



Statewide **Healthcare
Innovation** Plan

Improved health, improved healthcare, and lower cost for all Idahoans

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What **Makes** Us Healthy



What We **Spend** On Being Healthy





IDAHO STATE HEALTH INNOVATION PLAN

HOW DID WE GET HERE?

Idaho Healthcare System Redesign Efforts	
2007	<ul style="list-style-type: none">◦ Governor Otter convened Healthcare Summit
2008	<ul style="list-style-type: none">◦ Governor Otter tasked Select Committee on Health Care◦ Idaho Health Data Exchange (IHDE) established◦ Safety Net Medical Home Initiative - 1st Patient Centered Medical Home (PCMH) Project in Idaho
2010	<ul style="list-style-type: none">◦ Idaho Medical Home Collaborative (IMHC) established
2013	<ul style="list-style-type: none">◦ Idaho awarded Center for Medicaid and Medicare Innovation (CMMI) planning grant to develop State Healthcare Innovation Plan (SHIP)
2014	<ul style="list-style-type: none">◦ Governor Otter establishes Idaho Healthcare Coalition (IHC)◦ Idaho submits CMMI testing application◦ \$39M State Innovation Model grant awarded



IMHC PILOT OUTCOMES

- Savings Per Member Per Mon (PMPM) from 2013-2014
- Reduced Utilization
 - Inpatient admissions; Readmissions; ER admissions
- 29 (of 30) recognized National Committee Quality Assurance (NCQA) clinics
- Self-reported 20-25% improvement in PCMH transformation change concepts
 - Quality improvement policies; Empanelment; Organized evidenced-based care
- Continued Primary Care Provider/Practice networking





PRIMARY SHIP GOAL

Redesign Idaho's healthcare delivery system to evolve from a fee-for-service, volume-based system to a value-based system of care that rewards improved health outcomes.



SHIP SUPPORTING GOALS

Goal 1: Transform primary care practices across the state into patient centered medical homes (PCMHs).

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical health neighborhood.

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

Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs.

Goal 5: Build a statewide data analytics system.

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

Goal 7: Reduce healthcare costs.



SHIP SUPPORTING GOALS

Goal 1: Transform primary care practices* across the state into patient centered medical homes (PCMHs).

*165 clinics over 3 years (55/yr)

- SHIP Manager, Quality Improvement Specialist, and Admin Assistant hired through the local public health districts
- PCMH Contractor
 - Both will work collaboratively to provide support, resources, and education to PCMHs

PCMH Pillars
Comprehensive
Patient-centered
Coordinated
Accessible
Quality
Safety



SHIP SUPPORTING GOALS

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood.

- EHR support
- Linkage with IHDE
- Data Analytics Contractor

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

- 7 Regional Health Collaboratives supported by the local public health districts



SHIP SUPPORTING GOALS

Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs

- A total of 50 of the 165 clinics will be designated ‘virtual’ based on rural locations and receive additional support for:
 - CHEMS
 - CHW
 - Telehealth



SHIP SUPPORTING GOALS

Goal 5: Build a statewide data analytics system.

- Data Analytics Contractor TBD
 - Clinic, regional, and statewide data reporting

Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.

- Multi-payer Payment Model
 - Medicaid, Blue Cross of Idaho, Pacific Source, Regence



SHIP SUPPORTING GOALS

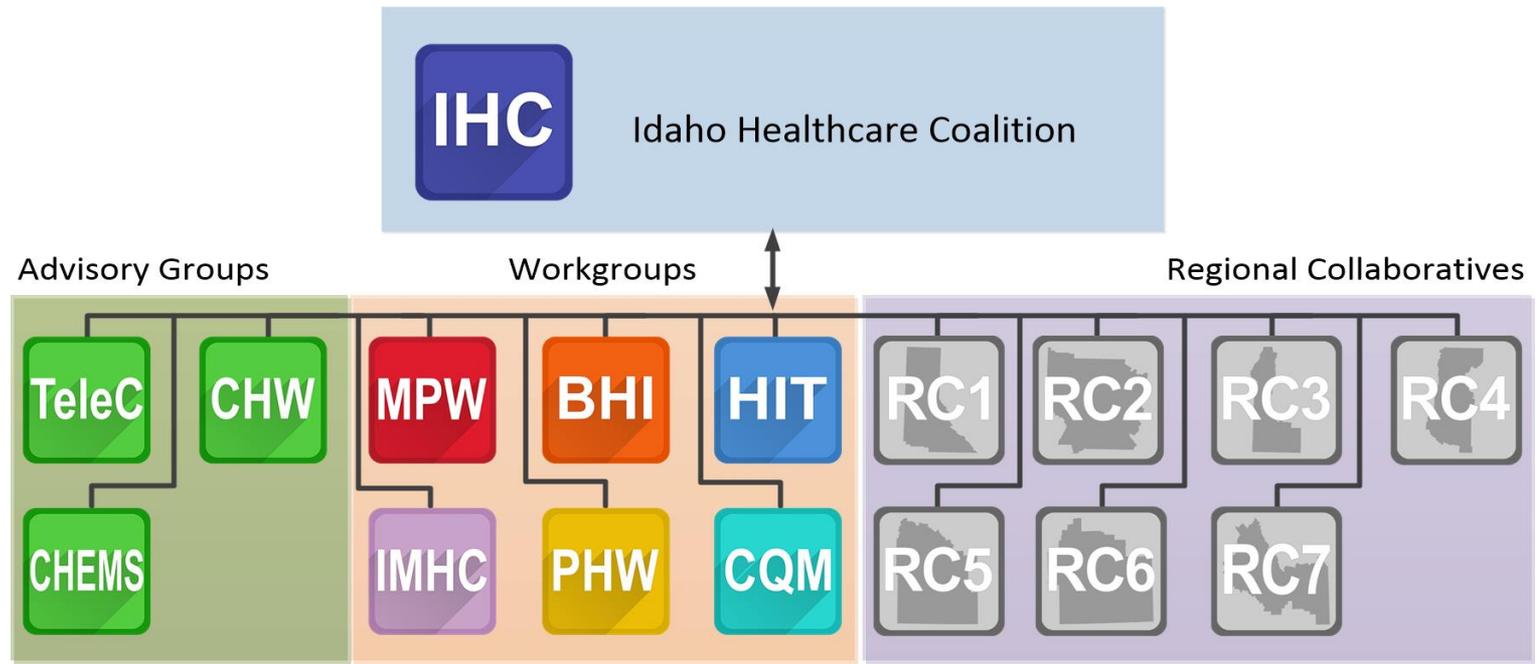
Goal 7: Reduce healthcare costs

- Dependent on successes of Goals 1 - 6



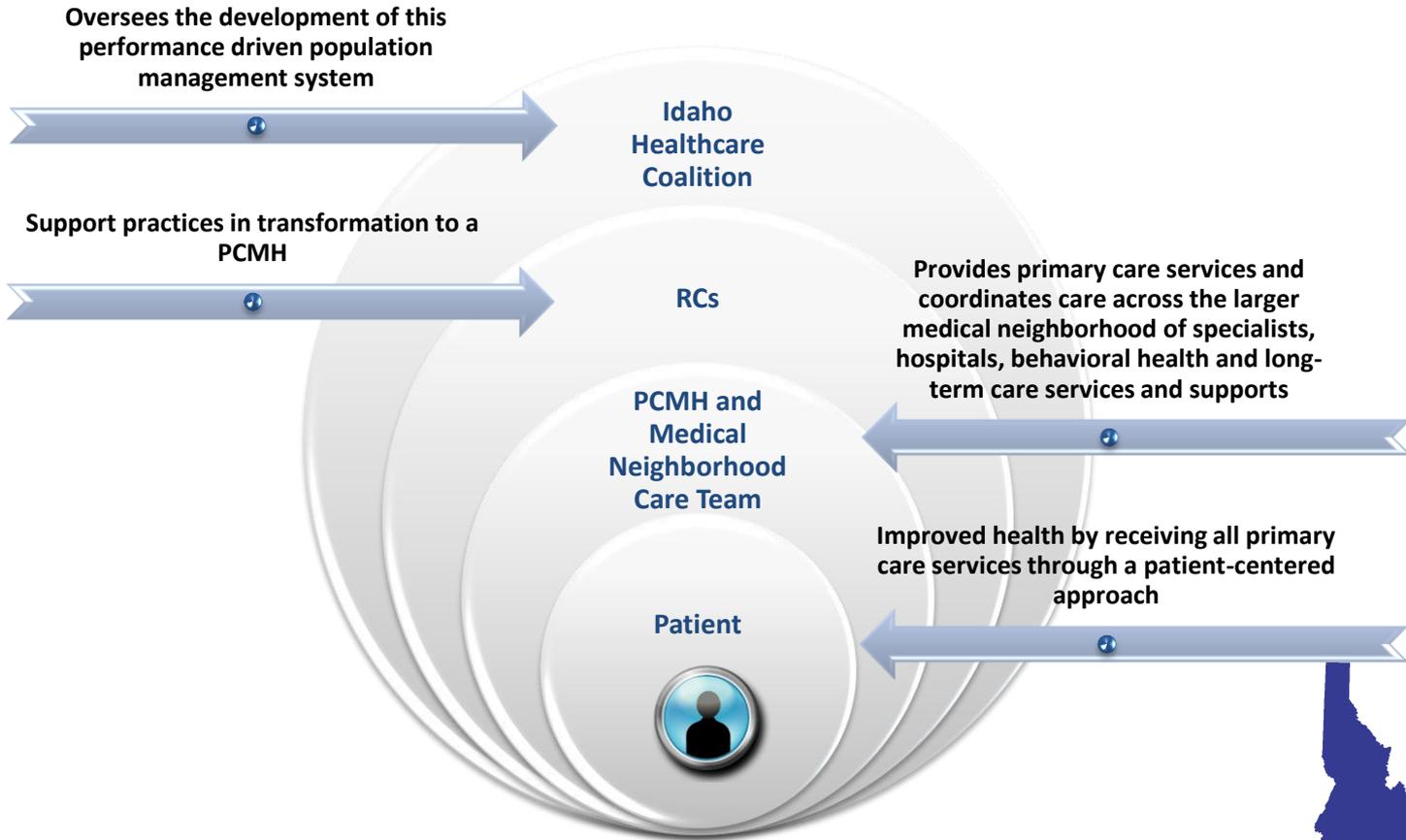


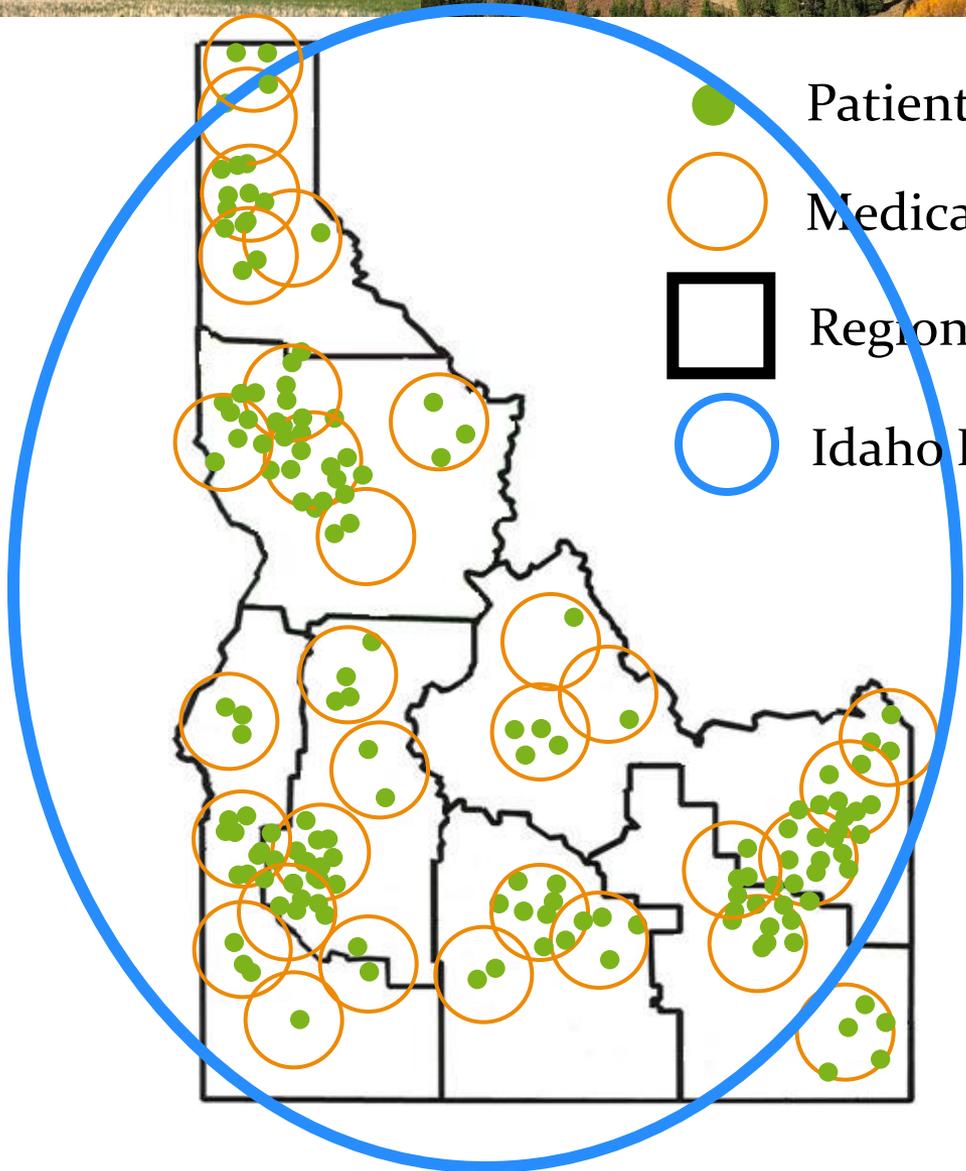
STRUCTURE & GOVERNANCE





OVERVIEW





- Patient Centered Medical Home (PCMH)
- Medical Health Neighborhood
- Regional Collaborative
- Idaho Healthcare Coalition (IHC) / SHIP



MEDICAL HEALTH NEIGHBORHOOD

- Diverse and interconnected clinical-community partnerships
- Medical, behavioral, social and public health supports that improve health and prevent disease
- PCMH serves as the patient’s primary “hub” and coordinator of health care delivery



PCMH GEOGRAPHIC DISTRIBUTION

- Regions (Health Districts) were allocated the number of clinic slots based on 2014 census population estimates

Region	Population	Clinic Slots
Region 1	221,398	7
Region 2	107,033	5
Region 3	268,080	10
Region 4	468,980	15
Region 5*	190,496	4
Region 6	168,854	6
Region 7	209,623	8

*Two slots from Region 5 were reallocated to Regions 1 and 7



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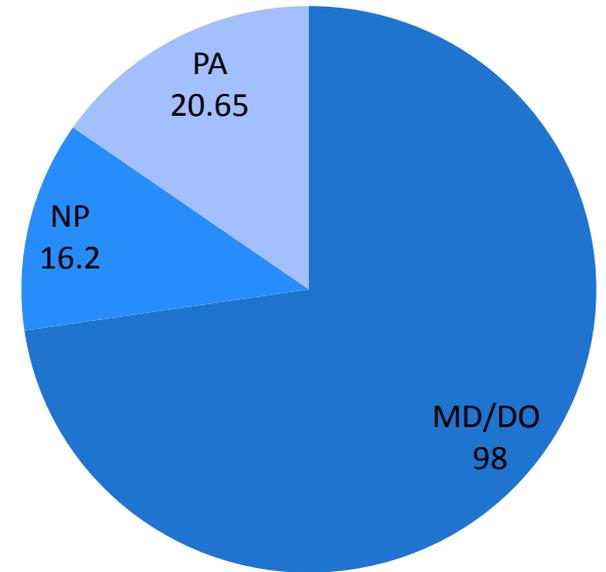
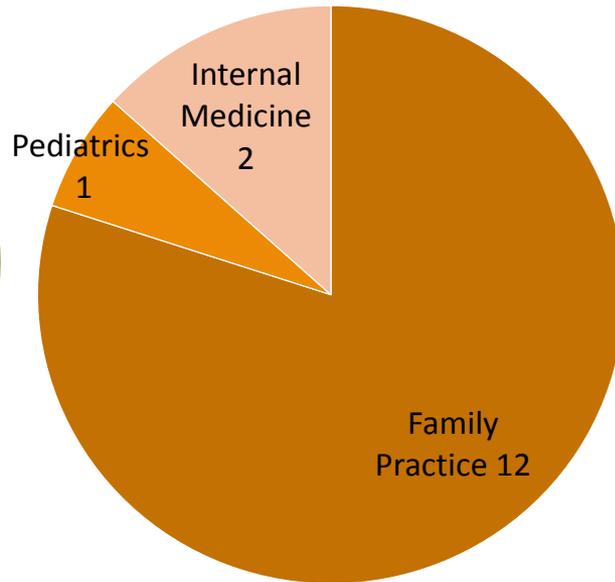
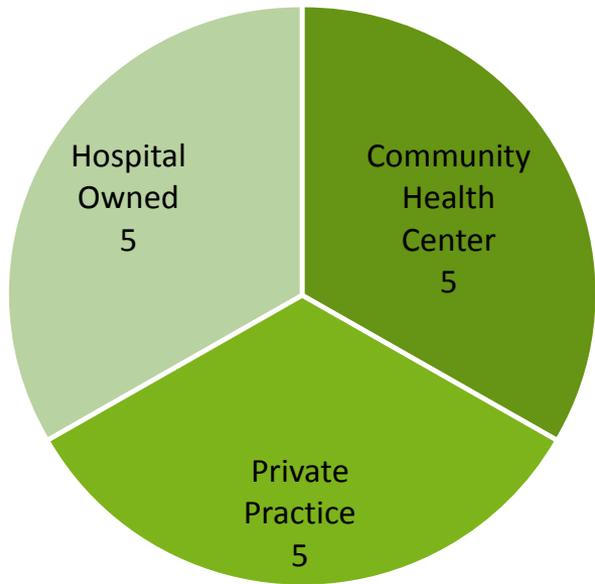
REGION 4 SELECTED CLINICS

SHIP Cohort 1 Clinics	
Desert Sage Health Center Mountain Home	Primary Health Medical Group Boise (Overland)
Glenns Ferry Health Center Glenns Ferry	Primary Health Medical Group Boise (Pediatrics)
Family Medicine Residency of Idaho Boise (Emerald St)	Primary Health Medical Group – Boise (West Boise)
Family Medicine Residency of Idaho Meridian	Terry Reilly – 23 rd St. Boise
Family Medicine Residency of Idaho Boise (Raymond St)	St. Al's Medical Group Eagle Health Plaza
St. Luke's Payette Lakes McCall	St. Al's Medical Group Boise (McMillan)
Sonshine Family Health Center Boise	St. Al's Medical Group Boise (Overland)
St. Luke's Internal Medicine Boise (Cloverdale)	



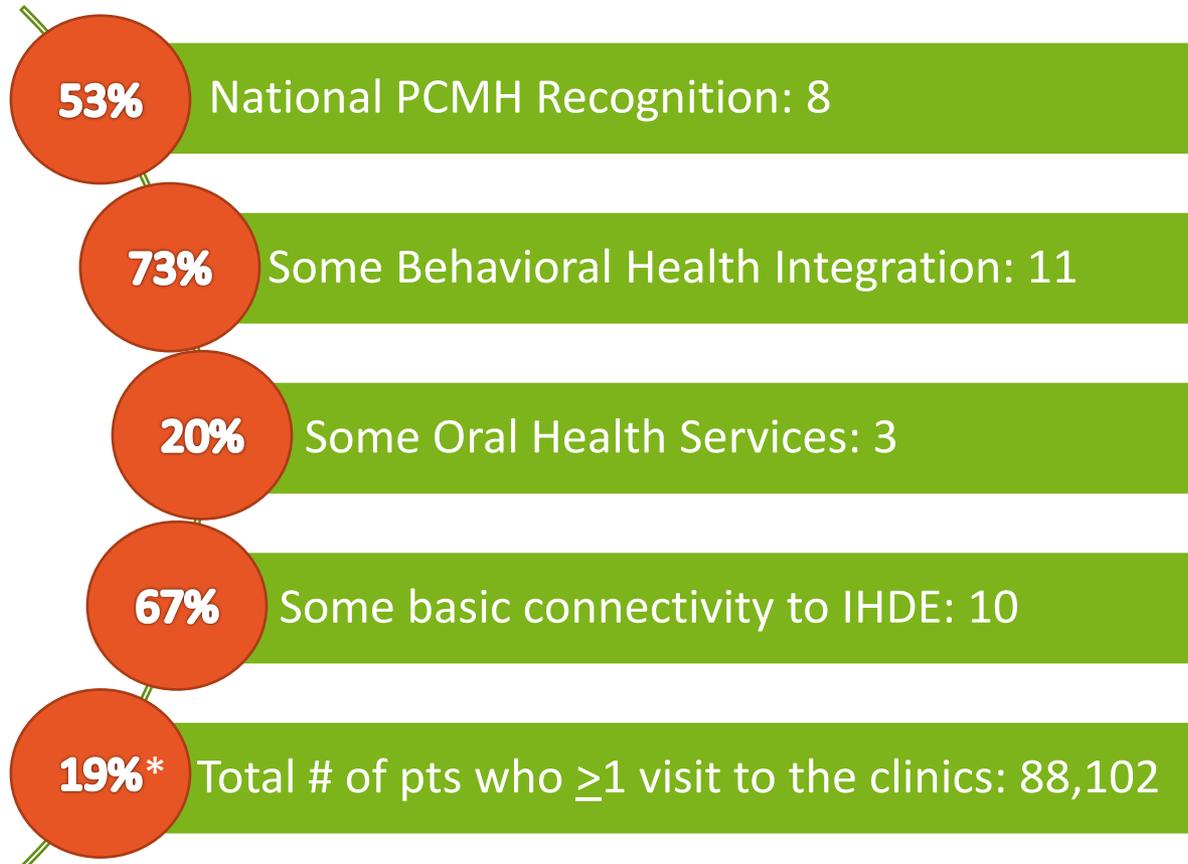


REGION 4 SELECTED CLINICS





REGION 4 SELECTED CLINICS



*of Region 4 population total (n = 468,980)

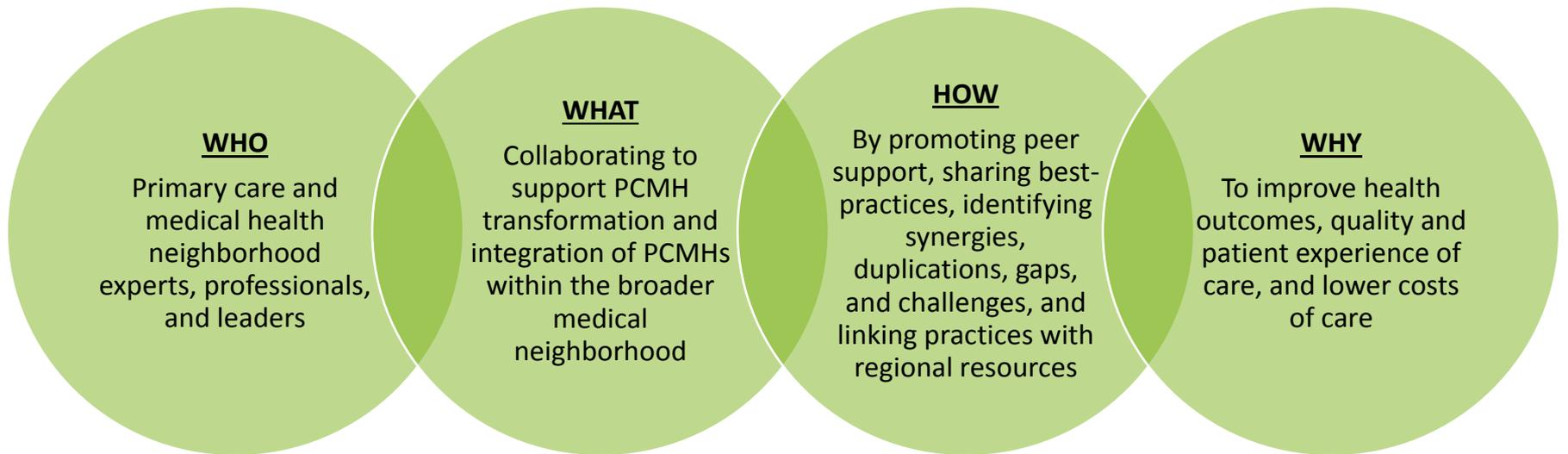


THE VALUE OF HEALTH COLLABORATIVES

Gina Pannell, SHIP Manager



CENTRAL HEALTH COLLABORATIVE



Communicate



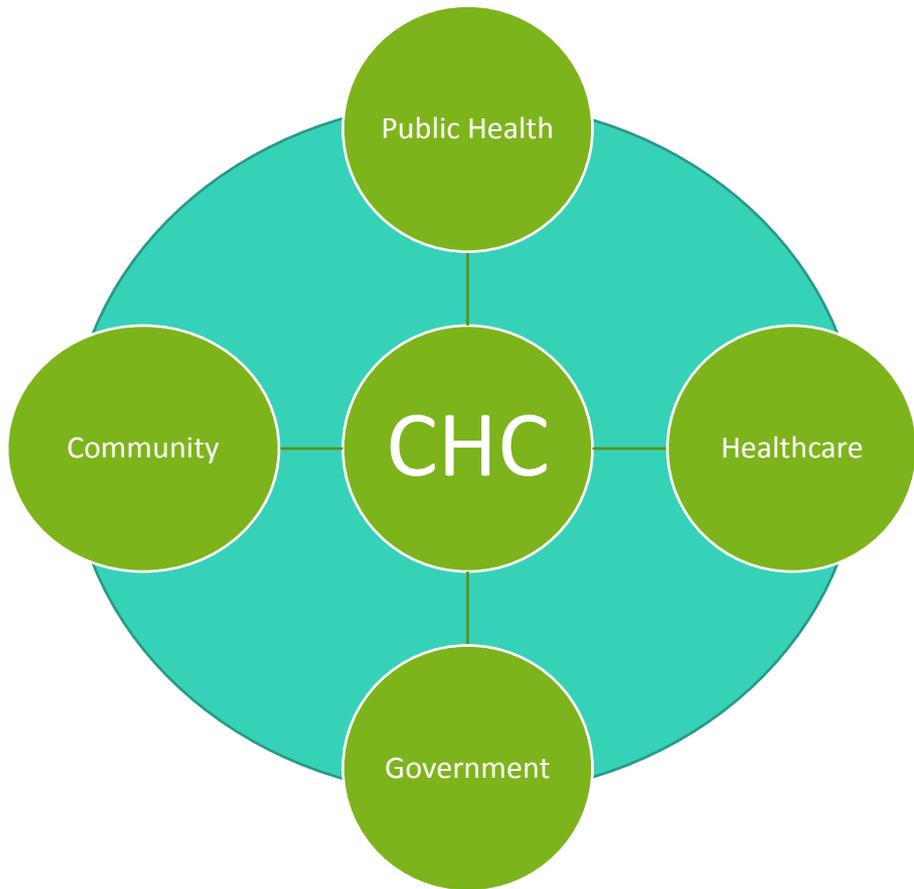
Educate



Innovate



CHC ROLE



Social Determinants of Health

Economic Stability

Education

Social and Community Context

Health and Health Care

Neighborhood and Built Environment



YOUR EXPERTISE AND THE CHC



The National Academy of Medicine, in their motto, quotes Goethe: *Knowing is not enough; we must apply. Willing is not enough; we must do.*

Institute of Healthcare Improvement:

<http://www.ihl.org/resources/Pages/AudioandVideo/WIHIEnduringCollab.aspx>



OUR FOCUS AREAS



PCMH Transformation support



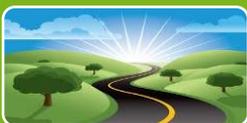
Medical health neighborhood



Communication and advocacy



Population health



Sustainability



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PRINCIPLES TO GUIDE COLLABORATIVES

- Take strategic risks
- Establish, share, and measure aims
- Remove barriers to progress
- Share knowledge and expertise freely
- Innovate
- Harness collective social and intellectual capital



CENTRAL HEALTH COLLABORATIVE

- Assisting the IHC with successful implementation of SHIP goals
- Advisory, not directive
- Communicates with IHC and other Regional Collaboratives
- Supports regional population health initiatives
- Works in partnership with healthcare professionals, hospitals, public health departments, and others
- Analyzes clinical and claims data for analysis and reporting



LEGACY/SUSTAINABILITY OF RCs

- This is a State Innovation Model (SIM) Test grant
 - Funding is for demonstration and infrastructure building
- No one has all of the answers right now
- There will be regional nuances & cross-district issues to address
- Requires stakeholder engagement to address population health
- Building enduring relationships is vital



THAT BRINGS US TO TODAY....

