Idaho Healthcare Coalition

Quarterly Progress Report
SFY16 Q3

TABLE OF CONTENTS

INTRODUCTION

The Idaho Healthcare Coalition (IHC) is a driving force for Idaho's healthcare system transformation and a key decision-making body. Officially established on February 25, 2014 through Executive Order 2014-02, the IHC has grown from 31 members to 47 members to further ensure diverse and broad stakeholder participation in the State's overall transformation and the Statewide Healthcare Innovation Plan (SHIP) Model Test.

The IHC meets monthly and is co-chaired by Dr. Ted Epperly, a practicing Idaho family physician, and Denise Chuckovich, DHW Deputy Director. The IHC focuses on directing and monitoring Statewide Innovation Model (SIM) Test activities to advance the implementation of the Idaho SHIP.

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

IHC Workgroups and Advisory Groups

Six Workgroups have been established by the IHC and three existing advisory groups have been recruited to assist the IHC in carrying out the immense amount of work that must be completed to achieve SHIP's seven goals. An organizational chart is included as Appendix A. In total there are presently over 247 unique individuals active in the IHC and related workgroups and advisory groups.

Each Workgroup and advisory group has a charge related to implementing the SHIP goals in Idaho, and project charters that identify specific activities, milestones, deliverables, and timeframes that each Workgroup is responsible for to support the IHC in achieving the goals that have been created. The IHC, with support of DHW, monitors the State's healthcare system transformation and, as needed, assists the Workgroups with making adjustments to their project charters to maintain alignment with the overall transformation goals. The Workgroup chairs serve on the IHC and bring recommendations from the Workgroups to the IHC for consideration and final decisions. The DHW Office of Healthcare Policy Initiatives (OHPI) is responsible for the administration and management of SHIP Model Test activities.

Several changes have been identified this quarter as a result of Idaho's planning efforts in the pre implementation period. Key revisions to Idaho's goals and objectives include:

Idaho envisions a statewide healthcare system transformation that changes the standard of practice for healthcare in Idaho, delivering integrated, efficient, and effective primary care services through the patient-centered medical home (PCMH). The PCMH clinics will be integrated within the local Medical-Health Neighborhood, and supported and incentivized by value-based multi-payer payment methods. Through this transformation, Idaho will improve the quality and experience of care for all Idahoans, improve health outcomes, and control costs. Idaho envisions a statewide healthcare system in which:

1. PCMH teams provide high quality, integrated, and coordinated care for all Idahoans in a cost effective way. The system is patient-centered and partners with engaged patients in shared decision-making. Health promotion and wellness are central tenets of Idaho's healthcare redesign.

2. The broader healthcare system is organized at the regional level as robust Medical-Health Neighborhoods, integrating a spectrum of ancillary healthcare providers and non-medical community-based organizations with primary care.
3. All providers are linked electronically so clear and timely communication occurs.
4. Public and private payers are aligned to support these practices through a blended payment methodology that values outcomes over volume.

All of these principles, activated at the community level, will create the sustainable healthcare system Idaho needs. Idaho has translated these principles into seven goals (listed on Page 5), which, when achieved, will advance the mission of Idaho's statewide healthcare transformation.

During this quarter, the following was achieved:

- Mercer Project Management and Financial Analysis Contractor
  - Formal acceptance of SHIP Operations Plan by CMMI/January, 2016
  - Developed Master Project Management Plan in concert with OHPI SHIP staff
  - Presentation of Final Goal Charters for adoption by the IHC
  - Developed Communication Key Messaging Pieces for IHC and Workgroups

- SHIP Operations
  - Approval of Year 2 non-competing continuation application for Year 2/Model Test Year 1 Funding for grant year 2/1/2016 – 1/31/2017 in the amount of $9,659,215
  - JFAC Presentation – January 19th, 2016
  - Health IT Project Manager was hired during the month of December.
  - Administrative Assistant was hired during the month of February to refill a vacancy.
  - State Evaluator RFP process initiated and finalized
  - Submittal of Year 2 Requests for Release of Funds and Contracts finalized for Project Management and Financial Analysis, Data Analytics Contract, PCMH Transformation and Technical Assistance Contract and Ada County Paramedics CHEMS contract
  - FFATA Reporting of SHIP Contractors and sub-grantees completed and submitted February 17, 2016

Mission and Vision

The goal of the SHIP is to redesign Idaho's healthcare system, evolving from a fee-for-service, volume based system to a value based system of care that rewards improved health outcomes.

Goal 1: Transform primary care practices across the state into patient-centered medical homes (PCMHs).
Idaho will test the effective integration of PCMHs into the larger healthcare delivery system by establishing them as the vehicle for delivery of primary care services and the foundation of the state's healthcare system. The PCMH will focus on preventive care, keeping patients healthy and keeping patients with chronic conditions stable. Grant funding will be used to provide training, technical assistance and coaching to assist practices in this transformation.

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.
Idaho's proposal includes significant investment in connecting PCMHs to the Idaho Health Data Exchange (IHDE) and enhancing care coordination through improved sharing of patient information between providers.

Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical-health neighborhood.
At the local level, Idaho's seven public health districts will convene Regional Collaboratives that will support provider practices as they transform to PCMHs.

Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs.
This goal includes training community health workers and integrating telehealth services and *community health emergency services into rural and frontier practices. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically underserved communities.*

Goal 5: Build a statewide data analytics system that tracks progress on selected quality measures at the individual patient level, regional level and statewide.
Grant funds will support development of a state-wide data analytics system to track, analyze and report feedback to providers and regional collaboratives. At the state level, data analysis will inform policy development and program monitoring for the entire healthcare system transformation.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.
Idaho's four largest commercial insurers, Blue Cross of Idaho, Regence, PacificSource and Select Health along with Medicaid will participate in the model test. Payers have agreed to evolve their payment model from paying for volume of services to paying for improved health outcomes.

Goal 7: Reduce overall healthcare costs
Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs will be reduced by $89M over three years through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care and outcomes rather than volume of service. Idaho projects a return on investment for all populations of 197% over five years.

MEMBERSHIP UPDATE

The current IHC roster of appointees has been included (Appendix B). The professional   affiliation, expertise, and contribution to the IHC is included in the matrix.

The 2016 IHC meeting calendar includes the following meeting dates:

      I.   May 18, 2016
     II.   June 8, 2016
    III.   July 13, 2016
    IV.   August 10, 2016
     V.   September 14, 2016
    VI.   October 12, 2016
   VII.   November 9, 2016
  VIII.   December 14, 2016

ACCOMPLISHMENTS & PROGRESS

A. Facilitate and support the transformation of primary care practices to the PCMH model:

Briljent, LLC, the SHIP PCMH Transformation Contractor along with sub-contractors, Health Management Associates and Myers & Stauffer are currently developing a PCMH transformation portal to be utilized by clinics undergoing SHIP PCMH Transformation.

PCMH PORTAL:
Access to the PCMH Transformation Portal will be:
   A. Secure
      a. Encrypted Connection (Secure Socket Layer)
      b. Login Form is the only public facing page
      c. Registration through administrator only
   B. Hierarchical
      a. Access is controlled by a "Top Down" hierarchy which segregates information based on the user's access level.
         i. A practice level user will never have access to information for a different practice.
         ii. Public Health District (PHD) users will have access to all practice level information for practices within their district, but will not have access to practice level information for practices outside their district.
   C. Discrete
      a. There will be no financial, banking or personal information presented on the portal.
         i. Most information will be "Read-Only" for most users. All materials will be reviewed before it is made visible to users.

Numerous access levels will be defined in the portal, and a silo method will be used to manage access to the portal based on user categories. Users can be assigned to one or more access categories, and will only be able to access content where their assigned access category matches the access category assigned to the content item. The most restricted access levels will be the individual provider practices. Each clinic will be assigned a unique access category, to allow each clinic to view information specific to that clinic, as well as any additional content available to all logged-in users.

PAYMENT & INCENTIVE DISTRIBUTION
The PCMH Transformation Portal will interface with the Incentive- Payment Accounting System (I-PAS) accounting system for distribution of incentive payments to allow clinics and PHD Staff to collaborate and track progress within the context of the entire cohort. Key features include:

   A. Dashboard – Will include a de-identified way for clinics to view how they stand in relation to other clinics
   B. Help desk – A clinic that wants to reach out to a clinic that is doing well, would reach out to the help desk to connect them
   C. Forum – Affinity groups forum discussions are possible by topic or issue – users will be able to set alerts and receive updates from the forums.
   D. Document Sharing – Documents will be shared at state and district levels.

E. Usage – Methods for tracking and promoting usage of the portal will be developed and implemented.
F. PHD Staff Collaboration – The Portal and weekly meetings will encourage PHD staff to collaborate and share information to promote the success of every clinic.

Incentive payment measures were developed to encourage clinic participation. These measures include:

A. Incentive Payment Measure 1
   a. $10,000 incentive payment will be paid in one installment to SHIP approved practice locations that have:
      i. A completed application and
      ii. A fully executed contract with Briljent.
B. Incentive Payment Measure 2
   a. $5,000 will be paid based on evidence of PCMH accreditation or recognition from one of the following:
      i. Oregon Patient-Centered Primary Care Home (PCPCH)
      ii. National Committee for Quality Assurance (NCQA) PCMH Recognition 2014
      iii. Accreditation Association for Ambulatory Health Care, Inc. (AAHC) Medical Home Accreditation
      iv. The Joint Commission (JC) Primary Care Medical Home (PCMH)
      v. Other SHIP approved programs
C. Incentive Payment Measure 3
   a. $2,500 will be paid to individual practice locations with a SHIP approved virtual PCMH component of one or a combination of the following:
      i. Telehealth
      ii. Community Health Worker (CHW)
      iii. Community Health Emergency Medical Services (CHEMS)

Agreements from Briljent were distributed to clinics on February 1, 2016, with a due date of February 12th, as a legal agreement between the Cohort 1 PCMH clinics and Briljent and their subcontractors. Once signed, the Idaho Health Data Exchange (IHDE) will contact the clinics and send out business agreements needed to begin establishing a shared connection between the IHDE and Cohort 1 PCMH clinics. A welcome letter was sent to Cohort 1 clinics on February 9, 2016, which outlined next steps. A Memorandum of Understanding (MOU) was also distributed to help ensure the clinics have a description of the Department's roles and responsibilities. The MOU also outlines the responsibilities of the clinics to engage in PCMH transformation, data and information collection and IHDE connectivity for all three model test years.

All 55 clinics qualified to receive the first incentive payment. HMA is working with clinics to reach accreditation to receive the second incentive payment. Briljent and HMA are both working on tracking performance participation and clinic participation in webinars and learning collaboratives.

The first learning collaborative took place with cohort one clinics at the University of Phoenix on March 2-3, 2016 in Boise, Idaho. HMA worked with PHD staff members to continue their training to become better informed on PCMH transformation. HMA is putting together a webinar to address clinic questions about the differences in recognition between clinics.

COHORT 1 CLINIC TRANSFORMATION PLAN
The Transformation Plan for Cohort 1 Clinics is outlined below:

A. Section 1 – Goals
   a. The Goals section is further divided into "Standard 1" through "Standard 6", "HIT", and "PC/BHI". These sections will flow down the page, with the ability to expand or collapse each section.
   b. The headings for each of the Section 1 areas are:
      i. Standard 1: Patient-Centered Access
      ii. Standard 2: Team-Based Care
      iii. Standard 3: Population Health Management
      iv. Standard 4: Care Management and Support
      v. Standard 5: Care Coordination and Care Transitions
      vi. Standard 6: Performance Measurement and Quality Improvement
      vii. HIT: Health Information Technology Capabilities
      viii. PC/BHI: Primary Care/Behavioral Health Integration
B. Section 2 – Progress
   a. The Progress section supports one or more entries for each Section 1 Area of Focus for Change which has a major gap or for which improvement goals are set.
C. Section 3 – Notes
D. Section 4 – Coaching
   a. The Coaching section is for documentation by the Clinic Staff. The monthly progress will be reviewed during the coaching calls.

PCMH COHORT CLINICS
By the end of the SIM Model Test period, Idaho will have 165 practices around the State transformed from a traditional primary care practice to a well-integrated, coordinated PCMH model supported by value-based payment models. Refer to Appendix C for further demographic information on the Cohort 1 Clinics.

PCMH PATIENT BROCHURE
Mercer has created a brochure for clients of Cohort 1 Clinics to be included in the communication toolbox. The brochure is a useful tool and will be available in English and Spanish through the clinic portal. The brochure was presented to the IHC and members were asked to provide feedback regarding the brochure or how to use it properly.

Behavioral Health Integration (BHI) SURVEY
As a component of PCMH transformation, the Division of Behavioral Health (DBH) received a National Academy for State Health Policy (NASHP) grant to facilitate the integration of behavioral health into primary care practices. The Behavioral Health Integration (BHI) Workgroup defined integration in the following manner:

- Combines medical and behavioral health services.
- Addresses the full spectrum of health concerns patients present to primary care providers.
- It is NOT a replacement for specialty mental health.

Onsite surveys were conducted by DBH staff (between October 14 and December 14, 2015, with 47 primary care clinics enrolled in the Idaho Medicaid Home Health Program) to ascertain the current level of behavioral

health integration in Idaho primary care practices. The Idaho Behavioral Health Integration Survey assessed each provider's:

A. Level of behavioral health integration into primary care.
B. Referral practices and tracking.
C. Communication practices both internal and external.
D. Agreements with specialty services providers.
E. Screening tools and frequency of use.
F. Current training for all staff.

The survey revealed strengths among Idaho clinics which can be expanded to new clinics and maintained or enhanced in current clinics. These strengths included:

A. Primary care physicians (PCP) provide treatment for mental health issues on a routine basis but not as often for chemical dependency issues.
B. PCMH recognition rates were high among survey participants (94%), which lead to good referral processes, access to BH care, and missed appointment follow-up for BH clients.
C. Community Health Centers (CHC) and Rural Health Centers (RHC) report higher integration due to funding diversity.
D. Screening tools are used but not consistently or routinely for all patients. The Patient Health Questionnaire (PHQ) versions 2 and 9 were the most common screening tool. Screening rates appeared higher among CHC/RHC.
E. High use of Electronic Health Records (EHRs) increases ability to access information across disciplines.

The survey also demonstrated that a variety of locally-driven approaches work best for integrating behavioral health into primary care practices. The following recommendations offer opportunities for enhancement and act as a guide to help current and future cohorts:

Provide Technical Assistance for:
A. Mission Statements
B. Business Planning
    i. MOU's and Agreements
    ii. Organization Readiness
    iii. Policies and Procedures
    iv. Culture Shift (Individual, Clinic, Community, Public)
    v. Workforce Recruitment, Training, and Retention
    vi. Clinical Tools
    vii. Collaboration with Relevant Community Partners
    viii. Collaboration with BH Peers
C. Promote Universal Screening
D. Provide Training on BH Topics: SBIRT, Motivational Interviewing, Mental Health First Aid
E. Promote BH Registries/Reviewing of Outcomes
F. Expand use of Tele-Health

For further details on the survey methods and demographics of participating clinics refer to Appendix D.

B. Develop regional collaboratives to support local practices in transformation and integration of PCMHs with the medical neighborhood that includes secondary and tertiary care consultants, hospitals, behavioral health and other community support services:

Representatives from the seven RCs provided updates to the IHC in January 2016 and reported the following:

Regional Health Collaborative 1 has met three times and planned a kick off on March 30th. The collaborative has discussed challenges and what they need from the IHC; they are looking for help with Nextgen EMR and access to more data to determine their selection of clinical quality measures.

Regional Health Collaborative 2 has met twice. All clinics in their region are already NCQA level three. They are developing their medical-health neighborhood and working on how to support subsequent cohorts. The RC is requesting assistance with developing the medical-health neighborhood and its components. The collaborative is hoping to develop an online presence in the next six months. The collaborative would also like help with measuring medical-health neighborhood performance and behavioral health integration.

Regional Health Collaborative 3 has established fifteen members and is committed to ensuring diverse representation that mirrors the care community. As a collaborative, the region has had three meetings and is meeting once a month. They have sent out invitations to their peers across the region for participation in workgroups to assist with PCMH transformation. The RC is identifying health groups within the communities and how to support health care across these communities as part of the medical-health neighborhood. The collaborative is involved in several healthcare coalitions within their region.

Regional Health Collaborative 4 has nineteen members in their collaborative including representation from fourteen clinics. The collaborative has created diverse member representation from all facets of the health care community. Next steps include preparing for PCMH transformation plans to be completed so the RC can assist clinics with their individual PCMH transformation goals. The collaborative will also be identifying different challenges of clinics and providers and begin work on referral networks and referral management systems.

Regional Health Collaborative 5 has met seven times. In addition to the established members the collaborative is seeking representatives from the Sun Valley and Wood River Valley areas. With only four clinics in Cohort 1, RC5 has the smallest collaborative. The collaborative is developing a subcommittee to address their need for more communication about the Idaho Health Data Exchange and payment plans.

Regional Health Collaborative 6 currently has six clinics in Cohort 1. The collaborative is allocating time to clinics based on their individual needs. The Regional Health Collaborative is a rotating committee; everyone on this committee has to bring something to the table that will help clinics undergoing PCMH transformation. Committee membership will change based on help requested from the clinics or other committees. Moving forward the collaborative will be addressing sustainability of PCMH transformation. The collaborative will be seeking more information on best practices for the sharing of behavioral health notes to primary care doctors.

Regional Health Collaborative 7 has eight clinics in Cohort 1 and all are represented on the collaborative. The RC will focus on building the medical-health neighborhood in a way that can best help their patients; additionally the RC will be identifying gaps and areas of need for clinics. The collaborative seeks to promote networking, avoiding duplication, and building off of other regional collaborative best practices will be the best way to help clinics,

clients and patients. They would also like to see further progress on behavioral health integration, payment reform, data analytics, and identification of sustainable funds post SHIP.

C. Recognize the critical issues related to Idaho's healthcare provider workforce shortage and work closely with the Idaho Health Professions Education Council (IHPEC), established by executive order in 2009, to ensure that SHIP activities align with the Council's workforce development strategies:

COMMUNITY HEALTH EMS

Strong engagement of the Community Health EMS (CHEMS) agencies in Idaho resulted in the formation of a CHEMS Outcome Measures Workgroup to identify outcome measures, data collection mechanisms, recruitment and outreach strategies to identify CHEMS agencies for SHIP. To test some of these ideas, an early adopter program was developed during the pre-implementation year, where one CHEMS agency agreed to pilot the SHIP CHEMS model and provide feedback and recommendations to the Outcome Measures Workgroups. A nationally recognized subject matter expert has also been consulted to identify best practices for implementation, metrics identification and payment/reimbursement strategies.

The CHEMS Measures Workgroup met on January 22, 2016 to establish a common foundation for Idaho CHEMS and corresponding measures development and to identify preliminary CHEMS measures. Several subject matter experts assisted with metrics identification processes for CHEMS. These subject matter experts included:

A. Matt Zavadsky, Public Affairs Director at MedStar Mobile Healthcare, is a national expert on CHEMS implementation and measurement. Matt shared his vast experience and knowledge and answered workgroup questions.
B. Mark Babson, Community Paramedic for Ada County Paramedics, shared Ada County Paramedics' experience in integrating CHEMS into its operations. Guest speakers, Dave Reynolds (Moscow Fire and EMS) and Rob Veilleux (Teton Valley Ambulance), shared their experience with CHEMS in rural areas of Idaho.
C. Wayne Denny, Bureau Chief for Bureau of EMS and Preparedness, provided context for CHEMS within the Idaho EMS community.

The Workgroup spent the majority of the meeting reviewing the draft CHEMS measures and working toward consensus on the proposed core set of measures that Idaho agencies would collect to demonstrate the value of Idaho CHEMS. The broader concept of CHEMS in Idaho was contrasted with CHEMS as it relates to the current SHIP effort for which the first set of core measures is required. The CHEMS measures identified were:

A. Health-Related Quality of Life
B. Reduction in More Expensive Visits/Interventions
C. Cost Savings
D. Percentage of Patients Connected with PCP
E. Partner Satisfaction Assessment
F. CHEMS Employee Satisfaction
G. Numbers of Paramedics Advanced Life Support (ALS) Across Idaho
H. Community Engagement

Eight (8) paramedics from three (3) EMS agencies will start a year-long community paramedicine education at

Idaho State University. In addition, the CHEMS Advisory Group is collaborating with the Boise State University's Master of Public Health Program Evaluation class lead by Professor Sara Toevs to explore avenues to address sustainability. For a further recap of the CHEMS Outcome Measures Workgroup refer to Appendix E.

COMMUNITY HEALTH WORKERS

Community Health Worker (CHW) Advisory Group engaged many stakeholders over a series of meetings and brought in national experts to assist in the decision making process for selection of a CHW training curriculum. In November, they recommended adoption of the Massachusetts curriculum to the IHC with some modifications to adapt it to Idaho specific requirements. Planning efforts continue with a goal to launch the CHW curriculum in September, 2016. Refer to Appendix F for further detail on the CHW training curriculum and delivery system.

The CHW Workgroup met with the DHW Diabetes, Heart Disease and Stroke Programs to coordinate outreach in identifying and recruiting potential CHW students for the first training cohort. Elke Shaw-Tulloch presented the Population Health Workgroup concept document to the IHC. This document is meant to define what the words population health means in all aspects, is a white paper to be used a as a conversation starter to further define population health and the medical-health neighborhood.

TELEHEALTH

The Idaho Telehealth Council SHIP Subcommittee was charged with developing a Telehealth expansion plan to operationalize and expand Telehealth services in rural communities as part of the SHIP. This effort includes integrating Telehealth in PCMHs to improve access to behavioral health and specialty care and establishing Telehealth in CHEMS programs. The Subcommittee consists of over 30 Idaho stakeholders, including representation from various DHW divisions, hospitals, associations, health districts, fire departments, and other key partners from across the state.

SHIP Telehealth goals include the following:
1. Establish rural Telehealth capacity in 18 PCMHs across a range of specialty services.
2. Establish rural Telehealth capacity in 18 PCMHs to provide behavioral health services.
3. Establish Telehealth services in 6 CHEMS programs.

SHIP resources to support these goals include developing a grant program which incorporates site and virtual training, technical assistance, and coaching, as well as funding to purchase Telehealth equipment. The Telehealth SHIP Subcommittee met twice to further review and refine the Telehealth implementation plan. As part of the process, the Subcommittee engaged Oregon State Office of Rural Health to survey processes and documentation related to Telehealth implementation (which was a part of the Oregon's SIM grant). For further detail on Telehealth Pre-Implementation Planning refer to Appendix G

D. Establish quality outcome measures and methods to collect and analyze individual patient and population health outcomes:

HealthTech Solutions, LLC (HTS) was selected as the Data Analytics vendor in January 2016. HTS has extensive data analytics experience, particularly in the governmental realm, and the SHIP team is excited to welcome them on board (http://thinkhts.com/). Contract Manager Sandeep Kapoor, PMP is the CEO of HTS and will serve as the primary point of contact for the contractor's performance. The HTS team has extensive experience in HIT/HIE and Medicaid Enterprise Systems operations.

The HIT data element mapping subcommittee was formed in January to ensure development of reporting capabilities for data analytics/clinical quality measures. Metrics for reporting of the Model Test Year 1 Clinical Quality Measures were identified and include:

1. Tobacco cessation intervention (SIM): Percentage of patients identified as tobacco users who received cessation intervention during the two-year measurement period.
2. Weight assessment and counseling for children and adolescents (SIM): Percentage of children, 2 through 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.
3. Comprehensive diabetes care (SIM): The percentage of patients 18-75 with a diagnosis of diabetes, who have optimally managed modifiable risk factors (A1c<8.0%, LDL<100 mg/dL, blood pressure<140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD) with the intent of preventing or reducing future complications associated with poorly managed diabetes.[1]

A fourth clinical quality measure will be identified in April 2016 to comply with our annual reporting requirements to CMMI. The clinical quality measures for Year 1 Model Test will be presented to the CQM and HIT Workgroups as well as the IHC in early April for their comments.

E. Advance primary care payment methods that align with the PCMH model, encouraging public and private payers to reimburse for improved health outcomes rather than volume of visits:

Idaho Medicaid is one of the statewide payers restructuring their program to align with the goals of the SHIP. Effective February 1, 2016, Idaho Medicaid has restructured the Healthy Connections and Health Home Programs to incentivize primary care providers to transform their clinics into PCMHs and to align with the SHIP goals. The new payment structure is divided into four PMPM Payment Tiers. Details on the transition, the payment structure and requirements can be found at:
http://healthandwelfare.idaho.gov/Portals/0/Providers/Medicaid/MA1602.pdf

Patients are attributed to practices based on their provider selection, or if no provider is selected, attribution is based on their past claims and proximity to provider locations and provider availability. Providers will receive per member per month payments (PMPM) for attributed patients to support activities directed towards improved patient care and better coordinated services. PMPM Payment amounts will vary depending on member and provider characteristics, as outlined in Appendix H.

New regulations are under development to support these changes. Providers had the opportunity to participate in drafting rules and providing input on specific requirements through negotiated rulemaking sessions. Rates were developed to support care management employees and physician involvement in practice transformation

Healthy Connections primary care program will shift to a multi-tiered reimbursement structure based on the primary care provider's ability to impact patient health, including:

1. Healthy Connections: Basic care coordination and referral management similar to existing rates;
2. Healthy Connections Access Plus: As above, but including increased access to care through extended clinic hours or other access models Additional payment similar to existing rates;
3. Healthy Connections Care Management: As above, but including a care management model for chronically ill patients – community health worker, community health emergency medical services, basic behavioral health integration, or an "under construction" patient centered medical home Additional payment to support care management activities;
4. Healthy Connections Medical Home: Similar to the existing Health Home program, but providing a nationally recognized (NCQA, URAC, AAAHC, or Joint Commission) patient centered medical home for all patients rather than just the chronically ill, additional payment to support full patient centered medical home is provided in Tier 4.

After February 1, 2016 the Health Home program will merge with the Healthy Connections program. These programs are being restructured to incentivize Providers to transform to the PCMH model and to align with the SHIP goals. Additional information is available at www.idmedicaid.com.

F. Provide guidance to expand health information technology (HIT) at the practice level, enhancing PCMHs' use of electronic health records (EHRs), enabling the coordination of care and redundancies found in the current healthcare delivery system and, at the state level compiling population health data for quality measurement and improvement:

Idaho Health Data Exchange (IHDE) provided the HIT workgroup with an update related to building connections to Medicaid and SHIP clinics. During the Model Design phase, Idaho's stakeholders identified limited opportunities in the existing landscape to coordinate data collection and analysis across payers and populations. These limitations have historically prevented Idaho from fully developing the capacity to collect and analyze statewide data. Idaho's SIM Model Test HIT Plan provides a pathway to increasing this capacity. The HIT Plan describes how Idaho will build capacity across the system and sets a strong foundation for implementing increasingly robust HIT solutions as the PCMH model evolves. The HIT Plan aims to support a successful PCMH model in Idaho by building a platform for Model Test participants to collect and share data for purposes of patient collaboration, patient engagement, continuous quality improvement, reporting, and analytics.
HIT is a critical component underpinning the overall SIM Model Test and is a primary driver of Idaho's healthcare system transformation. The HIT Plan describes the State's plans to establish the data and analytical capability to support PCMHs and other organizations in improving coordination and delivery of care, exchanging clinical information, and improving the health of the population. The full HIT Plan, developed in accordance with CMS' "Health IT Plan: Supplemental Guide for Model Test", can be found in Appendix I.

Idaho's HIT Plan seeks to support the implementation of Idaho's State Innovation Model (SIM) Test by building a network of technology at multiple levels of Idaho's healthcare system including: electronic health records (EHRs) that collect, store, and transmit health information; the Idaho Health Data Exchange (IHDE) that supports interconnectivity and communication between providers, caregivers, and patients; Telehealth services for individuals in remote locations; and a statewide health data analytics system. By using health information more effectively and efficiently throughout Idaho's health system, HIT has the potential to empower patients and their providers, make healthcare and the health system more transparent, enhance the study of care delivery and payment systems, and drive substantial improvements in care, efficiency, and population health.

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

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

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

The HIT Workgroup advises and addresses the technology needs of the SIM Model Test. The Workgroup's scope includes increasing data sharing, interconnectivity, analytics, and reporting. To assist with this work, contractors have been procured, who will bring additional resources and focus on building HIT capacity within the state. This assistance will also contribute to the ongoing sustainability of the HIT Plan activities after the Model Test has concluded.

DHW has continued to prioritize the development of a statewide healthcare data analytics system with the feedback provided by the workgroup, an essential component in monitoring the implementation of the SHIP and the transformation of the statewide healthcare system in Idaho.

G. Develop a long-range plan for sustainability and growth of Idaho's transformed healthcare system:

In July 2015, Mercer representatives met with the Multi-Payer Workgroup to discuss the proposed procedures for capturing baseline financial data to be used in the cost savings financial analysis. This analysis will provide valuable insights on how the Triple Aim outcomes of a healthy population, exceptional patient care and affordable costs can be actualized. The financial analysis completed during the SHIP planning phase will be updated, ensuring that all requirements for the financial analysis are met. Participating payers (Idaho Medicaid, Blue Cross, PacificSource, Regence Blue Shield and Select Health) will be engaged in this process to obtain data and implement ongoing financial analysis.

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

DATA COLLECTION PROCESS

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

The scope of the financial analysis includes the following:

A. The populations being addressed and their respective total medical costs as per member per month and population total. The populations include, but are not limited to, Medicare, Medicaid and/or CHIP, and commercial payer populations.
B. The anticipated cost savings resulting from specified interventions, including the types of costs that will be affected by the model and the anticipated level of improvement by target population and basis for expecting savings.
C. The related expected total federal cost savings and ROI during the project period for the state model test, as well as on a projected annualized basis after the end of the model test.

Activities over the course of the four year grant include: A) Recalculating the current financial analysis using actual data to establish a baseline; B) Calculating Return on Investment (ROI) for the end of year three (3) of the SHIP Model Test and two (2) years beyond the end of the SHIP Model Test; C) Annual actuarial analyses to evaluate cost savings against established targets and D) Trend analysis to gauge how well we are on track for three (3) and five (5) year ROI.

EXPECTED OUTCOMES

By implementing a value-based model, Idaho expects to save $89 million through reductions in ED utilization for non-emergent episodes, inpatient admissions, inpatient re-admissions, admissions to the neo-natal intensive care unit (NICU), and through increases in the generic fill rate for prescribed pharmaceuticals. This goal includes the need to measure overall costs to determine a true cost savings. Therefore, the primary deliverable for this goal is to project the overall cost savings by implementing the SIM Model Test and comparing actual results to the projected savings.

The actuarially certified projection creates a cost savings estimate to compare to actual results during the Model Test period. It contributes to the Triple Aim by creating financial goals to lower overall costs. To achieve the projected $89 million in cost savings over three years and a return on investment for all populations over five years , at least 165 practices must become designated as PCMHs, contract with payers, and establish reimbursement based on outcomes rather than volume. The achievement of Goal 7 is also contingent upon the successful implementation of all other goals.

Upon implementing these steps for Goal 7, there are also risks that the care model will fail to achieve the cost-saving assumptions. Each assumption includes inherent risk, including patient compliance, successful implementation of primary care, in addition to unforeseen epidemics or acute care needs. Patient compliance remains difficult to incent. Monitoring and follow-up calls by the PCMH care team should help hold patients accountable for following prescribed treatment plans. The successful implementation of primary care is imperative to meeting the cost savings assumptions. This step requires availability and access to all necessary specialists and providers included in the primary care team and PCMH.

Finally, the cost saving model does not account for unforeseen epidemics that may regionally cause increases in utilization or acute care needs as a result of accidental injury or illness.

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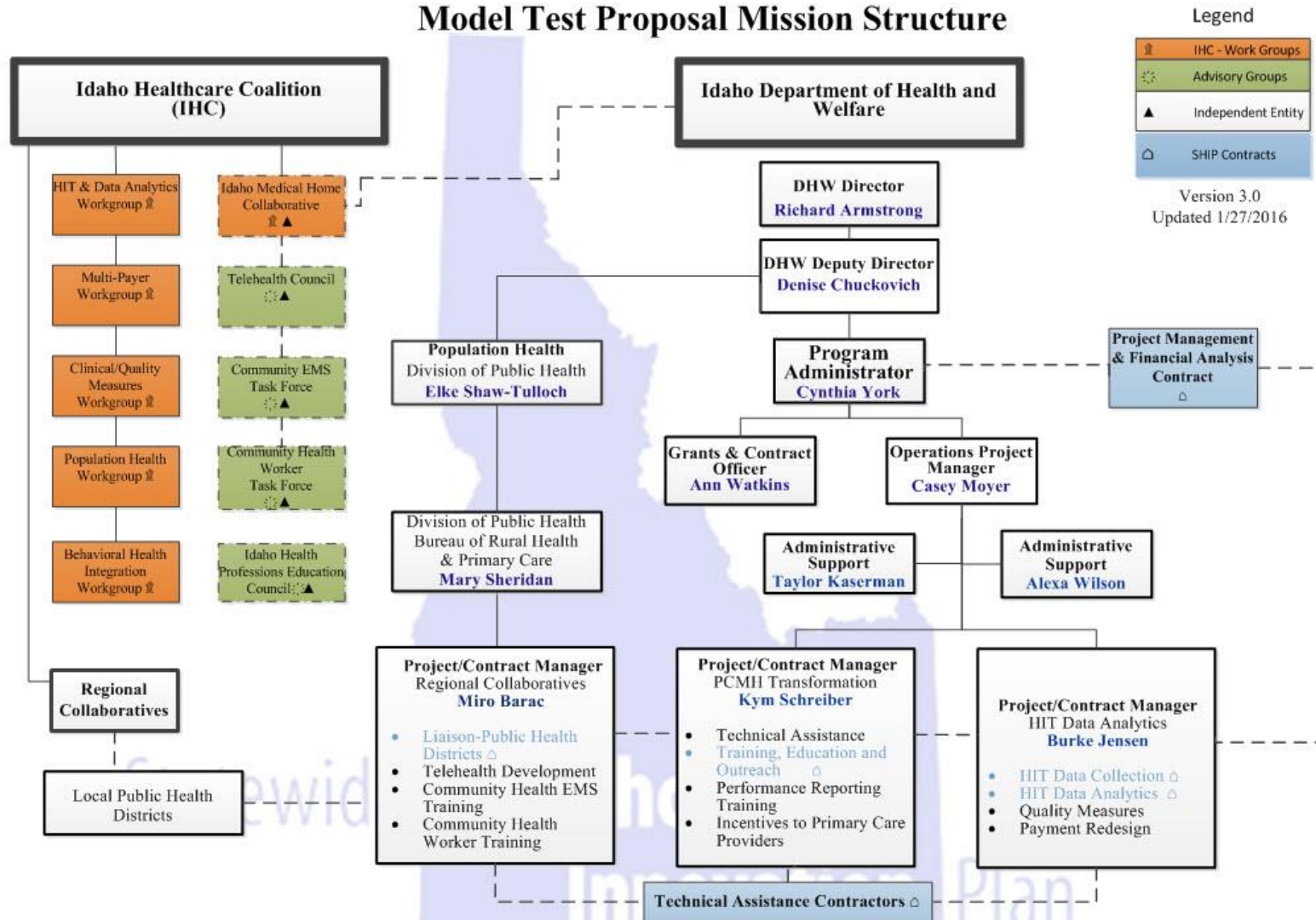
APPENDICES

Appendix A

Model Test Proposal Mission Structure

Legend

🏛	IHC - Work Groups
☼	Advisory Groups
▲	Independent Entity
⌂	SHIP Contracts

Version 3.0
Updated 1/27/2016

Idaho Healthcare Coalition (IHC)

- HIT & Data Analytics Workgroup 🏛
- Multi-Payer Workgroup 🏛
- Clinical/Quality Measures Workgroup 🏛
- Population Health Workgroup 🏛
- Behavioral Health Integration Workgroup 🏛

- Idaho Medical Home Collaborative 🏛 ▲
- Telehealth Council ☼ ▲
- Community EMS Task Force ☼ ▲
- Community Health Worker Task Force ☼ ▲
- Idaho Health Professions Education Council ☼ ▲

Regional Collaboratives

Local Public Health Districts

Idaho Department of Health and Welfare

DHW Director
Richard Armstrong

DHW Deputy Director
Denise Chuckovich

Population Health
Division of Public Health
Elke Shaw-Tulloch

Program Administrator
Cynthia York

Project Management & Financial Analysis Contract ⌂

Grants & Contract Officer
Ann Watkins

Operations Project Manager
Casey Moyer

Division of Public Health Bureau of Rural Health & Primary Care
Mary Sheridan

Administrative Support
Taylor Kaserman

Administrative Support
Alexa Wilson

Project/Contract Manager
Regional Collaboratives
Miro Barac

- Liaison-Public Health Districts ⌂
- Telehealth Development
- Community Health EMS Training
- Community Health Worker Training

Project/Contract Manager
PCMH Transformation
Kym Schreiber

- Technical Assistance
- Training, Education and Outreach ⌂
- Performance Reporting Training
- Incentives to Primary Care Providers

Project/Contract Manager
HIT Data Analytics
Burke Jensen

- HIT Data Collection ⌂
- HIT Data Analytics ⌂
- Quality Measures
- Payment Redesign

Technical Assistance Contractors ⌂

Examples of Foundational Partnerships for the Medical-Health Neighborhood
Idaho Oral Health Alliance, Idaho Academy of Nutrition and Dietetics, Idaho Caregivers Alliance, Idaho Alzheimer's Planning Group, Idaho Council on Suicide Prevention, local behavioral health boards, local boards of health, Healthy Eating Active Living (HEAL) Idaho, Diabetes Alliance of Idaho, Tobacco Free Idaho Alliance, Comprehensive Cancer Alliance of Idaho, Time Sensitive Emergency Council, Idaho Immunization Coalition

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
IHC Leadership				
Ted Epperly, MD *President and CEO* **Family Medicine Residency of Idaho**	*Dr. Epperly is a nationally-respected healthcare system transformation leader and has led Idaho's efforts in transformation over the past two years during Idaho's model design phase and now will lead our model test as chair of the Idaho Healthcare Coalition.*	**May 2013- Present**	**Governor Appointed, Chair, Idaho Healthcare Coalition**	*Family Medicine Residency of Idaho 777 N. Raymond St. Boise, ID 83704* <u>*Ted.epperly@fmridaho.org*</u>
Denise Chuckovich, Deputy Director, Department of Health and Welfare	Ms. Chuckovich serves as Co-Chair of the IHC and DHW lead on Idaho MTP implementation. As the state agency responsible for MTP implementation. DHW leadership is critical to the success of Idaho's efforts.	September 2012- Present	DHW lead on MTP and IHC co-chair	Department of Health & Welfare 450 W State St., 3rd Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-5500 <u>ChuckovD@dhw.idaho.gov</u>
State Leadership				
Richard Armstrong, Director, Department of Health & Welfare	Mr. Armstrong is the director of the Idaho Dept. of Health and Welfare and provides critical cabinet level leadership. He has identified the MTP as a high priority DHW strategic initiative.	September 2012- Present	Mr. Armstrong provides highest level leadership within DHW and Idaho state government officials. He participates in monthly IHC meetings and provides strong liaison relationships with other cabinet members, Governor's Office, legislators.	Department of Health & Welfare 450 W State St., 3rd Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-5500 <u>ArmstrongR@dhw.idaho.gov</u>
Scott Carrell, Executive Director, Idaho Health Data Exchange	Mr. Carrell represents the Idaho Health Data Exchange which will play a key role in data sharing and analytics in Idaho's MTP.	June 2013-Present	Mr. Carrell represents the Idaho Health Data Exchange, a critical element of Idaho's model test. The IHDE will provide connectivity for PCMHs participating in the	Idaho Health Data Exchange 450 W State St P.O. Box 6978 Boise, ID 83707

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Chair, HIT Work Group			model test.	scarrell@idahohde.org
Ross Edmunds, Behavioral Health Division Administrator, Department of Health and Welfare	Mr. Edmunds is the state Behavioral Health Authority and provides focus on BH integration with primary care.	September 2014 - Present	Mr. Edmunds brings the behavioral health community perspective to the IHC and is leading Idaho's work in BH System transformation.	Behavioral Health Division Department of Health & Welfare 450 W State St., 3rd Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-5726 EdmundsR@dhw.idaho.gov
Lisa Hettinger, Medicaid Division Administrator, Department of Health and Welfare	Ms. Hettinger represents Idaho's Medicaid program.	May 2014 – Present	Ms. Hettinger represents of Idaho's public payer who play a critical role in developing a value based reimbursement plan for Idaho PCMHs.	Medicaid Division Department of Health & Welfare 3232 Elder St Boise, ID 83705 208-364-1804 HettingL@dhw.idaho.gov
Nicole McKay, Deputy Attorney General	Represents Idaho's Attorney General	January 2015. Previous DAG in role since 10/13	State Deputy Attorney General provides legal guidance to DHW and IHC, particularly in the areas of anti-trust, conflict of interest, and contracting.	State Deputy Attorney General Department of Health & Welfare 450 W State St., 10th Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-5540 McKayN@dhw.idaho.gov
Tammy Perkins Sr. Special Assistant for Health and Social Svcs Office of the	Ms. Perkins represents the Governor's office on the IHC. Governor Otter has been a strong supporter of healthcare system transformation since he took	June 2013-Present	Represents governor's office, communicates key policy direction from governor, and serves a conduit back to governor re IHC policy recommendations.	Office of the Governor State Capitol P.O. Box 83720 Boise, ID 83720 tperkins@gov.idaho.gov

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Governor	office in 2007.			
Elke Shaw-Tulloch, Public Health Division Administrator, Department of Health and Welfare	Ms. Tulloch represents the state Health Division within the Dept. of Health and Welfare	August 2013 - Present	Ms. Tulloch represents the state level public health division perspective	Public Health Division Department of Health & Welfare 450 W State St., 4th Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-6996 ShawE@dhw.idaho.gov
Mary Sheridan, Bureau Chief, Bureau of Primary and Rural Health Care, DHW Health Division	Represents state level rural health and primary care office.	September 2012	Ms. Sheridan provides a focus on rural healthcare delivery that is critical to Idaho's model test initiative.	Public Health Division Department of Health & Welfare 450 W State St., 4th Fl. P.O. Box 83720 Boise, ID 83720-0036 208-332-7212 SheridaM@dhw.idaho.gov
Cynthia York, Program Administrator, Office of Healthcare Policy Initiatives	Provides leadership for the initiative within DHW.	March 2014	Ms. York is responsible for the day to day operations of the Office of Healthcare Policy Initiatives which will be responsible for Idaho's Model test implementation.	Office of Healthcare Policy Initiatives Department of Health & Welfare 450 W State St., 3rd Fl. P.O. Box 83720 Boise, ID 83720-0036 208-334-5574 YorkC@dhw.idaho.gov
Legislative Leadership				
Lee Heider, Senator,	Senator Heider provides legislative	July 2013-Present	Senator Heider, as chair of the Idaho	Idaho Legislature

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Idaho Legislature Chair, Senate Health and Welfare Committee	perspective and support to Idaho's healthcare transformation plan. He has been an unfailing supporter of the SHIP and instrumental in developing Senate support for the plan.		Senate Health and Welfare Committee, provide senate level leadership and connectivity for Idaho SHIP. He speaks regularly in support of the SHIP in senate hearings, and healthcare discussions.	1631 Richmond Dr. Twin Falls, ID 83301 lheider@senate.idaho.gov
Fred Wood, MD, Representative Idaho Legislature Chair, House Health and Welfare Committee	Representative Wood provides legislative perspective and support to Idaho's healthcare transformation plan. He has been an unfailing supporter of the SHIP and instrumental in developing House support for the plan. Rep Wood is also a physician, so brings that invaluable perspective to discussions as well.	July 2013-Present	Representative Wood, as chair of the Idaho House Health and Welfare Committee, provide house level leadership and connectivity for Idaho SHIP.	Idaho Legislature P.O. Box 1207 Burley, ID 83318-0828 fwood@house.idaho.gov
Physicians				
Andrew Baron, MD, Medical Director Terry Reilly Health Services Chair, Quality Work Group Chair, District 3 Regional Health Collaborative	Dr. Barron is medical director at Terry Reilly Health Services, a FQHC, serving large numbers of uninsured Idahoans.	July 2013-Present	Dr. Barron represents a community health center perspective, serving many low-income and uninsured patients.	Terry Reilly Administrative Office 211 16th Avenue, North Nampa, ID 89687 abaron@trhs.org andrew.baron.md@gmail.com

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Keith Davis, MD, Independent Physician President, Idaho Medical Association Board of Trustees Chair, District 5 Regional Health Collaborative	Dr. Davis is an independent family physician practicing in a large rural area. He is the only physician in his county and represents the views of rural physicians.	June 2013-Present	Represents small rural practice perspective. Also in leadership role at Idaho Medical Association.	Shoshone Family Medical Center NCQA Level 3 PCMH 113 S. Apple St. Shoshone, ID 83352 docdavis4L@hotmail.com
Scott Dunn, MD, Idaho Academy of Family Physicians Co-Chair, Idaho Medical Home Collaborative Chair, District 1 Regional Health Collaborative	Dr. Dunn is an independent family physician practicing in a small Idaho community.	June 2013-Present	Dr. Dunn represents small rural physician practice that has fully implemented PCMH and achieved NCQA level 3 recognition.	Family Health Center 606 N. 3rd Ave. #101 Sandpoint, ID 83864 dunn6@juno.com
David Peterman, MD, President Primary Health Co-Chair, Multi-Payer Work Group	Dr. Peterman is a pediatrician and represents a large primary care organization.	June 2013-Present	Dr. Peterman brings the perspective of both a pediatrician and president of an independent multi-clinic family practice.	Primary Health Medical Group 6348 Emerald St. Boise, ID 83704 david.peterman@primaryhealth.com
Dave Schmitz, MD Family Medicine Residency of Idaho,	Dr. Schmitz works with family medicine residents who are practicing in rural Idaho communities.	July 2014-Present	Dr. Schmitz represents Idaho Health Professions Education Council, and Idaho workforce issues.	Family Medicine Residency of Idaho 777 N. Raymond St. Boise, ID 83704-9251

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Chair of Idaho Health Professions Education Council				dave.schmitz@fmridaho.org
Provider Membership Associations				
Yvonne Ketchum, Executive Director Idaho Primary Care Association	Ms. Ketchum represents the membership association for Idaho's 13 community health centers. The CHCs have clinic sites in 40 locations across the state, including many rural communities.	November 2015-Present	Ms. Ketchum represents Idaho's 13 CHCs which provide primary care, dental and BH services to 10% of Idaho's population.	Idaho Primary Care Association 1087 W River St, Sui. 160 Boise, ID 83702 yketchum@idahopca.org
Deena LaJoie, Idaho Academy of Nutrition& Dietetics	Dieticians will plan a critical role in individual and population health.	March 2015 - Present	Ms. LaJoie represents the state's dieticians and can provide the important perspective of the role of diet and nutrition in maintaining personal and population health.	716 N. Troutner Way Boise, ID 83712-7545 208-284-2674 deenal@gmail.com
Susie Pouliot, Chief Executive Officer Idaho Medical Association	Ms. Pouliot represents the Idaho membership association for Idaho physicians.	June 2013-Present	Ms. Pouliot represents Idaho's physician community, including primary care and specialty care.	Idaho Medical Association 305 W. Jefferson St. Boise, ID 83702 susie@idmed.org
Neva Santos, Executive Director Idaho Academy of Family Physicians	Ms. Santos represents the Idaho membership association for Idaho family physicians.	June 2013-Present	Ms. Santos represents Idaho's family practice physician community.	Idaho Academy of Family Physicians 777 N. Raymond St. Boise, ID 83704 idahoafp@aol.com

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Larry Tisdale, CFO Idaho Hospital Association	Mr. Tisdale represents the membership association for Idaho's hospitals.	June 2013-Present	Mr. Tisdale represents Idaho's hospitals including large hospital systems as well as many small critical access hospitals.	Idaho Hospital Association 615 N. 7th St. Boise, ID 83702 ltisdale@teamiha.org
Jennifer Wheeler, Idaho Oral Health Alliance (IOHA)	Ms. Wheeler represents the oral health provider community	June 2015-Present	IOHA represents a consortium of oral health providers who bring needed expertise regarding the integration of oral health with physical health	IOHA PO Box 2039 Boise, ID 83701 jwheeler@idahooralhealth.org
Healthcare Systems				
Mike Dixon, MD, Executive Director, North Idaho Health Network	Dr. Dixon represents a network of physicians in N. Idaho.	June 2013-Present	Dr. Dixon represents views of physician networks.	1250 W. Ironwood Dr. Ste. 201 Coeur d'Alene, ID 83814 mdixon@nihn.net
Casey Meza, Executive Director, Affiliated Health Services Kootenai Health	Ms. Meza represents a large healthcare system in N. Idaho.	December 2014-Present	Ms. Meza brings the perspective of a large healthcare delivery system in N Idaho.	Kootenai Health 2003 Kootenai Health Way Coeur d'Alene, ID 83814 CMeza@kh.org
Daniel Ordyna, CEO Portneuf Medical Center	Mr. Ordyna represents a large healthcare system in S.E. Idaho.	March 2015 - Present	Mr. Ordyna brings the perspective of a large healthcare delivery system in SE Idaho.	Portneuf Medical Center 777 Hospital Way Pocatello, ID 83201 Daniel.ordyna@portmed.org
David Pate, MD, President and CEO St. Luke's Health System	Dr. Pate represents a large Idaho healthcare system with multiple sites in S. Idaho.	June 2013-Present	Dr. Pate brings the perspective of a large healthcare delivery system in S. Idaho.	St. Luke's Health System 190 E. Bannock St. Boise, ID 83712 pated@slhs.org

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Robert Polk, MD, Vice President & Chief Quality Officer, St. Alphonsus Health System	Dr. Polk represents a large Idaho healthcare system, with multiple sites in the Boise area.	September 2014-Present	Dr. Polk brings the perspective of a large healthcare delivery system in S. Idaho.	St. Alphonsus Health System 1055 N. Curtis Road Boise, ID 83706 jrobpolk@sarmc.org
Janet Willis, Assistance Director, Nursing Education VA Medical Center	Ms. Willis is a RN at the Idaho VA medical Center with particular expertise with the patient centered medical home.	September 2014-Present	Ms. Willis represents the nursing perspective in development of the PCMH and also bring the perspective of the Veterans Administration (VA)	VA Medical Center 500 W. Fort St. Boise, ID 83702 Janet.willis@va.gov
Payers				
Josh Bishop, Vice President & Regional Idaho Director, PacificSource	Mr. Bishop represents a large private payer in Idaho	June 2015-Present Pacific Source reps have been participating in SHIP discussions since 2013.	Josh Bishop represents one of Idaho's largest private insurers who play a critical role in developing a value based reimbursement plan for Idaho PCMHs.	PacificSource 408 E Parkcenter Boulevard, Suite 100 Boise, ID 83706 Josh.bishop@pacificsource.com
Melissa Christian, Vice President, Network Management Regence Blue Shield of Idaho	Ms. Christian represents a large private payer in Idaho.	This payer has been participating in multi-payer discussions in Idaho since 2010.	Ms. Christian represents one of Idaho's largest private insurers who play a critical role in developing a value based reimbursement plan for Idaho PCMHs.	Regence Blue Shield of Idaho 1211 W. Myrtle St. #110 Boise, ID 83702 Melissa.christian@regence.com
Jeff Crouch, Vice President	Mr. Crouch represents a large private	July 2013-Pesent	Mr. Crouch represents one of Idaho's largest private insurers who play a critical	3000 E. Pine Ave. Meridian, ID 83642

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
Provider Services, Blue Cross of Idaho Co-Chair, Multi-payer workgroup	payer in Idaho.		role in developing a value based reimbursement plan for Idaho PCMHs.	jcrouch@bcidaho.com
Lisa Hettinger, Medicaid Division Administrator, Department of Health and Welfare	Ms. Hettinger represents Idaho's Medicaid program.	May 2014 – Present	Ms. Hettinger represents of Idaho's public payer who play a critical role in developing a value based reimbursement plan for Idaho PCMHs.	Medicaid Division Department of Health & Welfare 3232 Elder St Boise, ID 83705 208-364-1804 HettingL@dhw.idaho.gov
Anne Wilde, JD, Representative Employers Health Coalition of Idaho	Ms. Wilde represents large employers' interests in improving Idaho's healthcare system.	May 2014-Present	Ms. Wilde represents Idaho's large employers whose understanding and support of PCMH and shifting reimbursement models will be critical to payer support of PCMH reimbursement.	Employers Health Coalition of Idaho P.O. Box 6230 Boise, ID 83707-6230 annewilde@wseco.com
Regional Public Health Districts				
Lora Whalen, District Director, Idaho Public Health District 1 (Panhandle)	Represents one of Idaho's 7 public health districts.	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Panhandle Health, 8500 N Atlas Hayden, Idaho 83835 208-415-5102 lwhalen@phd1.idaho.gov
Carol Moehrle, District Director, Idaho Public Health	Represents one of Idaho's 7 public health districts.	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Public Health Idaho North Central 215 10th Street Lewiston, Idaho 83501

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
District 2 (North Central)				208-799-3100 cmoehrle@phd2.idaho.gov
Nikole Zogg, District Director, Idaho Public Health District 3 (Southwest)	Represents one of Idaho's 7 public health districts.	December 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Southwest District Health, 13307 Miami Lane Caldwell, Idaho 83607 208-455-5315 nikolezogg@phd3.idaho.gov
Russell Duke, District Director, Idaho Public Health District 4 (Central)	Represents one of Idaho's 7 public health districts.	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Central District Health, 707 N. Armstrong Place Boise, Idaho 83704 208-375-5211 rduke@cdhd.idaho.gov
Rene LeBlanc, District Director, Idaho Public Health District 5 (South Central)	Represents one of Idaho's 7 public health districts.	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	South Central 1020 Washington Street North Twin Falls, Idaho 83301 208-737-5902 rleblanc@phd5.idaho.gov
Maggie Mann, District Director, Idaho Public Health District 6 (Southeastern)	Represents one of Idaho's 7 public health districts	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Southeastern Idaho Public Health 101 Alvin Ricken Drive Pocatello, Idaho 83201 208-233-9080 MMann@siph.idaho.gov
Geri Rackow, District Director, Idaho Public Health	Represents one of Idaho's 7 public health districts	February 2015-Present	PHD role to develop Regional Collaborative, support developing PCMHs, develop medical neighborhoods.	Eastern Idaho Public Health 1250 Hollipark Drive Idaho Falls, ID 83401

Appendix B
Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
District 7 (Eastern)				208-533-3163 grackow@eiph.idaho.gov
Regional Collaboratives				
Glenn Jefferson, MD, Valley Medical Center	Dr. Jefferson is the chair of the North Central Health Collaborative (PH District 2)	September 2015 - Present	As a voting member of the IHC, appointee will assume the role of a liaison between the IHC and the North Central Health Collaborative, providing expertise to, and soliciting feedback from the IHC in regard to organizing, operationalizing and sustaining the health neighborhood.	Valley Medical Center 2315 8th Street Lewiston, ID 83501 208-746-1383 GJefferson@ValleyMedicalCenter.com
Kevin Rich, MD, Family Medicine Residency of Idaho	Dr. Rich is the chair of the Central Health Collaborative (PH District 4)	September 2015 - Present	As a voting member of the IHC, appointee will assume the role of a liaison between the IHC and the Central Health Collaborative, providing expertise to, and soliciting feedback from the IHC in regard to organizing, operationalizing and sustaining the health neighborhood.	Family Medicine Residency of Idaho 777 N Raymond Street Boise, ID 83704 Kevin.Rich@FMRIdaho.org
William Woodhouse, MD, Family Medicine ISU	Dr. Woodhouse is the chair of the Southeastern Health Collaborative (PH District 6)	September 2015 - Present	As a voting member of the IHC, appointee will assume the role of a liaison between the IHC and the Southeastern Health Collaborative, providing expertise to, and soliciting feedback from the IHC in regard to organizing, operationalizing and sustaining the health neighborhood.	465 Memorial Drive Pocatello, ID 83201 WDHouse@fmed.ISU.edu
Boyd Southwick, MD, Family First Medical Center	Dr. Southwick is the chair of the Eastern Health Collaborative (PH District 7)	September 2015 - Present	As a voting member of the IHC, appointee will assume the role of a liaison between the IHC and the Eastern Health	Family First Medical Center 3614 Washington Street Idaho Falls, ID 83401

Appendix B
## Idaho Healthcare Coalition (IHC) Appointees

Appointee	Rational for Engagement	Timeframe for Engagement	Appointee Role/ Responsibilities	Contact Information
			Collaborative, providing expertise to, and soliciting feedback from the IHC in regard to organizing, operationalizing and sustaining the health neighborhood.	BSouthw@FamilyFirstIF.com
Community Stakeholders				
Karen Vauk, President & CEO Idaho Foodbank	Ms. Vauk represents the Idaho Foodbank, and serves on the IHC as a community partner representative.	August 2014- Present	Ms. Vauk represents a key community partner. Food insecurity for low income Idahoans can greatly impact health outcomes.	The Idaho Foodbank 3562 South TK Avenue Boise ID 83705-5278 208-336-9643 ext. 2693 kvauk@idahofoodbank.org

Appendix C

Cohort 1 Clinic Demographics

SHIP Cohort 1 by Region

Region	N	%
District 1 - Panhandle	7	13
District 2 – North Central	5	9
District 3 - Southwest	10	18
District 4 - Central	15	27
District 5 – South Central	4	7
District 6 - Southeastern	6	11
District 7 - Eastern	8	15
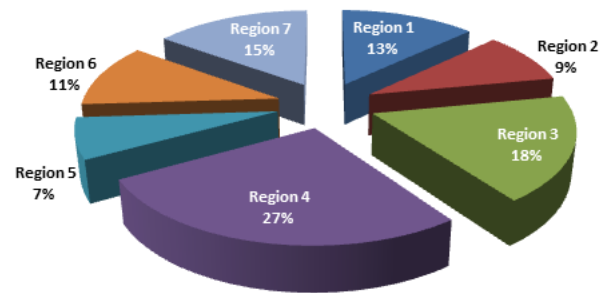
SHIP Cohort 1 by Practice Type

Practice Type	N	%
FQHC/CHC*	25	45
Health System/Hospital System Owned	12	21
IHS*	2	4
Private	14	25
RHC	3	5
*One IHS clinic also identified themselves as a CHC		

SHIP Cohort 1 by Specialty Type
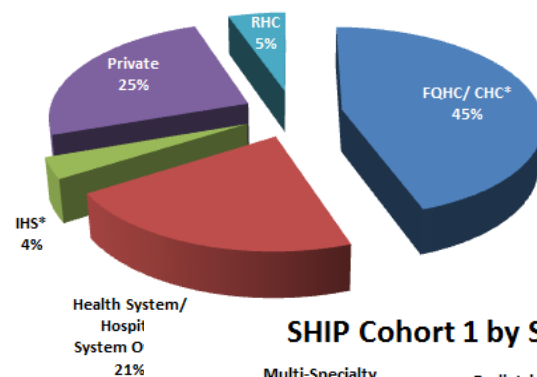
Specialty Type	N	%
Family Medicine	44	80
Internal Medicine	2	4
Mental and Behavioral Health	1	2
Endocrinology/Metabolism	1	2
Multi-Specialty	4	7
Pediatrics	3	5
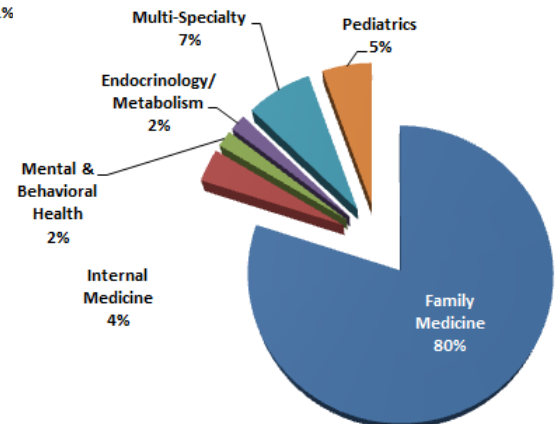
PCMH Accreditation	N	%
Not Currently Recognized	23	42
AAAHC	1	2
Joint Commission	4	7
NCQA Level 2	10	18
2011	9	
2014	1	
NCQA Level 3	17	31
2011	16	
2014	1	

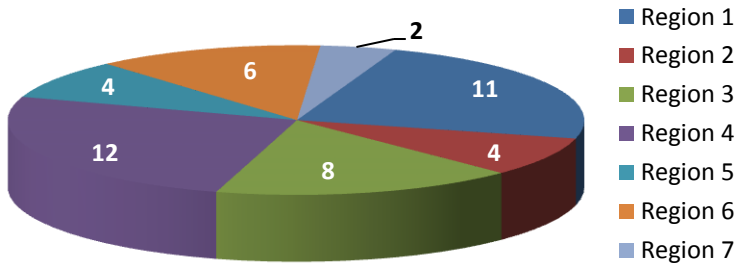### SHIP Cohort 1 PCMH Accreditation
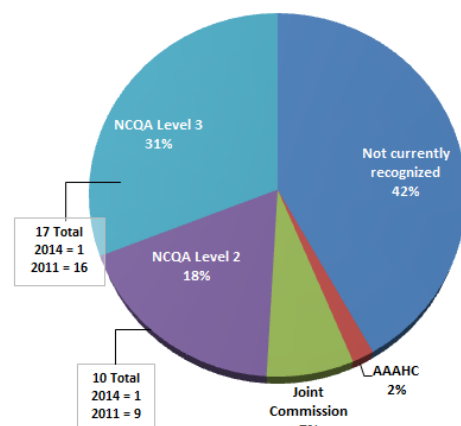
Appendix D

Behavioral Health Integration Survey

47 Idaho Medicaid Health Homes

- Region 1: 11
- Region 2: 4
- Region 3: 8
- Region 4: 12
- Region 5: 4
- Region 6: 6
- Region 7: 2

PCMH Recognition Levels

- NCQA 1: 3
- NCQA 2: 10
- NCQA 3: 31
- Other: 1
- None: 2

Clinic Type

- FQHC: 27
- Private: 12
- RHC: 1
- Hospitals: 7
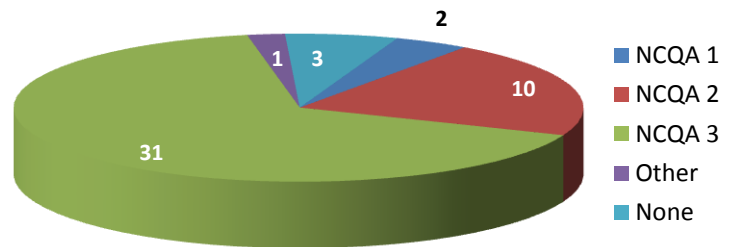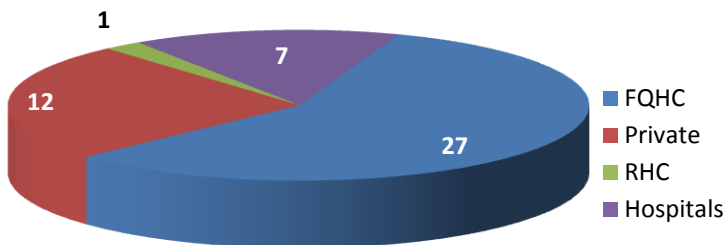
Primary Findings

Primary Care Physicians Routinely
- Treat mental health (mild-severe)
- Refer out chemical dependency

High PCMH Recogition (94%)

Community Health Centers and Rural Health Clinics
- Higher integration due to funding diversity

Behavioral Health Integration
- Did not always correlate to collaboration

Record and Referral Sharing
- Often one-way communication

Memorandum of Agreements
- Low frequency

Screening Tools
- Not used consistently or routinely

Behavioral Health Registries
- Low frequency or strategic use of information

Behavioral Health Training
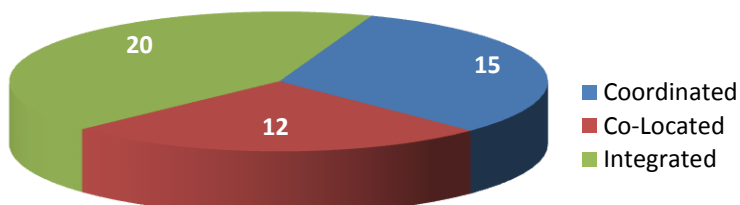- Rare in most clinics

Telehealth
- Very low utilization

Clinic Specialty

- Family Practice: 34
- Internal Medicine: 1
- Multi-Specialty: 5
- Pediatrics: 6

Behavioral Health Integration

- Coordinated: 15
- Co-Located: 12
- Integrated: 20
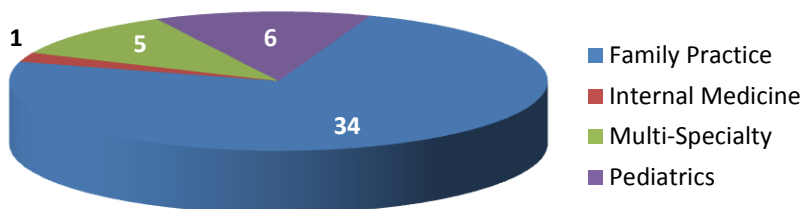
Appendix E

CHEMS Outcome Measures Workgroup

The CHEMS Outcome Measures Workgroup was charged with developing and implementing Community Health Emergency Medical Services (CHEMS) programs in rural and underserved communities as part of the virtual patient-centered medical home (PCMH).

a. Business need
   i. To expand primary care reach and capacity.
   ii. To improve access to healthcare services in rural and underserved communities with limited healthcare resources.
   iii. To ensure that CHEMS becomes an asset for the medical-health neighborhoods where gaps in services exist.
   iv. To ensure that CHEMS becomes part of the primary care team and improves access to healthcare services.
b. CHEMS Metrics Workgroup Meeting on January 22, 2016.
   i. Project Background and Local Perspectives
      1. Mary Sheridan, Bureau Chief, Bureau of Rural Health and Primary Care
         a. Mary provided an overview of how CHEMS fits within the context of the Statewide Health Innovation Plan.
      2. Wayne Denny, Bureau Chief, Bureau of EMS and Preparedness
         a. Wayne provided context for CHEMS within the Idaho EMS community.
      3. Mark Babson, Community Paramedic, Ada County Paramedics
         a. Mark shared Ada County Paramedics' experience in integrating CHEMS into its operations. Guest speakers, Dave Reynolds (Moscow Fire and EMS) and Rob Veilleux (Teton Valley Ambulance), shared their experience with CHEMS in rural areas of Idaho.
   ii. CHEMS Implementation and Measurement – A National Perspective
      1. Matt Zavadsky, Public Affairs Director, MedStar Mobile Healthcare
         a. Matt, a national expert on CHEMS implementation and measurement, shared his vast experience and knowledge and answered workgroup questions. His bio and slides were included in the workgroup participant materials.
   iii. Next Steps/Action Items
      1. The planning team will develop draft talking points and provide them to the workgroup sub team for feedback prior to the next workgroup meeting.
         a. (Sub team: Mike Mikitish, Christine Packer, Dr. Davis, Linda Rowe, Petra Thorseth, Robert Veilleux, Dave Reynolds)
      2. The next workgroup meeting will be February 25, 2016 in Boise.

Appendix F

CHW Curriculum and Delivery Model

The CHW Training Committee was charged with determining the recommended CHW training curriculum and delivery model for Idaho. The Committee consisted of over thirty Idaho stakeholders, and included representation from various divisions of the Idaho Department of Health and Welfare, and several health districts, hospitals, clinics, post-secondary institutions, and other key partners from across the state. A national CHW training expert was also consulted to advise this effort.

On October 15, 2015, the Committee identified the key competencies necessary for Idaho's CHWs, and then systematically analyzed the training curricula and delivery models offered in four states. The Committee came to consensus on the training curricula and delivery method(s) that would best meet Idaho's current needs for CHW development.

The CHW Training Committee recommended a training model that closely mirrors the State of Massachusetts' curriculum, with some adaptations. It recommends that Idaho CHW's receive a core curriculum, estimated at 64 hours, accompanied by electives to allow for flexibility in meeting the specific needs of Idaho's regions and agencies.

CHW Training Recommendations for Idaho

Part 1: Core Curriculum - Required
- Outreach education
- Community organizing
- Leadership skills
- Assessment techniques
- Public health
- Harm reduction and prevention
- Cross-cultural communication
- Emergency care
- Motivational interviewing
- Health insurance benefits
- Mental health
- Substance abuse
- Chronic disease

Part 2: Three Electives – Options including, but not limited to:
- Tobacco
- Cancer
- Methods for serving underserved populations
- Team-based care
- Personal safety
- Crisis management
- Advanced diabetes
- Children

- Weight management

The Committee agrees the following supporting considerations should be integrated:
- An organizational/agency readiness assessment (and accompanying provider training, if needed)
- Process evaluation and outcome measures
- The role of Regional Collaboratives in coordinating and refining the training, electives, etc.

The Committee recommends the following Idaho CHW training delivery methods:
- Core training delivered in person or live on-line, whenever possible
- Utilizing technology, such as podcasts and online discussion boards, to facilitate learning and optimize face-to-face classroom time
- Electives possibly offered online to facilitate accessibility (see Regional Collaboratives' role)
- A train-the-trainer system to support local relevance and training accessibility/sustainability

Appendix G

Telehealth Council SHIP Subcommittee

In November 2015, the Telehealth Council SHIP Subcommittee met for a facilitated day-long planning meeting to identify key action steps necessary to expand telehealth services in PCMHs and CHEMS programs. The Subcommittee meeting notes and information was presented to the Idaho Telehealth Council in December 2015. A high-level summary of the expansion plan is presented below and details are found in the Subcommittee notes at: http://ship.idaho.gov/workgroups/telehealthcouncil.

Overarching themes and observations from the day-long planning meeting include the following:

1. Developing and implementing a telehealth readiness assessment for PCMHs will help identify opportunities and barriers for establishing or expanding telehealth programs.
2. Providing training, coaching, mentoring, best practice resources, and billing education are needed to support program development in the PCMH.
3. Establishing telehealth in Community Health Emergency Medical Services (CHEMS) programs will require additional research, training, and resource development.

The Idaho Telehealth Council SHIP Subcommittee recommends an expansion plan that includes the following elements and action steps:

Phase One – Assessment
1. Conduct a PCMH medical-health neighborhood needs assessment to identify the community's healthcare needs, services gaps, and barriers that may potentially be addressed through telehealth.
2. Conduct a readiness assessment to measure the PCMH or CHEMS readiness to develop and implement a new telehealth program or expand a current program; the assessment will also identify unmet needs to establishing or expanding a telehealth program and may include:
   a. Availability of telehealth policies and procedures, capacity to identify a PCMH or CHEMS champion/telehealth coordinator, evaluation of technical infrastructure (equipment and sufficient bandwidth), determination of patient need for additional healthcare services, availability and capacity of providers to deliver needed healthcare services via telehealth, availability of funding and reimbursement opportunities, and determining resource needs.

Phase Two - Develop Telehealth Program & Evaluation Plan:
1. Create a detailed telehealth program plan, which may include a telehealth integration plan, communications strategy, revenue model, training and education, marketing, and technical support.
2. Develop an evaluation plan, specific to the telehealth program's development phase, to monitor the program, and provide quality assurance and risk management.

Phase Three - Implement & Support:
1. Implement or enhance an existing telehealth program, including the purchase of equipment, technical assistance, training and education, and peer learning or mentoring opportunities.
2. Provide assistance with billing and reimbursement, credentialing and licensing, and offer practice standards guidance.

Phase Four - Evaluate & Monitor:
1. Evaluate the telehealth program with metrics such as utilization rates, user satisfaction, cost effectiveness, patient outcomes, potential patient cost savings due to reduced travel for distant services, and new patient populations.
2. Use evaluation data to enhance existing services and improve program performance.
3. Continue to monitor the telehealth program and provide ongoing professional development.

The Subcommittee acknowledged significant challenges and barriers to telehealth adoption and expansion in Idaho and the need for intentional and conscientious oversight of expansion plan implementation.

Appendix H

Idaho Medicaid Healthy Connections Payer Strategy Summary
Updated January 2016

Idaho Medicaid plans to implement changes to its payment structure for its Healthy Connections primary care program to incentivize patient centered medical home development in coordination with the State Healthcare Innovation Plan (SHIP). Patients are attributed to practices based on their provider selection, or if no provider is selected, based on their past claims and proximity to provider locations and provider availability.

- Providers will receive per member per month payments (PMPM) for attributed patients to support activities directed towards improved patient care and better coordinated services.
- PMPM Payment amounts will vary depending on member and provider characteristics, as outlined in the table below.
- New regulations are under development to support these changes. Providers had the opportunity to participate in drafting these rules and providing input on specific requirements through negotiated rulemaking sessions.
- Rates shown below were developed to support care management employees and physician involvement in practice transformation

Healthy Connections Payments – Available to All Participating Healthy Connections Primary Care Providers			
Primary Care Program	**PMPM amount**	**Qualification for Payment**	**Administrative Requirements**
Healthy Connections Limited PMPM to reflect the minimal care coordination needs of patients	**$2.50** for <u>all</u> attributed Basic Plan Participants • *Well children* • *Well adults* • *Pregnant women* **$3.00** for <u>all</u> attributed Enhanced Plan Participants • *Aged 65 and up* • *Disabled and chronically ill adults* • *Children with special health care needs* *Individuals with severe and persistent mental illness or serious emotional disturbance*	**Similar to existing Healthy Connections requirements:** • Monitor and manage patient care • Provide preventive, routine and urgent care. • Coordinate care and provide referrals for designated services. • Management and documentation of patient's medications. • 24/7 after-hours access to a medical professional for purposes of referral to services.	**Reduced** - Referral no longer required for following services also requiring a physician's order • Durable Medical Equipment • Occupational Therapy • Physical Therapy • Speech Therapy • Hospice • Children's Developmental Disability Services

Idaho Medicaid Healthy Connections Payer Strategy Summary
Updated January 2016

Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications			
Primary Care Program	**PMPM amount**	**Qualification for Phase One Payments**	**Administrative Requirements**

Healthy Connections Access Plus
 	
For providers with minimal care coordination and enhanced access to care
	$3.00 for all attributed Basic Plan Participants
	$3.50 for all attributed Enhanced Plan Participants
		Similar to existing Healthy Connections requirements with addition of enhanced access to care:
		
		• Complete a tier application.
		• Provide preventive, routine and urgent care
		• Coordinate care and provide referrals for designated services.
		• Management and documentation of patient's medications.
		• 24/7 after-hours access to a medical professional for purposes of referral to services.
		• Enhanced patient access to care – must meet one of the following:
		  o 46 hours of access to care for patients
		  o Nearby Service Location with extended hours and shared EMR within same organization
		  o Patient portal to enhance access to care
		  o Telehealth - remote healthcare services
		  o Other – must be approved by the Dept.
			Reduced - Referral no longer required for following services also requiring a physician's order
			• Durable Medical Equipment
			• Occupational Therapy
			• Physical Therapy
			• Speech Therapy
			• Hospice
			• Children's Developmental Disability Services

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

Idaho Medicaid Healthy Connections Payer Strategy Summary
Updated January 2016

Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications			
Primary Care Program	**PMPM amount**	**Qualification for Phase One Payments**	**Administrative Requirements**
Healthy Connections Care Management *For providers with some patient centered medical home capabilities*	$7.00 for <u>all</u> attributed Basic Plan Participants $7.50 for <u>all</u> attributed Enhanced Plan Participants	**Proposed criteria – similar to existing "Healthy Connections" program requirements with the addition of some PCMH capabilities** *Required:* • Complete a readiness assessment and tier application. • Complete Patient Centered Medical Home Assessment (PCMH-A). • Create a well-defined 1 - 3 year plan to achieve national PCMH recognition. This plan must be submitted within six month and will be monitored by Medicaid primary care staff. • Enhanced patient access to care– must meet one of the following: o 46 hours of access to care for patients o Nearby Service Location with extended hours and shared EMR within same organization o Patient portal to enhance access to care o Telehealth - remote healthcare services o Other – must be approved by the Dept. • Provide physician leadership for PCMH efforts. • Dedicated care coordinator staff or equivalent support for care management of individuals with chronic illnesses. • Established connection to the Idaho Health Data Exchange (IHDE). *And one of the following:* • Enhanced care management activities – community health emergency medical services or community health workers, promotora model, home visiting model, or similar enhanced care coordination model with proven results. • Population health management capabilities - registry reminder system or other proactive patient management approach. • Behavioral health integration – co-located or highly integrated model of behavioral and physical health care delivery. • Referral tracking and follow-up system in place. • National Committee Quality Assurance (NCQA) level 1.2.pr 3 PCHM recognition or Utilization Review Accreditation Commission (URAC), Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC) or other PCMH national recognition.	**Reduced** - Referral no longer required for following services also requiring a physician's order • Durable Medical Equipment • Occupational Therapy • Physical Therapy • Speech Therapy • Hospice • Children's Developmental Disability Services

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

Provider Capability Payments – Additive to Patient Complexity Payments, Based on Provider Qualifications			
Primary Care Program	**PMPM amount**	**Qualification for Phase One Payments**	**Administrative Requirements**

Healthy Connections Medical Home
 	
Providers with advanced patient centered medical home capabilities
	$9.50 for all attributed Basic Plan Participants
	
	$10.00 for all attributed Enhanced Plan Participants
		Proposed criteria – similar to existing "Health Homes" program requirements:
		
		• Complete a readiness assessment and tier application.
		• Complete Patient Centered Medical Home Assessment (PCMH-A).
		• NCQA level 2 or 3 patient centered medical home recognition: URAC, Joint Commission, AAAHC or other patient centered medical home national accreditation.
		• Established bi-directional connection to the Idaho Health Data Exchange (IHDE) with demonstrated share relationship.
		• Provide physician leadership for PCMH efforts.
		• Dedicated care coordinator staff or equivalent support for care management of individuals with chronic illnesses.
		• Quality improvement activities directed at increased performance for quality measures.
		• Enhanced patient access to care – must meet one of the following:
		   ○ 46 hours of access to care for patients
		   ○ Nearby Service Location with extended hours and shared EMR within same organization
		   ○ Patient portal to enhance access to care
		   ○ Telehealth - remote healthcare services
		   ○ Other – must be approved by the Dept.
			Reduced - Referral no longer required for following services also requiring a physician's order
			
			• Durable Medical Equipment
			• Occupational Therapy
			• Physical Therapy
			• Speech Therapy
			• Hospice
			• Children's Developmental Disability Services

Quality Measure Reporting

Quality measurement tracking and reporting is a key component of Medicaid's strategy to support patient centered medical homes. Data will be exchanged between Medicaid and the provider, and vice versa. This will be a key piece of future payment strategies.

During the first phase of implementation (as outlined in the tables above) a claims data dashboard will be reported back to provider locations by Healthy Connections representatives:

- *Diabetes* – A1C completion
- *Asthma* – Asthma Emergency Department visits
- *Low Birth Weight* – Low birth weight per 100 births
- *Medication Management* – Adherence to Anti-Psychotics for Individuals with Psychotic Diagnoses
- *Acute Care Hospitalization* – Percent of patients admitted

Quality measure reporting will expand to include clinical data collected through the Idaho Health Data Exchange for SHIP core measures when that functionality becomes available.

Future Development Timeline

2016	Implementation of first phase as described above
2016 – 2017	Development of capacity to collect clinical measures through IHDE
	• Work with IHDE and SHIP data analytics contractor to develop methods for clinical measure data collection and reporting
	• Work with primary care providers to build EMR gateways to IHDE to facilitate data reporting
2017	Payment for performance based on quality measures begins for select providers on a voluntary basis
	• Quality measures will be collected via IHDE
2018	Expansion of payment for performance, to partially replace fee schedule reimbursement for providers electing to participate
2019 on	Development of shared savings approaches to reimbursement and fully capitated payments to primary care providers electing to participate

Appendix I

STATEWIDE HEALTHCARE INNOVATION PLAN

HEALTH INFORMATION TECHNOLOGY PLAN

IDAHO DEPARTMENT OF HEALTH AND WELFARE

Introduction

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

By using health information more effectively and efficiently throughout Idaho's health system, HIT has the potential to empower patients and their providers, make healthcare and the health system more transparent, enhance the study of care delivery and payment systems, and drive substantial improvements in care, efficiency, and population health. Details on the core elements of Idaho's HIT Plan in support of the SIM Model Test can be found in Table 1 — Health IT Support for Data/Information for Driver Diagram.

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

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

Figure 14 — PCMH Data Collection and Use
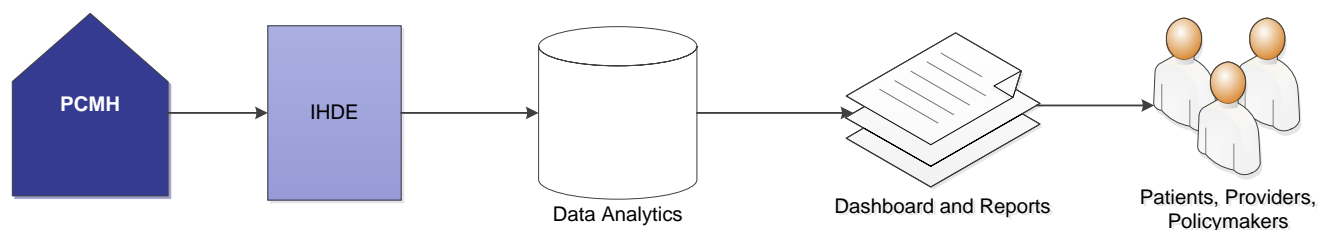
Idaho's HIT Plan also promotes the use of advanced health technology, such as telehealth, electronic health records (EHRs), patient portals, and clinical decision support tools to:

1. Reduce barriers to access for those living in rural areas.
2. Improve provider collaboration and coordination.
3. Increase patient engagement.
4. Increase training and specialized care in geographically isolated areas of the State.
5. Provide tools for population health monitoring and management
6. Gather statewide data that informs the activities needed to improve the quality of care, control healthcare costs, and achieve improved health outcomes.

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

1. Use technology, such as EHRs and remote patient-based monitoring systems, to coordinate care over time and across settings.

Over the three-year Model Test period, the IHDE will engage 165 PCMH clinic sites statewide to both adopt and use EHR technology and to connect to the IHDE. As the model matures, DHW and the IHC will determine the most appropriate ongoing HIT infrastructures to provide data aggregation and analytic support to facilitate Idaho's population health management. Idaho's SIM Model Test also supports improving rural patient access to a PCMH by developing 50 virtual PCMHs which includes integrating a component such as telehealth into these practices to support both physical healthcare and the integration of behavioral health and other specialty services.

2. Use technology to support maintaining a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations and other providers of services and suppliers.

Idaho's seven public health districts (PHDs) will support the Regional Health Collaboratives (RCs), which in turn will support practices as they transform to a PCMH and continue to expand their capabilities. RCs will convene and link PCMHs to the broader Medical/Health Neighborhood to coordinate patient care throughout the provider community. Connectivity via the IHDE for PCMHs, hospitals, and other organizations will allow for rapid electronic exchange of information and facilitates communications that cement lasting relationships among the patient's circle of supports. Under Idaho's SIM Model Test, PCMHs will receive community health needs assessment results from the RCs; these results will help drive healthcare strategic planning within the PCMH and across Idaho's healthcare landscape.

3. Use technology to enable a team-based approach to interventions, such as comprehensive care assessments, care planning and self-management coaching.

Broad-based care coordination, facilitated by the RCs and PCMHs and realized through HIT, will be essential for improving care quality, reducing errors and redundant services, keeping costs down, and promoting a patient-centric approach to healthcare in Idaho in which the patient is empowered to manage his or her healthcare.

4. Use technology to enable service providers and suppliers to share information with patients, caregivers, and other service providers on a

Idaho's first step in setting the technological foundation for coordinating care is the adoption and use of EHRs by 165 PCMHs and 21 hospitals, and ensuring their HIE capability can be leveraged to securely transmit and receive patient information through the IHDE. Over time, as Idaho further defines and develops its HIT infrastructure, additional users across the Medical/Health Neighborhood, specifically patients, will have access to real-time

real-time basis.	information sharing.

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

Table 1 — Health IT Support for Data/Information for Driver Diagram

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

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

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
5. Readmission rate within 30 days: Percentage of patients who were readmitted to the hospital within 30 days of discharge from the hospital.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
6. Avoidable emergency care without hospitalization (risk-adjusted): Percentage of patients who had avoidable use of a hospital ED.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
7. Elective delivery: Rate of babies electively delivered before full-term.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Hospital EHR collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.
8. Low birth weight rate (PQI 9): This measure is used to assess the number of low birth weight infants per 100 births.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Vital Statistics and hospitals collection, retention and transmission of data to IHDE and Data Analytics solution.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	P: Hospital reporting mechanisms. IT: Hospital connections to the IHDE.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
9. Adherence to antipsychotics for individuals with psychotic diagnoses: The percentage of individuals 18–64 years of age during the measurement year with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to medication compliance and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.
10. Weight assessment and counseling for children and adolescents: Percentage of children, 2–17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to counseling for nutrition and physical services and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.

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

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
13. Childhood immunization status: Percentage of children two years of age who have had four DtaP/DT, three IPV, one MMR, three H influenza type B, three Hepatitis B, one chicken pox vaccine, and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to childhood immunization status and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.
14. Adult BMI assessment: Percentage of members 18–74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	RCs, PCMHs, State, patients, payers, and the Centers for Medicare & Medicaid Innovation (CMMI).	Provider use of EHRs supports collection and retention of clinical information; the statewide healthcare Data Analytics Contractor supports aggregation and analysis; dissemination methodology TBD by Data Analytics Contractor.	O: The IHC and DHW will determine these changes in concert with the Data Analytics Contractor to be selected.	N/A	O: Patient flows (business operations) at the clinic level are not standardized related to BMI assessment and entry of data within EHRs. IT: Health IT will interface with IHDE to report this metric for the analytic solution.

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

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

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

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

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

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

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

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

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

Idaho SHIP Health Information Technology Plan

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
44. Goal 5: PCMHs with access to the analytics system: CUM # (%) of designated PCMH (sites) with access from the Data Analytics Contractor to the analytics system that provides dashboards and reporting.	RCs, PCMHs, State, and CMS.	Data collection – PCMH connection to Data Analytics Contractor. Data analytics – Data Analytics Contractor.	TA: to PCMHs on connection to Data Analytics Contractor. IT/O: PCMH connection to Data Analytics Contractor.	N/A	IT: Complete patient data may not be available since all providers are not yet connected to IHDE.
45. Goal 5: PCMH quality measure reporting: CUM # (%) of quality measures that are reported by all designated PCMHs.	RCs, PCMHs, State, and CMS.	Data collection – PCMH reporting. Data analytics – Data Analytics Contractor and State Evaluation Vendor.	TBD with Data Analytics Contractor and State Evaluation Vendor.	N/A	TBD
46. Goal 5: PCMHs that receive community health needs assessment results: CUM # (%) of designated PCMHs (sites) that receive community health needs assessment results from an RC.	RCs, PCMHs, State, and CMS.	TBD	TBD	N/A	TBD
47. Goal 6: Payer adoption of new reimbursement models: CUM # (%) of payers representing at least 80% of the beneficiary population that adopt new reimbursement models.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
48. Goal 6: Providers participating in value-based purchasing and alternative payment models: CUM # (%) of providers who are under contract with at least one payer to receive alternative (non-volume based) reimbursements.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.
49. Goal 6: Individuals receiving care through value-based purchasing and alternative payment models: CUM # (%) of beneficiaries attributed to all providers for purposes of alternative reimbursement payments.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.
50. Goal 6: Percentage of non-fee-for service (FFS) payments: Percentage of payments made in non-FFS arrangements compared to total payments made.	State and CMS.	N/A	N/A	N/A	O: Data collection from payers that will be used to leverage this metric.

Metric: What data will be used to track progress (how much and by when)?	Who needs the data? (1) State (2) HC delivery systems/managed care entity (3) providers (4) patients/ enrollees.	What Health IT is needed to support data collection, retention, aggregation, analysis, and dissemination?	What Health IT policy (P), technical assistance (TA), technology (IT), or business operation (O) changes are required and by when?	Identify and explain policy levers that will be used (if applicable).	Identify challenges & additional clarifications regarding Health IT Policy (P), TA, technology (IT) or business operation (O) changes required by item.
51. Goal 7: Per member per month (PMPM) cost: Total population-based PMPM index, defined as the total cost of care divided by the population risk score.	State and CMS.	N/A	N/A	N/A	N/A
52. Goal 7: Return on investment (ROI): Annual financial analysis indicates cost savings and positive ROI. Target ROI is 225%.	State and CMS.	N/A	N/A	N/A	N/A

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

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

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

1. HIT Governance

Organizational Structure and Decision-Making Authority Related to Health IT

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

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

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

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

Figure 15 — HIT Plan Organizational Chart
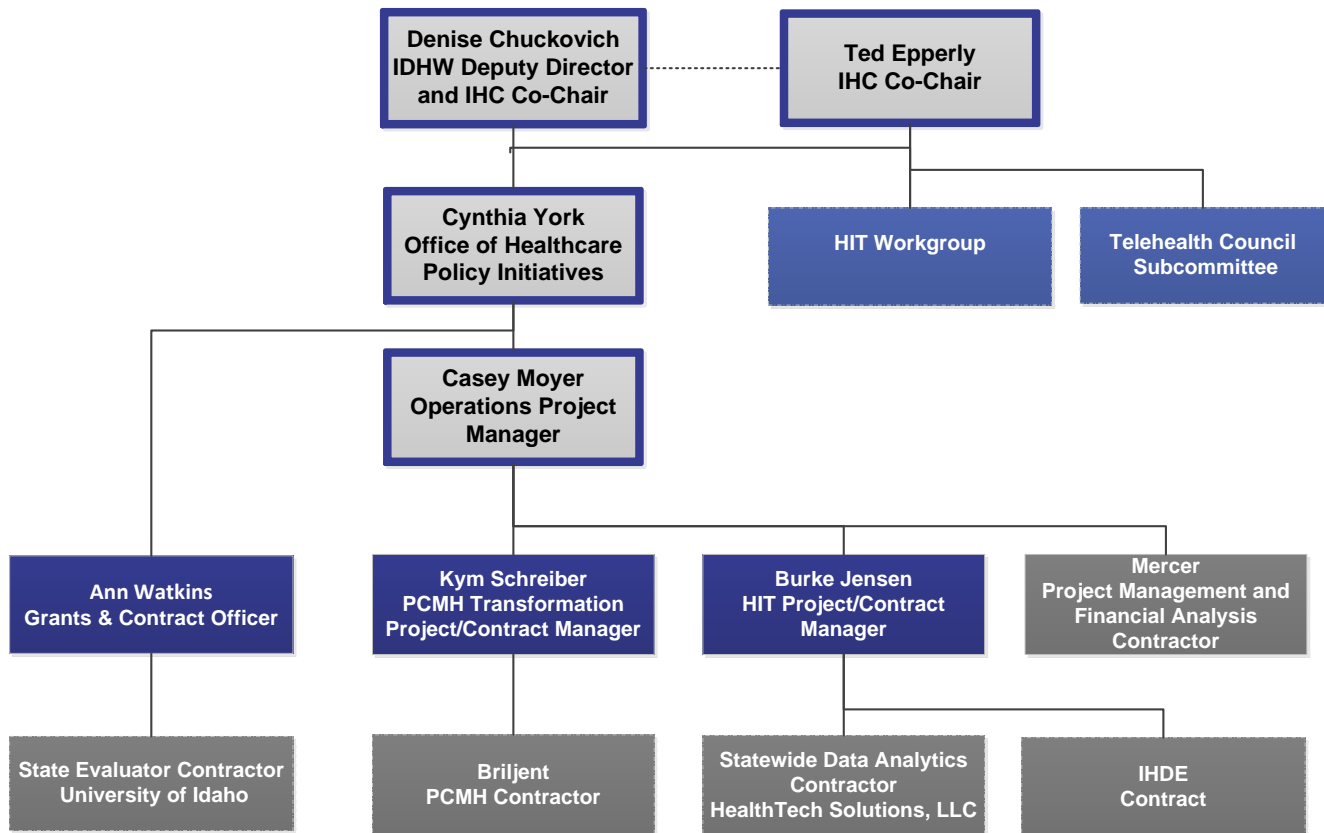
HIT Organizational Capacity

Implementation of the SIM Model Test HIT Plan provides an important opportunity for Idaho to build organizational capacity and infrastructure in this critical area. Throughout the Model Test, Idaho will continue to build its HIT organizational capacity and infrastructure through multiple sources including HIT experts, contractors, and other stakeholders. HIT-related positions are identified in Table 2. In this work, Idaho will continue to leverage the experience and expertise of its stakeholder partners, including the IHDE and the IHC's HIT Workgroup members, who have developed Idaho's SIM Model Test HIT Plan.

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

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

Table 2 — Health IT Related Positions

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

HIT Lead					Contact Information	
Health IT Activity	Position/Title (including Government Agency)	State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)	First Name	Last Name	Phone Number	Email Address
Project Management, Goal 2, and Goal 5	Operations Project Manager – SHIP	HS	Casey	Moyer	208-334-5581	Moyerc@dhw.idaho.gov
Goal 1	DHW Project/Contract Manager - PCMH Transformation	HS	Kymberlee	Schreiber	208-334-5577	SchreiberK@dhw.idaho.gov
Goal 3, Goal 4, Regional Health Collaboratives, CHEMS, and CHW	DHW Project/Contract Manager - Regional Health Collaboratives	HS	Miro	Barac	208-334-5594	BaracM@dhw.idaho.gov
Goal 3 and Regional Health Collaboratives	Chief, DHW Bureau of Rural Health and Primary Care	AS	Mary	Sheridan	208-334-0669	SheridaM@dhw.idaho.gov
Administrative Support	Administrative Assistant	HS	Kim	Thurston	208-334-0612	ThurstoK@dhw.idaho.gov
Grant Management	Grants & Contract Officer	HS	Ann	Watkins	208-334-5579	WatkinsA@dhw.idaho.gov
Strategic Direction	IHC Co-Chair	A	Ted	Epperly	208-954-8744	Ted.Epperly@fmridaho.org
HIT and Data Analytics Workgroup	Workgroup Chair, IHDE Executive Director	A	Scott	Carrell	208-332-7261	Scarrell@idahohde.org
Multi-Payer Workgroup	Workgroup Co-chair	A	Jeff	Couch	208-331-7564	Jcrouch@bcidaho.com

	HIT Lead				Contact Information	
Health IT Activity	**Position/Title (including Government Agency)**	**State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)**	**First Name**	**Last Name**	**Phone Number**	**Email Address**
Multi-Payer Workgroup	Workgroup Co-chair	A	David	Peterman	208-955-6500	David.peterman@primaryhealth.com
Clinical Quality Measures Workgroup	Workgroup Co-chair	A	Andrew	Baron	208-866-5029	Abaron@trhs.org
Telehealth Council	Telehealth Council Chair	A	Stacey	Carson	208-489-1401	Scarson@teamiha.org
PCMH Transformation	Briljent Lead, PCMH Transformation Contractor	C	Grace	Chandler	317-735-3497	Gchandler@briljent.com
PCMH Transformation	Health Management Associates (HMA) Lead, PCMH Technical Assistance Subcontractor	C	Lori	Wieselberg	312-641-5007	Lweiselberg@healthmanagement.com
PCMH Transformation	Myers and Stauffer Lead, PCMH Incentives Subcontractor	C	Jared	Duzan	317-846-9520	JDuzan@mslc.com
HIT Data Analytics	Data Analytics Contractor	C	TBD	TBD	TBD	TBD
SIM Model Test Evaluation	State Evaluation Contractor	C	TBD	TBD	TBD	TBD

	HIT Lead				Contact Information	
Health IT Activity	**Position/Title (including Government Agency)**	**State Appointed Staff (AS), State Hired Staff (HS), Contracted (C), Appointed (A)**	**First Name**	**Last Name**	**Phone Number**	**Email Address**
Project Management and Financial Analysis	Principal, Mercer Government Human Services Consulting	C	Katie	Falls	202-536-7451	Katie.Falls@mercer.com
Project Management and Financial Analysis	Senior Associate, Mercer Government Human Services Consulting	C	Jennifer	Feliciano	954-838-3406	Jennifer.Feliciano@mercer.com
Project Management and Financial Analysis	Senior Associate, Mercer Government Human Services Consulting	C	Maggie	Wolfe	202-331-2635	Maggie.Wolfe@mercer.com
IHDE Contract	IHDE	C	Scott	Carrell	208-332-7261	Scarrell@idahohde.org

Table 3 outlines projected expenditures by project area, with the associated identification of primary drivers and metrics for each project area.

Table 3 — Health IT Organizational Capacity – Project Management Budget Support

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

Health IT Stakeholder Engagement

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

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

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

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

HIT Stakeholder Priorities

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

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

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

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

Table 4 — Idaho SHIP HIT Workgroup Directory

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

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

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

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

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

By the fourth quarter of SIM Model Test Year 3, Idaho aims to implement several enhancements to the IHDE in support of healthcare transformation, including:
1. Increasing participation in IHDE by adding 165 PCMHs and 21 hospitals.
2. Expanding HIE data sharing agreements to support SHIP activities.
3. Expanding IHDE capabilities and system architecture.
4. Increasing IHDE's organizational capacity.
5. Expanding EHR data integration and other functionality.
6. Advancing analytic and reporting capabilities and providing value-added data analytics and reporting services to participants, the IHC and RCs.

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

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

- Total number of Medicaid MU-EPs who have received a payment with 2014 Certified System = 405 (402 unique EPs)
- Total number of Medicaid MU-EHs who have received a payment with 2014 Certified System = 17

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

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

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

Leveraging and Expanding Existing Public/Private Health Information Exchanges

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

2. Policy

Relevant Idaho Healthcare Policy Levers

As described in the Operational Plan, Idaho's SIM Model Test rests on a foundation of supporting legislative and executive action that created a framework for Idaho's healthcare transformation. However, while CMS-required components related to HIT are in place among Idaho's public payers, Idaho statute does not currently include additional requirements of public or private payers related to

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

1115 Medicaid Waivers and State Plan Amendment

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

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

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

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

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

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

Methods to Improve Transparency and Encourage Innovative Uses of Data

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

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

Promotion of Patient Engagement and Shared Decision Making

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

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

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

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

Year 1:

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

Year 2:

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

Year 3 and ongoing:

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

Table 5 — HIT Support for Patient Engagement and Shared Decision Making

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

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

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

Table 6 — Multi-payer Strategies to Enable and Expand Use of Health IT

Multi-payer Health IT Strategy	Payers	By Payer Status: (Planned, Engaged or Currently Participating)	Implementation Date (Indicate if expected date or actual date)
Implementation of HIT strategies and tools at the payer level to support alternative payment arrangements. HIT strategies will vary by payer, but in general include: • Beneficiary attribution • Encounter data • Claims processing and payment • Tracking of up-front PMPM payments • Data collection and reporting • Provider HIT tools	Medicaid, Medicare, Blue Cross, PacificSource, Regence, and Select Health.	Status varies by payer.	Implementation dates vary by payer.
Future plans for the IHDE include payer participation in HIE.	To be determined.	Planned	The HIT workgroup will be addressing this in Spring 2016.
Payer support for Virtual PCMH use of telehealth and advanced HIT tools.	Multiple payers are currently participating in the telehealth subcommittee.	Planned	Evaluation and planning are currently underway with an anticipated plan delivery date of May 2016.

3. Infrastructure

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

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

Table 7 below outlines the Health IT tools required to achieve these objectives.

Table 7 — State Implementation of Health-IT Tools to Coordinate Care

Health IT Tools	Purpose of Analytical Tools *(Identification and assessment — indicate type, coordination of care, decision support, other name)*	Status *(Planned, designed, implemented, operational and indicate as of date)*
EHR technology	Individual clinical data collection to support coordination of care among providers, PCMHs, caregivers, and others in the Medical/Health Neighborhood, and enable patients' greater access to information needed for self-management of healthcare.	Planned/operational (depending on provider)
HIE technology	System capable of receiving and transmitting clinical data, care summaries and communications between providers, PCMHs, caregivers, and others in the Medical/Health Neighborhood.	Planned/operational (depending on provider's connection to IHDE)
Clinical and claims-based data analytics system	System capable of collecting and standardizing data necessary for producing quality measurements reporting. System functionality includes: • Data retrieval and standardization from multiple source types including relational databases, data warehouses, analytic databases, distributed database systems, distributed file systems, and text files in a variety of formats. • Producing data analytics for participating clinic level, county level, RC level, and statewide level. • Data dictionaries. • Data controls and integrity. • Standard reports, ad hoc reports, dashboards, and scorecards. • Capability to track, analyze, and report feedback to individual providers on selected performance and outcome measures to improve their practice. • Role-based security with access controls.	Planned

Health IT Tools	Purpose of Analytical Tools *(Identification and assessment — indicate type, coordination of care, decision support, other name)*	Status *(Planned, designed, implemented, operational and indicate as of date)*
Statistical analysis	Initial analytical output for the following four performance measures: • Tobacco cessation intervention. • Weight assessment and counseling for children and adolescents. • Comprehensive diabetes care. • Additional performance measurement — TBD (from Idaho's Catalog of Performance Measures).	Planned
Predictive modeling	Identifying future utilization and projected outcomes.	Planned (dependent upon analytic vendor response)
Decision analytics	Analysis including variance measurement and statistical significance.	Planned
Telehealth technology	System capable of enabling patients in rural areas to receive healthcare services (including primary care, behavioral health, specialty evaluation, and monitoring) remotely; and to support workforce training in underserved areas.	Planned/operational (depending on provider)

Telehealth and Remote Patient Monitoring

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Technical Assistance

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

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

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

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

Table 8 — State Health IT TA to Providers

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