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

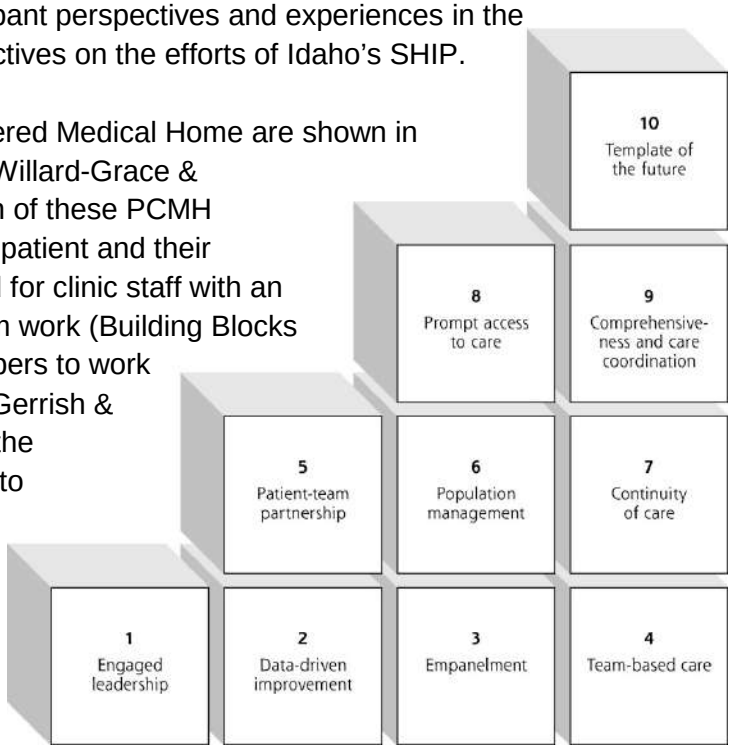

FIGURE 1 Ten Building Blocks for the Patient Centered Medical Home
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guided by data on the patient's risk status (Building Blocks #2, 3 and 6). Services are linked to these longitudinal risk assessments and focused to provide more comprehensive care 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.

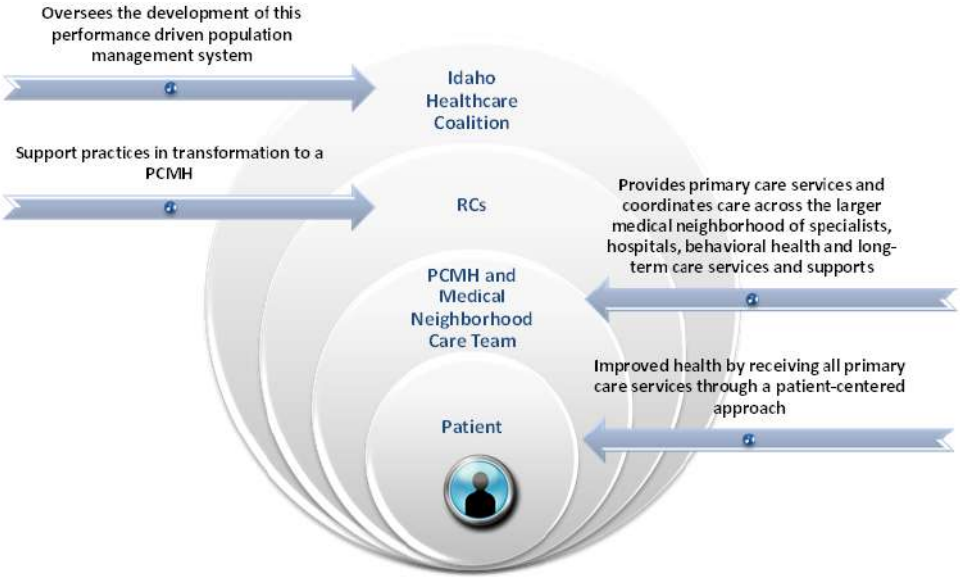

FIGURE 2 Conceptual Model of the State of Idaho's Statewide Healthcare Innovation Plan Retrieved from http://ship.idaho.gov/

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.

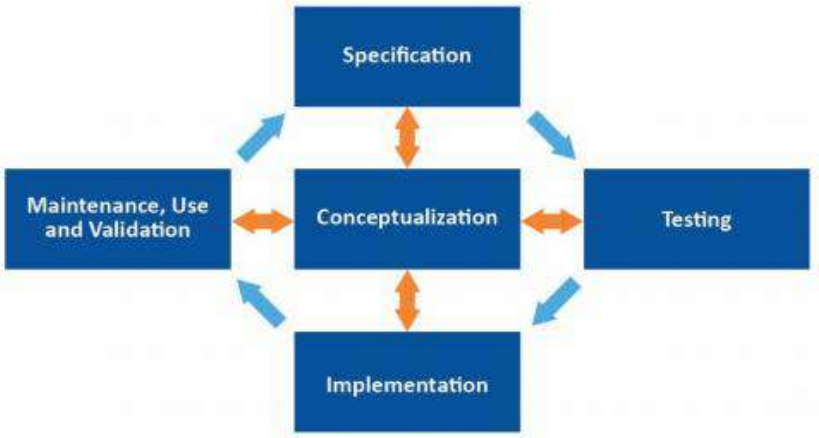

FIGURE 3 Lifecycle of an Electronic Clinical Quality Measure

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

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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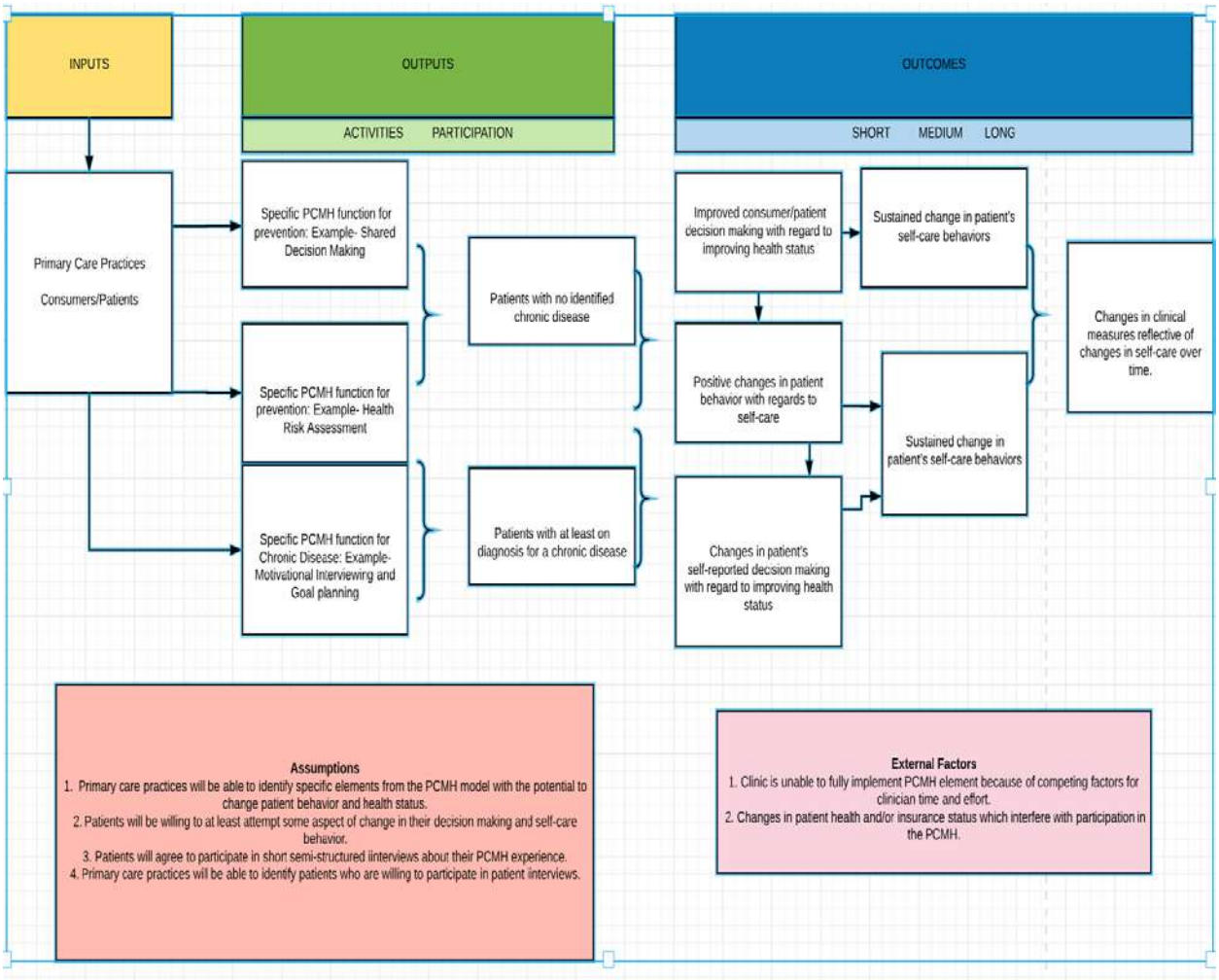
Appendix A

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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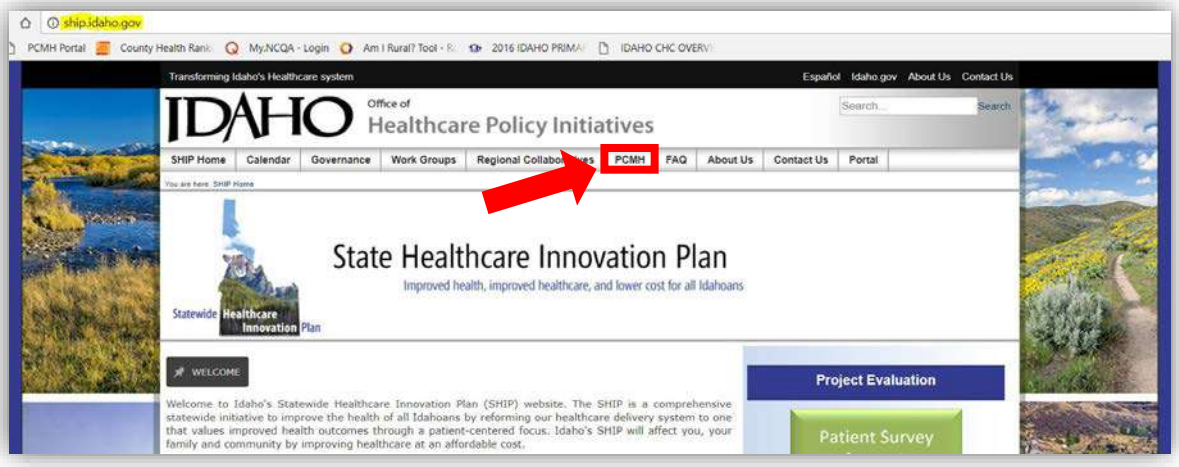
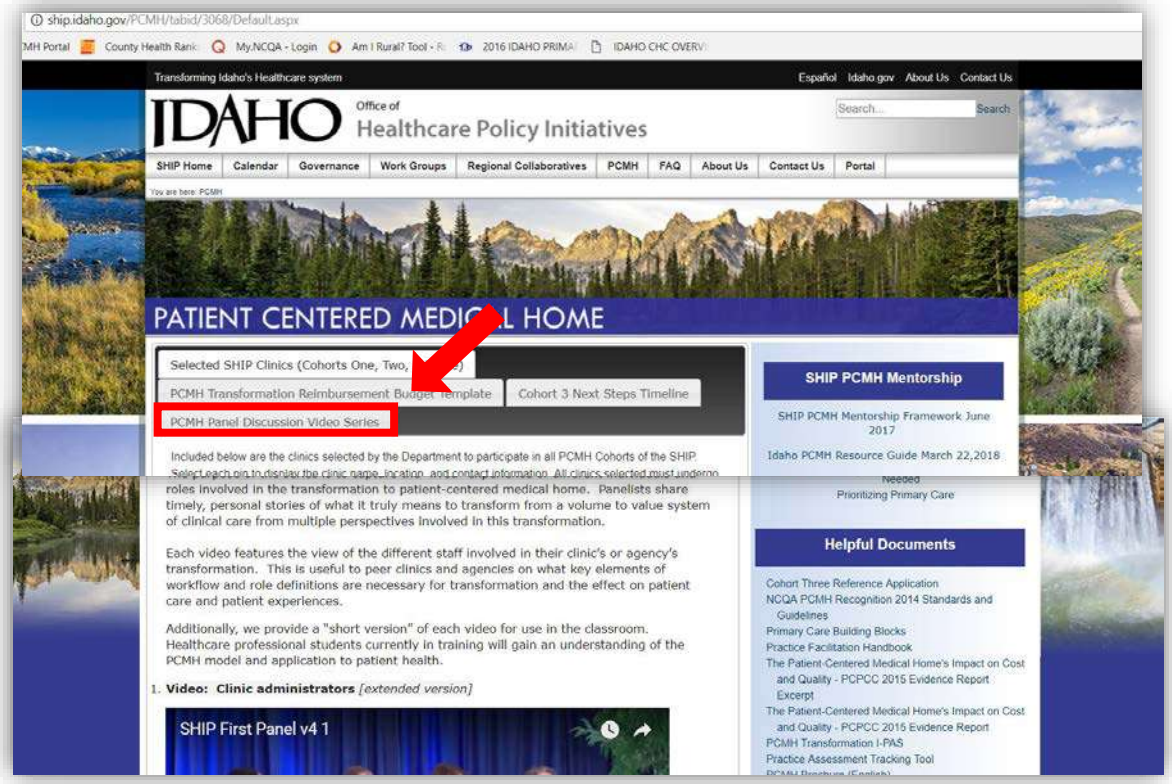
Appendix I

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

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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

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

QUESTION #4: 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.

<u>QUESTIONS #8 AND #9:</u> 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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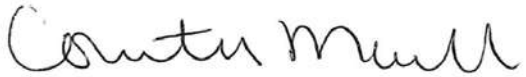
Appendix A
CHEMS/Community Partnership Example

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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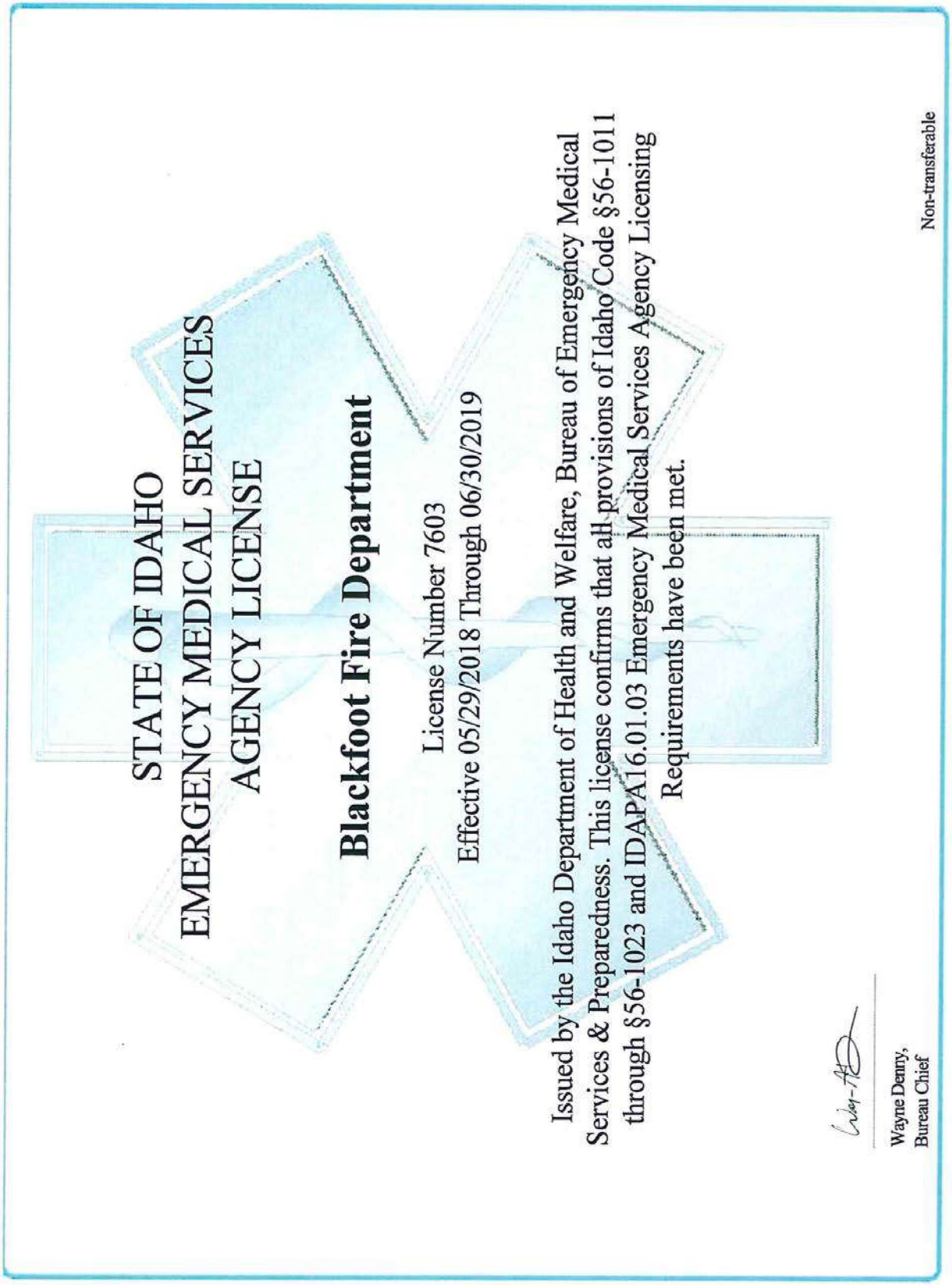

STATE OF IDAHO
EMERGENCY MEDICAL SERVICES
AGENCY LICENSE

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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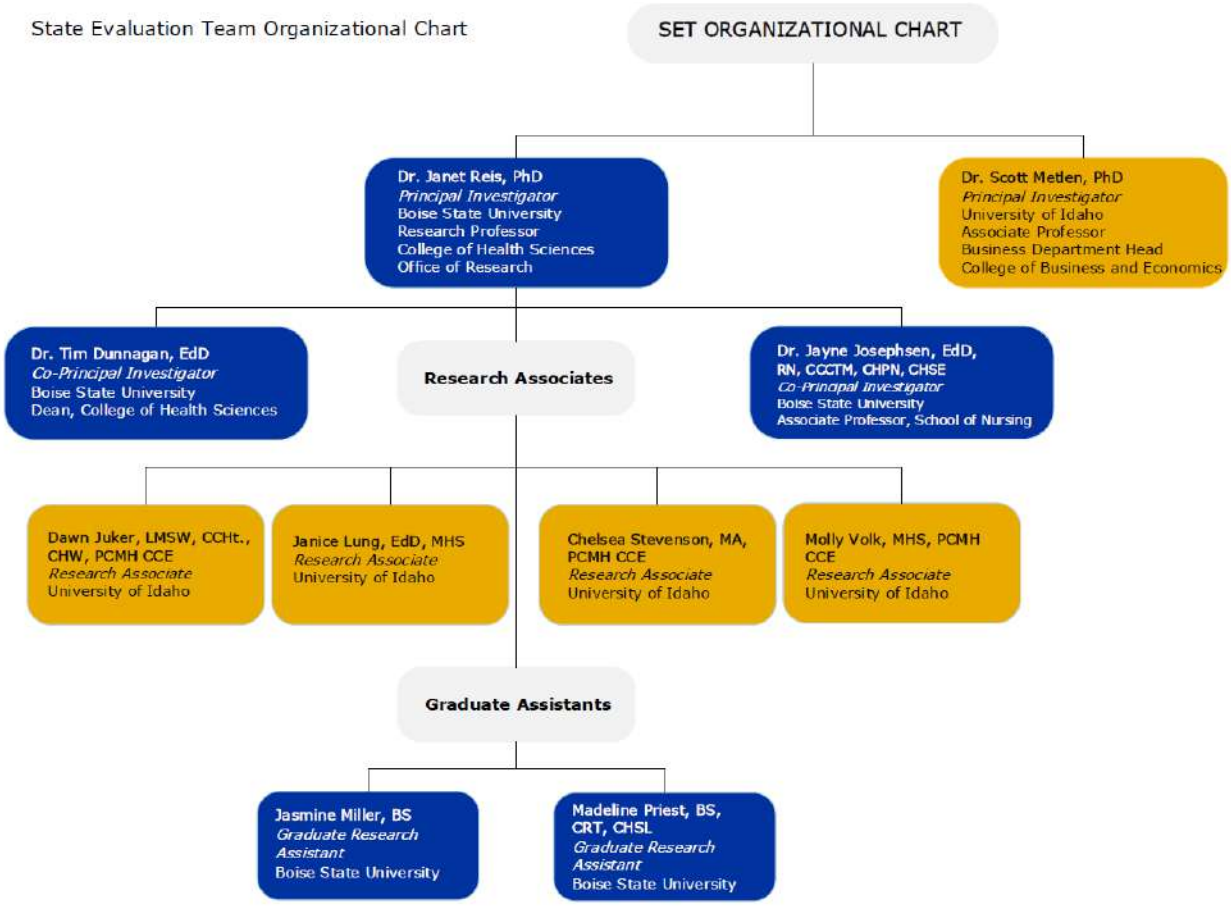
Figure 4. State Evaluation Team Organizational Chart



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