant EHR technology.
- The department's Self Reliance team was provided with a feasibility study along with a cost analysis for the EHR Incentive Management System.
- Established Cisco Enterprise License Agreement to enhance the agency's cybersecurity posture for federal and state security controls and compliance.
- Implemented Cisco Identity Service Engine to meet security compliance requirements.
- Continued migration of DHW online Office products including Office 365, Exchange Online, and OneDrive.
- Vital Statistics Event System Re-Write. To modernize, innovate business processes, and increase efficiency, the current mainframe system being used to record vital events was re-written in a modern language that will allow for increased supportability and the elimination of mainframe processing costs.
- Criminal History Unit Application Enhancements for Child Care. We will issue two different types of clearances for applicants, depending on the services they provide to the vulnerable population that we seek to protect. A federal auditor finding questioned whether federal criminal information was accessible to non-DHW users, and is being addressed by enhancing the security mode to limit who can access the information.
- Continued progress in deployment and implementation of network infrastructure at a department co-location site to provide critical

information systems fail-over as part of disaster recovery and business continuity.
- Child Support Modernization. We are working to replace the converted Chilld Support Enforcement System application with a more customer-facing, maintainable, and supportable solution that better serves the citizens of Idaho.
- DHW Mainframe Application Decommissioning Initiative. For approximately 40 years, DHW has been using the State Controller's Office (SCO) mainframe processor for computer processing in support of the DHW business needs. During this year, functional processes were removed and redesigned, except for the department's Financial System, which will be replaced by the SCO's Statewide Financial System Initiative (Luma). Current technology methodologies were utilized during the decommissioning project to eliminate excessive mainframe processing costs.

Accomplishments directly associated with protecting the health and safety of Idahoans:
- Completed Phase VI of the Health Alert Network (HAN), providing an updated user interface for an improved user experience and simpler, more intuitive workflows. Incorporated user-requested features and updated the documentation to reflect the system enhancements
- Year 6 of the Idaho Electronic Health Record Incentive Management System, which provides users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard-compliant Electronic Health Record Technology.

Initiatives to "Go Green"
- Continued virtualization of our servers to reduce the number of physical devices on the network to reduce power and cooling requirements.
- All newly purchased computers are Energy Star rated and configured with policies that put all computers into sleep mode after a period of inactivity, resulting in less power used within the entire agency and a smaller energy footprint.
- The migration to Office 365 and cloud data on OneDrive, equating to less physical storage hardware. With OneDrive, we will continue to reduce the server footprint and the need for additional expansion of hardware storage space.
- Implementation of collaboration technologies to enhance the remote meetings experience, online participation in training sessions, and remote collaboration for business meetings and project planning sessions. Implementation of these technologies will reduce the need for travel due to options for real-time video conferencing, document sharing, and shared virtual workspaces.
- An enterprise-wide electronic document management solution is in the planning phase. The agency will be able to track, manage,

and store all types of electronic documents, drastically reducing the agency's paper consumption, printer consumables, and physical document storage space, resulting in a reduced cost to the agency and the environment.

- Completed Projects and Initiatives: Completed Phase VI of the Health Alert Network (HAN) Modernization. This phase included an updated user interface, more intuitive workflows, and user-requested features.
- Criminal History Unit (CHU) enhancements for child care. Security was updated to limit who can view criminal history data; the unit gained the ability to charge various fees; and the rules engine was updated.
- DHW Mainframe Systems Decommissioning Initiative, to remove and replace department applications with modern technology, except for the department's financial system. To include: Child Support, Energy Assistance, Enhanced Work Services, Vital Statistics Events System, etc.
- Replacement of the department's mainframe job scheduling software with a Windows-based software solution.

Current Projects and Initiatives:
ITSD has additional initiatives and projects in progress to support the ever-evolving technology needs of the department:

- Idaho Electronic Health Record (EHR) Incentive Management System: Modifications and enhancements will provide users with an efficient means of processing and tracking federally-funded incentive payments to Medicaid providers that attest to the adoption of standard compliant Electronic Health Record (EHR) technology.
- Core Security (formerly Courion) Access Management: Implementing an automated identification access process to enable more secure, efficient services to DHW staff and improve audit trails while reducing compliance and operational risk.
- Vital Statistics Event System Rewrite: Modernize the current Vital Statistics Event application by rewriting it in a supportable language and removing it from the State Controller's mainframe.
- Assessment and Certification Tool Enhancements: Changes to security will ensure that designated staff have the minimum permissions they need to perform their job functions. Additional changes will be made to support additional participating vendors that offer Medicare/Medicaid supported plans (MMCP).
- Fraud and Investigation Tracking System (FITS) Medicaid Rewrite, which will allow expansion for business process modernization and reporting needs for fraud investigative tracking. The new rewrite will be more maintainable, and easier to upgrade within the agency's infrastructure.
- Women, Infants, and Children (WIC) Mainframe Check printing. Moving this process into a Windows environment using VPSX.
- External Partner Portal project, which is a SharePoint site used in conjunction with DHW's external partners. This project will allow DHW business units to safely and securely share data and collaborate with external partners.

- Currently evaluating and testing enhanced mobile device management products to address the federal and state required critical cybersecurity controls.
- Implementing AppDynamics application performance manager to monitor and manage application and network performance, and to gain end-to-end visibility across the enterprise.

Major Projects in Progress

Child Welfare Modernization

- Function: Re-platform the iCARE product onto a Microsoft Dynamics 365 /.NET architecture (from Natural for Window). Enhancing the access and usability of the system and reformatting the database for additional data collection, data quality, and reporting functionality.
- Status: The iCARE system is past the end of its serviceable life cycle. iCARE remains functional but is expensive to modify. Many modern tools cannot be effectively incorporated into the product without considerable cost. These conditions result in unsustainable support and maintenance costs, lost opportunities for improvements, and unnecessary delays in responding to the needs of children and staff.
- Replacement strategy: Purchasing the Microsoft Dynamics 365 platform and providing experienced integration teams to move the functionality into the new platform. Additionally, the purchase and integration of LaserFiche, a document management system, will provide storage and retrieval capabilities to enhance the efficiencies of the iCARE system and case management for the Child Welfare division. Moving to the new architecture will facilitate the use of modern development methodologies, as well as the contemporary technologies that aid in effective and efficient work cycles. Funding comes from a mix of SACWIS/CCWIS federal funding and state general funds. The percent cost share will change from a (roughly) 70/30 federal to state allocation, to a 50/50 arrangement in FY 2019. The project will continue through 2021.

Child Support Modernization: Modernization of the Child Support System from the migrated code and data which successfully took place in 2017. Modernization efforts include new user interfaces, streamlined processes and additional information allowing the CS staff to provide information more effectively to the citizens of Idaho.

- Status: After the successful ITSD initiative to migrate the mainframe applications off the State Controller's Office mainframe, Phase II of the project was to modernize the system and enhance many of the capabilities to provide more information and to streamline many of the processes previously utilized in the Child Support program. Modernization continues for the Child Support system, and includes key components such as IBES referral, case open, "Do Not Enforce" task management, employment, paternity, income, and financial views.
- Replacement strategy: Phase II will be to re-write the user interface, and to increase functionality and enhancements to accommodate

process improvements in support of the critical business needs.

Health Alert Network (HAN) Modernization, Phase VII

- Function: The Idaho HAN system is an automated system designed to rapidly deliver time-critical, health-related information to designated health partners. Redesign the HAN system to leverage newer application architectures, allowing for increased supportability of current functionality and ease of implementing future enhancements. Provide an updated user interface for an improved user experience and simpler, more intuitive workflows. Incorporate user requested features and update the documentation to reflect the system enhancements.
- Status: This initiative is continuing to move forward through 2018.
- Replacement strategy: Phase VII will continue through June 2018 and is funded through a federal grant. This project is part of a multi-phased project to modernize the Health Alert Network throughout the state.

Security Implementation

The department has acquired several robust IT security solutions including hardware, software, and maintenance services through an enterprise license agreement with a premiere vendor. This cost-effective solution is to enhance the department's IT security posture and to maintain the DHW network and cybersecurity infrastructure to meet DHW's strict cyber requirements. It also aligns with the Idaho Governor's Cybersecurity Executive Order No. 2017-02 requiring all executive branch agencies to implement the first five Center for Internet Security Critical Security Controls (CIS Controls and CSC Top 5 controls).

DHW is also required to implement the complete Top 20 Critical Security Controls (CSC Top 20) to meet security compliance that is audited annually by the Internal Revenue Service and Centers for Medicare and Medicaid Services, and every three years by the Social Security Administration and other federal agencies. These audits are based on the National Institute of Standards and Technology (NIST) Special Publication 800-53, IRS (IRS Publication 1075 Tax Information Security Guidelines), and CMS MARS-E standards to meet HIPAA privacy and security safeguard.

Assessment and Certification Tool:

The ACT system marries three separate systems – the Children's Personal Care Services Assessment Tool, the Regional Medicaid Services Tool, and the Uniform Assessment Instrument – together into a fully integrated, cohesive environment, which allows the collection and the maintenance of data for assessing a client's actual functioning level, social skills, and physical and cognitive abilities from age one though adulthood. This information is used to help provide Medicaid assistance for clients who need additional resources.

- Status: With two of the systems (Regional Medicaid Services Tool and Uniform Assessment Instrument) incorporated into ACT, work is being done to include the final system (Children's Personal Care Services

Assessment Tool.

Women, Infants, and Children (WIC) Electronic Benefits System (eWIC): eWIC is a project that will implement the use of Electronic Benefits Transfer (EBT) cards for WIC food benefits. Magnetically encoded payment cards (like credit cards), will be issued to WIC participants. Participants will use the cards to redeem benefits. The cards are replacing WIC checks. This project is federally-mandated to be completed no later than October 2020.

- Status: This project will continue through 2019.
- Replacement strategy: Working with third party vendors (CDP/FIS, CQuest and Maximus) to enhance the WIC food benefit delivery process, and adding the EBTI (eWIC) functionality enhancement. The existing check functionality will continue while rolling out the eWIC cards via a rollout schedule.

Division of Licensing and Certification

Tamara Prisock, Administrator, (208) 364-1959

The Division of Licensing and Certification ensures that Idaho healthcare facilities and agencies are in compliance with applicable federal and state statutes and rules. The division oversees licensing and certification activities for the following types of health care providers:

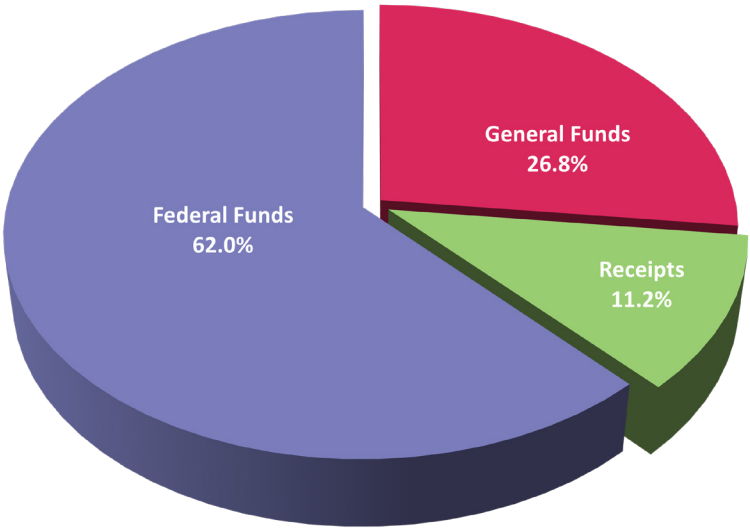
- Ambulatory surgery centers
- Certified family homes
- Developmental disability agencies
- Home health agencies
- Hospice agencies
- Hospitals
- Portable x-ray providers
- Intermediate care facilities for people with intellectual disabilities
- Nursing homes
- Outpatient physical therapy and speech pathology
- Renal dialysis centers
- Residential care or assisted living facilities
- Residential habilitation agencies
- Rural health clinics

Each unit within the division conducts its responsibilities in ways that promote individuals' rights, well-being, safety, dignity, and the highest level of functional independence.

The division also works closely with health care providers, offering training, technical assistance, and resources aimed at improving the quality of care as well as compliance with licensing or certification requirements. Below are a few examples of the work we are doing with Idaho health care providers:

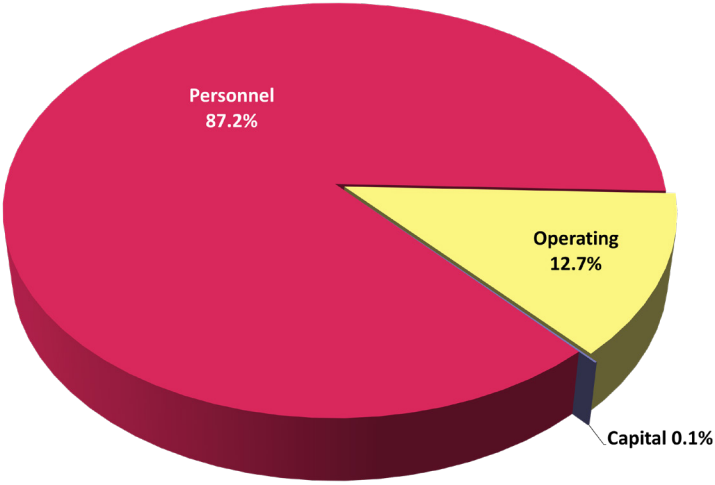
- We continue to work with nursing facilities and the Department of Labor to address shortages of certified nurse aids (CNAs) and registered nurses (RNs).
- We offer extensive training to facility administrators on how to investigate incidents, accidents, and complaints in facilities.
- We provide regular "Administrator Boot Camps" for new assisted living facility administrators, as well as specialized training for nurses who work in assisted living facilities.
- We continue to work with Idaho's Division of Professional and Technical Education to develop and deliver training in medication assistance to certified family home providers.
- We developed specialized, on-line training for certified family home providers on how to care for individuals with mental illness who present difficult behaviors.
- We present training to nursing facility management on the federal certification survey process.

SFY 2019 Funding Sources



Authorized FTP: 71.9; Original appropriation for SFY 2019: General Funds $1.96 million, Total Funds $7.3 million; 0.24% of Health and Welfare funding.

SFY 2019 Expenditure Categories



Bureau of Facility Standards

The Bureau of Facility Standards, in cooperation with the Centers for Medicare and Medicaid Services (CMS), serves and protects Idahoans requiring health-related services, supports, and supervision in care. The bureau licenses and certifies a variety of healthcare providers and suppliers, such as skilled nursing facilities, intermediate care facilities for the intellectually disabled, hospitals, home health agencies, end-stage renal dialysis centers, ambulatory surgical centers, and hospice providers. The bureau also is the single focal point for fire, life safety, and healthcare construction standards in the state.

The Bureau of Facility Standards administers three programs:

1. Long-Term Care
2. Non-Long-Term Care
3. Facility Fire Safety and Construction

The Long-Term Care Program conducts licensing and certification activities to ensure that the state's 81 long-term care facilities, which have 6,233 beds, are in compliance with federal regulations and state rules. These facilities cannot receive Medicare or Medicaid payments if they do not comply with regulations.

The Non-Long-Term Care Team is responsible for surveying, licensing, and certifying approximately 375 healthcare providers in the state, including 51 hospitals; 62 home-health agencies with 24 branch locations; 31 end stage renal dialysis centers; 55 hospice agencies with 33 branch locations; 51 ambulatory surgery centers; 64 intermediate care facilities for the intellectually disabled; 49 rural health clinics; seven occupational therapy/physical therapy clinics with 18 extension units; and six portable X-ray providers. These facilities must comply with federal and state regulations to receive Medicare or Medicaid payments.

The Facility Fire Safety and Construction Program provides oversight and management of the facility fire safety and building construction requirements for all federally-certified healthcare facilities or state-licensed facilities. This team performs facility plan reviews and approvals; on-site plan inspections and finalizations; consultations; and periodic facility fire and safety surveys, which include complaint and fire investigations.

Certified Family Home Program

Certified Family Homes (CFH) provide a safe, family-style living environment for adults who need some assistance with the activities of daily living but do not require a more restrictive institutional setting. There are usually one or two adult residents in a certified family home.

The CFH Program ensures that services are provided in a safe, home-like environment where residents can receive the appropriate services and supports to promote their health, dignity, personal choice, and community integration. This program provides a safe and stable residence for approximately 3,000 individuals in more than 2,400 homes across the state.

Developmental Disabilities Agency/Residential Habilitation Agency Certification Program

This program ensures developmental disability services and residential habilitation supported living services are provided in accordance with state laws and rules, and that they reflect national best practices.

Developmental disability agencies are privately owned entities certified by the state to provide services to adults and children with intellectual disabilities on an out-patient basis. There are 69 developmental disabilities agencies operating in 159 locations throughout the state.

Residential habilitation agencies are privately owned entities certified by the state to provide services to adults. They consist of an integrated array of individually-tailored services and supports. These services and supports are available to eligible participants and are designed to assist them in living successfully in their own homes, with their families, or in an alternate family home. There are 67 residential habilitation agencies operating 105 businesses throughout the state.

Children's Agency Licensing Program

This program licenses children's residential care facilities, outdoor therapeutic programs, foster care agencies, adoption agencies, and private non-accredited schools operating in Idaho, to ensure services and care is provided to children in accordance with state licensing rule requirements.

Children's agencies are privately-owned and are funded through private pay arrangements and/or state contracts. There are 29 residential care facilities, one outdoor therapeutic program, four foster care agencies, four adoption agencies, and one private non-accredited school operating in Idaho.

Residential Assisted Living Facility Program

This program ensures that businesses that provide residential care or assisted living services to Idaho residents comply with state statute and rules. In Idaho, the residents of residential care or assisted living facilities include 60 percent private-pay residents and 40 percent Medicaid participants. The primary diagnosis of people in these facilities include 45 percent elderly, 34 percent Alzheimer's/dementia, 13 percent mental illness, 3 percent

developmental disability, 1 percent traumatic brain injury, and 4 percent physical disability or other need for assisted care.

There are 377 facilities in Idaho, operating under 286 licenses, and representing 10,393 beds. Facilities range in size from six to 160 beds. The average building size has been increasing each year, with most of the facilities being constructed with 50 or more beds. Many small facilities, particularly those that serve people with mental illness, have closed.

The program enforces compliance with state rules, and works closely with residents, families, partners in the industry, advocates, other governmental agencies, and stakeholders to ensure safe and effective care to residents. Information on assisted living facilities in Idaho is easily accessible to the public via the FLARES public portal:
https://www.flareslive.com/portal/SearchFacility.aspx

The survey teams provide consultation, technical assistance, and education to improve compliance and promote better health outcomes. Education is accomplished through regular training sessions for the industry, quarterly newsletters, a website with multiple best practice tools and resources, on-line courses, and by coordinating training for the industry by local and national experts.

Workload

The division completed 4,581 surveys (including complaint investigations) in calendar year 2018, which was 401 more surveys than the 4,180 surveys (also including complaint investigations) completed in calendar year 2017. Also, during 2018, 309 new health care entities were licensed/certified to operate in Idaho.

New Entities Licensed / Certified in 2018		
Facility Type	**Number**	**Number of beds**
Nursing Facilities	4	293
Hospitals	2	95
Assisted Living	6	367
Hospice Agencies	11	N/A*
Home Health Agencies	2	N/A*
Renal Dialysis Centers	2	N/A*
Rural Health Clinics	1	N/A*
Developmental Disabilities Agencies	2	N/A*
Residential Habilitation Agencies	3	N/A*
Children's Agencies	2	N/A*
Certified Family Homes	274	412
Total	**309**	**1,167**

**Note: State surveyors do not count the number of beds in entities that deliver health and medical services and are not residential settings.*

Division of Medicaid

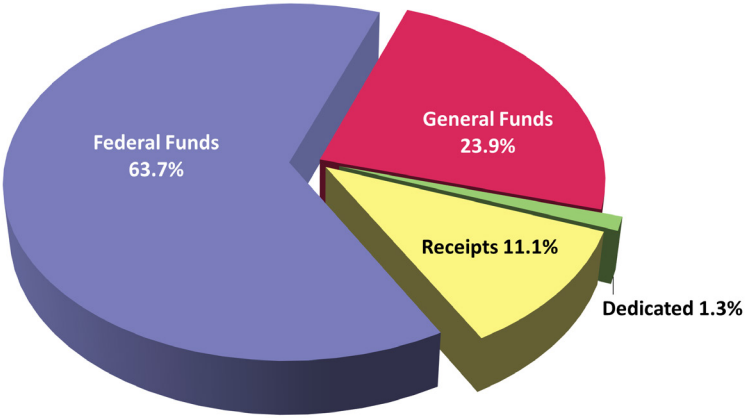
Matt Wimmer, Administrator, (208) 334-5747

The Division of Medicaid administers comprehensive healthcare coverage for eligible Idahoans in accordance with Titles XIX and XXI of the Social Security Act and state statute. The division contracts with individual healthcare providers, agencies, institutions, and managed care entities to provide healthcare services for low-income families including children, pregnant women, the elderly, and people with disabilities.

Medicaid participants have access to covered benefits through three plans that align with health needs:

1. The **Basic Plan** is primarily designed to meet the health needs of those in generally good health and those without disabilities.
2. For individuals with more complex needs and medical conditions, the **Enhanced Plan** adds developmental disability, children's service coordination, and long-term care services and supports.
3. Individuals who are dually enrolled in Medicare and Medicaid have access to the **Coordinated Plan**. This plan affords them the same services as the Enhanced Plan and allows them to enroll in managed care designed to streamline the Medicare and Medicaid benefits. There are many advantages to enrolling in managed care, but one of the most popular value-add services is access to a care coordinator who assists people with complex medical conditions as they navigate the system.

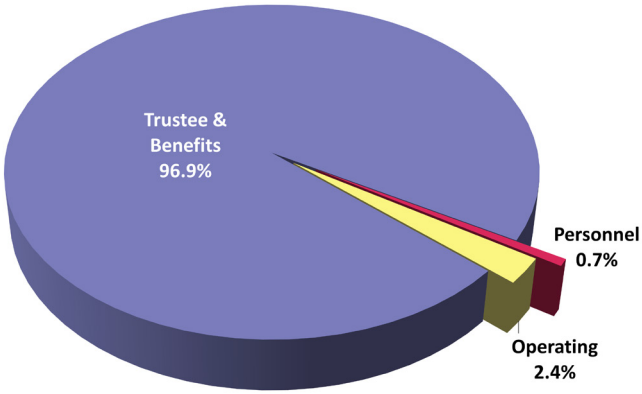
SFY 2019 Funding Sources



Authorized FTP: 216; Original Appropriation for SFY 2019: General Funds $585.2 million, Total Funds $2.5 billion; 80.2% of Health and Welfare funding.

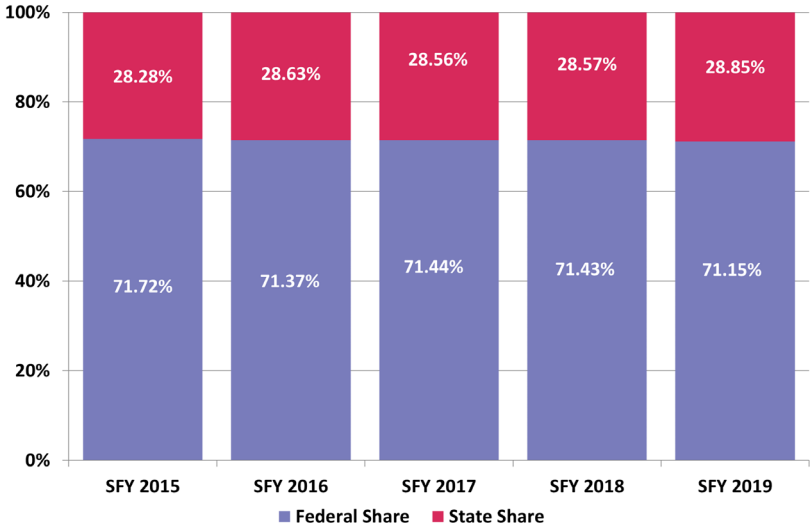
Just over 3 percent of Medicaid's budget is spent on administration, while about 97 percent is paid directly to service providers. This means that each $1 of state general fund spending results in $4.22 that is paid mostly to private healthcare providers who are part of the Idaho healthcare delivery system.

SFY 2019 Expenditure Categories



Funding Medicaid: The Impact of the Federal Medical Assistance Percentage (FMAP) Rate

The FMAP is the percentage the federal government shares of the costs associated with all services provided to Medicaid recipients. The FMAP represents how Idaho's per-capita income compares to the national average.



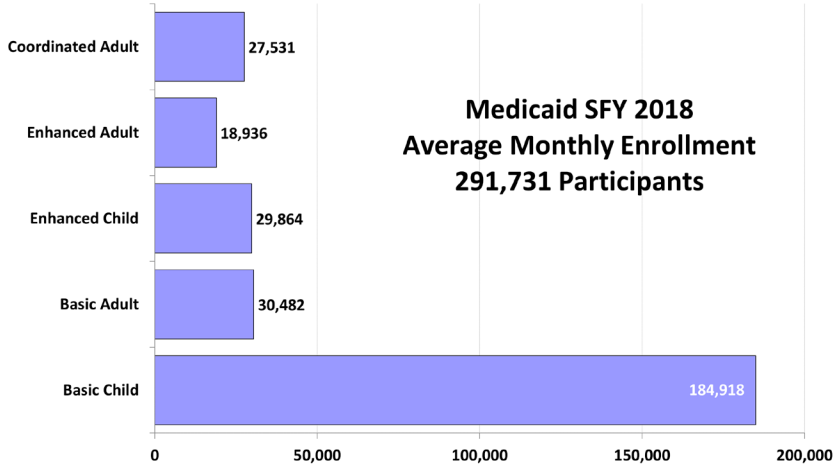
SFY 2018 Budget Analysis

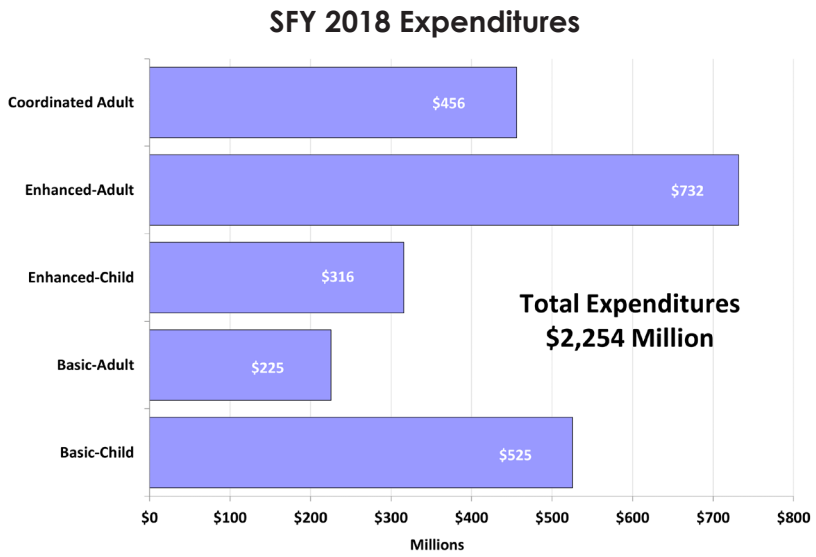
After years of increased Medicaid eligibility, the average number of monthly eligible members dropped in 2018. This was due to a couple of factors. First, Self-Reliance's (SR) federal partners reduced the allowed time for participants to submit their annual re-enrollment information from 30 days to 10 days. Second, SR conducted a statewide re-evaluation process that resulted in an additional decrease of eligible members.

Enrollment and Expenditures Comparison

Medicaid enrollment averaged 291,731 participants per month in SFY 2018, a 3 percent decrease from the SFY 2017 enrollment of 300,838. The projected growth rate is forecast to decline overall in SFY 2019, and then increase slightly for SFY 2020. Medicaid growth should begin to more closely match historical average growth before the recession.

SFY 2018 Enrollees
Average Monthly Participants

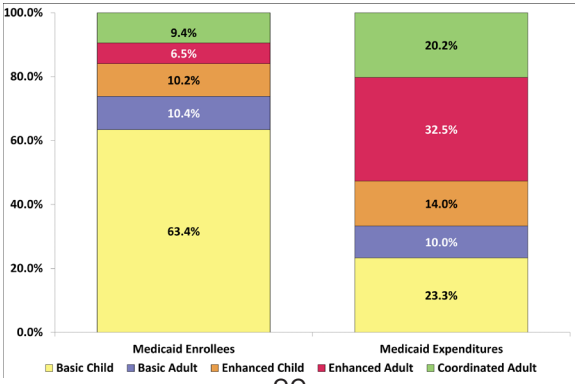




SFY 2018 Enrollment and Expenditure Comparison

Coverage costs for children enrolled in the Basic Plan average less than $240 a month, while children enrolled in the Enhanced Plan average approximately $880 a month. By comparison, an adult enrolled in the Basic Plan costs $616 a month, while an adult enrolled in the Enhanced Plan averages almost $3,219 a month. Participants enrolled in the Enhanced Plan have more intense healthcare needs that may be so severe that they require an institutional level of care.

Many participants enrolled in the Coordinated Plan are elderly and have greater needs for medical services, including long-term care services such as assisted living facilities or nursing homes. A participant enrolled in the Coordinated Plan costs an average of $1,380 a month because Medicare pays the majority of their medical expenses.



Medicaid Initiatives

Medicaid Managed Care

Medicaid currently has managed care programs for dental services, non-emergent medical transportation, outpatient behavioral health, and comprehensive managed care for those who are eligible for both Medicare and Medicaid. Medicaid also provides a Patient-Centered Medical Home care management program through its Healthy Connections primary care benefits.

Patient-Centered Medical Home (PCMH): Medicaid implemented the Healthy Connections PCMH tier incentive program in 2016 as the initial phase to support primary care providers to transition to the upcoming Medicaid value-based payment reform. Under this model of care, patient treatment is coordinated through the primary care provider to ensure patients receive the necessary care when and where they need it, in a manner they can understand. Over the past two years, 260 of 480 Healthy Connections Primary Care Clinics have advanced PCMH tiers and 53 percent of all Healthy Connections participants are enrolled with an advanced PCMH clinic.

Healthy Connections is expanding and currently collaborating with Healthy Connections providers, network providers, and stakeholders throughout the state in the development of three value-based programs, with roll-out expected in 2019 and 2020. Under the Medicaid payment reform effort, participating providers will have the opportunity to earn a share of the savings by improving quality and reducing costs. These programs will be voluntary and will not affect the current Medicaid payment arrangements.

Healthy Connections Value Care Programs: Medicaid is launching three value-based programs through the Healthy Connections Value Care (HCVC) transformation program.

- Healthy Connections Accountable Care Organizations: Expect to implement at least two accountable care organizations in southwest Idaho in 2019 and roll-out statewide in 2020 and 2021.
- Healthy Connections Accountable Primary Care Program: Expect to implement statewide in 2019.
- Healthy Connections Episodes of Care: Expect to implement in 2020.

The Healthy Connections Value Care Program supports the Department of Health and Welfare's strategic objective to transform Idaho's healthcare delivery system to promote healthier Idahoans while increasing healthcare quality and reducing costs. Medicaid will offer financial incentives to providers who control their health care costs and achieve benchmarks for selected national quality measures related to patient care. Participation is voluntary. Each region of the state will have:

- Regional Care Collaborative (RCC): The RCC will be established by the department and accountable for identifying healthcare needs across the region and seeking collaborations to improve cost, quality, utilization and data sharing.
- Community Health Outcome Improvement Coalition (CHOICe): The CHOICe will be established by the department and will be accountable for identifying opportunities to improve health and wellness, create health equity, and address the social determinants of health in their communities. CHOICe may be eligible to receive a portion of shared savings, which will be based on regional performance and will be distributed back to the community through a granting process. These shared savings will be used to fund community initiatives that advance population health.

Outpatient Behavioral Health Managed Care: The Idaho Behavioral Health Plan (IBHP) is in its fifth year of operation. The contract with Optum Idaho to administer IBHP services has been extended through June 30, 2019. Primary focus areas continue to be access improvement and supporting the network in providing evidence-based, outcome-driven services.

The divisions of Medicaid and Behavioral Health and Optum Idaho continue working toward the implementation of the Youth Empowerment Services (YES) project for children and youth diagnosed with a severe emotional disturbance. In January 2018 Optum Idaho began the Person-Centered Plan review and approval process for members meeting Medicaid SED eligibility, which requires the development and approval of a Person-Centered Plan. Optum launched the first group of new services on July 1, 2018, and additional services are in development for implementation throughout the following year.

Implementation for the new services requires a tremendous amount of communication, training, and support for the IBHP provider network, which is led by Optum. For more information about YES, please visit www.youthempowermentservices.idaho.gov. For information about Optum, visit www.Optumidaho.com.

Nursing Facility Quality Payment Program: Nursing facilities annually contribute to an assessment fund. These funds are matched with federal monies and distributed to each contributing nursing facility based on Medicaid bed days, which are counted as overnight stays in the facility. Changes made to the "Assessment Fund" statute during the 2018 session of the Idaho Legislature will allow the department to distribute the monies, in part, based on quality performance starting in 2021.

The Nursing Facility Quality Payment Program was developed by a workgroup of nursing facility stakeholders and the department, with the overarching goal of improving the care and lives of nursing facility residents throughout Idaho. Each nursing facility currently reports data on 10 quality

measures. The measures include performance areas such as reports of moderate to severe pain, falls, and urinary tract infections.

Before full implementation of the Nursing Facility Quality Payment Program in 2021, each nursing facility will receive quarterly reports of their quality scores so they can track their progress through the year and potentially improve their performance prior to full implementation. The work group will continue its collaborative efforts to further enhance the program and promote quality care in Idaho's nursing facility community.

Managed Care for Dual Eligibles: The Medicare Medicaid Coordinated Plan (MMCP), which was expanded in 2014, is designed to coordinate all health-related services for participants in both Medicare and Medicaid. Covered benefits include: hospital and medical services, prescription drugs, behavioral health services, Aged and Disabled waiver benefits, community- based rehabilitative services, personal care services, and nursing home care. The purpose of the MMCP is to coordinate benefits to ensure that people who are eligible for both programs receive the most integrated care possible.

Molina Healthcare of Idaho joined Blue Cross of Idaho to administer the MMCP. Dually eligible participants who live in counties where both plans administer the MMCP will be able to select from Blue Cross of Idaho or Molina Healthcare to participate in the program.

Idaho Medicaid is currently in the implementation phase of a new program called Idaho Medicaid Plus, which is designed for dually eligible participants who do not elect to enroll into the MMCP. Idaho Medicaid Plus is offers an improved service delivery system of Medicaid benefits for dually eligible members. This program was piloted in Twin Falls County in the fall of 2018. Enrollment in Idaho Medicaid Plus will be mandatory for dually eligible members who are not enrolled in the MMCP and who also are not tribal members, pregnant women, or participating in the Adult Developmental Disabilities waiver program. Idaho Medicaid Plus will be phased in in additional counties during 2019.

Managed Care for Dental Services: Managed Care of North America (MCNA) Dental continues to administrator the Idaho Smiles Medicaid Dental Program for the department. Since MCNA began managing the Idaho Smiles program, there has been a substantial increase in utilization – 32 percent of the Medicaid population is accessing their dental benefits. Utilization continues to increase with the adult Medicaid population. MCNA continues its outreach efforts to increase the provider network, which has grown to over 550 providers. MCNA has reinstated enhanced dental benefits for all Medicaid eligible adults on the Basic Plan and the Pregnant Women's Program as of July 1, 2018 at the direction of the 2018 Idaho Legislature.

The department is also working closely with Medicaid stakeholders to propose an increase to the fee schedule reimbursement rates for the Idaho Smiles provider network.

Non-Emergent Medical Transportation: The Non-Emergent Medical Transportation (NEMT) program helps ensure that Idaho Medicaid participants have access to health care services. On March 6, 2018, MTM began providing NEMT services in Idaho. MTM and the department have worked closely to implement a nationally recognized statewide NEMT driver training program to improve safety and services for Medicaid participants. The department continues to work with MTM and other stakeholders to create efficiencies and improvements for the NEMT program. For more information about MTM, visit www.mtm-inc.net/idaho/.

Youth Empowerment Services (YES)

With Legislative approval, Idaho Medicaid implemented a new eligibility group for youth in support of Youth Empowerment Services (YES) on Jan. 1, 2018. This eligibility group is for youth younger than 18 who are over income for traditional Medicaid but have been determined to have a serious emotional disturbance. The income limit for this eligibility group is 300% of the federal poverty guidelines.

Medicaid also implemented an independent assessment process, which is being administered by Liberty Healthcare. This assessment includes the completion of a comprehensive diagnostic assessment and the state-approved functional assessment tool called the Child and Adolescent Needs and Strengths (CANS) to determine whether the youth has a serious emotional disturbance and is eligible to access Idaho Medicaid at the higher income limit.

New and modified services began implementation on January 1, 2018. All services have been designed to meet the terms of the settlement agreement to the extent that Medicaid funds can be used. For more information about YES, please see pages 26-27 or visit www.YES.Idaho.gov.

Idaho Home Choice

The Idaho Home Choice Program, implemented in October 2011, rebalances long-term care spending from institutionalized care to home- and community-based care. The program was originally awarded a five-year grant but is now in its eighth year of operation and has been extended through calendar year 2020. Idaho Home Choice has helped 530 participants transition from institutions into their communities.

At the end of the 10-year grant period, the program expects to have diverted $3,531,977 of Medicaid state general fund spending from institutionalized care to home and community-based care to support the

transition of 600 individuals into their communities. The Division of Medicaid, Idaho Commission on Aging, State Independent Living Council, and service providers from the Centers for Independent Living and Area Agencies on Aging continue to build the necessary infrastructure to support Idaho Home Choice benefits beyond the end of the grant.

Developmental Disabilities

Children's Developmental Disability Services Enhancement: New federal regulations state that services that prevent, correct, or ameliorate a condition for children with developmental disabilities must be provided in the state plan benefit package. In 2016, the department launched the children's benefit project in collaboration with providers, parents, and other advocates. The new regulations were used as an opportunity to further develop and enhance Idaho's services to ensure children's needs are being addressed through evidence-based and evidence-informed practices. The rules around these service enhancements will be presented to the 2020 legislature.

Community NOW! Service Recommendations: In January 2017, the Department of Health and Welfare, in collaboration with the Idaho Council on Developmental Disabilities (ICDD), launched the Community NOW! collaborative workgroup. It was created in part to help implement the settlement agreement in the KW v. Armstrong lawsuit, but more importantly to hear the voices of adults with intellectual and developmental disabilities. Community NOW! is made up of individuals with intellectual and developmental disabilities, family members representing those who cannot represent themselves, DHW staff, IDCC, service providers, the American Civil Liberties Union, (the attorneys representing people with intellectual and developmental disabilities), Deputy Attorneys General, Disability Rights Idaho, and other advocates. From January to June 2017 Community NOW! conducted 21 meetings in Boise and 14 meetings around the state. Based on the information gathered at these meetings, Community NOW! produced the Service and Support Recommendations report and presented it to DHW leadership. The current focus of Community NOW! is person-centered planning, the group's number one recommendation. DHW has committed to continued collaboration to explore, respond to, and implement the report's recommendations whenever possible. Learn more about Community NOW! at http://mychoicematters.idaho.gov/.

Health Information Technology for Economic and Clinical Health (HITECH)

The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law in 2009 for the promotion, adaption, and meaningful use of health information technology. Medicaid has initiated two programs under HITECH to reach the goal of statewide care coordination and overall improvement of care in Idaho:

- Medicaid support for connecting Idaho Medicaid primary care clinics to the Idaho Health Data Exchange (IHDE). This gives Medicaid primary care providers the ability to send and receive information through IHDE to support clinical quality measures and care coordination. Currently, 91 of Idaho's Medicaid primary care clinics can send and receive information through IHDE, and 92 organizations have access to view the IHDE portal. Medicaid will continue to work with IHDE this year to connect additional clinics and hospitals which will help provide greater support and value across the state.

Technology Performance

The Division of Medicaid works closely with contractors for Idaho's Medicaid Management Information System (MMIS) to make system enhancements, improve services to stakeholders, and meet the Centers for Medicare and Medicaid Services (CMS) requirements.

- Molina Medicaid Solutions handles provider enrollment and processing fee-for-service medical claims. The weekly payout from the Molina system averaged $36 million in SFY 2018. This represents payments for fee-for-service claims and managed care fees.
- Magellan Medicaid Administration manages pharmacy benefits. The weekly payout was approximately $4.1 million.
- Truven Health Analytics is a data warehouse and decision support system. The Truven system continues to serve as the Medicaid data warehouse and to support the needs for reporting and information analytics for the Division of Medicaid.
- MMIS contractors saved Idaho Medicaid almost $4.5 million through the Health Insurance Premium Payment Program by helping 406 people acquire and/or retain health insurance that was the primary payer for Medicaid-eligible participants.
- MMIS contractors ensured that Medicare was the primary payer for the 45,652 Medicaid participants who have Medicare through the Medicare Savings Program.

Financial Operations

During SFY 2018, the Bureau of Financial Operations:

- Recovered more than $10 million through the Estate Recovery Program.
- Saved Idaho Medicaid almost $60,000 through the Health Insurance Premium Payment Program by helping 141 people acquire and/or retain health insurance that was the primary payer for Medicaid-eligible participants.
- Ensured that Medicare was the primary payer for the 46,893 Medicaid participants who have Medicare through the Medicare Savings Program.
- Recovered more than $4.8 million from primary insurance, casualty and liability claims, and provider overpayments.

Office of Healthcare Policy Initiatives

Casey Moyer, Administrator, (208) 334-0600

The Office of Healthcare Policy Initiatives (OHPI) was established in 2015 and manages a four-year model test grant the Idaho Department of Health and Welfare (IDHW) received from the Center for Medicare and Medicaid Innovation (CMMI) to implement Idaho's Statewide Healthcare Innovation Plan (SHIP). OHPI is housed within the Director's Office and has oversight responsibility for the day-to-day operations of $39.6 million in grant funds and over 40 vendor contracts.

SHIP was developed to transform Idaho's healthcare system and improve the health of Idahoans. Efforts focused on moving delivery of primary care services to a team-based, care-coordinated patient-centered medical home (PCMH) model, exchanging electronic health data and implementing value-based payment (VBP) models that reward cost-effective quality care.

During 2018-2019, OHPI released and monitored the appropriate use of grant funds, convened stakeholder and staff workgroups, coordinated all activities across SHIP, assessed and mitigated risks, assisted in establishing transformation milestones and monitored progress. This centralized system for supporting, monitoring and tracking progress has been an important component of the model and has remained stable throughout the implementation of the model test.

Activities have focused on seven project goals organized around the triple aim e.g. to improve health outcomes, to improve quality and patient experience of care and to reduce healthcare costs. The model was completely unique to Idaho; it was built on a comprehensive statewide assessment of Idaho's strengths, barriers and gaps, and was designed by Idaho stakeholders to leverage elements of the healthcare system that were working well and to address barriers that were impeding progress.

Goals to Transform Idaho's Healthcare Delivery System

- **Goal 1:** Transform primary care practices across the state into PCMHs.
- **Goal 2:** Improve care coordination through electronic health records (EHRs) and health data connections among PCMHs and across the medical-health neighborhood.
- **Goal 3:** Establish seven regional collaboratives to support the integration of each PCMH with the broader medical-health neighborhood.
- **Goal 4:** Improve patient access to PCMHs in rural areas by developing virtual PCMHs.
- **Goal 5:** Build a statewide data analytics system.

- **Goal 6:** Align payment mechanisms across payers to transfer payment methodology from volume to value.
- **Goal 7:** Reduce healthcare costs.

Highlights

Work on SHIP began in 2013 when Idaho stakeholders came together to study Idaho's current healthcare system and develop a plan for transformation. The six-month planning process involved hundreds of Idahoans across the state working together to develop a new model of care. In early 2014 Gov. C.L. "Butch" Otter established the Idaho Healthcare Coalition (IHC), which serves as the advisory group for SHIP. The coalition has continued to build on earlier stakeholder work and momentum.

IHC members include private and public payers, legislators, health system leaders, primary care providers, nurses, and representatives of healthcare associations and the community. Experience with the SHIP program has demonstrated the benefit of public/private collaborations to address clinical and economic changes needed to achieve effective healthcare transformation.

OHPI's experience with SHIP demonstrates the value of public/private collaborations, the effectiveness of program design and engaged stakeholders as well as the clinical and economic changes needed for effective transformation. The OHPI operations team works with multiple contractors to support healthcare system transformation and the implementation of SHIP's seven goals.

Technical Assistance Offered to Support Idaho's Healthcare Delivery Transformation

Contractors hired by IDHW to perform technical assistance operations for the model test are:

- Mercer, LLC: provides project management and financial analysis. A detailed Project Implementation Plan is prepared annually, and a financial analysis with actuarial certification is prepared for all four years of the grant. This analysis measures reduction in health care costs (or reduced growth in costs).
- Briljent, LLC: provides subject matter expertise to assist in transformation efforts, quality improvement, and PCMH training for primary care clinics participating in SHIP.
- Idaho Health Data Exchange (IHDE): establishes connections with Electronic Medical Records (EMRs) at clinics to improve care coordination and information sharing among providers.
- HealthTech Solutions, LLC (HTS): SHIP's data analytics contractor, responsible for establishing a connection with IHDE and developing best practices for reporting clinical quality measures. At the state level, data analysis will inform policy development and program monitoring

for the entire healthcare system transformation.
- Subgrants with the seven public health districts were executed to hire SHIP staff to assist in the support of regional collaboratives, medical health neighborhoods, and PCMH transformation. The seven public health districts convened regional collaboratives in 2015 that support provider practices as they transform to PCMHs.
- Statewide project evaluation is being conducted in partnership with University of Idaho and Boise State University. This state-level evaluation is required by Center for Medicare and Medicaid Innovation and utilizes a mixed methodology of data collection including patient interviews, provider surveys, and focus groups to evaluate the success of specific goals.
- Several smaller contracts are in place to assist in the planning, design, and operation of the virtual patient-centered medical home components of community health workers, community health emergency medical services, and telehealth. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically-underserved communities.

Our PCMH transformation model recognizes the challenges that many primary care practices face in converting to a value-based healthcare environment. Support is provided with on-site training and coaching, virtual training and coaching, and a web-based quality improvement portal. All types of primary care practices are represented in the three cohorts of clinics, ranging from rural single-practitioner offices to large practice networks and federally-qualified health centers. A goal has been established by stakeholders, that over the next five years the number of primary care practices who are organized under the PCMH model will double.

During this year, OHPI continued to emphasize and focus on incorporating the full universe of statewide transformational solutions that further advance healthcare delivery reform. Idaho's healthcare stakeholders and residents have received invaluable benefits from the transformation efforts to improve the way Idahoans receive healthcare and build the necessary infrastructure to maintain and advance these changes. OHPI has continually assessed the state's healthcare performance, identified programmatic and policy gaps and developed recommendations for improvement.

Milestones

The following milestones were accomplished during 2018-2019:

- The IHC's seven workgroups and two advisory groups regularly met for discussion and to develop actionable strategies and plans that assist in achieving Idaho's seven goals. The value of stakeholder engagement has been reinforced as the complexities of changing the state's healthcare system were addressed.
- Fifty-three clinics were selected to participate in PCMH Cohort Three.

The number of clinics participating in SHIP totals 163.

- About 98% of the clinics of the 166 clinics enrolled in SHIP continue to be engaged in PCMH transformation. Adoption of the PCMH model of care requires significant work to build PCMH capacity. Adoption of the PCMH model has been accelerated statewide with provision of PCMH transformation support at the regional level and through national experts.
- Idaho's four largest commercial insurers, Blue Cross of Idaho, Regence Blue Shield, PacificSource, and Select Health, along with Medicare and Medicaid, are participating in the model test. Payers are evolving their payment models from paying for volume of services to paying for improved health outcomes.
- The increase in value-based payment coupled with new care delivery models such as PCMH have bent the cost curve in Idaho. Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs were reduced by $213 million over the life of the grant through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care, and outcomes rather than volume of service.
- Clinics continue to evolve their business models and adapt new strategies to adjust to the changing landscape of payment reform initiatives.
- Innovative workforce development strategies were developed and implemented to address the state's critical health professional workforce shortages, including the training of community health workers, the establishment of community health emergency medical services programs, and the establishment of 13 telehealth grants to expand medical services in rural, under-served communities.
- Idaho's plan included significant investment to connect patient-centered medical homes to the Idaho Health Data Exchange and enhance care coordination. More resources were invested in the health information exchange infrastructure. The health information technology environment in Idaho continues to shift, with increased electronic health records conversions at the practice level that require changes in workflows and policies.
- Project ECHO launched a practice model on opioid addiction and treatment through a multi-point videoconferencing to conduct virtual clinics with community providers, particularly those in geographically isolated areas lacking access to specialists.

Division of Operational Services

Catherine Libby, Administrator, (208) 334-0632

The Division of Operational Services provides contracting and purchasing services, facility management, business operations support services, human resource management, and coordination of administrative hearings and public records requests.

Contracts and Purchasing

- Purchases services and products in support of department needs, coordinating with the Department of Administration's Division of Purchasing for purchases valued at $5 million and above.
- Provides technical expertise and administrative oversight for DHW competitive bidding, contract and subgrant development and implementation, and product purchases from state wide contracts. There were approximately 1,580 active contracts and subgrants department-wide during SFY 2018, with a total value of approximately $2.3 billion. Additionally, there were approximately 130 contracts for commodities and goods in place and over 1,200 direct purchase orders produced in SFY 2018.
- Develops and maintains DHW's contract and purchasing repositories.
- Develops and maintains contracts and purchasing policy, procedure, and guidance documentation.
- Provides contract management, monitoring, and purchasing training for department staff, and collaborates with the Department of Administration to ensure compliance with purchasing rules and regulations.

Facilities and Business Operations

- Monitors, negotiates, and coordinates leases for 32 buildings totaling more than 640,000 square feet in collaboration with the Department of Administration.
- Manages the operation, care and repair of eight DHW-owned buildings that total about 80,000 square feet.
- Prepares and submits DHW's annual Capital, Alterations, and Repair budget request to the Permanent Building Fund Advisory Council and prepares agency project requests for legislative funding.
- Coordinates and manages statewide remodeling and alteration construction projects funded through the Permanent Building Fund Advisory Council or agency funds.
- Assists and provides consultation to the two state hospitals, Southwest Idaho Treatment Center, and the state laboratory on facility issues.
- Evaluates existing facility use, and prepares space reports and plans for future facility needs.
- Oversees new construction of buildings, land sales, acquisitions, and

disputes.
- Coordinates and manages interoffice moves and relocations.
- Contracts telephone, power, and data cable installations to ensure uniformity, adherence to DHW standards, and cost controls.
- Manages regional purchases of all paper products, office supplies and postage.
- Administers purchases, statewide allocation, repair, maintenance, and use of motor pool vehicles.
- Contracts with independent contractors and coordinates with the Department of Administration to provide security for various DHW buildings.
- Assists with assessing and managing security threats and safety concerns at department work sites.
- Manages the department's asset inventory and disposal of surplus items.
- Provides facility and operational support for regional staff in all regional offices. These include:
    - **North HUB:** Ponderay, Kellogg, Coeur d'Alene, Moscow, Lewiston and Grangeville
    - **West HUB:** Payette, Caldwell, Nampa, Boise, and Mountain Home
    - **East HUB:** Twin Falls, Burley, Pocatello, Idaho Falls, Preston, Blackfoot, Rexburg and Salmon.

Human Resources

- Develops, implements, oversees, and maintains policies and procedures to protect privacy and confidentiality and limit access to information in DHW records based on business need.
- Ensures DHW personnel actions comply with federal and state laws and that DHW's information privacy practices are closely followed.
- Provides consultation in support of system-wide approaches and recommendations for compensation, position utilization, and classification.
- Supports the department's commitment to advance equal opportunity in employment through education and technical assistance.
- Educates employees on how to maintain a respectful workplace where employees are treated with courtesy, respect, and dignity.
- Consults and manages resolution of civil rights complaints, compliance, employee relations, and agency audits or site reviews.
- Identifies, promotes, coordinates, develops, and provides training to employees on topics including leadership, management, supervision, communication, and program-specific topics.
- Administers DHW's Learning Management System and facilitates development and implementation of online learning opportunities for DHW staff.
- Provides management and consultation on effective recruitment and selection strategies for filling current and future needs.

Administrative Support

- Coordinates DHW activities related to administrative hearings and public records requests.
- Develops, implements, and maintains policies, procedures, and educational resources related to administrative hearings and public records.

Division of Public Health

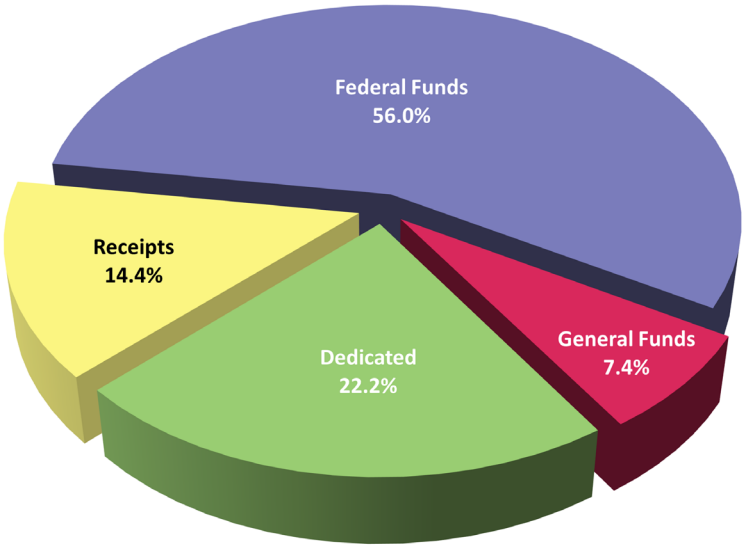
Elke Shaw-Tulloch, Administrator, (208) 334-5950

The Division of Public Health, nationally accredited through the Public Health Accreditation Board, protects the health and safety of Idahoans through a range of services, including immunizations, nutrition services, chronic and communicable diseases surveillance and intervention, food safety regulation, emergency medical personnel licensing, vital records administration, health statistics compilation, rural healthcare provider recruitment, laboratory services and bioterrorism preparedness.

The division's programs and services promote healthy lifestyles and prevention activities while monitoring and intervening in disease transmission and health risks as a safeguard for Idahoans. The division contracts and coordinates with local public health districts and other local providers to deliver many of these services throughout the state.

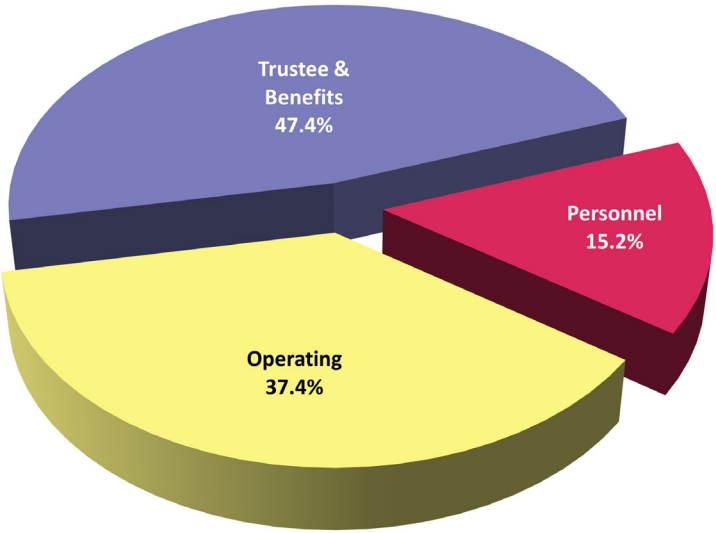
The division includes the bureaus of Clinical and Preventive Services, Community and Environmental Health, Emergency Medical Services and Preparedness, Vital Records and Health Statistics, Laboratories, Rural Health and Primary Care, Communicable Disease Prevention, Public Health Business Operations, and the Suicide Prevention Program.

SFY 2019 Funding Sources

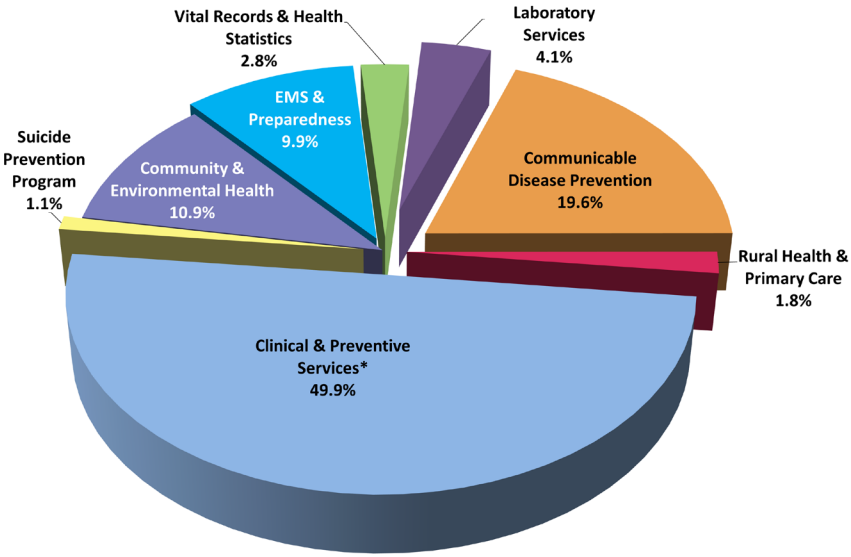


Authorized FTP: 237.02; Original SFY 2019 Appropriation: General Funds $8.9 million, Total funds $120.8 million; 4% of Health and Welfare funding.

SFY 2019 Expenditure Categories



SFY 2019 Spending by Bureau or Program



**The Bureau of Preventive Services include WIC and its associated food costs. WIC is the Special Supplemental Nutrition Program for Women, Infants, and Children.*

2018: Protecting Public Health in Idaho

Division of Public Health: The Division of Public Health was awarded 5-year accreditation status on June 6, 2017, through the national Public Health Accreditation Board (PHAB). As part of this accreditation status, PHAB requires annual reporting to document continuous quality improvement efforts made on standards identified during the PHAB site visit as opportunities for improvement. The division was required to report on only 9 of the 108 measures assessed. At review of the report, PHAB was satisfied at the division's effort and no long requires reporting on those nine measures. Annual reporting will continue, but the focus will be more about the changing culture of the division, as opposed to conformity to the standards. IDHW is one of 31 state public health departments to be accredited and has been featured on PHAB's "Accreditation Works" news report.

Bureau of Clinical and Preventive Services: During the 2017 legislative session, a law was passed that directed the Idaho Department of Health and Welfare to create a public education program about a common virus called Cytomegalovirus or CMV105. CMV is a virus that rarely causes problems for healthy people. However, when a pregnant woman is infected with CMV, it may cause serious health problems for her unborn baby. The virus is common in settings with young children, such as child care centers, schools, and church nurseries. The Idaho Maternal and Child Health Program worked with partners to create educational products and launch a website with information and resources about CMV: www.CMV.dhw.idaho.gov . Resources have been shared with health care providers who care for pregnant women and children, child care facilities, schools, churches, WIC clinics, and the general public. The Maternal and Child Health Program will continue to work with partners to enhance educational tools and resources to build awareness about reducing CMV transmission among pregnant women or women who may become pregnant.

During the 2018 legislative session, the Idaho Newborn Screening Program was successful in passing rule changes to require screening for Critical Congenital Heart Disease (CCHD). As of July 1st, 2018, all babies born in Idaho must be screened for CCHD. Babies with CCHD can look and act healthy at first but can have serious complications within hours to weeks after birth. If caught early, these heart defects are typically treatable through surgery or some other procedure. In Idaho, it is estimated that approximately 55 babies are born each year with CCHD. The Newborn Screening Program can provide training and technical assistance to facilities and is monitoring screening data collected on the birth certificate to ensure babies receive appropriate follow-up care.

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) continues the process of moving from paper to electronic benefits (WIC EBT or eWIC). Work has begun with the Management Infor-

mation System contractor CQuest and the quality assurance contractor MAXIMUS. Idaho WIC joined the Department's (SNAP/TANF/Cash) contract with Fidelity Information Systems (FIS) and Custom Data Processing (CDP) for EBT processing. The program goal is to make the transition by 2019. It is federally required by 2020.

WIC is also in the process of implementing an online nutrition education option for participants called WICSmart. WICSmart is a free smartphone app that allows WIC participants to complete nutrition lessons related to their family's interests and needs. Once a participant completes a lesson, the information may be accessed by their WIC clinic.

The HIV, STD, and Hepatitis Section coordinated with community-based partners in northern and south-central Idaho to initiate HIV mobile testing activities. Mobile testing services will help broaden access to HIV/STD testing in geographic areas experiencing provider gaps and underserved rural populations.

Bureau of Communicable Disease Prevention: The Healthcare-Associated Infection Program partnered with the Bureau of Rural Health and Primary Care, the Idaho Bureau of Laboratories, and Qualis Health to hold Regional Antibiotic Stewardship and Antibiotic Resistance Town Hall meetings across Idaho. Participants identified successes and challenges in promoting appropriate antibiotic use in healthcare settings. The meetings provided stakeholder and community input for future statewide activities and education campaigns that will focus on encouraging appropriate antibiotic use to reduce the development of antibiotic resistance.

The Epidemiology Program has integrated the use of whole genome sequencing (WGS) into disease cluster and outbreak detection in Idaho. Whole genome sequencing is a laboratory method that can identify the "DNA fingerprint" of organisms and allows epidemiologists to identify disease transmission patterns. The program leveraged whole genome sequencing to respond to a cluster of people infected with HIV, to confirm transmission of tuberculosis and intervene. The program also used it to aid in response to a multi-state outbreak of severe E. coli O157:H7 infections that disproportionately impacted Idaho residents.

The Idaho Immunization Program (IIP) enhanced Idaho's immunization registry, the Immunization Reminder Information System (IRIS). The first enhancement makes it easier for Idaho providers enrolled in the Vaccines for Children program to perform annual re-enrollment electronically rather than with paper forms. Enhancements also enabled the system to more efficiently exchange immunization data with provider medical record systems. Users can now query patient immunization records via a secure "real-time" web service to ensure immunization information is current and accurate.

Idaho Bureau of Laboratories: The Idaho Bureau of Laboratories (IBL) provides testing, inspection, training and outreach laboratory services for stakeholders throughout Idaho. In SFY 2018, IBL worked to enhance biosafety, hazard risk management, and dangerous goods packaging and shipping capability throughout the Idaho Sentinel Laboratory Network (ISLN). The ISLN is a collaboration between IBL and 48 clinical laboratories throughout Idaho with the goal of enabling clinical lab staff to rapidly recognize and refer potential biothreat or high consequence pathogens to IBL for confirmatory testing.

IBL staff developed an eight-hour short course focusing on biosafety, risk management, biothreat agents, and proper shipping requirements and provided this training in seven regional locations from the panhandle to eastern Idaho. ISLN labs that couldn't attend one of the regional workshops received an onsite visit where IBL staff provided safety items and information to help improve lab awareness. Thankfully, high consequence pathogens are rarely encountered, but lab staff always need to be on the lookout for them and must be able to safely handle and ship them to IBL. The 2018 emergence of human plague and tularemia cases in Idaho helped to reinforce this and demonstrate the important role that the Idaho Sentinel Laboratories play in protecting public safety.

Bureau of Community and Environmental Health: The Bureau of Community and Environmental Health (BCEH) staff is passionate about collaborating, connecting, and partnering to address cross-cutting, populations-based health issues. BCEH facilitated the second Collaborating for Health Conference (C4H) that brought statewide partners together to discuss disease prevention and management and to foster community-clinical linkages. National speakers engaged attendees in topics including: health equity and health disparities; adverse childhood experiences (ACEs) influence on health outcomes; the value of prevention and built environments; and transforming interventions to advance public health. Through rich discussions, partnerships and engagement, C4H provides a platform to build on successes, strengthen partnerships, and develop a healthier Idaho.

Bureau of Vital Records and Health Statistics: The National Center for Health Statistics (NCHS) has recognized Idaho for meeting all requirements of the Vital Statistics Cooperative Program. Areas of excellence include the bureau's quick transmission time (measured from the date an event was filed with our office versus when the event is provided to NCHS). The bureau provides all events within one business day. The bureau maintains stringent data standards to ensure quality of data on its records.

Bureau of Rural Health and Primary Care: The bureau is a key partner in the Statewide Healthcare Innovation Plan (SHIP), with a focus on efforts to improve access to health care services in rural and underserved communities. These efforts include establishing Community Health Emergency

Medical Service programs, community health worker programs, expanding telehealth in patient-centered medical homes and supporting Project ECHO (Extension for Community Health Outcomes). These innovative projects continue to grow. Partnership efforts are focused on transitioning these initiatives after the SHIP grant ends in 2019.

The bureau is successfully expanding medical education loan repayment opportunities for clinicians serving in designated health professional shortage areas (HPSAs). An HPSA designation is required to qualify for loan repayment opportunities. The bureau conducts ongoing analysis of provider shortages in Idaho.

Bureau of Emergency Medical Services and Preparedness: The Business Operations and Support section is working on the updated Prehospital Electronic Record Collection System (PERCS) Elite. The section is concluding the beta testing phase and beginning the rollout for general use. The updated system (NEMSIS 3.4.0) will interface with IGEMS (Idaho Gateway for EMS) and allow for a seamless push of information from an agency's licensure file to PERCS Elite. This capability permits users to use a single set of login credentials for Idaho's Emergency Management Services (EMS) system (PERCS Elite and IGEMS). The new system will include interfaces to improve timeliness, accuracy, and customer satisfaction. The interfaces currently being developed and implemented are for the licensure system and Time Sensitive Emergency (TSE) Data Registry. In addition to the above, the section is working with the EMS Section on quality improvement projects, the bureau's strategic plan, and the Community Health EMS pilot.

The EMS section worked on identifying critical care definitions and standards. These were added to the Emergency Medical Services Physician Commission's Standards Manual. Efforts continue in fostering partnerships with critical access hospitals and EMS agencies throughout the state to provide safe and appropriate patient transfers.

Senate Concurrent Resolution 135 allowed the bureau to conduct town hall meetings as a follow up to the meetings conducted in 2012. All the comments, suggestions and data will be compiled, and a report will be created for presentation to the Legislature. While addressing the barriers with recruitment and retention in our rural volunteer areas, a temporary rule was approved. The Emergency Medical Responder ambulance certification will allow EMR providers to be the attendant in an ambulance with a patient. The temporary rule went into effect on July 1, 2018. Additional education has been finalized and is available to all EMS agencies.

The State Communications Center (StateComm) continues the effort of becoming an Emergency Medical Dispatch Accredited Center of Excellence, with emphasis on training and quality improvement. The National Academies of Emergency Dispatch, through its College of Fellows, has es-

tablished a high standard of excellence for emergency medical dispatch, providing the tools to achieve it at both the dispatcher level through certification and at the communication center level through the accreditation program. Once successful, StateComm will be the only Emergency Medical Dispatch Accredited Center of Excellence in Idaho. StateComm will join a growing number of accredited centers of excellence across the U.S. and in other countries that provide superior, up-to-date public care and efficient use of resources to achieve maximum results. StateComm also is working in Idaho Public Safety Answering Points to streamline the organ donor notification process and increase the number of prehospital death notifications reported to StateComm.

The Time Sensitive Emergency (TSE) Program has been busy implementing Idaho's TSE System. Each of the six regional TSE committees have been formed and include local critical access hospitals, larger tertiary facilities, and many different EMS agencies. The program began accepting facility applications for designations for trauma, stroke, and cardiac centers in January 2016. As of August 2018, the status of designations is as follows:

- 40 applications have been received for designation.
- 31 have been approved and designated by the TSE Council.
- 7 are in various stages of completion.
- 21 hospitals have one or more TSE designations.

Bureau of Public Health Business Operations: The Public Health Business Operations bureau leads the public health accreditation work for the Division of Public Health. Over the past year the bureau has focused on strengthening data use and access for staff and outside partners. The division's data website: www.gethealthy.dhw.idaho.gov continues to expand with the development of interactive dashboards for population health measures.

The bureau has also spent considerable time in the past year working to dial in subrecipient monitoring for the 400+ subgrants the division has with partners statewide. The bureau is increasing accountability and requiring more transparency in this area.

The bureau also launched a new internal process for identifying quality improvement needs. The Quality Improvement Reporting System, built in SharePoint, allows staff members to log business processes that are not working efficiently or that consistently conflict with policy. Items entered into this system are reviewed regularly and projects are initiated if a trend is identified.

Suicide Prevention Program: The Suicide Prevention Program continued to provide a comprehensive approach to suicide prevention in Idaho through public awareness, education, consultation, training, and support using evidence-based and evidence-informed programs and messaging

during SFY 2018. Some of the highlights include:

- Implementing a statewide marketing plan based on the idea that everyone has a role in preventing suicide. "Rock Your Role" television spots aired statewide for three months and collateral materials were produced and distributed in every county across Idaho.
- Providing funding and support for the Idaho Suicide Prevention Hotline.
- Providing funding and support for youth suicide prevention through the State Department of Education, including two-day trainings for 10 new schools and booster trainings in 12 schools that had already had initial training in Sources of Strength for youth, and suicide prevention training for all staff at 20 schools. Technical assistance, consultations and/or site visits were provided to over 60 schools.
- Developing and distributing statewide educational brochures and tools on suicide prevention and intervention tailored for specific populations including older people, parents, youth, school personnel, gun owners, and behavioral health providers.
- Providing administrative support to the Idaho Governor's Council on Suicide Prevention and regularly convening a group of suicide prevention stakeholders.
- Submitting a federal grant application to implement the Zero Suicide model, which is an approach used by health systems to close all gaps through which suicidal people may fall when accessing health care.
- Facilitating a task force dedicated to limiting access to lethal means for those who are suicidal, and developing packets of materials for use by gun shops. Packets were distributed in one Idaho region.
- Providing 78 suicide prevention trainings to nearly 4,000 professional groups, including behavioral health providers, medical staff, school personnel, detention officers, law enforcement, call center staff, and many others.

All program activities support the Idaho Suicide Prevention Plan and align with the IDHW strategic plan.

Bureau of Clinical and Preventive Services

Clinical and Preventive Services are delivered primarily through subgrants with local public health districts and contracts with community-based organizations. Bureau sections include HIV, STD and Hepatitis; Special Supplemental Nutrition for Women, Infants and Children (WIC); and Maternal and Child Health.

HIV, STD and Hepatitis Section

The HIV, STD and Hepatitis Section (HSHS) is made up of four separate programs that manage and monitor HIV prevention, HIV care, STD pre-

vention, and prevention services related to viral hepatitis in Idaho.

HSHS works closely with local public health districts, community health centers, federally qualified health centers, and community-based organizations to ensure prevention and care services are available to target populations.

The primary HIV prevention services include HIV testing, counseling, and referral services for pre-exposure prophylaxis (PrEP) and linkage to HIV medical care; condom distribution; and HIV disease investigation services for newly infected people and their partners. HSHS also manages services for those infected with HIV, including medical case management, the AIDS Drug Assistance Program (ADAP), and support services to enhance access to and retention in HIV medical care and treatment.

STD prevention-related services through HSHS are mainly offered through partnerships with local public health districts. Services include STD testing and treatment; STD education and outreach; and STD disease investigation services for newly infected people and their partners.

HSHS is currently working on the implementation of the Hepatitis Care Cascade Project, which is aimed at increasing screening and detection of Hepatitis C in the baby boomer population and linking newly diagnosed patients to medical care.

HSHS monitors HIV and STD trends throughout the state and deploys resources to partners so targeted interventions can be implemented to combat the spread of disease. Data from 2017 indicates (see chart on next page) that the rate of chlamydia in Idaho continues to increase compared to previous years. The rates of both gonorrhea and syphilis in Idaho also continue to increase at unprecedented rates.

Rate of Sexually Transmitted Diseases			
CY	**Chlamydia**	**Gonorrhea**	**Syphilis**
2017	360.8	56.3	7.8
2016	351.5	37.7	7.5
2015	340.2	28.5	4.9
2014	333.1	27.1	2.8

Note: Rates per 100,000 of population. For HIV/AIDS data, please see Bloodborne Diseases on pages 117-118.

Women, Infants and Children (WIC) Section

WIC offers nutrition education, nutritional assessment, and vouchers for healthy foods to low-income families to promote optimal growth and development. The program is entirely federally funded. It provides an average of $51 per participant each month in grocery vouchers for prescribed healthy foods based on a nutrition assessment. The section also provides counseling in nutrition and breastfeeding to more than 64,000 participants annually. WIC services are delivered through the seven Idaho public health districts, Marimn Health, and Nimiipuu Health.

Clients Served Monthly and Average Monthly Voucher Value				
Year (SFY)	**2015**	**2016**	**2017**	**2018**
Clients served	40,951	39,473	37,209	34,422
Average voucher	$58	$52	$50	$51

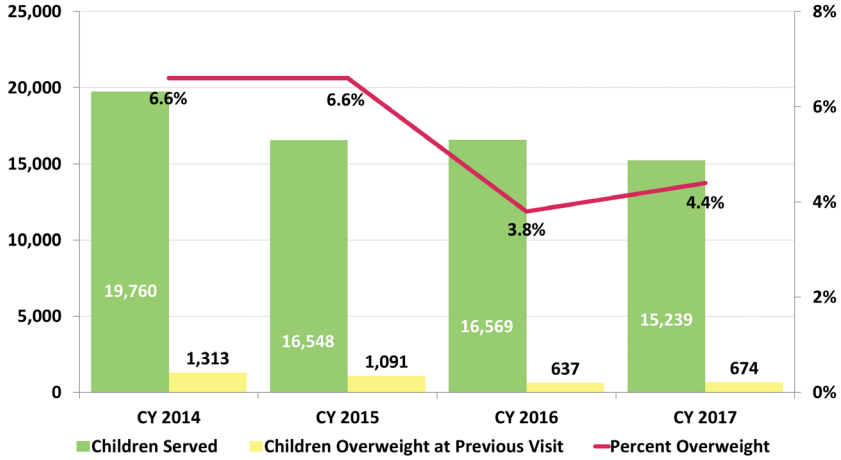
The vouchers WIC provides to parents and caretakers can be used to purchase specific foods based on a child's or pregnant woman's nutritional risks. WIC education focuses on encouraging families to eat meals together, make healthy food choices, eat more fruits and vegetables, limit juice intake, avoid sweetened beverages, increase physical activity and play, and limit sedentary screen time.

Participants typically receive nutrition education four times a year. In addition to clinical assessments related to nutritional status, children are weighed and measured at certain visits to obtain Body Mass Index (BMI).

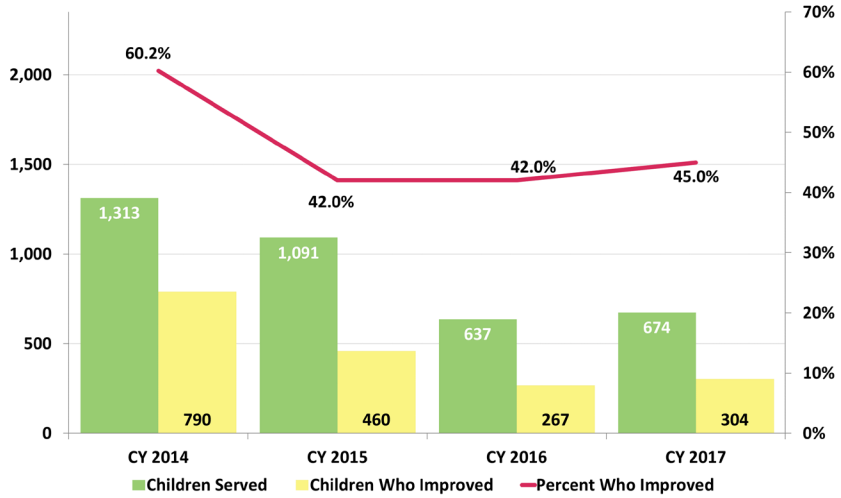
WIC provides early intervention through nutritional counseling to caretakers of nearly half of all infants (up to 12 months of age) born in Idaho. In 2017, the program served 15,239 children ages 2 to 5 years. Of those children, 674 were identified as overweight based on their BMI and having two valid measures for comparison. Through WIC nutritional counseling, 304 children (45%) improved their weight status by at least 1 percentile on the Centers for Disease Control and Prevention's BMI for Age Chart at their next WIC visit.

During 2015, the Idaho WIC section transitioned from having six-month certification periods for children participating in WIC to 12-month certification periods. Because of that change, the data collection period was extended to a 13-month time frame to allow for making a comparison of two valid BMI measurements. For more information, please visit www.WIC.dhw.idaho.gov.

Children Served and Those Overweight, Ages 2-5



Overweight Children (ages 2-5 years) with Improved Status



Maternal and Child Health (MCH) Section

Family Planning, Adolescent Pregnancy Prevention, Newborn Screening, Home Visiting and Children's Special Health Programs are part of the MCH Section.

The Family Planning Program administers funding to four local public health districts and two federally-qualified health centers to provide comprehensive family planning services for Idahoans at 43 clinic sites, including services at one juvenile detention center and one women's correctional facility.

During CY 2017, the Family Planning Program served 9,360 clients in 14,885 visits. Of those clients, 10.5% (988) were 15-17 years old and both male and female. Seventy-eight percent of participants had household incomes at or below 150% of the federal poverty level.

Idaho's teen pregnancy rate is 9.5 pregnancies per 1,000 females ages 15-17, well below the Healthy People 2020 goal of no more than 36 pregnancies per 1,000 females. It is also below the average national rate of 22 for the same group. Idaho's teen pregnancy rate is more than 50% lower than it was 10 years ago, when the rate was 22.9.

Idaho Teen Pregnancy Number and Rate (Ages 15-17 years)		
CY	**Number**	**Rate per 1,000 females**
2017	275	7.4
2016	346	9.5
2015	374	10.6
2014	369	10.7

Note: Idaho teen pregnancy numbers and rates are based on live births, induced abortions, and reportable stillbirths (only those fetal deaths with a gestational period of 20+ weeks or that weigh 350+ grams are required to be reportable by law). The U.S. teen pregnancy rate includes live births, induced abortions, and all fetal deaths. Because fetal deaths are an extremely small proportion of teen pregnancy outcomes for Idaho (less than 1%) and are a sizable proportion of teen pregnancy outcomes for the U.S. (estimated 18 percent), Idaho and U.S. rates are not comparable.

The Newborn Screening Program works with hospitals, birthing centers, and other healthcare providers to ensure that all babies born in Idaho are screened for 48 harmful or potentially fatal conditions, including phenylketonuria (PKU), cystic fibrosis, galactosemia, and congenital hypothyroidism. As of July 2018, all babies also must be screened for critical congenital heart disease (CCHD) using pulse oximetry.

Newborn screening provides an opportunity for diagnosis and treatment through early detection. Timely treatment allows for normal growth and development and a reduction in infant morbidity and mortality. Most infants with conditions identified through screening show no obvious signs of disease immediately after birth. It is only with time that conditions that could affect an infant's health and development become more obvious.

In Idaho, two newborn screens are conducted, one within 24 to 48 hours of birth and another when the infant is between 10 and 14 days old. For conditions detected using the blood spot, some conditions are detected on the first screen and others on the second screen. For each screen, a small amount of blood is collected from the baby's heel and placed on special filter paper. The filter paper is sent to a regional laboratory for testing. When a screening is positive the Newborn Screening Program coordinates with the laboratory and a baby's healthcare provider to ensure timely diagnosis and treatment. For CCHD screenings, providers ensure babies are linked with appropriate diagnostic services and follow-up care.

The Newborn Screening Program has been screening Idaho babies since 1963. New technology allows screening for many conditions from a small amount of blood. While each of the screened conditions is rare, collectively they affect about 1 in 1,000 infants. On average, there are 20 to 30 diagnosed conditions each year in Idaho. For more information, please visit www.NBS.dhw.idaho.gov.

Number of Diagnosed Conditions by Type and Calendar Year

Condition	2014	2015	2016	2017
Biotinidase Deficiency	0	0	1	1
Congenital Hypothyroidism	6	8	8	5
Cystic Fibrosis	5	8	6	4
Galactosemia	1	0	0	0
Maple Syrup Urine Disease	0	1	0	0
Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD)	2	2	4	5
Phenylketonuria	0	1	5	3
Other	5	7	2	4

Number of Babies Screened, Presumptive Positives, and Diagnosed Conditions by Year			
CY	**Babies Screened**	**Presumptive Positives**	**Diagnosed Conditions**
2017	21,604	1,359	22
2016	21,998	1,141	24
2015	22,276	1,063	27
2014	22,263	989	20
2013	21,769	1,067	19

Data are based on babies receiving first newborn screen.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program provides funding to the seven public health districts across the state to deliver evidence-based, voluntary home visiting services to expectant parents and families with young children. Participating families gain knowledge and skills to support their children's health and well-being, ensuring a great start to life. Using MIECHV funding, the local public health districts provide home visiting services to 12 Idaho counties using two evidence-based home visiting models: Parents as Teachers and Nurse Family Partnership.

The Parents as Teachers (PAT) home visiting model serves pregnant women and families with children from birth to 5 years old. Families may enroll at any point, from pregnancy until the child is 5. PAT parent educators offer 12 to 24 visits annually, depending on the needs of the family. The PAT curriculum offers services to families for at least two years between pregnancy and kindergarten. Program target outcomes include:

- Increase parent knowledge of early childhood development and improve parenting practices.
- Provide early detection of developmental delays, health issues.
- Prevent child abuse and neglect.
- Increase children's school readiness and school success.

The Nurse Family Partnership (NFP) home visiting model serves first-time, low-income pregnant mothers and their babies. An NFP home visitor must have at least a bachelor's degree in nursing and in most cases maintain registered nursing (RN) credentials. NFP clients receive their first nurse home visit prior to the 29th week of pregnancy, and visits continue happening weekly or bi-weekly until the child is 20 months and then monthly until the child is 2 years old. Program target outcomes include:

- Improve prenatal health and outcomes.
- Improve child health and development.
- Improve families' economic self-sufficiency and maternal life course development.

Families Served Through Home Visiting Services in Idaho		
FFY	**Number of Families Enrolled**	**Number of Home Visits**
2017	641	6,487
2016*	639	6,504
2015	310	2,433
2014	140	1,507
2013	n/a	n/a

** Received expansion funds*

Bureau of Communicable Disease Prevention

The Bureau of Communicable Disease Prevention encompasses programs that monitor disease trends and epidemics, prevent the spread of communicable diseases, assist newly arrived refugees as they receive health screenings, help safeguard Idaho's food supply, and prevent diseases through immunizations.

Epidemiology

Epidemiology staff track reportable disease trends that impact Idahoans, including whooping cough, salmonellosis, and tuberculosis. They offer consultation and direction to public health districts about the investigation and prevention of communicable and infectious diseases; develop interventions to control outbreaks and prevent future infections; and deliver tuberculosis consultation and treatment services.

Disease surveillance capacity in Idaho is increasing with advances in the use of electronic reporting systems. The use of electronic systems significantly reduces the time it takes to receive and respond to reports of disease and then intervene. Today, more than 97% of reports from laboratories are handled electronically. Idaho's version of the Idaho National Electronic Disease Surveillance System has become fully integrated and is used to monitor data for all reportable diseases. The program now can receive case reports for reportable diseases electronically from clinical electronic health record systems, increasing the ability to rapidly exchange information and respond to reports of disease to prevent further transmission.

Bloodborne Diseases

Bloodborne diseases such as HIV and hepatitis B and C are usually trans-

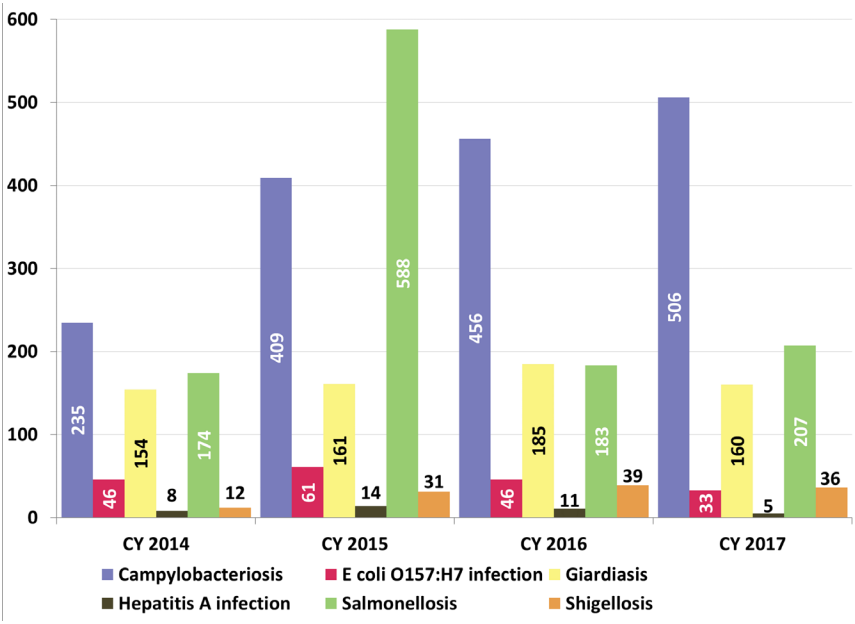
mitted through infected blood when people share contaminated needles, during blood transfusions, or in the exchange of bodily fluids during sexual contact.

Bloodborne Diseases by Calendar Year				
	2014	**2015**	**2016**	**2017**
Bloodborne diseases	43	60	64	71
New HIV/AIDS	21	43	47	53
Idaho residents living with HIV/AIDS	1,544	1,648	1,738	1,842
Acute Hepatitis B	11	12	7	6
Acute Hepatitis C	11	4	10	12

HIV/AIDS presumed living in Idaho is defined as all reports of HIV or AIDS in Idaho, regardless of residence at diagnosis and not reported as deceased.

Enteric Diseases (Diseases of the Intestine)

Enteric diseases affect the gastrointestinal system and are transmitted primarily through contaminated food and water, or hand-to-mouth because of inadequate handwashing after bathroom use.



Food Protection

The Food Protection Program protects the public from illnesses associated with the consumption of food. The program provides oversight, training, and guidance to environmental health specialists at local public health districts in Idaho. It is also responsible for laws regulating food safety.

Idaho's public health districts issue licenses and perform regulatory inspections of food establishments such as restaurants and delis; investigate complaints from the public; and educate food establishment owners and staff about food safety and how to prevent foodborne outbreaks. The Food Protection Program and environmental health specialists at the public health districts work closely with epidemiologists to investigate foodborne illnesses suspected to be associated with licensed food establishments and other sources, taking steps to reduce disease and prevent outbreaks.

Food Protection				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018***
Foodborne outbreaks	13	16	10	10
Licensed food establishments	5	4	4	2
Other sources/ venues	8	12	6	8
People Ill	348	81	77	29

** Data are provisional. Only confirmed and probable outbreaks and cases are counted.*

Refugee Health Screening Program

The Refugee Health Screening Program's primary responsibility is to ensure that refugees who resettle in Idaho receive a timely health screening and necessary follow-up care. The program works with providers and resettlement agencies in the state to ensure a timely and complete health assessment is performed, referrals are made for follow-up care when health conditions are identified, and education about the Idaho healthcare system is provided.

The program also engages partners such as the Idaho Division of Welfare and the Idaho Office for Refugees to ensure newly arrived refugees are provided the resources and assistance necessary to become integrated and contributing members of Idaho communities.

Immunization Program

The Idaho Immunization Program (IIP) strives to increase the rate of immunized children in Idaho as well as awareness of vaccine-preventable diseases. IIP provides educational resources to the public and healthcare providers. It also oversees the federally funded Vaccines For Children (VFC) program in Idaho that provides vaccines for children who meet at least one of these criteria: 1) Medicaid eligible; 2) uninsured; 3) underinsured; or 4) American Indian or Alaskan Native.

Using federal and state funds, IIP distributes vaccines to private and public healthcare providers for free for all Idaho children from birth through age 17. Healthcare providers can charge a fee for administering a state-supplied vaccine but they cannot charge for the vaccine itself. This ensures that all Idaho children have access to recommended vaccines, regardless of their ability to pay.

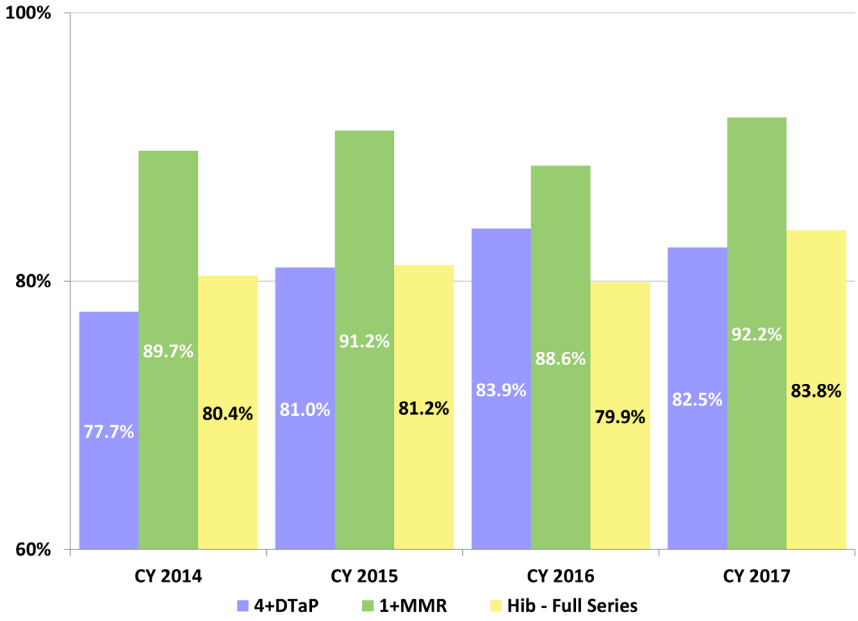
The IIP also conducts quality assurance site visits with providers who are enrolled in the VFC program. Site visits are important opportunities to provide information on vaccine efficacy as well as updates about state and national immunization trends, disease outbreaks, new vaccines, and recommendations by the national Advisory Committee on Immunization Practices (ACIP).

IIP works with schools and licensed childcare providers to increase the number of children who receive all ACIP-recommended immunizations. School and childcare outreach activities include educational opportunities and technical assistance for school nurses and facility staff. IIP staff provide training and assistance to increase the knowledge of school nurses and staff about the immunization schedule, school or childcare immunization rules, and protocols for vaccine-preventable disease outbreaks among children in the facility. For the 2017 to 2018 school year, 86.1 percent of children enrolled as kindergartners in Idaho schools were up to date on all immunizations as required in Idaho Administrative Rules.

Number of Childhood Vaccine Preventable Diseases by Calendar Year

	2014	2015	2016	2017
***Haemophilus influenzae* b (Hib,) invasive**	0	1	0	1
Measles	0	0	0	0
Mumps	26	8	1	5
Pertussis (whooping cough)	367	194	83	89
Rubella	0	0	0	0
Total	393	203	84	95

Immunization Rates for Select Childhood Vaccines



Immunization Reminder Information System (IRIS)

IRIS is a web-based immunization information system operating since 1999 that allows healthcare providers, schools, and childcare facilities to access vaccine records for people of all ages who live in Idaho.

IRIS was an "opt-in" registry until 2010, meaning people had to provide consent before their records could be stored in the system. Beginning in July 2010, Idaho's registry became "opt-out." This means the electronic birth certificates for all babies born in Idaho are entered into IRIS. The system remains a voluntary registry because parents and/or legal guardians can have their children's records removed at any time, if desired.

The IRIS database was migrated to a new code platform in 2012 and is now based on the open-source Wisconsin Immunization Registry (WIR). Versions of the nationally recognized WIR system are deployed in more than 20 states.

See chart on next page.

Idahoans Enrolled in Registry				
	SFY 2015	**SFY 2016**	**SFY 2017**	**SFY 2018**
Ages 0-35 months	79,096	79,599	78,442	74,245
Ages 3-5 years	85,949	84,967	85,872	84,729
Ages 6-18 years	392,079	407,195	420,740	412,239
Ages > 18 years	845,722	940,347	1,044,899	1,081,537
Total	1,402,846	1,512,108	1,629,953	1,652,750

Vaccine Distribution

The IIP provides vaccines for children eligible through the Vaccines for Children (VFC) Program, sponsored by the federal Centers for Disease Control and Prevention (CDC). The IIP also purchases additional vaccines for all other Idaho children. For each of the last three years, the program distributed more than 700,000 vaccine doses statewide to about 340 providers, including local public health districts, hospitals, clinics, and private physicians.

Vaccine Adverse Event Reporting System (VAERS)

In SFY 2018, Idaho submitted 3 reports to the Vaccine Adverse Events Reporting System. Reports contain possible adverse reactions to vaccines, as reported by physicians and public health districts.

This vaccine reporting system evaluates each report to monitor trends in adverse reactions for any given vaccine. Most adverse reactions are mild and vary from pain and swelling around the vaccination site to fever and muscle aches. Serious adverse reactions to vaccines rarely occur.

Number of Adverse Reactions and Rate per 10,000 Vaccinations			
SFY	**Adverse Reactions**	**Vaccines Administered**	**Rate/10,000**
2018	3	873,951	<0.1 (0.03)
2017	11	940,659	0.1
2016	15	1,075,786	0.1
2015	10	897,605	0.1

Healthcare-Associated Infections Prevention Program

Healthcare-associated infections (HAIs) are infections that develop during or soon after medical treatment for a separate medical condition. HAIs can result from patients' own bacteria; be associated with surgery or invasive medical devices; or be due to exposure to bacteria, viruses, fungi, or spores transmitted from contaminated healthcare workers' hands, environmental surfaces, or medical equipment. Bacteria found in healthcare settings are often resistant to commonly prescribed antibiotics, making HAIs more difficult to treat.

HAIs are the most common complication of hospital care. An estimated 722,000 infections and 75,000 deaths are attributable to HAIs every year in the United States. HAIs result in an estimated $30 billion annually in excess healthcare costs nationally.

Idaho's HAI Prevention Program is actively engaged in reducing HAIs by working with Idaho healthcare facilities to provide infection prevention education and training, performing site visits to hospitals with high infection rates, convening prevention collaboratives, and providing resources to track HAIs and prevent outbreaks.

Idaho Bureau of Laboratories

The role of the Idaho Bureau of Laboratories (IBL) is to provide laboratory services that support DHW programs, the public health districts, other state agencies, and Idaho residents. The bureau offers core services in four areas:

Testing

- Communicable disease agents: enteric, respiratory, vaccine-preventable, zoonotic, sexually transmitted, and emerging infectious diseases.
- Contaminants in drinking and environmental water, food, and soil samples: acute and chronic contaminants regulated by the Safe Drinking and Clean Water Acts.
- Biological and chemical threats: agents of biological or chemical terrorism.

Inspection

- Clinical and drinking water laboratories
- X-ray and mammography units
- Air quality monitoring stations

Training

- On-site, hands-on analytical, biosafety, dangerous-good shipping and compliance training
- Continuing education workshops, webinars and online courses

- Student internships for college credit

Outreach

- Coordination of the Idaho Sentinel Laboratory Network for the rapid detection and referral of possible biothreat agents
- Clinical laboratory biosafety and security risk assessment
- Participation in public safety drills, exercises, and events with Regional Response HazMat Teams and the 101st Civil Support Team
- Publication of applied public health research

Effective quality management is critical to ensure that the services provided by the laboratory meet regulatory requirements. The bureau is regulated by four different regulatory agencies or programs. As part of an accredited health department, IBL public health and safety surveillance work adheres to the standards of the Public Health Accreditation Board (PHAB).

IBL environmental health testing is regulated by the Environmental Protection Agency (EPA). The lab is an EPA-certified drinking water laboratory and serves as the Principal State Laboratory for the Idaho Department of Environmental Quality and the Alaska Division of Environmental Health (via an interstate partnership agreement). The laboratory bureau chief serves as the drinking water certification authority for Idaho, ensuring that commercial laboratories throughout the United States that test Idaho drinking water comply with both state and federal laboratory certification requirements.

IBL performs limited clinical diagnostic testing for the assessment of patient health and is certified as a high-complexity clinical laboratory by the Centers for Medicare and Medicaid Services (CMS). IBL houses the only full-service tuberculosis laboratory in Idaho, provides analytical support for the Division of Public Health's Refugee Health Screening program, and serves as a reference laboratory for the detection of antibiotic resistant bacteria and other esoteric or emerging pathogens.

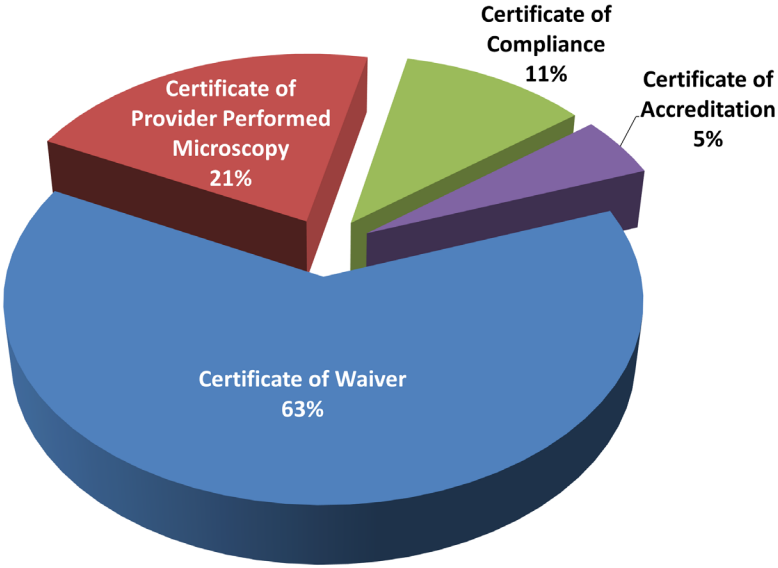
IBL is a registered entity through the Centers for Disease Control and Prevention Division of Select Agents and Toxins (DSAT). IBL must comply with all DSAT biosafety, biosecurity, and incident response regulations as the only Laboratory Response Network (LRN) reference laboratory for biological and chemical threat agents in Idaho.

The bureau operates the Idaho Radiation Control Program, which licenses all devices that produce x-rays in Idaho and inspects licensed facilities to ensure they are meeting state radiation safety and training requirements. In SFY 2018, there were 1,430 licensed facilities using x-ray devices across a variety of health care, academic, and industrial settings.

The bureau also registers all clinical laboratories performing patient testing

in Idaho. In SFY 2018, there were 1,394 registered clinical laboratories in Idaho. CMS certifies laboratories based on the complexity of testing offered. The certificate designation for each lab indicates the type of the testing they are qualified to do. For example, 62% of Idaho registered labs performed only simple waived testing and hold a Certificate of Waiver (COW). Many physicians' offices perform more complex microscopy testing and have a Provider Performed Microscopy (PPM) certificate. Larger moderate and high complexity laboratories receive either a Certificate of Compliance (COC) if they are inspected by the Idaho Clinical Laboratory Inspector or a Certificate of Accreditation (COA) if their labs are regulated under a CMS approved accreditation agency like the College of American Pathologists or The Joint Commission.

SFY 2018 Registered Clinical Laboratories by Certificate Type



The Clinical Lab Inspector surveys all Certificate of Compliance (COC) laboratories in Idaho every two years on behalf of the Centers for Medicare and Medicaid Services. The COW and PPM labs do not require surveys, and the COA labs are surveyed by the accreditation agency.

For more information about the Idaho Bureau of Laboratories please visit: www.statelab.idaho.gov.

Bureau of Community and Environmental Health

The Bureau of Community and Environmental Health promotes and protects the health of Idahoans by providing strategies to reduce risk behaviors and prevent injuries; programs to prevent and control chronic diseases; and policies and strategies to prevent and reduce exposure to contaminants.

The bureau is made up of the following programs:

- Tobacco Prevention and Control – Project Filter
- Breast and Cervical Cancer – Women's Health Check
- Comprehensive Cancer Control
- Physical Activity and Nutrition
- Fit and Fall Prevention
- Oral Health
- Diabetes Prevention and Control
- Heart Disease and Stroke Prevention
- Sexual Violence Prevention
- Drug Overdose Prevention
- Environmental Health Education and Assessment
- Toxicology

Tobacco Prevention and Control

The Tobacco Prevention and Control Program, referred to as "Project Filter" works to create a state free from tobacco-related death and disease. Project Filter addresses tobacco use and secondhand smoke exposure by promoting healthy behaviors. The program fosters statewide coordination for successful tobacco control with these program goals:

- Prevent initiation of tobacco use among youth.
- Promote tobacco cessation among users.
- Eliminate exposure to secondhand smoke.
- Identify and eliminate tobacco-related disparities.

Idaho is 11th best in the nation for its low percentage of adults who smoked in 2016, which was 14.5 percent. The national rate of adults who smoked was 17.1 percent.

Despite a continued focus on eliminating tobacco-related health disparities, the prevalence of tobacco use and subsequent health consequences continue to disproportionately impact specific populations. American Indians/Alaskan Natives, Hispanics and Latinos, members of the Lesbian, Gay, Bi-Sexual, Transgender (LGBT) community, those of low socio-economic status (Low SES), those living with mental illness, Medicaid participants, and veterans represent Idaho population groups that experience

tobacco-related health disparities. In 2016, smoking rates were highest in populations with low SES, at 33.8 percent, followed by those who reported 14 or more mentally unhealthy days at 30.5 percent, American Indian/ Alaskan Natives at 29.4 percent, LGBT at 22.7 percent, and veterans with 18.4 percent.

Project Filter targets programmatic efforts and funds toward the support and promotion of the Idaho QuitLine. The Idaho QuitLine provides barrier-free tobacco cessation benefits to all Idaho residents regardless of income or insurance status. These benefits include free telephonic counseling as well as free nicotine replacement therapy such as patches, gum, and lozenges.

Project Filter conducts state-wide, multi-media efforts to promote Idaho Quitline cessation services. Media efforts include TV and radio ads; digital media including banner ads for news outlets, YouTube, and pre-roll ads on video; Facebook, Twitter and Instagram; and event sponsorship and advertising.

Project Filter also performs outreach on the local level, partnering with each of the seven public health districts in Idaho to support efforts to eliminate tobacco use at the community level. These efforts include technical assistance in the development of tobacco-free policies, free signage to reflect these policies as well as promotion of cessation classes and the Idaho QuitLine at community events.

In an effort to consistently improve and measure its efforts, Project Filter has an evaluator on staff and manages several third-party evaluations and surveys throughout the year. These activities include a third-party evaluation of the services provided by the Idaho QuitLine, an evaluation of the effectiveness of its media efforts, as well as the Adult Tobacco Survey, which measures Idaho residents' attitudes regarding tobacco use and policies.

Physical Activity and Nutrition Program

The Idaho Physical Activity and Nutrition Program (IPAN) promotes a culture of health and vigor by encouraging and enabling all Idahoans to be physically active and make healthy food choices. IPAN promotes these ideals by enhancing education and awareness, supporting successful community programs and practices, and encouraging community designs and public policies that take residents' health into account.

According to The State of Obesity: Better Policies for a Healthier America 2016, Idaho now has the 36th highest obesity rate in the nation, at 27.4 percent. This is up from 18.4 percent in 2000 and 9.3 percent in 1990. Obesity is defined as having a Body Mass Index (BMI) of 30 or higher. In 2017, Idaho high school students had an obesity rate of 11.4 percent, also

ranking Idaho 36th nationally.

In 2016, 82.5% of Idaho adults reported not having consumed the recommended five servings of fruits and vegetables per day. In 2016, 20.2% of Idaho adults reported not participating in any physical activity over the past month. For Idaho youths, only 12.5% of high school students consumed vegetables three or more times during the past week. For activity, only slightly more than half (50.4%) of Idaho's high school students reported being active for at least 60 minutes on five or more days over the past week.

IPAN continues to work on combating the obesity epidemic through initiatives that support and facilitate physical activity and healthy eating. IPAN works in diverse settings across Idaho, such as child care centers, workplaces, farmer's markets, schools, and the design of communities to support Idahoans in making healthy choices in environments that promote good health.

Fit and Fall Proof™

The Idaho Physical Activity and Nutrition Program (IPAN) partners with local public health districts to implement a fall prevention exercise program for older adults called Fit and Fall Proof™(FFP). The program focuses on improving balance, strength, flexibility, and mobility to reduce the risk of falling, as well as increasing participants' emotional and social well-being.

Idaho's fall mortality rate is higher than the national rate. The three-year average fall mortality rate in Idaho for 2014-2016 (the most recent available data) was 12.3 per 100,000 (age adjusted) versus 8.9 per 100,000 for the U.S. during that same time period. Also, 87.4 percent of all unintentional deaths by falls were among people ages 65 and older. During 2016, there were 62 more unintentional fall deaths among Idahoans 65 years of age or older. This represents a 40.5 percent increase in deaths from 2015.

In 2017, Idaho Emergency Medical Services responded to 9,153 fall-related calls for individuals ages 65 and older; nearly 6 percent more calls than were reported in 2015. More than 51 percent of those who fell were ages 85 or older. Eighty percent of those who fell were transported to a hospital. Females in this age group were twice as likely to report a fall injury and have a higher death rate for falls than males. Estimated costs associated with fall-related calls in Idaho are as high as $35 million.

Participation in FFP classes continues to expand, and now more than 129 sites offer the class to Idaho seniors. From July 2017 to June 2018, there were nearly 9,300 visits to FFP classes. The program consistently has a high retention rate, with 81 percent of participants returning for subsequent class sessions. Many FFP participants (35 percent) are from communities with a population of less than 10,000 residents, demonstrating the impor-

tance of the program in Idaho's rural areas.

Classes are led by trained volunteer peer-leaders and are offered in churches, libraries, senior centers, community rec centers, and other places where seniors gather. Public health districts promote the program by making presentations to community groups and stakeholders to generate interest, recruit new volunteer leaders, and increase the number of participants. Connections with physicians and physical therapists also are being made in hospitals and clinics across the state to increase the number of providers who screen for fall risks, counsel on preventive measures patients can take, and refer to local FFP classes.

Studies have shown that FFP has a positive impact on maintaining balance, preventing falls, increasing energy, and improving social connectedness. Participants comment that "the people, the laughter, and the friendship [they] share" is a great benefit of the program. As Idaho's aging population continues to grow, the need for effective community-based programs that promote "aging in place" also will increase. The FFP program is currently working on gaining evidence-based status to further prove its validity in design and effectiveness in improving the health and longevity of Idaho's senior population.

Age-Specific Injury Death Rates Because of Accidental Falls 2014-2016 (per 100,000 population)			
	<65-84 years	**85+**	**Age-Adjusted Rate**
Idaho	36.4	397.8	12.3
United States	30.7	249.8	8.9

Number of Deaths Because of Accidental Falls			
CY	**<65**	**65+**	**Total**
2016	28	215	243
2015	26	153	179
2014	28	201	229
2013	27	167	194

Idaho Comprehensive Cancer Control Program

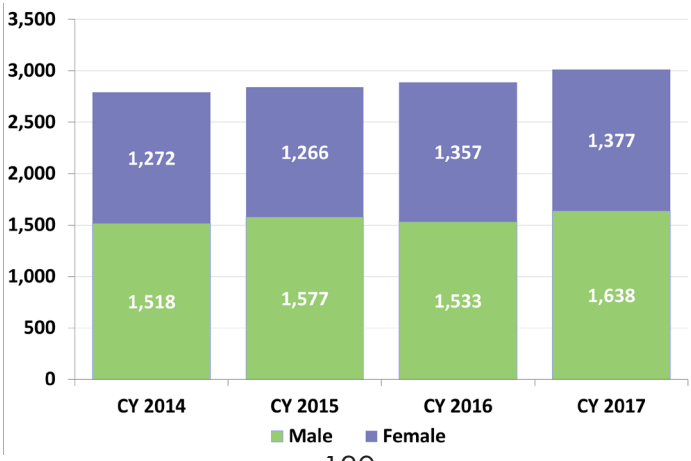
Cancer has been the leading cause of death in Idaho since 2008. An estimated 1 in 2 Idahoans will develop cancer during their lifetimes. Cancers that have good screening methods for early detection and that are highly treatable when detected early include colorectal, breast, and cervical cancers. Some of these can be prevented when abnormal cells are detected and removed before they become cancerous.

Idaho has some of the lowest screening rates in the United States for these cancers, but the Comprehensive Cancer Control Program is working to change that. The goal of the cancer program is to maintain and expand a coordinated, effective, comprehensive cancer control program that:

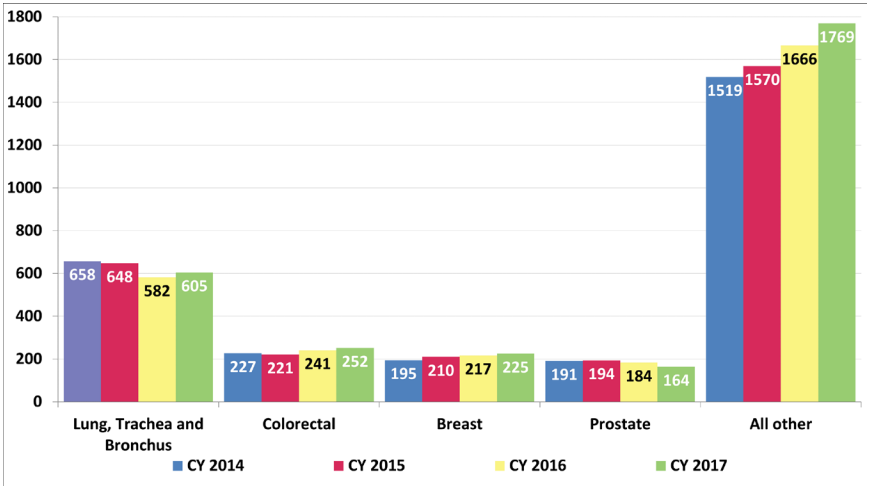
- Defines and raises awareness of the burden of cancer and related issues in Idaho.
- Develops new resources and networks with existing resources statewide.
- Implements evidence-based strategies to reduce the burden of cancer and improve the quality of life for people who have cancer or are in recovery.
- Increases awareness of preventive behaviors to decrease likelihood of Idahoans experiencing a cancer diagnosis according to current science and recommendations.
- Increases awareness of the importance of early detection and diagnosis, which leads to the improvement of cancer screening rates according to current science and recommendations.

In 2017, Idaho reported 3,015 cancer deaths, which was an increase from 2016, when 2,890 cancer deaths were reported. Cancer was the leading cause of death for females and the second leading cause of death for males in Idaho in 2017.

Idaho Cancer Deaths by Sex



Idaho Cancer Deaths by Primary Site of Malignancy



**Note: Colorectal cancer includes deaths caused by cancer of the colon and rectum; it does not include deaths caused by cancer of the anus. The numbers for breast cancer deaths include deaths for both men and women.*

Women's Health Check

Women's Health Check offers free breast and cervical cancer screening for low-income women. Historically, the program served women ages 30-64, but cervical cancer screening services are now available for women as young as 21years old. Qualifying participants must have incomes below 200% of the federal poverty level and must have no insurance coverage for breast and cervical cancer screenings.

The program is funded through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program, established in response to the Breast and Cervical Cancer Mortality Prevention Act of 1990.

In 2001, the Idaho Legislature passed Every Woman Matters law in response to the Breast and Cervical Cancer Prevention and Treatment Act of 2000. This law links women to Medicaid coverage for treatment of breast or cervical cancer if they are diagnosed through Women's Health Check. Women who are not enrolled in Women's Health Check but are diagnosed with breast or cervical cancer do not qualify for coverage under this law.

There are more than 400 individual providers and clinics across the state that provide screenings. After more than 20 years serving the women of Idaho, Women's Health Check has screened more than 35,000 women and funded almost 324,000 Pap tests, and almost 50,000 mammograms.

Diabetes Prevention and Control

The Idaho Diabetes Prevention and Control Program (DPCP), funded by the Centers for Disease Control and Prevention, aims to address the following longterm outcomes:

- Decrease proportion of people with diabetes with an A1C of less than 9.
- Increase number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss.

A statewide network of contractors, including local public health districts, health systems, evidence-based programs, and other partners works with the DPCP to:

- Increase access and coverage for diabetes self-management education and support programs for people with diabetes that are recognized by the American Diabetes Association and accredited by the American Association of Diabetes Educators.
- Increase use of pharmacist patient care processes that promote medication management for people with diabetes.
- Increase access to and coverage for the National Diabetes Prevention Program (DPP) lifestyle change program for people with prediabetes.
- Increase community clinical links that facilitate referrals and provide support to enroll and retain participants in the National Diabetes Prevention Program lifestyle change program.

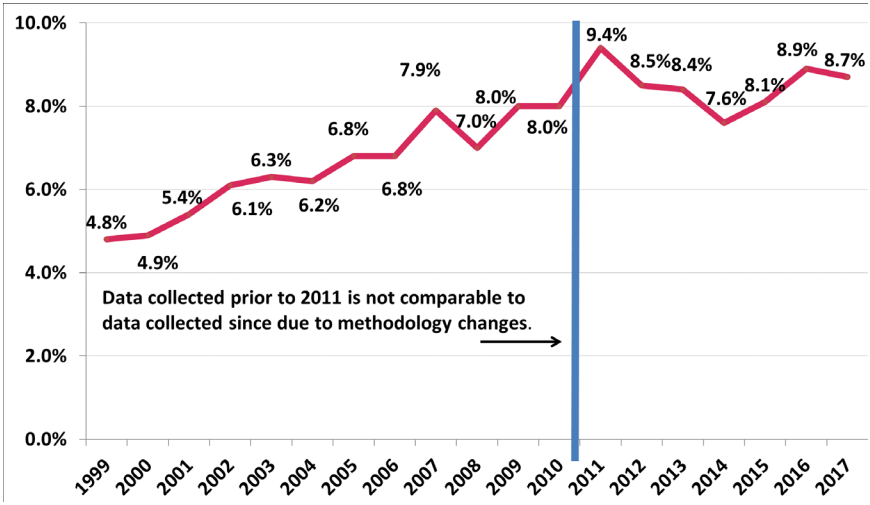
The Diabetes Prevention and Control Program provides community-level outreach to link people with several resources, including:

- The National Diabetes Prevention Program, an evidence-based lifestyle change program, can help participants with prediabetes lose 5% to 7% of their body weight and reduce their risk of developing type 2 diabetes by 58%.
- Diabetes self-management education and support programs, which are supported by a large body of evidence, are designed to improve health outcomes, lower medication use, decrease hospitalizations, and decrease other healthcare costs for people with diabetes.
- The Diabetes Alliance of Idaho (DAI) is an independent, volunteer organization made up of individuals and agencies dedicated to the prevention and reduction of the personal and public impact of diabetes in Idaho. The alliance includes representatives from the public, local health districts, universities, insurance, pharmaceutical companies, and a variety of community-based, voluntary, health, and professional organizations. Membership is open to individuals and organizations with an interest in diabetes prevention and management.

The prevalence of diabetes continues to increase nationally and in Idaho.

The increase is driven by the rate of people who are overweight and obese, the aging population, and the number of minorities who are at high risk for developing diabetes.

Percent of Idaho Adults Diagnosed with Diabetes



Oral Health

Oral health is a serious public health issue in Idaho. Oral disease contributes to the impact and cost of overall healthcare and can contribute to cardiovascular disease, stroke, pre-term birth, poorly controlled diabetes, and other systemic conditions. The Idaho Oral Health Program (IOHP), funded by the Maternal and Child Health Block Grant, Centers for Disease Control and Prevention, Health Resources & Services Administration, and the DentaQuest Foundation, works with oral health champions and partners across the state to perform the essential public health functions:

- Assess and track dental disease rates.
- Create, support, and evaluate evidence-based initiatives for community disease prevention.
- Develop state and regional oral health action plans to serve as roadmaps for improving oral health in Idaho.
- Facilitate active public/private partnerships to promote and support oral health.
- Reduce barriers to care and assure use of personal and population-based oral health services, especially in counties considered to be a Dental Health Professional Shortage Area.
- Conduct and review research for new insights and innovative solutions to oral health problems.
- Assess public perceptions about oral health issues and educate and empower the public to achieve and maintain optimal oral health.

- Support the statewide Idaho Oral Health Alliance.
- Promote and educate on the benefits of population-based services including school dental sealant clinics, fluoride varnish programs, community water fluoridation, and oral health education for at risk populations.

In addition to performing the essential public health functions, the IOHP provides funding to the local public health districts in the form of sub-grants. Activities conducted by the local public health districts include fluoride varnish clinics at: WIC, Head Start, and Early Head Start programs; and school-based dental sealant clinics in schools with more than 50% participation in the Free and Reduced Lunch Program. All the programs delivered by the public health districts include the provision of oral health screenings and/or assessments, oral health education, and dental home referral when necessary.

Key oral health findings for Idaho include the following:

- More than two-thirds (67.2%) of Idaho third-grade students had dental sealants on at least one tooth recommended for sealants. The Healthy People 2020 goal for children aged 6 to 9 years is a rate of 28.1% or better on one or more of their permanent first molar teeth.
- Nearly two-thirds of Idaho third graders (65.6%) had primary or permanent teeth with decay or filled caries or missing permanent teeth because of tooth decay. The Healthy People 2020 goal for children aged 6 to 9 years is a rate of 49% or less.
- In 2016, 57% of children enrolled in Medicaid had a dental visit.
- Of Idaho adults 18 years and older, 37% did not have a dental visit in 2016.

Heart Disease and Stroke Prevention

The Idaho Heart Disease and Stroke Prevention Program (HDSP), funded by the Centers for Disease Control and Prevention, works to increase control among adults with known high blood pressure and high blood cholesterol.

A statewide network of contractors, including local public health districts, health systems, evidence-based programs, and other partners, including health associations, works with the HDSP to:

- Increase reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol.
- Increase use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol.
- Increase community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol.

Bureau of Vital Records and Health Statistics

The Bureau of Vital Records and Health Statistics is responsible for the registration, documentation, correction, and amendment of vital events that include birth, death, marriage, paternity actions, adoption, and divorce. The bureau provides bio-statistical research and analysis of health trends that can be used to develop and shape future health interventions and programs.

The bureau issues vital record certificates and produces numerous statistical reports and publications. Information for obtaining an Idaho certificate is available at www.vitalrecords.dhw.idaho.gov . For statistical reports and publications, visit www.healthstatistics.dhw.idaho.gov .

Births, Deaths, Marriages and Divorces				
CY	**Births**	**Deaths**	**Marriages**	**Divorces**
2017	22,159	14,007	13,691	6,674
2016	22,462	13,370	13,595	6,786
2015	22,832	13,031	13,500	6,817
2014	22,888	12,610	13,699	6,943

Bureau of Rural Health and Primary Care

The Bureau of Rural Health and Primary Care administers programs to improve access to healthcare in rural and underserved areas of Idaho. To accomplish this, the bureau collects data that identifies health professional shortages, provides technical assistance, administers grants, and promotes partnerships to improve healthcare in rural areas.

Health professional shortage areas (HPSAs) are federal designations that indicate healthcare provider shortages in primary care, dental health, and mental health. The Health Resources and Services Administration scores HPSAs on a scale of 0-25 for primary care and mental health, and 0-26 for dental health. Higher scores indicate greater need. HPSAs are commonly used as a qualifier for state and federal resources such as clinician loan repayment opportunities. The bureau creates and manages HPSAs in Idaho.

Idaho Geographic Area with Health Professional Shortage Designation				
	CY 2014	CY 2015	CY 2016	CY 2017
Primary Care	96.4%	97.7%	97.7%	97.7%
Dental Care	97.0%	95.7%	95.7%	95.7%
Mental Health	100%	100%	100%	100%

Rural Health Care Access Program Grants for Primary Care and Dental Health Shortage Areas				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Grant Requests	$516,265	$419,727	$391,931	$317,025
Amount Awarded	$184,200	$180,200	$179,450	$179,350
Applicants	17	14	14	10
Awarded	8	7	9	7

Rural Physician Incentive Program

The Rural Physician Incentive Program (RPIP) is a medical education loan repayment program for qualifying physicians serving in federally-designated Health Professional Shortage Areas. Program funds are generated by fees assessed to medical students participating in state-supported programs at the University of Washington and University of Utah and state general funds.

The program began in July 2015. Physicians may receive up to $100,000 over four years ($25,000 per year) for medical education debt. In SFY 2018, 19 applications were received and eight new physician applicants were awarded RPIP grants. In total, 23 Idaho physicians received medical education loan repayment through this program in SFY 2018.

State Loan Repayment Program

The State Loan Repayment Program (SLRP) provides loan repayment for clinicians serving designated Health Professional Shortage Areas. SLRP began in September 2014 and is the first multi-discipline, state-based loan repayment program for clinicians and physicians. The loan repayment is provided through a federal grant; every award must be matched dollar-for-dollar with funds provided by the clinician's employer. Participating sites must implement a sliding-fee scale for low-income and uninsured patients. Loan repayment awards range from $10,000-$25,000 per year,

depending on the discipline and matching contributions. Thirty-seven clinicians and physicians are currently receiving loan repayment through this program.

For more information regarding the Bureau of Rural Health and Primary Care, please visit: www.ruralhealth.dhw.idaho.gov .

Bureau of Emergency Medical Services and Preparedness

The Bureau of Emergency Medical Services and Preparedness supports the statewide system of responding to critical illness and injury situations. Services include:

- Licensing Emergency Medical Services (EMS) personnel and services.
- Operation of the statewide EMS Communications Center (StateComms).
- Providing technical assistance and resources to EMS agencies.
- Supporting a statewide Time Sensitive Emergency system of care for trauma, stroke, and heart attack.
- Planning and coordination of the public health response to acts of bioterrorism, infectious disease outbreaks, and other public health threats and emergencies.

Emergency Medical Services Program

The bureau licenses EMS agencies based on the agencies' capabilities and deployment plans. Once licensed, EMS agencies must renew their licenses every year. The renewal process includes a site visit from the bureau to ensure compliance with licensure requirements. Annual site visits also provide the bureau an opportunity to provide technical assistance and guidance.

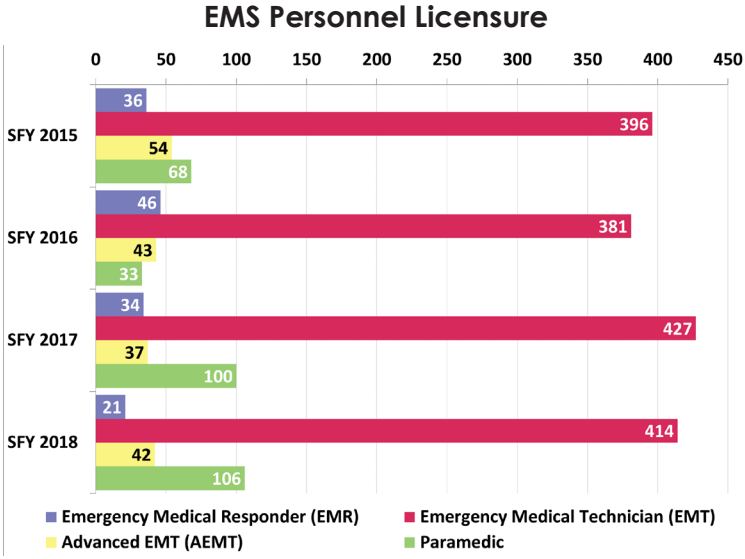
The bureau licenses EMS personnel when minimum standards of proficiency are met. All personnel licensed in Idaho must be trained in courses that meet or exceed the national EMS education standards.

To renew an EMS personnel license, a provider must meet continuing education requirements and provide documentation of demonstrated skill proficiency. Licenses are renewed every two or three years (depending on the level of license) in either March or September.

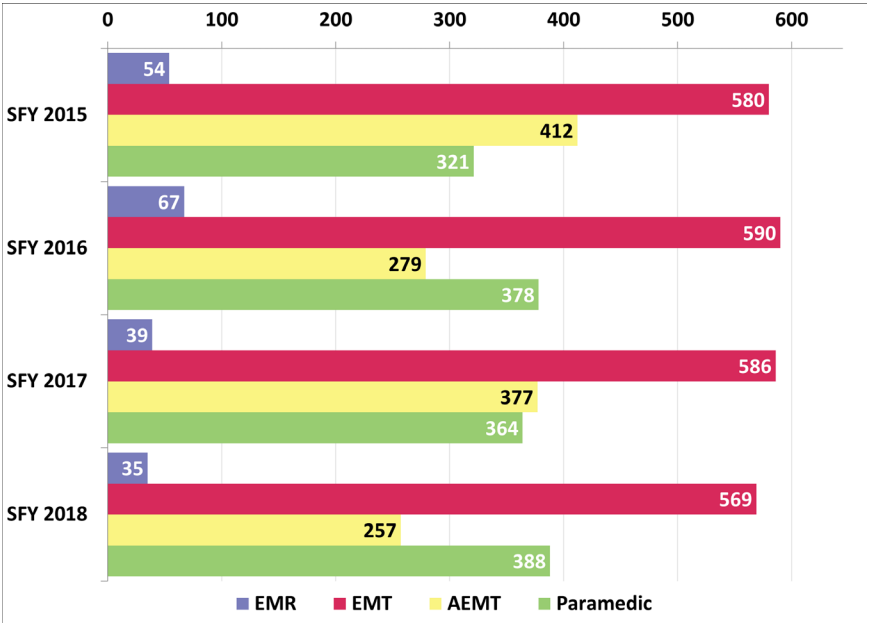
The bureau approves instructors to teach EMS courses, evaluates EMS courses, administers certification examinations, processes applications for initial licensure and license renewals. In addition, the bureau conducts investigations into allegations of misconduct by licensed EMS personnel, licensed EMS agencies, and EMS educators.

Personnel are licensed at one of four levels:

1. **Emergency Medical Responder (EMR):** The primary focus of the EMR is to initiate immediate lifesaving care to critical patients who access the emergency medical system. The EMR is trained and licensed to provide simple, non-invasive interventions to reduce the morbidity and mortality associated with acute out-of-hospital medical and traumatic emergencies.
2. **Emergency Medical Technician (EMT):** The EMT provides basic emergency medical care and transportation for critical and emergency patients. The EMT is licensed to provide basic non-invasive interventions focused on the management and transportation of out-of-hospital patients with acute medical and traumatic emergencies. A major difference between the EMR and the EMT is the knowledge and skills necessary to transport emergency patients.
3. **Advanced EMT (AEMT):** The AEMT provides basic and limited advanced emergency medical care for patients. The AEMT is licensed to provide basic and limited advanced interventions that are effective and can be performed safely in an out-of-hospital setting. The major difference between the AEMT and the EMT is the ability to perform limited advanced interventions for emergency patients.
4. **Paramedic:** The paramedic's primary focus is to provide advanced emergency medical care for critical patients. The paramedic is licensed to provide basic and advanced care, including invasive and pharmacological interventions. The major difference between paramedicd and AEMTd is the ability to perform a broader range of advanced skills and use of controlled substances.



EMS Personnel Licensure Renewal



EMS Dedicated Grants

The EMS Dedicated Grant program has operated since 2001 and provides funds for EMS vehicles and equipment for use by emergency medical personnel in the performance of their duties which include highway safety and emergency response to motor vehicle accidents. Funds are collected from the purchase of Idaho driver's licenses and renewal fees.

Transport ambulances, and vehicles for non-transport quick response, search and rescue, and extrication have been funded through this program. Patient-care equipment includes items to provide airway management, cardiac monitoring and defibrillation, communications, extrication, patient assessment, lifting and moving of patients, rescue, safety, spinal immobilization, fracture management, and monitoring vital signs. For more information on Idaho EMS, please visit www.IdahoEMS.org.

See chart on next page.

EMS Dedicated Grants				
	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Grant Requests	$3 M	$2.8 M	$2.9M	$3.1 M
Grants Awarded	$1.3 M	$1.4 M	$1.4M	$1.4 M
Vehicle Requests	25	23	17	19
Patient Care Equipment			113	119
Agencies Applying	48	49	64	72
Agencies Awarded	43	49	59	63

Public Health Preparedness Program

The bureau's Preparedness Program is responsible for increasing health system capacities to respond to acts of bioterrorism, infectious disease outbreaks, and other public health threats and emergencies. It coordinates local, regional and statewide planning to:

- Support infectious disease surveillance and investigation.
- Improve Idaho's surge capacity to adequately care for large numbers of patients during a public health emergency.
- Expand public health laboratory and communication capacities.
- Develop pandemic response capabilities.
- Provide for the distribution of medications, vaccines, and personal protective equipment.

The program works with many stakeholders to develop effective plans, mutual aid agreements, training, and exercises to provide coordinated and comprehensive all-hazards approaches to emergency health preparedness, response, and recovery measures.

Time Sensitive Emergencies Program

The 2014 Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) System of Care that includes three of the top five causes of deaths in Idaho: trauma, stroke, and heart attack. Studies show organized systems of care improve patient outcomes, reduce the frequency of preventable deaths, and improve the quality of life for patients.

A TSE system of evidence-based care addresses public education and prevention, 911 access, response coordination, pre-hospital response, transport, hospital emergency/acute care, rehabilitation, and quality improvement. The statewide TSE program will create a seamless transition between each level of care and integrate existing community resources to improve patient outcomes and reduce costs. It will get the patient to

the right place in the right time with the right care.

The bureau's TSE Program provides leadership, administrative support and technical assistance to the statewide TSE system. The program designates healthcare facilities as trauma, stroke, and/or heart attack TSE centers based on the facility's capabilities. There are five levels of trauma designation, three levels of stroke designation, and two levels of heart attack designation. Learn more about Idaho's TSE system here: http://www.tse.idaho.gov.

Idaho State EMS Communications Center

The Idaho State EMS Communications Center (StateComm) is a unique public health communications resource and dispatch center available 24/7/365 for many emergency response agencies throughout Idaho. Services that StateComm provides include but are not limited to:

- EMS dispatch in 16 rural communities.
- Public health threat notification to district and state public health departments.
- Coordinating medical control from EMS unit to hospital.
- Hazardous material response coordination.
- Critical Incident Stress Management coordination.
- Idaho Transportation Department dispatch (road closures, highway incidents, Dynamic Message Sign activation, Condition Acquisition
- Reporting System (CARS), 511 data entry.
- Aircraft tracking and flight following.
- Notifications of weather situations that could pose a threat.
- Emergency Medical Dispatch: Providing pre-arrival medical instructions to callers before EMS arrives.
- Organ donor coordination.
- Primary activation point for the Emergency Alert System (civil emergencies and AMBER Alerts).
- Primary notification point for the National Alert Warning System (NAWAS).
- Notification point for Idaho National Laboratories emergencies.
- Notification point for rail incidents.
- Notification point for logging emergencies.
- Coordination of search and rescue efforts.
- Point of contact for prehospital deaths; to notify the organ procurement centers

Learn more about StateComm here: https://healthandwelfare.idaho.gov/Medical/EmergencyMedicalServicesHome/StateCommunications/tabid/1605/Default.aspx

Bureau of Public Health Business Operations

Public Health Business Operations functions as a collaborating body to connect the business of public health across all bureaus and programs in the division through policy development, performance management, business process alignment, and infrastructure building. Business Operations leads the divisions efforts in public health accreditation, strategic planning, and workforce development. The bureau also houses the Public Health Institutional Review Board. The bureau includes five staff with expertise in cross-cutting areas of health data analytics, performance management, communication, legislative affairs, and federal grant compliance.

- **Health Data Analytics:** The Division of Public Health collects, manages, and maintains large amounts of population health data. The Health Data Analytics program manager works to improve data sharing and use across the division and with partners, including the public.
- **Performance Management:** Key elements of public health accreditation are performance management and continuous quality improvement. The division has a Performance Management and Quality Improvement plan that guides staff in their efforts to consistently apply the Plan-Do-Study-Act process as they assess their programs and work to achieve their targeted goals. The Performance Improvement Manager provides staff training and technical assistance to build the quality improvement skills of our workforce.
- **Communication:** The division recognizes the importance of communicating clearly and often with internal and external stakeholders. The Community Resources Coordinator serves as a focal point in the division, crafting and distributing communications to the division. This position also serves as legislative support for the division, managing how legislation is tracked and monitored, and ensuring division leadership is informed about legislative activity that could potentially impact public health programs.
- **Federal Grant Compliance:** Over 50% of the division's funding comes from federal public health agencies. Most of these funds are then distributed to partners across the state to implement public health programs in local communities. Ensuring these funds are spent appropriately and in alignment with the grant's intent is the role of the Federal Compliance Officer. This work is vast and requires constant communication and collaboration with division programs, the department's internal control, financial services, and contracts and procurement staff.

Suicide Prevention Program

Idaho and other mountain west states historically have some of the highest suicide rates in the nation. A total of 1,733 Idahoans completed suicide from 2013 to 2017. In 2016, the latest year for comparable state data, Idaho had the eighth highest suicide rate, after Alaska, Montana, Wyoming, New Mexico, Colorado, Nevada and Oklahoma. In 2017, Idaho's rate of 22.9 suicide deaths per 100,000 was 65% higher than the 2016 national rate of 13.9 per 100,000.

In 2017, 393 Idahoans completed suicide, which was a 10% increase from 350 suicides in 2016. Among Idaho's 10- to 34-year-olds, suicide was the second leading cause of death in 2017, with 103 suicide deaths in this age group.

From the 2017 Idaho Youth Risk Behavior Survey of high school students grades 9 - 12, a total of 20% reported seriously considering suicide, and 10% reported making at least one suicide attempt. Between 2013 and 2017, a total of 131 Idaho youth ages 19 and younger completed suicide.

Number of Completed Suicides by Age					
	10-14	**15-19**	**20-64**	**65+**	**Total**
CY 2013*	3	21	227	57	308
CY 2014	9	16	248	47	320
CY 2015	7	18	283	54	362
CY 2016	3	23	254	70	350
CY 2017	3	28	299	63	393

Rate of Completed Suicides by Age (per 100,000 population)					
	10-14	**15-19**	**20-64**	**65+**	**Total**
CY 2013*	2.5	18.5	24.7	25.5	19.1
CY 2014	7.3	13.9	26.8	20.1	19.6
CY 2015	5.7	15.4	30.3	22.2	21.9
CY 2016	2.4	19.4	26.8	27.5	20.8
CY 2017	2.3	23	31.1	23.8	22.9

**CY 2013: 10-14 includes one death younger than 10 years of age.*

Division of Welfare

Julie Hammon, Administrator, (208) 332-7258

The Division of Welfare/Self Reliance promotes stable, healthy families by helping Idahoans meet their basic needs and gain financial and health stability.

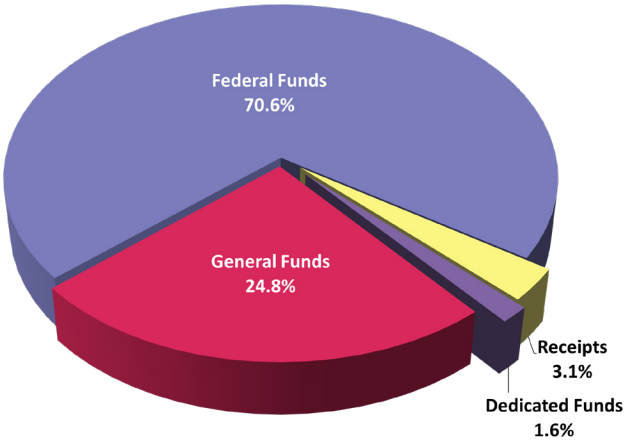
Programs administered by the division include:

- Child Support Services.
- Supplemental Nutrition Assistance Program (SNAP, or Food Stamps).
- Child Care.
- Temporary Assistance for Families in Idaho (TAFI-cash assistance).
- Aid to the Aged, Blind, and Disabled (AABD-cash assistance).
- Medicaid eligibility.
- Advanced Premium of Tax Credit to purchase private insurance.

These programs, also called Self Reliance programs, provide critical support options for low-income families and individuals while encouraging participants to improve their financial situations and become more self-reliant.

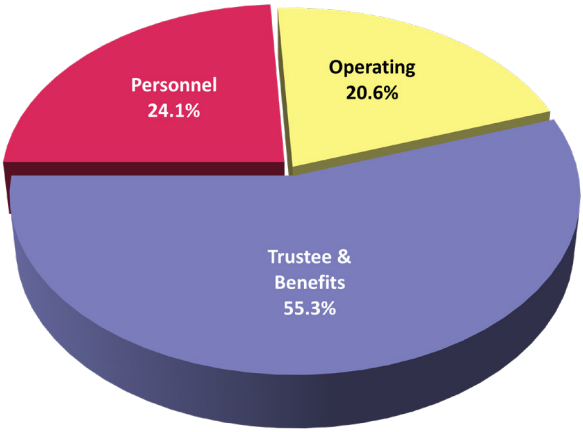
Self Reliance focuses on helping Idaho families live better through nutrition education, work and training programs, access to quality child care and early learning programs, and support services that help them be successful in the workforce. The division also administers additional programs through contracts with local partner organizations that provide food and assistance for home energy costs and home weatherization.

SFY 2019 Funding Sources

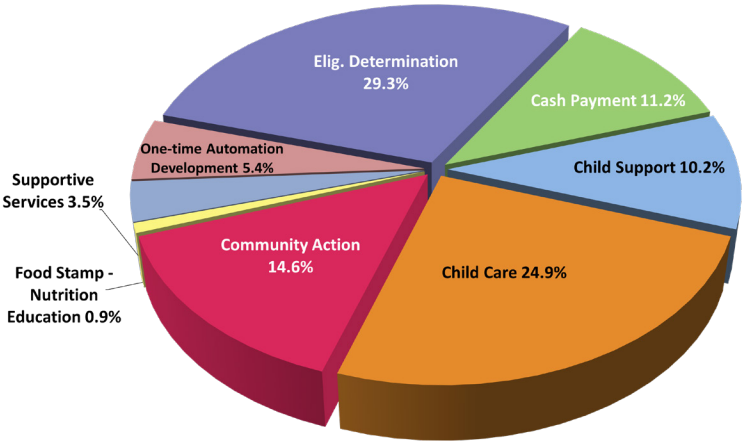


Authorized FTP: 619.5 Original Appropriation for SFY 2019 General Funds $43.5 million, Total Funds $175 million; 5.7% of Health and Welfare funding.

SFY 2019 Expenditure Categories



SFY 2019 Appropriation by Program



2018 Year in Review

Self Reliance programs and services
The Self Reliance programs are intended to help low-income families in Idaho gain stability and financial independence by providing critical support services. The combination of key supports such as health coverage, food and nutrition assistance, child care, child support and job search assistance helps families obtain employment or remain in the workforce as they balance their ability to pay a mortgage and utilities, and provide for their children. Helping Idaho's low-income families find and keep employment, especially during challenging times, enables them to enhance earning potential and gain stability until they no longer need the support of public assistance.

During SFY 2018, many households continued to need support during periods of unemployment or low wages to help supplement their family income for food, healthcare, and child care needs. Overall, growth in program participation is leveling as the economy has stabilized. Application and re-certification activities continue to be the division's focus as staff ensure eligibility determinations are accurate, and service delivery systems are effective.

The division currently serves about 164,000 families, who receive services from benefit programs in the following groups:

Families with children	Disabled adults	Seniors over 65	Non-disabled adults under 65
57%	21%	15%	7%

Approximately one in four participant families have at least one elderly or disabled member living in the household. About 325,000 individuals receive services through a benefit program in Idaho sometime throughout the year, with approximately 61% participating in one program and 39% participating in two or more programs.

The Division of Welfare also administers Idaho's Child Support Program. The primary focus is to ensure that children have support they need from both their parents. About 48% of families with a current child support case also participate in a benefit program.

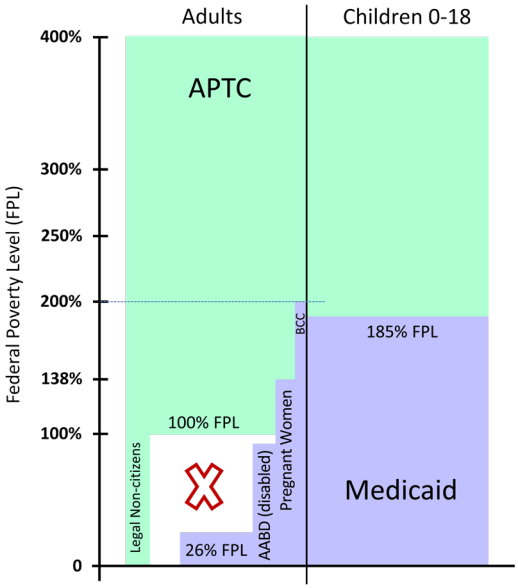
Health Coverage for Idaho Families
A major focus over the past several years has been to ensure that Idaho families have access to health insurance, either through Medicaid services when they are eligible or through eligibility for a tax credit to help pay for private insurance purchased on the state-based exchange. The division determines eligibility for all Medicaid programs and calculates

the Advanced Payment of Tax Credits (APTC) which is to be used in the purchase of a private health plan.

In 2018, DHW determined tax credit eligibility for approximately 96,000 Idahoans. Individuals eligible for the tax credit can use it to help pay for private health insurance purchased on Idaho's health insurance exchange, Your Health Idaho. The tax credit helped make health coverage affordable for many Idaho families.

Partnerships with Idaho's health insurance exchange, Idaho insurance companies, hospitals, and other stakeholders have ensured the pathway to healthcare coverage in Idaho is effective. Although the state still has a large gap in health coverage for adults who fall below 100% of the Federal Poverty Limit (FPL), Idaho has improved access to health coverage for many and has made these changes effectively, with one of the best and lowest cost systems in the nation.

Health Coverage Assistance



Generally Medicaid covers:
- Children 0% to 185% FPL
- Parents to 0% to 26% FPL

Generally APTC covers:
- Children 185% to 400% FPL
- Adults 100% to 400%

Other group coverage:
- Legal non-citizens get APTC from 0% to 100% FPL (working citizens do not)
- Aged/disabled get Medicaid from 0% to ~80 FPL
- Pregnant women get Medicaid from 0% to 138%
- Breast and cervical cancer diagnoses 0% to 200% FPL

No Medicaid/APTC coverage:
- Non-disabled adult US citizens from 0% to 100% FPL unless they are parents

Performance

The Division of Welfare met or exceeded federal standards for accuracy in all its self-reliance programs. Federal partners, other states, and national organizations continue to recognize program performance for exceptional innovation, service delivery redesign, and use of technology.

Idaho is a top-performing state for timeliness of services, accuracy in eligibility decision-making, and low administrative costs. This transformation

has been possible because of the strong commitment from Idaho leadership, supportive community partnerships, and skilled state employees who operate these programs.

Self-Reliance Services

The Division of Welfare provides services in three categories:

1. Benefit Program services include:

- Food assistance (Supplemental Nutrition Assistance Program (SNAP), or Food Stamps).
- Child care assistance (Idaho Child Care Program).
- Eligibility determination for Health Coverage Assistance (HCA), including Medicaid and the Advanced Payment of Tax Credits (APTC), which provides help for families to pay for private insurance purchased on the state health insurance marketplace.
- Cash assistance in the form of Temporary Assistance for Families in
- Idaho (TAFI) and Aid to the Aged, Blind, and Disabled (AABD) programs.

Applications are available in field offices around the state, as well as online, by phone, and through the mail. These services have strict eligibility requirements as identified in state and federal rules. Benefit program services are delivered to those receiving food stamps, TAFI, or AABD through the Electronic Benefit Transfer (EBT) system.

2. Child Support services include:

- Locating an absent parent, conducting paternity testing, and creating a new and/or enforcing an existing child support order, or modifying a support order.
- Providing medical support enforcement to ensure children are covered by health insurance.
- Helping other states enforce orders and collect child support for parents living in Idaho, which accounts for about one-fifth of Idaho's child support cases.

The Child Support Program uses secure electronic transfer of collected funds to distribute child support funds to families.

3. Partnership Program services include:

- Community Service Block Grants, which help eliminate the causes of poverty and enable families and individuals to become self-reliant.
- Nutrition-related services and food commodities.
- Low-income home energy assistance.
- Weatherization assistance to help low-income households conserve energy and save money.

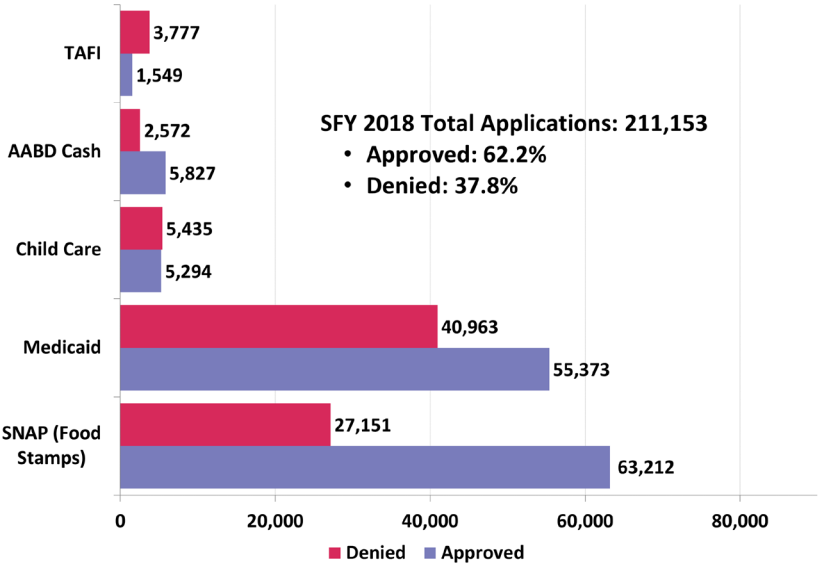
Partnership programs are supported by pass-through funds the division directs to local non-profit and community-based service providers. The division recognizes that local needs are often best met by local organizations. At the same time, local organizations throughout the state can benefit from a single entity overseeing administrative and fiscal management, rather than duplicating this function in each locale. Partnerships such as the Community Action Partnership Association of Idaho are essential in meeting needs of residents throughout the state.

Program Participation

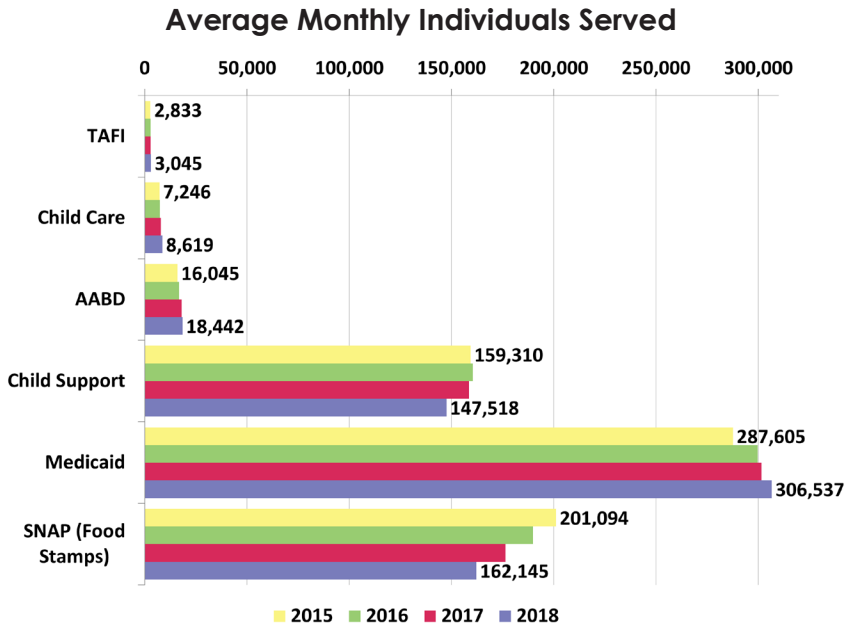
Participation in benefit programs, the Child Support Program, and partnership programs is measured by the average monthly caseload or individuals served each month, but these numbers do not give a complete picture of the number of people served during the year. The numbers also do not give an accurate picture of the workload for the Self Reliance staff.

Processing applications for citizens seeking services is labor intensive. Welfare/Self Reliance staff process all applications for services, but not all applications are approved. People who are denied services are not reflected in program participation and caseload counts, even though significant time and effort may have been expended in the application process.

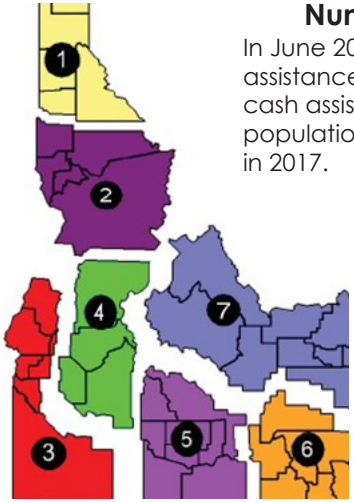
SFY 2018 Applications Approved and Denied



Benefit programs are designed to be work supports for low-income Idaho families. The division has designed benefit programs to encourage families to find and keep employment, and move on to higher wages and self-sufficiency. The SNAP (Food Stamps) and TAFI Programs have work participation requirements to help individuals find employment. The Idaho Child Care Program requires eligible families to have a qualifying activity, such as working, attending school or participating in training. As low-income families find success in the workplace, long-term outcomes for families and children improve.



Note: Many participants receive services from more than one program, so adding columns together will not produce the number of individuals receiving services; it includes duplicates. Child support data is a case count and does not reflect the number of individuals served. In 2018, 247,836 individuals were served in the Child Support Program. All programs are reported by State Fiscal Year except the Child Support Program, which reports by Federal Fiscal Year.



Numbers Served by Region

In June 2018, a total of 325,393 people received assistance in Medicaid, food stamps, child care, and cash assistance. This is 19 percent of the state's total population. More than 351,000 Idahoans were served in 2017.

Region 3, which includes Canyon County, has the greatest percentage of population receiving assistance services, while Region 4 has the lowest. Four of the seven regions have more than 20 percent of their populations receiving one of the four main assistance services.

Region	Estimated Population	Receiving Cash Payments	Child Care Assistance	SNAP (Food Stamps)	Medicaid	Totals
1	234,845 13.7%	3,276 1.4%	1,109 0.5%	20,776 8.8%	36,472 15.5%	42,995 18.3%
2	108,520 6.3%	1,573 1.4%	279 0.3%	7,864 7.2%	13,631 12.6%	16,012 14.8%
3	283,189 16.5%	4,638 1.6%	1,935 0.7%	35,111 12.4%	59,833 21.1%	70,022 24.7%
4	501,649 29.2%	5,431 1.1%	2,347 0.5%	35,042 7.0%	59,399 11.8%	70,457 14.0%
5	196,712 11.5%	2,255 1.1%	1,028 0.5%	18,517 9.4%	37,087 18.9%	42,815 21.8%
6	169,849 9.9%	2,548 1.5%	915 0.5%	17,946 10.6%	30,873 18.2%	36,217 21.3%
7	222,179 12.9%	1,958 0.9%	1,248 0.6%	20,238 9.1%	40,431 18.2%	46,875 21.1%
Totals	1,716,943 100.0%	21,679 1.3%	8,861 0.5%	155,494 9.1%	277,726 16.2%	325,393 19.0%

Note: Estimated population percentage (in column 2) represents regional share of the state's total population. Percentages under each program are the percentage of each region's population participating in that program. Many participants receive services through more than one program. The total (in the last column) is an unduplicated count of these four self-reliance programs.

Use of benefit programs remained flat in all parts of the state during SFY 2018. Region 3, where 70,022 individuals participated in a Self Reliance benefit program, had the highest service usages and led the state in enrollment in all four of the benefit programs. Idaho's most populous area, Region 4, which contains more than one-quarter of the state's population, had the lowest use of benefit programs, with 14 percent of residents receiving benefits.

Benefit Program Services

The Division of Welfare manages assistance and support services in five major programs:

1. Supplemental Nutrition Assistance Program (SNAP, or food stamps)
2. Child care
3. Medicaid eligibility
4. Eligibility for Advanced Payment of Tax Credits (APTC)
5. Cash assistance (through Temporary Assistance for Families in Idaho, and Aid to the Aged, Blind, and Disabled)

Supplemental Nutrition Assistance Program (Food Stamps)

Overview: The Supplemental Nutrition Assistance Program (SNAP), also known as the Food Stamp Program, helps low-income families maintain good health and nutrition. SNAP benefits are federally funded, but the state shares the cost of administering the program with the federal government. Benefits are provided through an Electronic Benefits Transfer (EBT) card, which works like a debit card.

To qualify for SNAP, a family must meet the following eligibility requirements:

- Be an Idaho resident who is either a U.S. citizen or meets specific criteria for lawful residency.
- Provide proof of identity.
- Meet income eligibility limits of 130% or less of the Federal Poverty Limit for family size.
- Have assets of less than $5,000.
- Meet stricter eligibility requirements if applicant is a student, legal immigrant, or convicted felon.
- Participate in a work search program, unless exempt.

All eligibility requirements are verified through electronic interfaces or documentation provided by the family. Once approved for SNAP benefits, a family must participate in a semi-annual or annual re-evaluation of their household circumstances. In the re-evaluation process, all elements of eligibility are reverified using these same methods.

SNAP recipients, unless exempt, must either be employed 30 hours per

week or participate in job-search activities to help them find or improve employment opportunities to continue receiving benefits. The primary focus of the work program is to help SNAP recipients get a job, keep a job, or find a better job. Failure to participate in this program results in the individual losing his or her SNAP benefits.

SNAP Benefit Amount: The amount depends on a variety of circumstances, such as the number of people in the household, income, and other factors. Generally, larger household sizes or lower incomes result in higher benefit amounts. In June 2018, the average SNAP allotment per person in Idaho was $105, or about $1.17 per meal.

What is available for purchase with SNAP?
Households may use SNAP benefits to purchase food to eat, such as:

- Breads and cereals.
- Fruits and vegetables.
- Meats, fish, and poultry.
- Dairy products.
- Seeds and plants that produce food for the household to eat.

Households may not use SNAP benefits to purchase alcoholic beverages, tobacco, or any nonfood items such as:

- Soaps or paper products.
- Pet foods.
- Household supplies.
- Vitamins and medicines.

SNAP benefits also may not be used for:

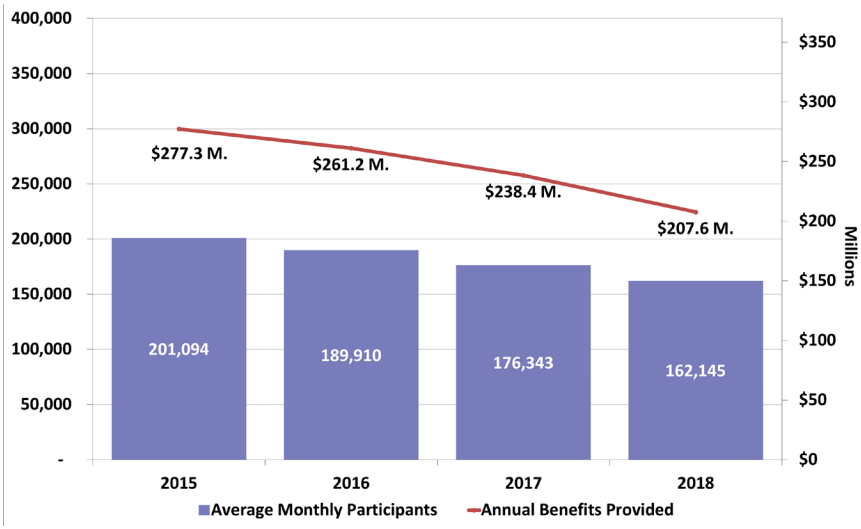
- Food that will be eaten in the store.
- Hot foods.

Caseload Growth:
SNAP enrollment is responsive to economic conditions, expanding during recessions and contracting during improved economic times. Idaho experienced SNAP expansion, realizing unprecedented participation growth beginning in 2007 and continuing through 2011. Over the past seven years, the state continues to see a slow, steady decline in the number of people who receive SNAP benefits as the economy improves and more jobs become available.

During SFY 2018, Idaho's SNAP caseload decreased, showing a reduction in the number of individuals receiving SNAP benefits from 168,500 in June 2017 to 155,500 in June 2018.

See chart on next page.

SNAP: Average Individuals Served Monthly and Total Annual Benefits Provided



Program Performance
Idaho's SNAP program continues to perform at a high level, without increases in staffing or administrative overhead costs. Over the past six years, Idaho has consistently remained one of the top states in the country for providing accurate benefits in a timely manner.

One of the goals of the Self Reliance program is to help families receive services as quickly as possible. In 2018, three out of four families eligible for food stamps received benefits the same day they applied. On average, eligible Idaho families receive benefits within two days of applying.

Idaho Child Care Program

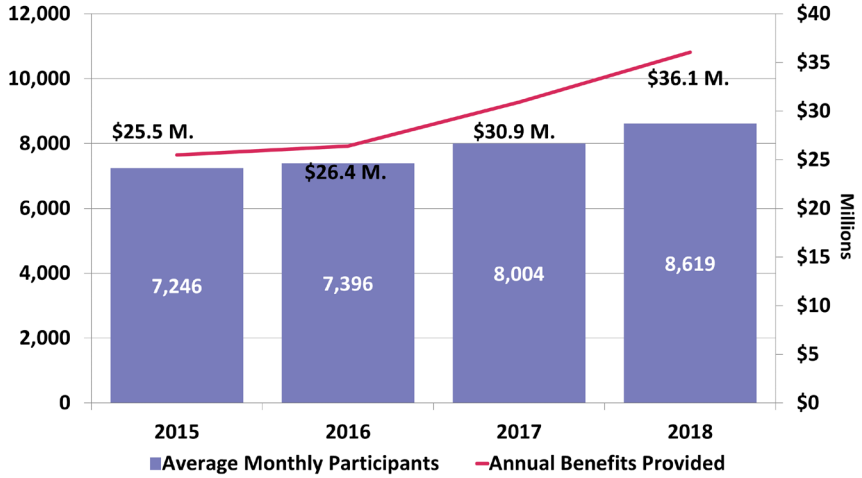
The Idaho Child Care Program (ICCP) provides critical work supports in the form of child care subsidies to low-income families, to assist with child care expenses so parents can maintain employment or complete their higher education. Child care assistance also plays a critical role in the development of the child by focusing on ensuring children have access to high quality child care.

Because of the high costs of child care, many parents earning near minimum wage could not afford to work and pay for child care without ICCP assistance. On average, ICCP provided services for approximately 8,619 children per month during SFY 2018, with total annual payments of $36 million.

To qualify for child care assistance, a family must meet the following eligibility requirements:

- Children must be under the age of 13.
- Parents must be working or attending school or training.
- They must be a U.S. citizen or meet specific criteria for lawful residence.
- Meet income eligibility limits of 130% or less of the Federal Poverty Limit for family size.

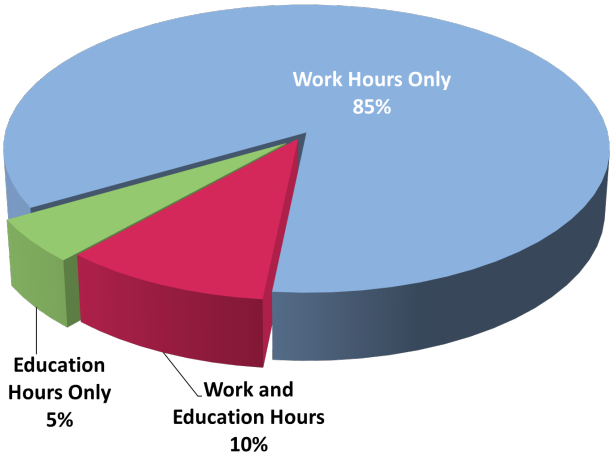
ICCP Average Monthly Children Served and Total Annual Benefits Provided



Eighty-five percent of parents are working. About 10% are attending school and working, while about 5% are only attending school. The ICCP supports these parents on their path to self-sufficiency.

The Idaho Child Care Program also helps families find child care providers in their area through the department's referral system. Last year, 1,308 child care referrals were provided for Idaho families. The Idaho Child Care Program also invests in the quality of care to support children's healthy development and learning by supporting child care licensing, quality improvement systems to help programs meet higher standards, and support for child care workers to receive more training and education.

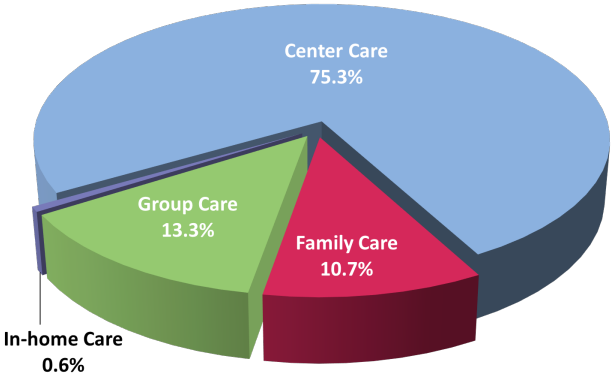
Qualified Activity Types



A provider is eligible to receive ICCP payments if they meet health and safety standards, which include annual CPR/first-aid certification, cleared background checks for all adults who have direct contact with children, and a health and safety inspection every year. Providers also must have ongoing health and safety trainings and professional development. Families may choose from the ICCP qualified providers to find the type of child care that best meets their needs.

The next chart is a breakdown of the type of child care parents receiving ICCP chose for their children in SFY 2018.

Types of Child Care Providers



In SFY 2018, the ICCP program provided resources, training, education, scholarships, and incentives to child care providers who sought to improve the quality of their child care programs. IdahoSTARS conducted 7,099 training sessions and provided 2,510 training scholarships and 41 academic scholarships statewide, at an annual cost of $260,386 in SFY 2018. IdahoSTARS also supported providers with $512,803 in program improvement grants and incentives.

Medicaid Eligibility

The Division of Welfare determines financial and personal eligibility for Medicaid services. To receive health coverage from Idaho Medicaid, a person must meet certain eligibility requirements.

An individual must fit one of the following categories:

- Be a child under the age of 19.
- Be a pregnant woman.
- Be an adult with a child under the age of 19.
- Have participated in the Idaho Foster Care Program at age 18 and is currently younger than age 27.
- Be age 65 or older.
- Be blind or disabled based on Social Security Administration criteria.

If one of the categories above is met, the person must then meet the following eligibility criteria:

- Be a citizen or legal immigrant.
- Be a resident of the state of Idaho.
- Household income must be less than the program income limits for the household size.
- Resources must not exceed the program resource limits. (There is no resource limit for people eligible for the Modified Adjusted Gross Income (MAGI) Medicaid program.)

To receive services, all the above eligibility requirements must be verified with documentation from the family or through federal or state computer interfaces:

- For all new applications.
- For the annual eligibility re-evaluation.
- Whenever a household or income change is reported.

The MAGI Medicaid program is designed to provide Medicaid benefit programs for children, pregnant women, and parents or caretaker relatives of dependent children. This program only considers the MAGI in the eligibility calculation, and does not include any resources.

Income limits are different for the different Medicaid categories. For example, a family of four (two adults and two children) would be eligible to receive Medicaid services for their children if their income is less than

$3,975 per month. The parents in this family would be eligible for Medicaid coverage if their income was below $439 per month. Income limits are different for individuals with disabilities and for pregnant women. Single adults with no children and no disabilities are not eligible for Medicaid coverage. A table showing eligibility income limits for Idaho Medicaid can be found at: www.benefitprograms.dhw.idaho.gov.

The average monthly Medicaid enrollment increased by 2 percent during SFY 2018. As of June 2018, nearly 278,000 people were receiving Medicaid services in Idaho. The Division of Welfare receives approximately 8,000 Medicaid applications per month. On average, an eligibility decision on a Medicaid application is made in four days. Participants must have their eligibility for Medicaid coverage reviewed every 12 months. The re-evaluation period takes place each fall to coincide with the open enrollment period for the Affordable Care Act. In SFY 2018, the department reviewed about 96,000 applications for health coverage assistance, including Medicaid and the Advanced Premium Tax Credit (APTC).

The Department of Health and Welfare partners with Your Health Idaho (YHI), the state insurance marketplace, to integrate the eligibility function in determining the Advanced Payment of Tax Credit (APTC). The APTC helps families with income between 100%-400% of the Federal Poverty Limit pay a portion of the cost of health insurance that can be purchased through the state-based exchange. These families are not eligible for Medicaid coverage. DHW processes all financial applications for YHI and determines the amount of tax credit a family is eligible to receive, and then re-determines that tax credit on an annual basis.

DHW allocates the costs for completing the eligibility function to YHI to ensure no state general funds or resources are used to pay for these services.

Cash Assistance

1. Temporary Assistance for Families in Idaho (TAFI)
The TAFI Program provides temporary cash assistance and work preparation services for families with children under the age of 18. The program serves an average of nearly 2,000 households and about 3,000 individuals.

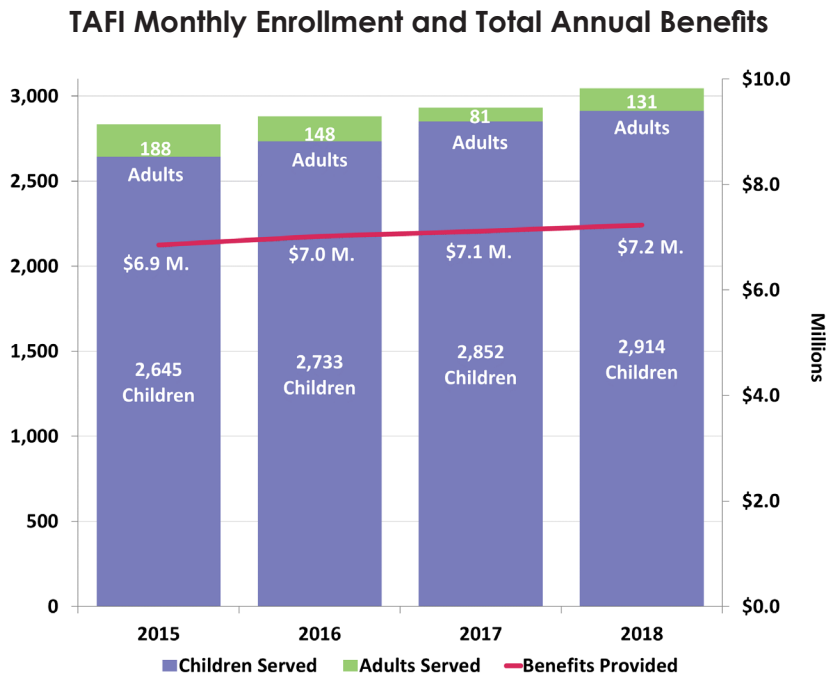
Approximately 94% of households in the program are child-only cases. The remaining 6% are single- or two-parent households. Child-only cases are usually relatives caring for a child whose parents cannot care for them.

Idaho TAFI beneficiaries receive a maximum of $309 per month, regardless of family size. These funds help pay for food, shelter, clothing, and other essentials. Idaho has a lifetime limit of 24 months of TAFI cash assistance for adults. To qualify for TAFI cash assistance, a family must meet the following eligibility requirements:

- Be an Idaho resident who is either a U.S. citizen or meets criteria for

lawful residency.
- Provide proof of identity.
- Meet income eligibility limits for family size.
- Meet personal asset limits.
- Cooperate with Child Support enforcement.
- Participate in drug and alcohol abuse screening, and comply with a treatment plan if determined to be in need of treatment.
- Participate in the Enhanced Work Services program and meet strict participation requirements.

Idaho's TAFI cash assistance program requires participation in work and education preparation activities that build or enhance the skills needed to increase participants' income so they become self-sufficient. They are required to participate 20 – 40 hours per week (depending on family composition) in approved activities, including, but not limited to: searching for a job, education directly related to employment, work experience opportunities, and treatment for substance use disorders. Failure to meet these required activities results in closure of the TAFI assistance and an additional penalty period during which the family is not eligible to receive TAFI cash. Child-only cases are not subject to work participation requirements.



2. Aid to the Aged, Blind, and Disabled (AABD)
AABD provides cash assistance to certain low-income people who also receive medical assistance because they are blind, disabled, or age 65 or older. AABD cash assistance is intended to supplement the person's income to help them meet the needs of everyday living.

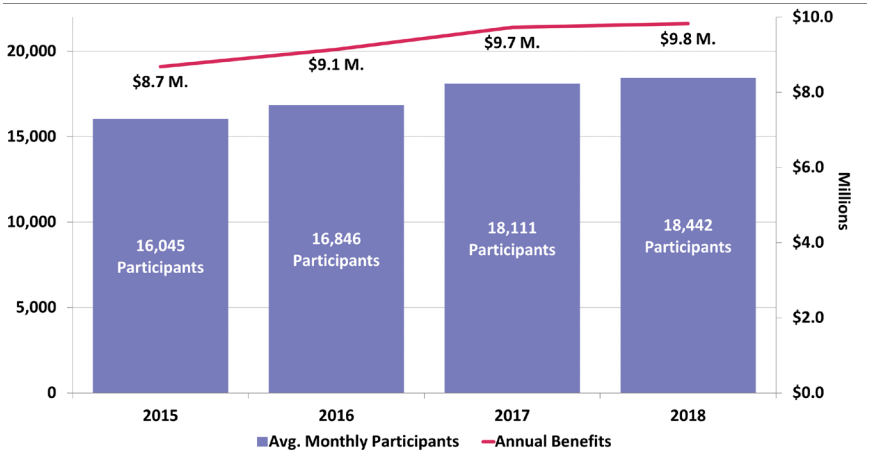
The state of Idaho currently meets the Maintenance of Effort (MOE) requirements established by the Social Security Administration to administer a State Supplemental Cash Program. The current MOE provides a monthly average cash benefit amount of $53 per enrollee. AABD cash payments are paid with 100% state general funds and can range anywhere from $18 per person to $198 per person, depending on the living arrangement of the person receiving the payment.

Individuals are eligible to receive AABD cash assistance if they meet the following requirements:

- The income limit for an individual receiving AABD cash assistance is $803 per month, or $1,145 per couple per month.
- Personal assets must not exceed $2,000 per person per month, or $3,000 per couple per month.
- An individual must be aged or disabled to qualify for the cash payment, and must receive Social Security Income or Social Security Disability Income.
- The living arrangement of the person will determine the amount of cash assistance he or she receives. People who live in a certified family home are not eligible for AABD cash benefits.

On average, 18,442 people received AABD cash payments each month during SFY 2018.

AABD Average Monthly Enrollment and Total Annual Benefits



Child Support Services

The Division of Welfare manages Idaho's Child Support Program. The program offers two types of services:

1. Receipting-only service, which records payments in the child support automated system and distributes the payment according to the court order.
2. Enforcement service, which establishes and enforces orders to ensure both parents are financially and medically responsible for their children.

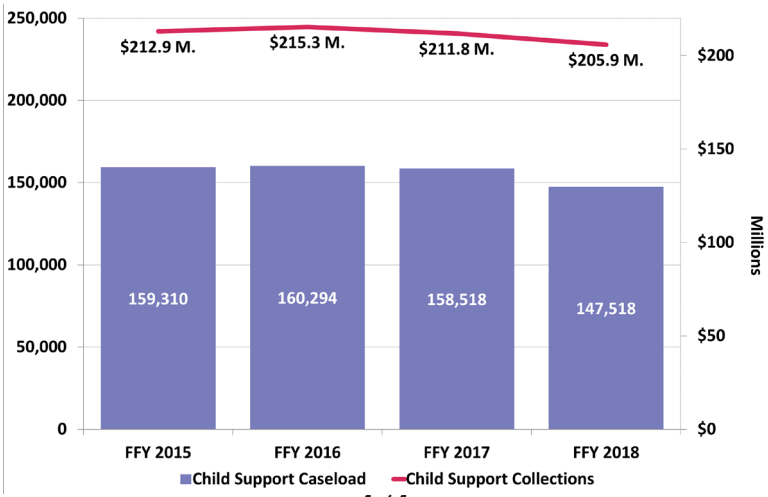
All child support orders that require payments to be made through the State Disbursement Unit qualify for receipting-only services at no cost. Any parent or guardian may apply for enforcement services for a $25 application fee. Enforcement services are required if a custodial parent is receiving cash assistance, food stamps, Medicaid, or child care; services are provided to the benefit recipient at no charge.

Enforcement services include:

- Paternity testing and paternity establishment to identify fathers.
- Locating non-custodial parents to pursue enforcement actions.
- Establishing and/or modifying court orders.
- Collecting and distributing child support payments.

In FFY 2018, the Child Support Program administered 147,518 child support cases. This includes 45,098 Receipting Services Only cases. The program collected and distributed more than $205.8 million. About 86% (or $176 million) of that is for enforced cases, and the remaining 14% (or $29 million) is from Receipting Services Only cases.

Monthly Average Caseload and Total Dollars Collected



About 48% of families with a child support case participated in a benefit program. DHW's goal is to ensure that children have access to the support needed to help them thrive and succeed. Child support can often be the stabilizing factor in ensuring children eat healthy, have access to healthcare, and have positive educational opportunities. DHW strives to support families in making this possible by obtaining and enforcing support orders and getting payments to custodial parents quickly for the care of the child. Idaho serves about 248,000 individuals through the Child Support Program every year.

Child Support Program Participation for FFY 2018

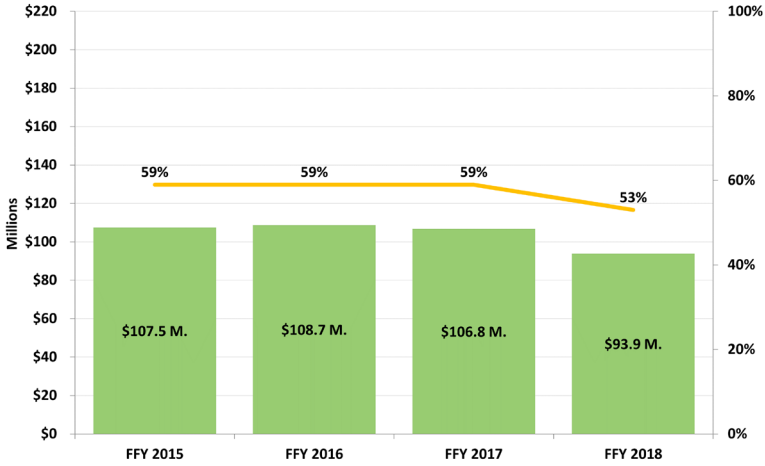
Parents and children	248,000 individuals*
Non-custodial parents	79,900
Custodial parents	78,700
Children receiving services	100,000

*Individuals may receive services from more than one case, making rows not additive to the total unduplicated count of individuals.

Child Support Enforcement Methods

The Idaho Child Support Program uses a variety of methods to enforce child support orders. Just half (50%) of Idaho child support cases owe past-due support. The primary tool for enforcing payments is wage withholding, where wages are automatically deducted from the payee's employment check. This requires coordination with employers across the state of Idaho. Other tools include new-hire reporting through electronic data matching, Social Security and Unemployment benefit income withholding, federal and state tax offsets, and direct collection methods, including financial institution data matching.

Child Support Collected Through Wage Withholding



The Idaho Child Support Program collects $6.13 for every dollar it spends. Idaho ranks 14th nationally for cost effectiveness in child support collections.

Wage Withholding: Wage withholding is one tool the state uses to collect child support payments. A wage withholding request is sent to the noncustodial parent's employer to collect and disburse current and arrears support on behalf of the noncustodial parent. Wage withholding collections account for 53 percent of all the state's child support collections, as shown in the chart above.

Intergovernmental

Idaho provides intergovernmental services to parents living in Idaho when the other parent lives in another state, a U.S. territory, on tribal land, or a foreign country. Idaho has reciprocity with all states in the U.S. and its territories. In FFY 2018, Idaho had 21,746 interstate cases, where one parent lived in another state. Idaho has 69 international cases, where one parent lives in another country with reciprocity in Idaho:

Australia	10	Canada	38	Sweden	1
England	5	Germany	11	Poland	1
Netherlands	1	Norway	1	Slovakia	1

In 2015, Idaho passed the Uniform Interstate Family Support Act of 2008, which refined existing practices for the establishment and enforcement of support orders with foreign countries who are party to an international treaty or who have entered reciprocating agreements. This important legislation will ensure privacy, consistency, and efficiency in establishing and enforcing support orders for people living in other states as well as in certain foreign countries.

Child Support Service Fees

The Child Support Program provides services for parents who need help in making sure both parents meet their responsibilities for the health and welfare of their children. The following fees are charged for specific services in child support cases:

- Child Support Service application fee: $25
- Income tax refund-attachment-state: $25
- Income tax refund-attachment-federal: $25
- Annual noncustodial parent collection fee: $25

Partnership Programs

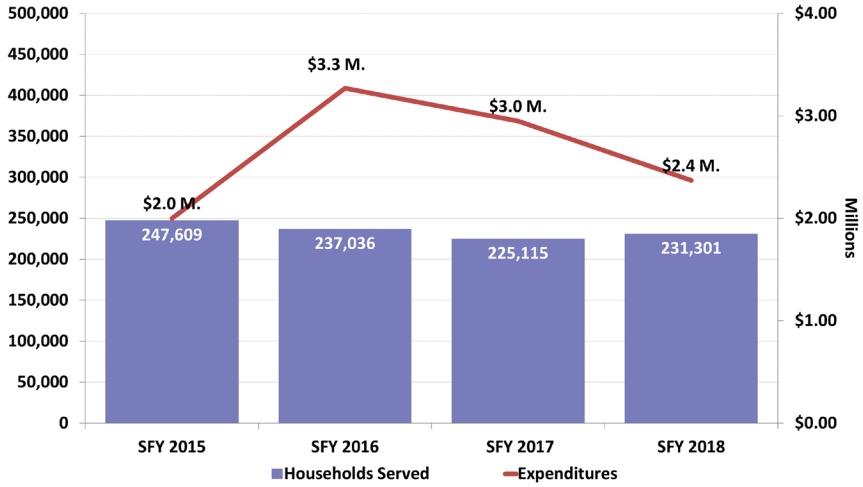
Partnership programs include a variety of services delivered across the state by local organizations, both public and private. Partner organizations providing these services on the division's behalf operate under contracts with DHW. Partner programs provide participants with emergency support, transportation, employment, home utility expenses, home weatherization, and food/nutrition services.

Much of the funding for these services comes from federal grants. The services provide additional work supports for low-income families and often meet their needs so they do not have to access DHW programs. Partnership programs also can bridge the gap for individuals and households transitioning from other DHW programs and services to full self-reliance.

Members of the Community Action Partnership Association of Idaho are the division's primary partners in providing these programs. Action Agency members help eligible community members in their regions through the following programs:

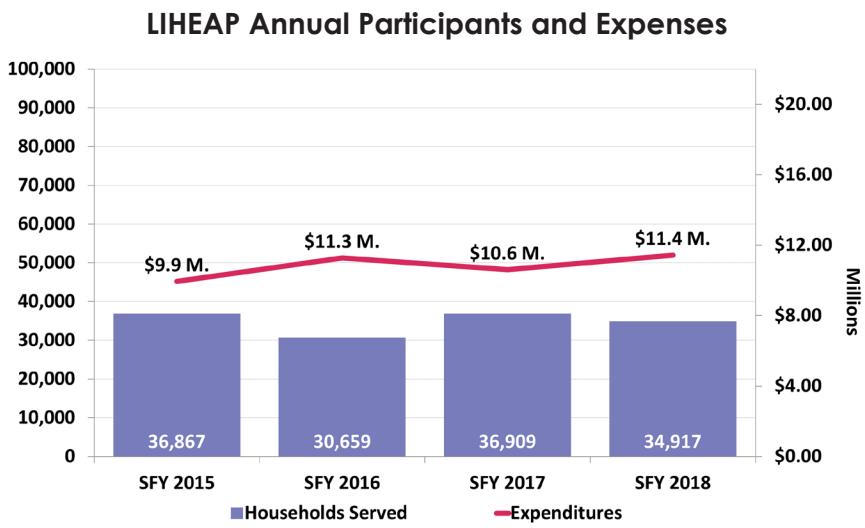
The Emergency Food Assistance Program (TEFAP) helps supplement the diets of people in Idaho in low-income households. Food for TEFAP is purchased from production surpluses and distributed to the state. In Idaho, community action agencies distribute these commodities through their warehouses to local food banks and soup kitchens. In SFY 2018, TEFAP distributed 2.5 million units of food valued at $2.4 million to 231,301 households.

TEFAP: Households Served and Annual Value of Distributed Food



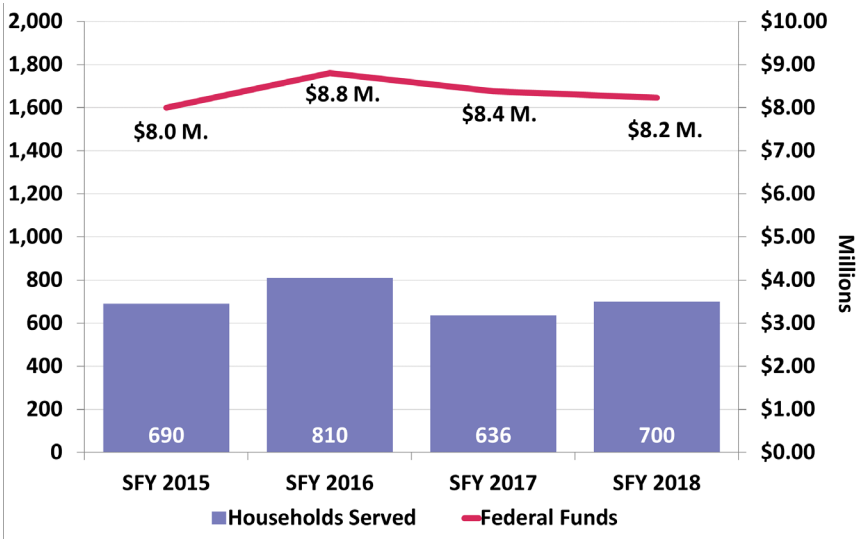
Community Services Block Grant (CSBG) funds programs that help eliminate the causes of poverty and enable families and individuals to become self-reliant. Services are delivered through locally operated and managed community action agencies and the Community Council of Idaho. Grant funds provide emergency and supportive services, employment-readiness training, individual and family development counseling, food, shelter, and transportation assistance. CSBG assisted 77,950 individuals and spent approximately $3.6 million in SFY 2018.

Low-Income Home Energy Assistance Program (LIHEAP) supports several energy conservation and education programs for low-income individuals. It also pays a portion of energy costs for qualifying households. LIHEAP is managed by local community action agencies that make utility payments directly to suppliers on behalf of eligible beneficiaries. The program helped 34,917 households pay $11.4 million in energy costs in SFY 2018. Up to $250,000 in voluntary contributions of Idaho's Grocery Tax Credit are also used to provide some funding to Idaho's LIHEAP Program.



Weatherization Assistance Program helps low-income families conserve energy, save money, and improve living conditions by upgrading and weatherizing their homes. Idaho's weatherization program is funded by utility companies, the U.S. Department of Health and Human Services, the Bonneville Power Administration, and the U.S. Department of Energy. Eligible efficiency measures include air sealing (weather-stripping and caulking), wall and ceiling insulation, heating system improvements or replacement, efficiency improvements in lighting, hot water tank and pipe insulation, and appliance replacement. The Weatherization Assistance Program provided $8.2 million for efficiency improvements to 700 Idaho households in SFY 2018.

Weatherization Assistance Program: Total Households Served and Annual Expenditures (Federal)



Note: The total funds represented in this chart are federal funds allocated to the state for weatherization services. Weatherization agencies also receive private funds from utility companies that are not included in these charts. Agencies typically use a mixture of private and federal funds to weatherize homes. Annual decreases in households served is due to an annual increase in the cost per unit limit from DOE, resulting in additional energy efficiencies to be installed per dwelling.

Glossary of Acronyms

ATR .....Access to Recovery Grant
AABD .....Aid to the Aged, Blind and Disabled
ACIP.....Advisory Committee on Immunization Practices
ACT ..... Assertive Community Treatment
ADA.....Americans with Disabilities Act
AED.....Automated External Defibrillator
AEMT.....Advanced Emergency Medical Technician
AIDS..... Auto Immune Deficiency Syndrome
AMH.....Adult Mental Health
APS.....Administrative Procedures Section
APTC.....Advanced Payment of Tax Credit
BOCAPS.....Bureau of Clinical and Preventiative Services in Public Health
BRFSS.....Behavioral Risk Factor Surveillance System
CAP..... College of American Pathologists
CCAI.....Comprehensive Cancer Alliance of Idaho
CHC ..... Criminal History Check
CDC.....Centers for Disease Control and Prevention
CFS.....Child and Family Services
CFH.....Certified Family Home
CHIP.....Children's Health Insurance Program
CLIA .....Clinical Laboratory Improvement Amendment
CMHP..... Children's Mental Health Project
CSBG.....Community Services Block Grant
CQI.....Continous Quality Improvement
CSES.....Child Support Enforcement System
CY .....Calendar Year
DD .....Developmental Disabilities
DDA .....Developmental Disability Agencies
DDI.....Design, Development, and Implementation
DIT.....Division of Information and Technology
DRA.....Deficit Reduction Act
DTaP..... Diptheria, Tetanus, acellular Pertussis
DUI..... Driving Under the Influence
EBT .....Electronic Benefits Transfer
EMR.....Emergency Medical Responder
EMS ..... Emergency Medical Services
EMT..... Emergency Medical Technician
ELT.....Executive Leadership Team
ETV.....Education and Training Voucher Program
EWS.....Enhanced Work Services

FACS .....Division of Family and Community Services
FFY ..... Federal Fiscal Year
FMAP.....Federal Medical Assistance Percentage
FNS.....Food and Nutrition Services at USDA
FPL.....Federal Poverty Limit
FTP .....Full-time Positions
FYI.....Foster Youth Alumni of Idaho
GED.....General Education Degree
HART.....Homes with Adult Residential Treatement
HCA.....Health Coverage Assistance
HIFA.....Health Insurance Flexibility Act
HIPAA.....Health Insurance Portability and Accountability Act
HIV..... Human Immunodeficiency Virus
HPV.....Human Papilloma Virus
HPSA.....Health Professional Shortage Area
IBIS.....Idaho Benefits Information System
ICCMH ..... Idaho Council on Children's Mental Health
ICCP..... Idaho Child Care Program
ICCCP.....Idaho Comprehensive Cancer Control Program
ICDD.....Idaho Council on Developmental Disabilities
ICF/ID..... Intermediate Care Facility for People with Intellectual Disabilities
ICPC .....Interstate Compact on the Placement of Children
ICWA .....Indian Child Welfare Act
DHW ..... Idaho Department of Health and Welfare
EBT.....Electronic Benefits Transfer
IIP.....Idaho Immunization Program
IRIS .....Immunization Reminder Information System
ITP.....Infant Toddler Program
LIHEAP.....Low Income Home Energy Assistance Program
LSO .....Legislative Services Office
MAGI.....Modified Adjusted Gross Income
MMIS ..... Medicaid Management Information System
MMRV.....Mumps, Measles, Rubella and Varicella
MOE.....Maintenance of Effort
MST.....Mountain Standard Time
OPE.....Office of Performance Evaluation
PCMH.....Patient-Centered Medical Home
PHA.....Premium Health Assistance
PIO.....Public Information Office(r)
PAN.....Physical Activity and Nutrition Program
PMO.....Project Management Office
PSR.....Psychosocial Rehabilitation Services
PWC .....Pregnant Women and Children

RAC.....Regional Advisory Committee
RALF.....Residential Care and Assisted Living Facilities
RCO.....Regional Care Organization
RFI.....Request for Information
RFP.....Request for Proposal
RMHB.....Regional Mental Health Board
RMHC.....Regional Mental Health Centers
RSO .....Receipting Services Only
SA.....Substance Abuse
SED.....Serious Emotional Disturbance
SFY..... State Fiscal Year
SHIP.....Statewide Healthcare Innovation Plan
SHN..... State Hospital North
SHS .....State Hospital South
SNAP (food stamps) .....Supplemental Nutitrition Assistance Program
SPP.....Suicide Prevention Program
SPAN.....Suicide Prevention Action Network
SRS.....Self-Reliance Services
STD.....Sexually Transmitted Diseases
STI.....Sexually Transmitted Infection
SUD.....Substance Use Disorder
SUR ..... Surveillance & Utilization Review
SWITC.....Southwest Idaho Treatment Center in Nampa
TAFI..... Temporary Assistance for Families in Idaho
TANF.....Temporary Assistance for Needy Families
TBI .....Traumatic Brain Injury
TEFAP..... The Emergency Food Assistance Program
TPC.....Tobacco Prevention and Control Program
VAERS.....Vaccine Adverse Event Reporting System
VFC.....Vaccines for Children
WAP.....Weatherization Assistance Program
WHC.....Women's Health Check
WIC.....Women, Infants and Children
WICHE.....Western Interstate Commission for Higher Education
YHI.....Your Health Idaho

(Please contact Niki Forbing-Orr at Niki.Forbing-Orr@dhw.idaho.gov to suggest additions to the acronyms glossary.)