



December 19th, 2019 3:00 pm

Location: 450 W. State St., 7th Floor,
Conference Room 7A

Meeting Minutes:

Member Attendees: Dr. Andrew Baron (phone), Norm Varin (proxy for Matt Bell), Kathy Brashear (phone), Denise Chuckovich, Dr. Keith Davis, Dr. Ted Epperly, John Heintz, Lisa Hettinger, Randall Hudspeth, Yvonne Ketchum-Ward, Dr. David Pate, Susie Pouliot, Patt Richesin, Neva Santos, Christina Thomas (phone), Larry Tisdale, Dr. Karl Watts, David Bell (proxy for Matt Wimmer), Nicole Zogg

OHPI Staff: Mary Sheridan, Ann Watkins, Shelby-Lyn Besler

Guests: Jim Borchers (phone), Phil Degan, Dieuweke Dizney-Spencer, Russ Duke, Director Dave Jeppesen, Craig Jones, Hans Kastensmith, Luke Kilcup, Janet Reis, Linda Rowe (phone), Stephanie Sayegh, Elke Shaw-Tulloch, Corey Surber (phone), and Prudence Vincent

Summary of Motions/Decisions:

Motion: Neva Santos moved to accept the minutes of the November 21, 2019, meeting of the Healthcare Transformation Council of Idaho as presented. **Outcome:** Passed
Second: Nikole Zogg

Motion: Susie Pouliot moved to accept John Heintz from Regence Blue Shield as a Payer Representative on the Healthcare Transformation Council of Idaho. **Outcome:** Passed
Second: Dr. Karl Watts

Motion: Denise Chuckovich moved to accept the Critical Access Hospital (CAH) workgroup charter as presented. **Outcome:** Passed
Second: Yvonne Ketchum-Ward

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; Review of Minutes; Action Items, and Agenda Review- *Dr. Ted Epperly & Dr. David Pate, Co-Chair of the HTCI* – **Action Items**

- ◆ Welcome everyone to the last meeting of 2019.
- ◆ Agenda order was modified to move discussion of the rural value-based budget model charter presentation after the introduction of John Heintz.

Appointment and Introduction of John Heintz, Payer Representative, Regence Blue Shield- *Dr. Ted Epperly & Dr. David Pate, HTCI co-chairs, John Heintz, Regence – Action Item*

- ◆ Mr. Heintz extensive experience with data analytics and value-based healthcare.
- ◆ Multi-state experiences will be valuable, particularly as it pertains to rural health initiatives.

Rural Value-Based Budget Model Workgroup Charter Presentation- *Patt Richesin, Kootenai Care Network, Larry Tisdale, Idaho Hospital Association, and Mary Sheridan, IDHW – Action Item*

- ◆ Briefly reviewed three objectives: 1) Develop a value-based model for CAHs and their primary care clinics, 2) Create training and educational models to support all staff in the transition to the proposed model, and 3) Create plausible, community-specific CAH staffing and infrastructure changes needed to successfully implement proposed model.
- ◆ The workgroup plans to complete the first phase of work by April 2020.
- ◆ The workgroup will meet monthly for full-day meetings from January – April 2020.

Idaho Health Data Exchange (IHDE) - *Hans Kastensmith, Executive Director*

- ◆ IHDE is adopting a new approach to its business and operations.
- ◆ Focus on value-based care and support to stakeholders with an emphasis on federally qualified health centers (FQHCs), small rural practices, critical access hospitals, and underserved areas.
- ◆ Several components are included in the framework and critical to building the foundational elements.
- ◆ Establishing an all claims database is a long-term goal.
- ◆ Key early initiatives include integrating the DHW Immunization Reminder Information System (IRIS) data and becoming the advanced directives central repository.
- ◆ New product offering designs will be released in about a month.
- ◆ Work and planning is underway to expand data sources and types to include claims (initially Medicaid), social determinants of health (SDOH), behavioral, geographic, homeless, corrections data, and many more.
- ◆ Received CMS funding to build the foundational elements.
- ◆ The key to success for IHDE is fostering and developing community engagement and support.

Idaho Academy of Family Physicians (IAFP) Survey Results- *Neva Santos, Executive Director*

- ◆ Started membership survey(s) in June 2018.
- ◆ Goal was to educate their members on topics important to Family Medicine and learn about their members' concerns/frustrations.
- ◆ In September 2019, the Value-Based Healthcare Survey was released to IAFP members with a 9% response rate. The lack of a higher response rate potentially indicated that many people were not well informed about value-based healthcare.
- ◆ Analysis of the 9% survey responses also revealed that additional education and training in value-based healthcare is needed for IAFP members.

Payor Provider Workgroup (PPW) Update- *Norm Varin, PPW Co-Chair*

- ◆ The PPW did not meet the month of December but will meet on January 24, 2020.

- ◆ In November, a presentation on sepsis by Kootenai Health staff demonstrated how they developed and implemented a program to address costs related to the treatment and diagnosis of sepsis. Their model also highlighted high levels of cooperation and coordination to achieve success.
- ◆ The financial analysis request for proposal was released in December 2019.
- ◆ The PPW is committed to continuing to meet to build value and to encourage others to get involved in their efforts.

Closing- *Dr. Ted Epperly*

- ◆ Future Meeting date: Thursday January 16th, 2020 from 3-5pm Mountain Time.

Meeting Adjourned: 04:50 pm

DRAFT



Healthcare Transformation Council of Idaho

Action Items

February 20, 2020 3:00PM

■ Action Item 1 – December HTCI Meeting Minutes

HTCI members will be asked to adopt the minutes from the December 19, 2019, HTCI meeting:

Motion: I, _____ move to accept the minutes of the December 19, 2019, meeting of the Healthcare Transformation Council of Idaho as presented.

Second: _____

HTCI
HEALTHCARE TRANSFORMATION
COUNCIL OF IDAHO

Value-Based Healthcare & the Healthcare Transformation Council of Idaho

Background

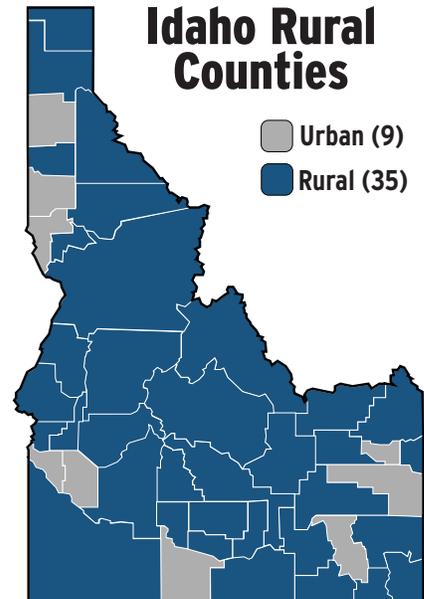
Value-based healthcare is a delivery model whereby providers, including hospitals, clinics and physicians, receive payments based on patient health outcomes and cost of care. Value-based payment agreements reward providers for helping patients to receive appropriate health screenings, benefits from preventive healthcare, improved health, reduced effects and incidences of chronic diseases, and live, overall, healthier lives. Patients receive cost-effective care that is designed to avoid unnecessary services, duplicative testing, or more expensive care than is necessary to achieve the desired outcome.

The Difference Between Value-Based Care and Fee-for-Service Care

In the fee-for-service model of care, providers receive payments based on the amount of healthcare services they deliver, regardless of whether the service was necessary, harmed the patient, or if a less expensive option would have produced the same or better outcome. The reimbursements do not reward quality, which creates adverse incentives that drive up costs. Fee-for-service payments also promote fragmentation, because providers receive payments for each service delivered, as opposed to value-based payments that, in the most advanced models, are fixed payments for all care or an episode of care that helps integrate and coordinate care.

Healthcare in Idaho

Idaho lags behind the nation in adopting value-based payment models. For rural and frontier providers, hospitals and clinics, implementing value-based payment models remains particularly difficult, as they often have limited financial resources to invest; lack interoperable data systems; face challenges with managing population health over large, sparsely populated geographical areas; and experience burdens of satisfying performance measurement and reporting requirements.



59% National rate for value-based payments

29% Idaho rate for value-based payments

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

January 2020

Benefits of Value-Based Care

Transitioning to a value-based healthcare delivery model provides many benefits to the state, including:

- Developing programs to align with public expectations of the healthcare delivery system while focusing efforts on containing state healthcare costs.
- Providing incentives for healthcare providers to deliver the best care at the lowest cost and help individuals achieve their best possible health.
- Advancing healthcare quality, improving population health and containing or reducing healthcare costs.

The Healthcare Transformation Council of Idaho (HTCI)

In February 2019, the state established the HTCI to continue Idaho's transformation efforts and movement towards value-based payment models. HTCI receives support from the Office of Healthcare Policy Initiatives (OHPI) in the Bureau of Rural Health and Primary Care, Division of Public Health.



Statewide Coordination, Collaboration and Support

HTCI provides leadership, coordination and communication to advance value-based healthcare in Idaho, in addition to leveraging resources strategically to overcome fragmented systems of care.

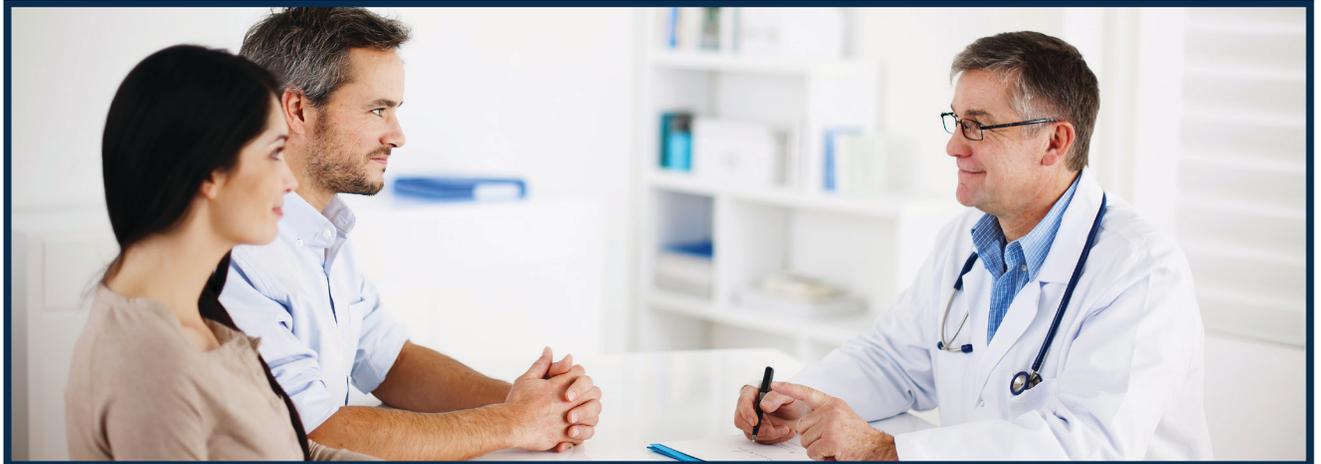
OHPI supports HTCI by implementing strategies and tactics that encourage the adoption of value-based models, so that Idaho can achieve a more efficient healthcare system with improved outcomes. OHPI also convenes workgroups, under the direction of HTCI, to move ideas into action. Current initiatives include advancing telehealth, identifying cost drivers to contain healthcare costs and developing an innovative value-based model for rural and frontier areas.

Although the four-year Statewide Healthcare Innovation Plan (SHIP) successfully initiated the shift from volume to value, additional time and collaboration remains critical to advancing healthcare reform in the state. Achieving value-based healthcare outcomes is a long-term, time-consuming and labor-intensive endeavor for healthcare providers and organizations. No state has already solved this problem that would allow Idaho to simply implement a solution. Many providers are already engaged in transformation efforts and are increasingly working toward value-based payment arrangements; however, challenges and barriers persist.

What Will Help the State Transition Successfully?

- Sustained funding for HTCI and OHPI to continue developing, implementing and leading statewide value-based efforts.
- Providers are investing significantly in the infrastructure necessary to be successful under value-based arrangements and incurring financial losses in the transition, which often takes years. Providers participate because it's the right thing to do, however, it is contrary to their best interest in the fee-for-service environment. Continuing to engage them in this is critical to success.
- Providers, clinics, hospitals and health system leaders must improve clinical quality, reduce inefficiencies and manage costs to thrive in a value-based setting.
- Resources, education and technical assistance will help support healthcare transformation to value-based models, especially in rural and frontier areas.

Examples of How Patients Benefit from Value-Based Healthcare



Care coordination contributes to value-based healthcare and improved health.

Scenario: Mr. Jones is a 54-year-old man with asthma

Fee-for-service model:

Mr. Jones makes repeated trips by ambulance to the hospital emergency department for shortness of breath. Each time, the emergency room physician and staff provide the necessary medications and treatments to alleviate his shortness of breath and discharge him home. Mr. Jones' shortness of breath continues to worsen, and he is transported to the emergency room nearly every three to four weeks. He receives multiple bills every time he is transported and treated, and he can no longer afford to pay the amount due.

Value-based healthcare model:

Mr. Jones made a trip by ambulance to the hospital emergency department for shortness of breath. The emergency room physician and staff provided the necessary medications and treatments to alleviate his shortness of breath and, before discharging him home, he and his family met with the nurse case manager. The case manager learned that Mr. Jones has a primary care provider that prescribed appropriate asthma medications, and that his clinic recently hired a nurse care coordinator. The care coordinator visited Mr. Jones at home and learned about issues impacting his health that were not apparent to his provider: his adult daughter recently moved home and smokes in the house; and Mr. Jones cannot afford his prescription medications but was embarrassed to tell his provider. The care coordinator spoke with Mr. Jones and his daughter to develop a plan to maintain a healthier home environment and spoke to his provider and pharmacy to find a more affordable medication. Mr. Jones had no trips to the emergency department in the following months.

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

January 2020

Appropriate screening contributes to value-based healthcare through early detection.

Scenario: *A primary care clinic has a very low rate of colon cancer screenings for their patients.*

Fee-for-service model:

Clinic staff understand that age-appropriate disease screening is essential to prevention, early detection, and management; however, patients just do not seem to schedule their colonoscopy when it is recommended and, under fee-for-service, there is no incentive for the clinic to spend the additional resources needed to reach out to patients and make the case for why they should proceed with the screening.



Value-based healthcare model:

The primary care clinic recently joined a value-based care network of providers. They were unhappy to learn their colon cancer screening rates were below every other clinic in the network. The clinic generated a list of eligible patients that had not received their colon cancer screening and contacted each patient. They learned the screenings did not occur for a variety of reasons and staff worked with every patient to resolve the issues. They referred patients for testing and followed up with them to assure the screening was completed. Months later, the clinic is the top performer in the network. Additionally, six patients were found to have cancerous lesions and had interventions while the cancer was early, more manageable, and far less costly to treat.



Advanced care planning contributes to value-based healthcare while aligning with a patient's end-of-life wishes.

Scenario: *Mrs. Smith is an 89-year-old woman with diabetes and heart failure.*

Fee-for-service model:

Mrs. Smith recently moved to Idaho to live with her son and daughter-in-law. Before moving to Idaho, she was hospitalized four times in the past nine months, was prescribed 11 different medications, and used oxygen to walk more than 20 feet. Her doctor also told her that her kidneys were failing, and she would need to start dialysis.

Her care providers assumed she would opt for all possible treatments, but no one took time to sit down with her and her family to discuss her wishes.

Value-based healthcare model:

Mrs. Smith sees a new provider after moving to Idaho. In preparing for the appointment, her new provider reviewed her medical records and scheduled a longer visit to discuss her end-of-life wishes. Mrs. Smith's son accompanied her to the appointment and said he had never broached the subject with her. The provider discussed her current health status, including the need for dialysis, and asked Mrs. Smith about her personal preferences. She told her doctor that if her condition worsens, she wanted to remain comfortable and stay at home. The provider connected Mrs. Smith and her family to hospice and palliative care for the support and care she had requested. The patient remained at home and kept comfortable; had meaningful interactions with her family and friends up until the end; and significant hospital, intensive care, and physician costs were averted.



Telehealth is a strategy providers may use to support value-based healthcare by providing readily accessible care instead of higher cost alternatives.

Scenario: *Cody, an active 10-year-old, wakes up early in the morning to get ready for school. He is complaining about red and itchy eyes.*

Fee-for-service model:

Cody's mom is getting ready for work and is not sure whether it is safe to send Cody to school. She decides to take him to an urgent care clinic for a diagnosis and get to work as quickly as possible. Unfortunately, there is a long wait. While Cody's mom is finally glad to hear he has severe allergy symptoms and not an infection, she has missed more time off work than anticipated.

Value-based healthcare model:

When Cody wakes up with red, itchy eyes, his mom connects to their primary care provider's practice through a secure audio and video connection. The provider reviews Cody's health history, asks his mom some questions, and examines his eyes via webcam. They determine Cody can be safely treated with over-the-counter antihistamines and understand they would be referred for an in-person visit, depending on how he responds. Cody's primary care provider group is part of a value-based healthcare network. Providers are incentivized to deliver the most efficient and effective care at the lowest cost. Cody goes to school and his mom does not miss much work as a result of the appointment.

Hospitals and health systems positively impact the social determinants of health by reinvesting shared savings from value-based healthcare models.

Scenario: *A local hospital serves an area of the state with high poverty and low per capita income. Food insecurity is often an issue for their patients and newly diagnosed diabetics cannot access the type of food needed to achieve better health.*

Fee-for-service model:

The hospital advises patients about a small, local foodbank; however, the foodbank does not have the resources to keep up with demand or the fresh produce needed for the hospital's diabetic patients. While the hospital supports the food bank through local fundraising by volunteers, their patients cannot achieve their best possible health without proper nutrition.



Value-based healthcare model:

The hospital participates in a value-based shared savings model with public and commercial payers. At the end of the year, the hospital receives a portion of the money saved and reinvests the savings in the community. This reinvestment will improve the health of the community and continue to drive down healthcare costs, which will result in even more savings. This year, the hospital establishes a collaborative partnership with other health and social service agencies in the community. The partnership is focused on increasing access to healthy food and education for diabetic patients. They also create a program for newly diagnosed diabetics and provider education, two months of appropriate food, and a weekly visit from a community health worker — all at no charge to the patient. As a result, the hospital is reducing unnecessary hospital admissions and emergency department visits, while the clinic is seeing an overall improvement in outcomes for diabetic patients.



WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE

Alexis Pickering, MHS

Health Strategist

February 20, 2020

DISCUSSION TOPICS

- Background
- Intro to Western Idaho Community Health Collaborative (WICHC)
- WICHC Structure
- Funding Council
- Braiding and Blending Funding
- Data Workgroup
- DASH Mentorship with Elevate Health
- Current WICHC Work Plan
- Looking Ahead

BACKGROUND

- Regional Collaboratives from Statewide Healthcare Innovation Plan
- Stakeholders recognized value in combining resources to achieve greater and sustainable impacts on community health
- Realization of the regional and intersectional health issues that need to be addressed upstream
- In year one, we received \$119,400 in one-time funding from Idaho State Legislature and \$40,000 in private funds
- First WICHC meeting on August, 6, 2019

INTRO TO WICHHC

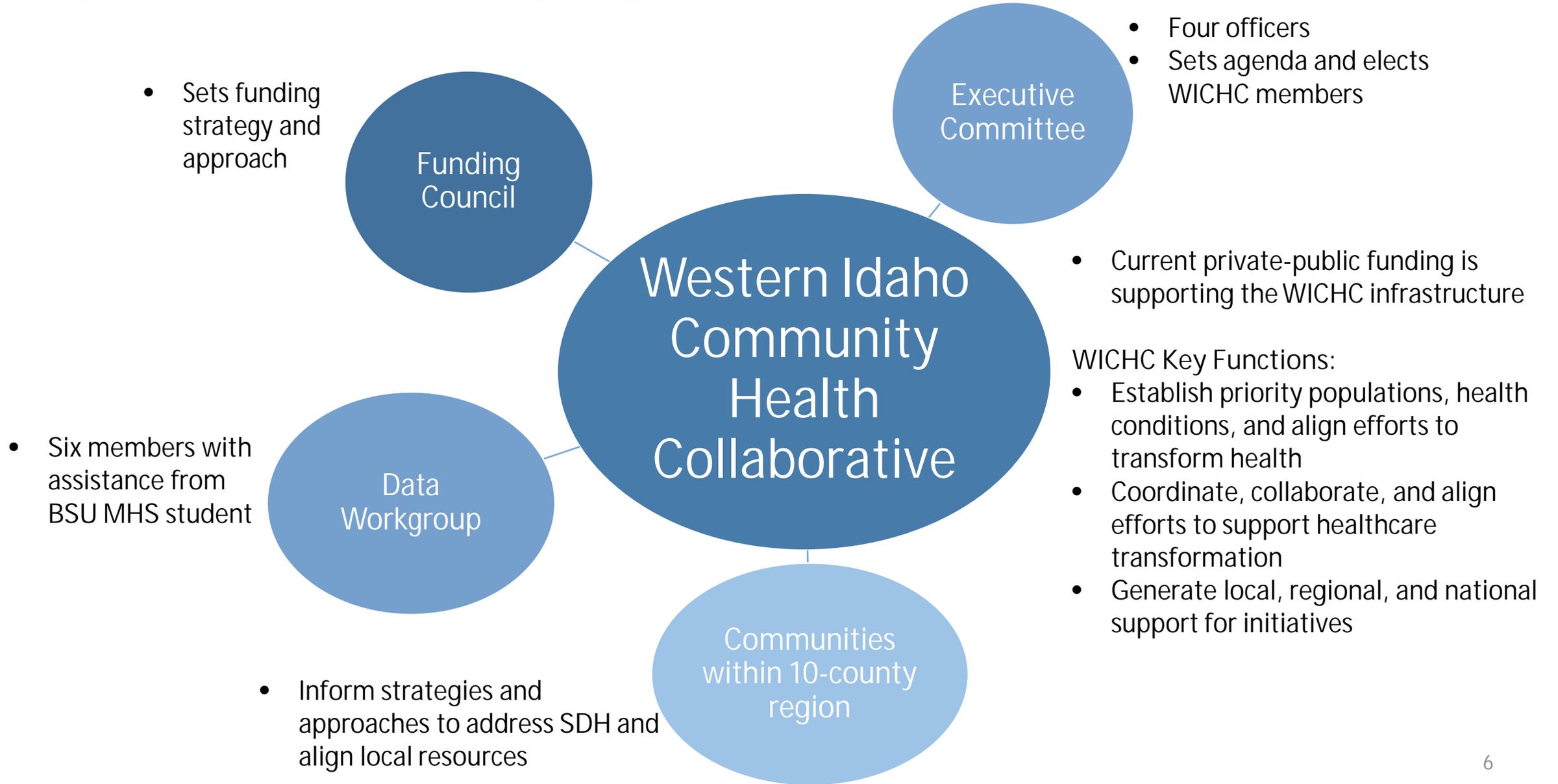
- Western Idaho Community Health Collaborative, WICHHC, for short
- Based on Collective Impact Model
- Multi-sector, public-private partnership
- Backbone organizations:
 - Central and Southwest District Health
- 21 diverse members representing public health, healthcare, social services
- Addressing the social determinants of health (SDH)

INTRO TO WICHC



- WICHC “aims to transform the health of our communities by collaborating, prioritizing, and collectively supporting the community health needs and healthcare transformation efforts that will have the greatest impact on improving health outcomes and lowering costs of healthcare”
- 10 counties served by Central and Southwest District Health
- 45% of Idaho population

WICHC STRUCTURE



FUNDING COUNCIL

- Current Members:
 - Blue Cross of Idaho Foundation for Health
 - Central District Health
 - PacificSource
 - Saint Alphonsus
 - Southwest District Health
 - St. Luke's
 - United Way Treasure Valley
- Continue to add Funding Council members
- Parameters for bringing on additional Funding Council members:
 - \$10,000 minimum financial contribution
 - Organizational mission alignment
 - Engagement

BLENDING AND BRAIDING FUNDING

- Private and philanthropic support
- Grants
- Health systems
- Re-investment of Shared Savings/CHOICe
- Community Development Financing
- Local and state government

WICHHC DATA WORKGROUP

- Identifying data to inform strategic plan and assessing system capabilities for data sharing
- Currently:
 1. Conducting an inventory of data resources/hubs that address the SDH
 2. Evaluate and provide direction on whether WICHHC should complete a meta-analysis of community health needs assessments across WICHHC region
 3. Research the use of predictive analytics in other multi-sector collaborations

DASH MENTORSHIP with Elevate Health

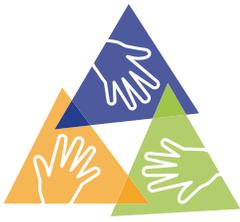
- Accountable Community for Health in Pierce County, WA
 - Operate Community Resiliency Fund
 - Partnership with United Way of Treasure Valley
 - Mentorship with All In Network
 - From March – December 2020
- Objectives:
 1. Learn core competencies and integrate community voice into WICHC strategies
 2. Explore strategies to operationalize health equity through community engagement
 3. Plan, design or enhance a local Care Continuum Network
 4. Assess partnerships, data, and infrastructure

CURRENT WICHHC WORK PLAN

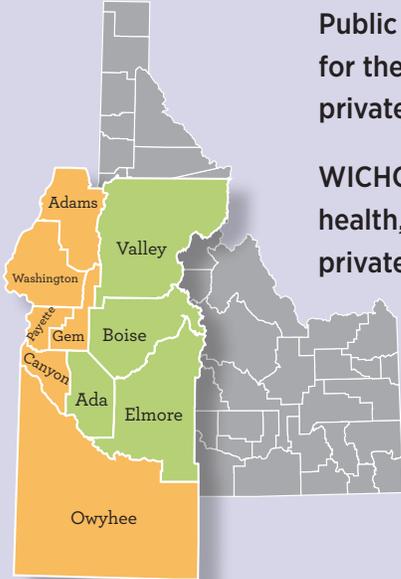
- Commented on VBP Medicaid RFI, advocating for SDH
- Currently following the Results-Based Accountability Framework to develop WICHHC strategic plan
 - Target population: ALICE population and below
- RWJF grant application on Aligning Systems for Health, in partnership with Boise State University
- Developing funding strategy (incoming and outgoing funding)
- Determine and develop data collection and sharing needs

LOOKING AHEAD

- How WICHC can collaborate with HTCI to address the social determinants to save costs and improve health
- Opportunities to partner and align:
 - Promote broad understanding and vernacular of population health and community health
 - Policy and systems work as we build a prevention-oriented health system
 - Funding upstream
 - Data sharing
 - Other?



WESTERN IDAHO COMMUNITY HEALTH COLLABORATIVE

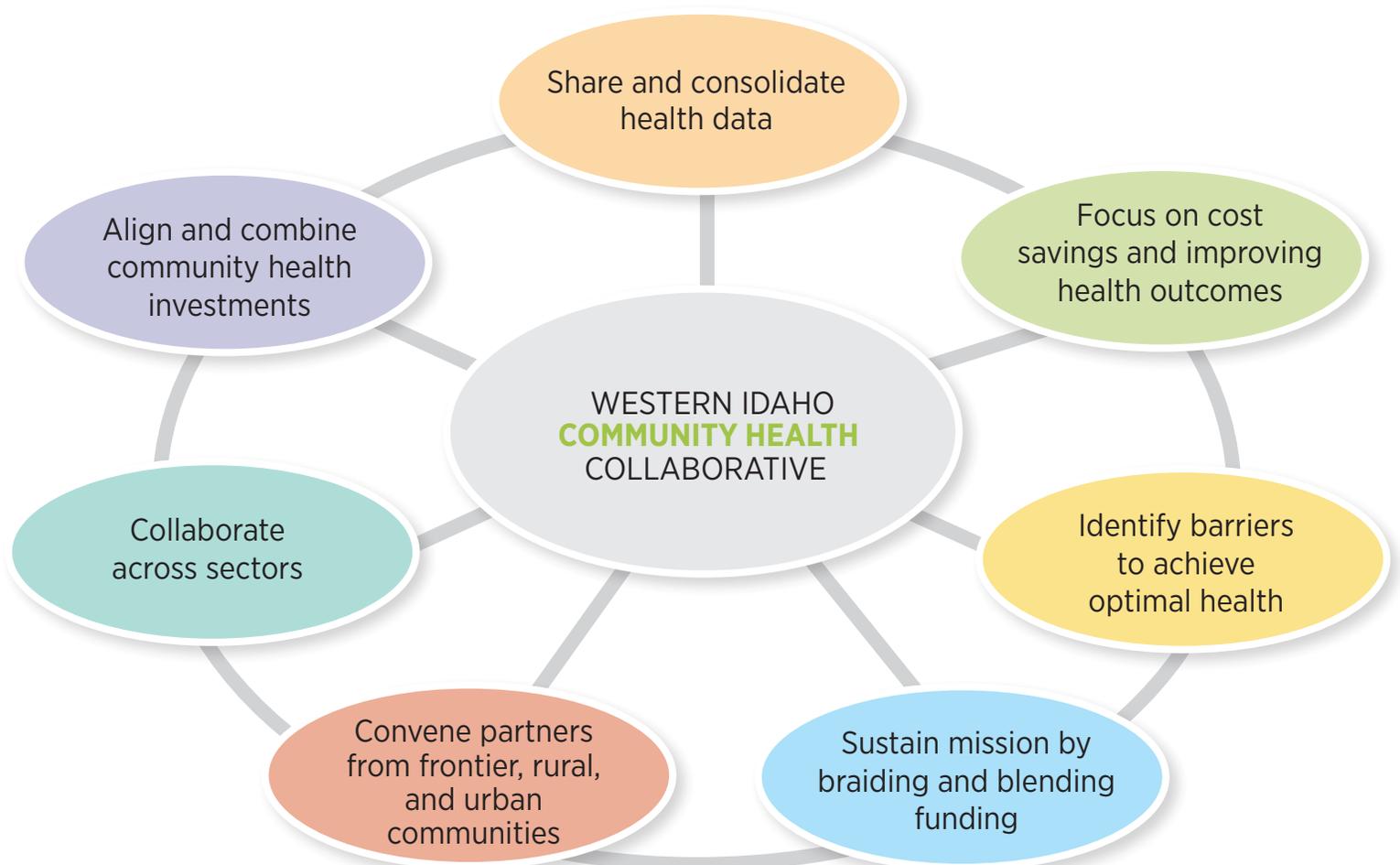


Public Health Districts III and IV are requesting \$105,400 in one-time funding for 1.2 FTE for the Western Idaho Community Health Collaborative (WICHC). Due to the increase in private funding, this is a 12% decrease from last year (\$119,400 FY20).

WICHC is a ten-county multi-sector partnership that brings together healthcare, public health, and social service agencies to address community health through upstream private and public investments.

MATCHING WICHC PRIVATE FUNDERS

- Blue Cross of Idaho
- Foundation for Health
- Saint Alphonsus
- St. Luke's Health System
- PacificSource Health Plans
- United Way of Treasure Valley





WICHC Accomplishments

Since Receipt of Funding on July 1, 2019:

Organization + Development

- Established charter for Funding Council and WICHC
 - Finalized membership and elected officers
 - Aligned multi-sector stakeholders and advocated for a sixth guiding principle to the Idaho Medicaid Value-Based Purchasing Request for Information to address the social determinants of health
 - Established a multi-sector data workgroup to determine how data will be compiled and shared to inform the strategic plan
 - Applied to be mentees as part of the Data Across Sectors for Health (DASH) Mentorship program
-

Research

- Invited and attended national meeting with subject-matter experts leading similar collaborations in Washington D.C.
 - Reviewed community health data from the ten counties
 - Currently participating in mentorship and learning opportunities with other states (Oregon, Washington, and Colorado) related to community collaborative development
-

Funding + Growth

- Added a funding partner, for a total of five private funders — Saint Alphonsus, St. Luke's, PacificSource, Blue Cross of Idaho Foundation for Health, and United Way of Treasure Valley
 - Actively in round two of the Robert Wood Johnson Foundation grant application for Aligning Systems for Health, with funding up to \$400,000 for 24 months. WICHC, in collaboration with Boise State University, was selected as one of 27 semifinalists out of 151 proposals
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Upcoming Efforts + Strategies for 2020

- » Establish priority areas and populations (such as Medicaid, 0-5 years old)
 - » Develop and implement strategic plan
 - » Apply for grant funding using funding council dollars as match requirements
 - » Select and fund community-led initiatives
 - » Determine and develop data collection and analytics needs for WICHC
 - » Continue to seek and add private funders
-



Contact
WICHC

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Yvonne Ketchum-Ward –CEO

Idaho Primary Care Association and CHCNI

- ▶ To support and strengthen Idaho CHCs by collaborating with payers to improve the health status of patients and to offer CHC services as a network to health plans, employers, and the State of Idaho

CHCNI MISSION STATEMENT

- ▶ Develop strong, healthy populations by evolving from a fee-for-service volume based model to a patient centered medical home model of care based on value and health outcomes through provider leadership and engagement.

CHCNI VISION

- ▶ Community Health Center Network of Idaho, (“CHCNI”) was created on May 14, 2012 and currently consists of 14 Federally Qualified Community Health Centers (CHCs) located throughout Idaho.
- ▶ CHCNI was created to support and strengthen Idaho CHCs by bringing the CHCs together as a single organization. CHCs collaborates with payers to balance the payer mix, raise visibility and credibility, increase coordination between CHCs, strengthen their reputation as a hallmark of quality and cost efficiency/effectiveness and improve the health status of patients

WHO IS CHCNI?

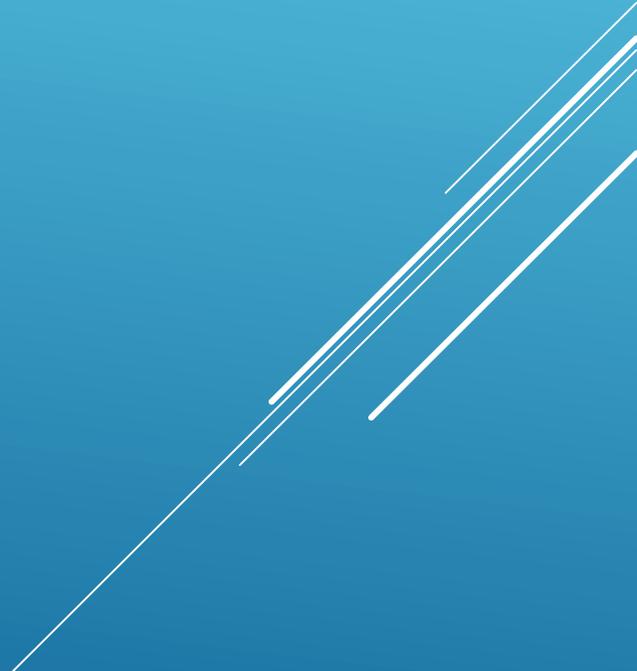
- ▶ The Idaho Primary Care Association (IPCA) has a Management Services Agreement with CHCNI to run the network.
- ▶ IPCA provides and employs all the support staff, data analysis, contract negotiation, quality improvement, accounting and financial reconciliation along with facilitating network meetings, creating agendas and recommending actions
- ▶ A CHC CEO independent of IPCA is elected as President.
- ▶ The CHCNI membership votes on renewing the MSA, approving contracts, hiring an auditor and oversees all activities under the MSA
- ▶ CHCNI meets monthly to discuss network business and progress and once every three years for strategic planning

ROLE OF PCA AND CHCNI

- ▶ Short Term - Development of a messenger model Independent Practice Association (IPA) and secure contracts with the insurers that currently offer plans through the exchange, Medicaid expansion, and other federally funded plans such as Medicare Advantage
- ▶ Long Term- Move toward negotiating with insurance plans for reimbursement tied to reductions in healthcare costs and improvements in the health outcomes of a defined patient population

FOCUS - 2013

- ▶ CHCNI is financially and clinically integrated which allows the Network to negotiate with insurance plans for reimbursement tied to reductions in healthcare costs and improvements in the health outcomes of a defined patient population.
- ▶ CHCNI has successfully contracted with payers to move from fee for service to pay for value
- ▶ In order to transform into this new model, a Quality Committee was formed in 2014.
- ▶ The Quality Committee is committed to:
 - ▶ promoting a culture of quality by continuously improving the quality of care and services rendered to patients at Community Health Centers while promoting effective and efficient utilization of health care resources.
 - ▶ consulting with and is advisors to CHC leadership to engage medical, behavioral health and dental directors to promote the highest quality and value of care possible and work collaboratively with insurers and the healthcare neighborhood to improve member health and value.

- ▶ CHCs have a like mission and focus.
 - ▶ We are:
 - ▶ agile to respond promptly to opportunities in the market place and enact change and implement best practices to achieve quality and cost goals.
 - ▶ primary care focused and nationally accredited medical homes.
 - ▶ considered Essential Community Providers offering not only medical services but also behavioral health, dental and enabling services to our patients and to health plans.
 - ▶ have a unique business model that bodes well to move fluently with the changes to pay for value and increased quality performance.
 - ▶ CHCNI is interested in partnering with payers who have a like mission, focus and goals of transforming healthcare in Idaho.
- 

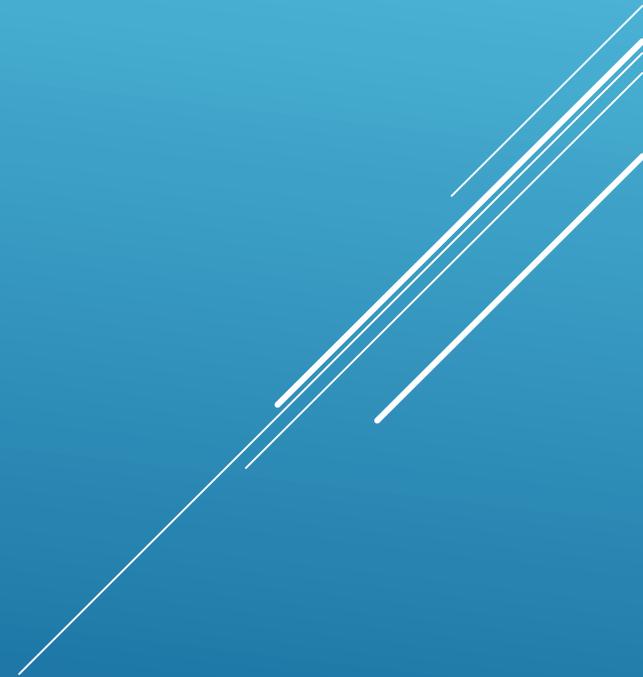
- ▶ Medicare ACO
- ▶ Regence Blue Shield of Idaho – Commercial Total Cost of Care, Medical Neighborhood
- ▶ Blue Cross of Idaho – Medicare Advantage and commercial Total Cost of Care
- ▶ Molina – Dual Eligibles
- ▶ PacificSource – Commercial and Medicare Advantage FFS
- ▶ St. Luke's Health Partners
- ▶ IDHW for Parolee Mental Health FFS, capitated PMPM and overhead expenses

WHO ARE OUR CURRENT PARTNERS

- ▶ Established a primary care network to provide statewide coverage for payers
- ▶ Coordination with the Idaho Department of Insurance to assure CHCs are required on payer panels for the exchange
- ▶ Financial and Clinical data sharing to improve care and financial performance
- ▶ Executed agreements with payers for value based reimbursement
- ▶ Maintained the integrity of our unique payment structure and population base
- ▶ We share data openly and support each other in achieving goals together
- ▶ We have meaningful quality improvement goals and engage staff at the CHCs in establishing those goals, CMO, Dental Directors, Pharmacists and other quality staff
- ▶ Hold each CHC accountable for our outcomes
- ▶ We act as one organization, not separate entities

CHCNI ACCOMPLISHMENTS

DATA REPORTING AND ANALYTICS- CREATING DASHBOARDS FOR MANAGING CARE



Visit planning report

Crowley, Patrick

1 Scheduled Appointment ^

6:59 AM Monday, December 2, 2019

Visit Reason: No Show Sick Visit

Paschke, Kathryn

MRN: 3657053

DOB: 4/6/1961 (58)

Sex at Birth: F

GI: Other

SO: Don't know

Phone: 351-254-3867

Language: German

Risk: **Moderate (30)**

Last Well Visit: 1/28/2019

Portal Access: 12/14/2018

Cohorts: High PHQ

PCP: Crowley, Patrick

Payer: Medicaid

Care Manager: Chris Ryan

DIAGNOSES (8)

AMI	ASM	CAD
CAD/No MI	COPD	DM
HIV	IVD	Diabetes

RISK FACTORS (6)

Act Preg	ANTICOAG	Chronic Opioid Tx
HDU	SUD	TOB

SDOH (14)

HOUSING	FOOD	UTILITY
INSURANCE	MATERIAL	SECURITY
CHILDCARE	TRANSPORT-MED	TRANSPORT-NONMED

ALERT

ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
Colon HiRisk	Overdue	1/28/2019	
Mammo HiRisk	Overdue	12/14/2018	
Pap HiRisk	Overdue	1/28/2019	
A1c	Out of Range	12/14/2018	11.7
Gonorrhea	Missing		
Viral Load Suppression	Missing		
ACE Screen	Missing		
AUDIT	Missing		

OPEN REFERRAL W/O RESULT

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Nutritionist	Ellen Bell / Brighton	4/12/2020	4/19/2020
Radiology	Ellen Bell / Boston	1/28/2019	2/6/2019

Creating dashboards for managing care

EXAMPLE OF PRE VISIT PLANNING REPORT TO SHOW GAPS IN CARE

Visit planning report

Crowley, Patrick 1 Scheduled Appointment ^

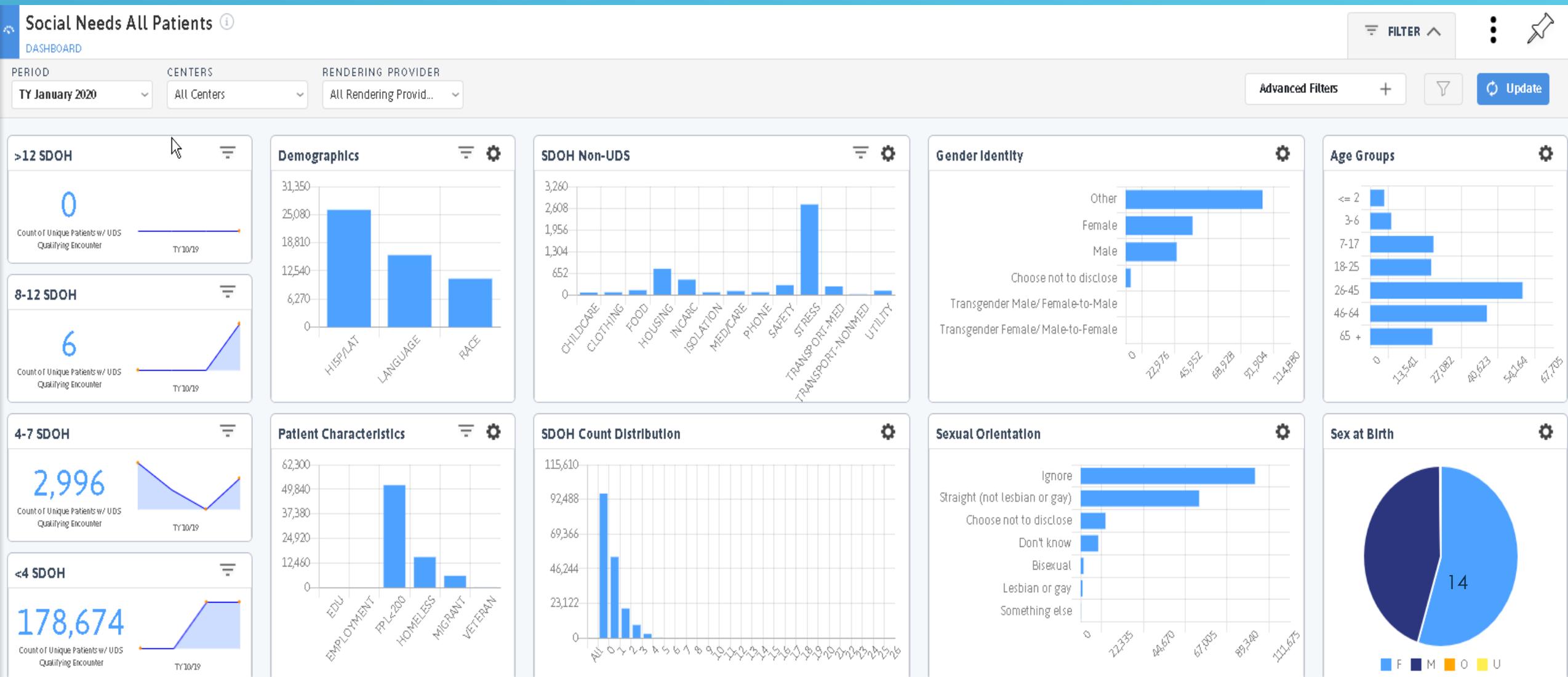
6:59 AM Monday, December 2, 2019 Visit Reason: No Show Sick Visit

Paschke, Kathryn MRN: 3657053 DOB: 4/6/1961 (58)	Sex at Birth: F GT: Other SO: Don't know	Phone: 351-254-3867 Language: German Risk: Moderate (30)	Last Well Visit: 1/28/2019 Portal Access: 12/14/2018 Cohorts: High PHQ	PCP: Crowley, Patrick Payer: Medicaid Care Manager: Chris Ryan
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DIAGNOSES (8)			ALERT	MESSAGE	MOST RECENT DATE	MOST RECENT RESULT
AMI	ASM	CAD	Colon HiRisk	Overdue	1/28/2019	
CAD/No MI	COPD	DM	Mammo HiRisk	Overdue	12/14/2018	
HIV	IVD	Diabetes	Pap HiRisk	Overdue	1/28/2019	
RISK FACTORS (6)			A1c	Out of Range	12/14/2018	11.7
Act Preg	ANTICOAG	Chronic Opioid Tx	Gonorrhea	Missing		
HOU	SUD	TOB	Viral Load Suppression	Missing		
SDOH (14)			ACE Screen	Missing		
HOUSING	FOOD	UTILITY	AUDIT	Missing		
INSURANCE	MATERIAL	SECURITY				
CHILDCARE	TRANSPORT-MED	TRANSPORT-NONMED				

OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Nutritionist	Ellen Bell / Brighton	4/12/2020	4/19/2020
Radiology	Ellen Bell / Boston	1/28/2019	2/6/2019

DRVS HAS VARIETY OF DASHBOARDS INCLUDING SDOH



TY January 2020

TY January 2020

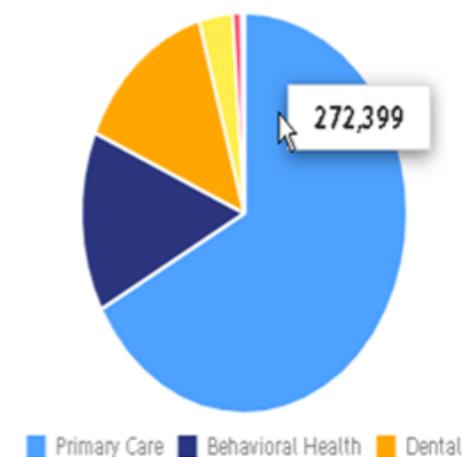
MEASURE	RESULT	CHANGE
Childhood Immunization Status (NQF 0038)	30.6%	+ 16.7% ▲
Cervical Cancer Screening (NQF 0032)	34.7%	+ 3.3% ▲
Child Weight Screening / BMI / Nutritional /Physical Activity Counseling (NQF ...)	47.6%	+ 8.3% ▲
BMI Screening and Follow-Up 18+ Years (NQF 0421/eCQM 69v7)	44.8%	- 6.5% ▼
Tobacco Use: Screening and Cessation (NQF 0028)	85.1%	+ 33.5% ▲
Use of Appropriate Medications for Asthma	88.8%	+ 4.9% ▲
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	75.7%	+ 8.0% ▲
IVD Aspirin Use (NQF 0068)	79.6%	+ 1.2% ▲
Colorectal Cancer Screening (NQF 0034)	38.3%	+ 10.8% ▲
Screening for Depression and Follow-Up Plan (NQF 0418)	62.8%	+ 11.2% ▲
HIV and Pregnant (UDS)	0.0%	- 0.3% ▼
Hypertension Controlling High Blood Pressure (NQF 0018)	67.4%	+ 4.1% ▲
Diabetes A1c > 9 or Untested (NQF 0059)	32.1%	- 4.8% ▼

117,465
PATIENTS

406,195
VISITS

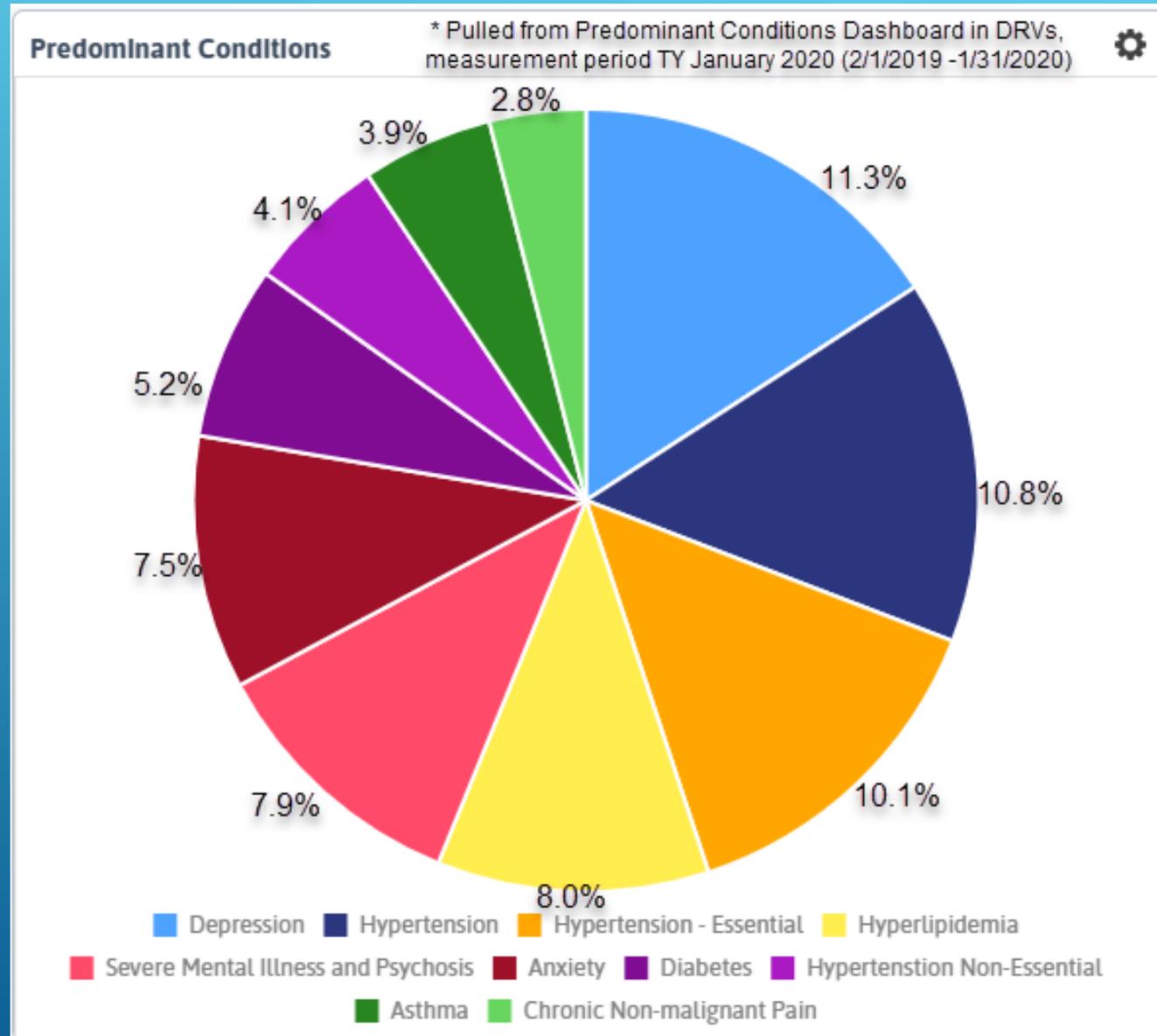
Visits by Service Line

TY January 2020

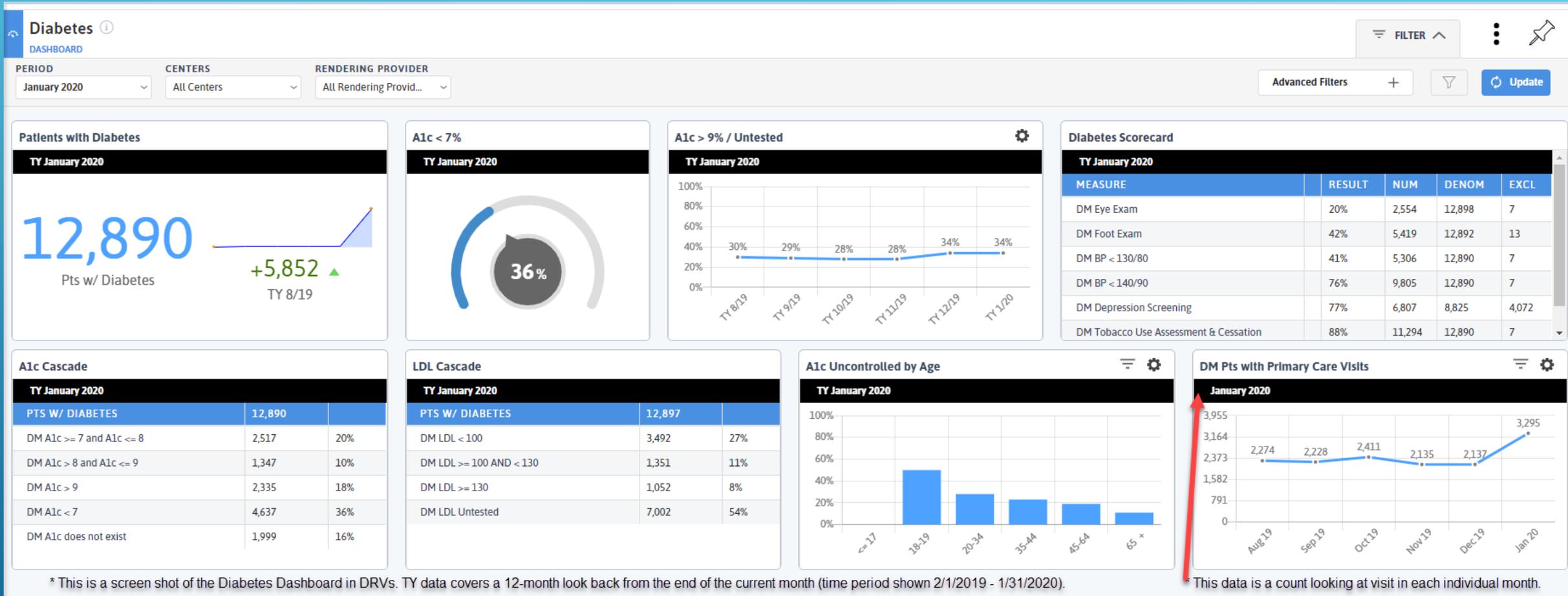


* This is a screen shot of our home screen in DRVs. TY data is shown with a look back period of 12-months from the end of the current month (2/1/2019 - 1/31/2020 shown)

PREDOMINATE CONDITIONS- HYPERTENSION AND DEPRESSION



DIABETES DASHBOARD

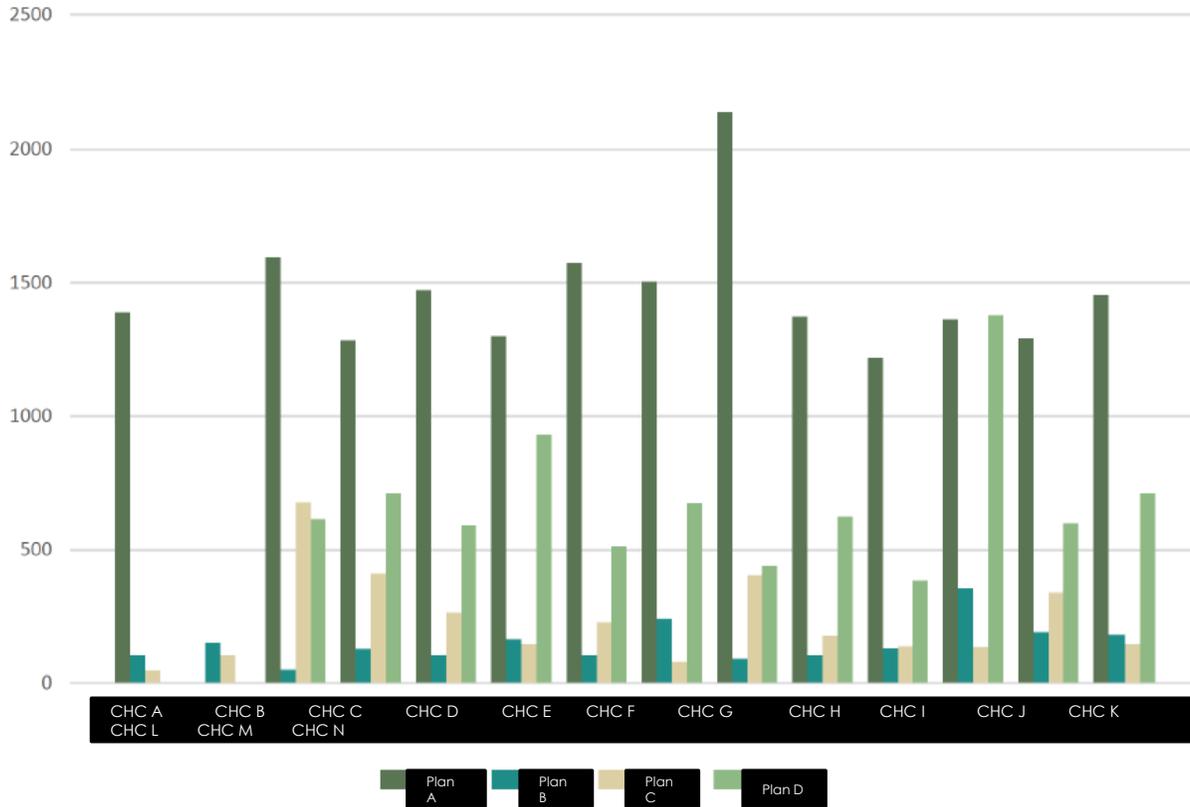


Performance Overview



CHCNI Value-Based Care Performance (February 2020)

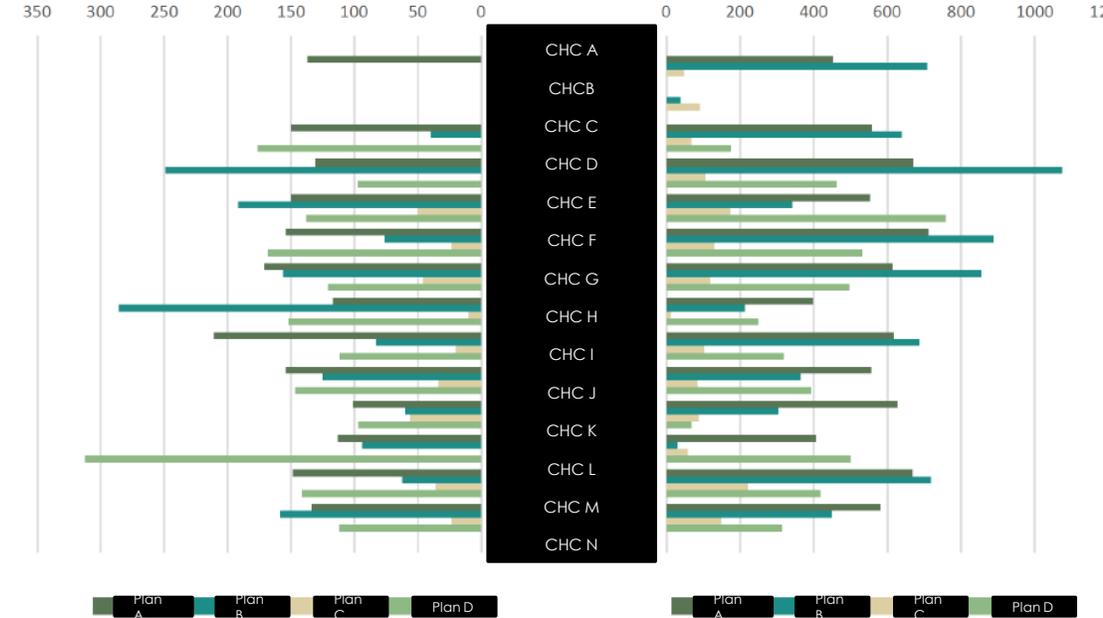
Medical Cost PMPM



ENTITY	Plan A	Plan A %	Plan B	Plan B %	Plan C	Plan C %	Plan D	Plan D %
CHCNI NETWORK	\$984		\$472		\$402		\$571	
CHC A	\$922	-6%	\$489	4%	\$381	-5%	\$514	-10%
CHC B	\$1014	3%	\$381	-19%	\$429	7%	\$593	4%
CHC C	\$925	-6%	\$507	7%	\$412	2%	\$631	11%

Inpatient Utilization /K

Emergency Utilization /K



Utilization /K

ENTITY	Inpatient				Emergency			
	Plan A	Plan B	Plan C	Plan D	Plan A	Plan B	Plan C	Plan D
CHCNI NETWORK	158.1	115.8	33.2	128.0	614.7	598.0	112.4	367.0
CHC A	116.5	285.7	9.9	151.8	398.1	214.3	13.2	250.0
CHC B	154.2	125.0	33.8	146.6	555.9	364.6	84.6	394.0
CHC C	210.7	83.0	20.2	111.3	618.0	685.9	103.5	319.0

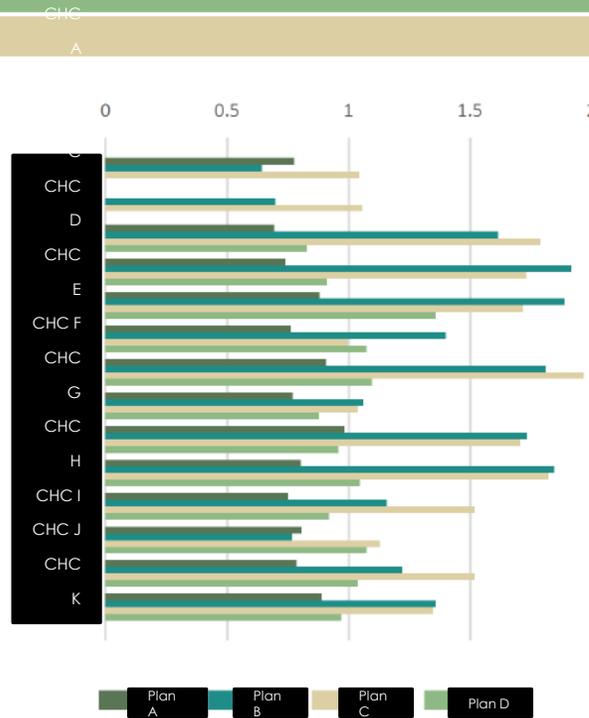
COST & UTILIZATION SCORECARDS

Performance Overview

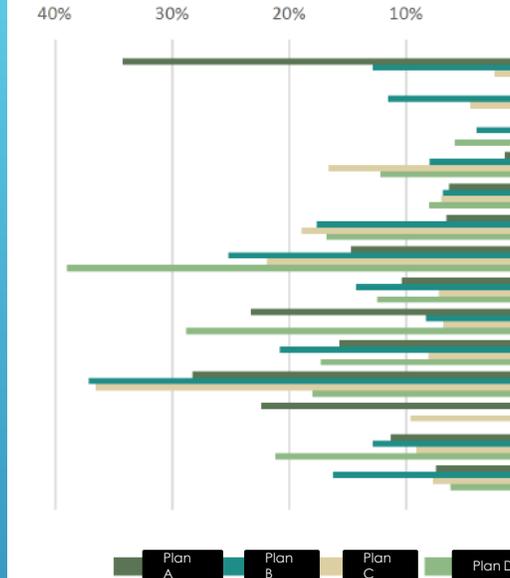
CHCNI Value-Based Care Performance (February 2020)

Risk Scores

ENTITY	Plan A	Plan B	Plan C	Plan D
CHCNI NETWORK	0.9	1.5	1.6	1.0
CHC A	0.8	0.6	1.0	0.8
CHC B	0.9	0.7	1.1	1.2
CHC C	0.7	1.9	1.7	0.9
CHC D	0.7	1.6	1.8	0.8
CHC E	0.9	1.9	1.7	1.4
CHC F	0.8	1.4	1.0	1.1
CHC G	0.9	1.8	2.0	1.1
CHC H	0.8	1.1	1.0	0.9
CHC I	0.8	1.8	1.8	1.0
CHC J	1.0	1.7	1.7	1.0
CHC K	0.7	1.2	1.5	0.9
CHC L	0.8	0.8	1.1	1.1
CHC M	0.8	1.2	1.5	1.0
CHC N	0.9	1.4	1.3	1.0



Annual Wellness Visits



ENTITY	Plan A	Plan B	Plan C	Plan D
CHCNI NETWORK	14%	19%	14%	19%
CHC A	34%	13%	14%	19%
CHC B	22%	12%	14%	19%
CHC C	2%	8%	14%	19%
CHC D	18%	4%	14%	19%
CHC E	6%	7%	14%	19%
CHC F	7%	18%	14%	19%
CHC G	15%	25%	14%	19%
CHC H	10%	14%	14%	19%
CHC I	16%	21%	14%	19%
CHC J	23%	8%	14%	19%
CHC K	28%	37%	14%	19%
CHC L	22%	8%	14%	19%
CHC M	11%	13%	14%	19%
CHC N	7%	16%	14%	19%

RISK SCORE AND AWW RATES

- ▶ Statewide we have 91 clinic sites in 52 communities
- ▶ Served 198,332 patients in 2018
- ▶ 65% of our patients are below 200% of FPL
- ▶ 32% are uninsured – 58,000 adults in 2018
- ▶ 27% private insurance, 14% Medicare, 27% Medicaid

WHO WE SERVE

