



Payer Provider Workgroup

Meeting Agenda

Wednesday, October 16, 2019, 9:30 AM – 11:30 AM (MT)

**PTC Building (Health and Welfare Central Office)
450 West State Street
Conference Room 2B
Boise, ID 83720**

Registration URL: <https://zoom.us/j/227960728>
Dial in: +1 669 900 6833 Meeting ID: 227 960 728
 One tap mobile +16699006833,227960728#

Anti-Trust Statement: It is the policy of the Healthcare Transformation Council of Idaho (HTCI), to conduct all its activities, and the workgroups associated with HTCI’s activities, in compliance with federal and state antitrust laws. During these meetings and other activities, including all informal or social discussions, each member shall refrain from discussing or exchanging competitively sensitive information with any other member.

9:30 AM	Welcome and opening remarks; roll call, anti-trust statement review; minutes review – <i>Norm Varin & Dr. Kelly McGrath, Co-Chairs</i> – ACTION ITEM
9:40 AM	Charter update: changed “top 10” to cost drivers impacted through collaboration (HTCI approved) Health Care Payment Learning & Action Network (HCP-LAN) categories. Inviting additional providers to participate in PPW discussion. Meeting schedule (November 18 th 1:30-3:30 PM, no meeting in December) – <i>Norm Varin & Dr. Kelly McGrath Co-Chairs</i>
10:10 AM	Request for Proposal (RFP) update – <i>Mary Sheridan</i>
10:30 AM	Division of Public Health data presentation and background on selecting four (4) priority areas - <i>Elke Shaw-Tulloch and Joe Pollard</i>
11:00 AM	Discuss and define strategy to identify 3 cost drivers to impact through collaboration- <i>Mary Sheridan</i>
11:30 AM	Adjourn

CHARGE:

Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.

FUNCTIONS:

- Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
- Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
- Serve as a convener of a broad-based set of stakeholders.
- Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.
- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
- Recommend and promote strategies to reduce overall health care costs.
- Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.
- Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- Promote efficiencies in the collection, measuring, and reporting of quality metrics.

HEALTHCARE TRANSFORMATION
COUNCIL OF IDAHO



September 16, 2019 1:30 pm

Location: 450 W. State St.,
10th Floor, Conference Room 10A

Meeting Minutes:

Member Attendees: Lydia Bartholomew, Craig Belcher (Phone), Pam McCord (Phone – Proxy Teresa Cirelli), Yvonne Ketchum-Ward, Kelly McGrath (Phone), Scott Oien (Phone), Robbie Roberts (Phone), Neva Santos, Larry Tisdale, Norm Varin, Jon Wilson (Phone), Matt Wimmer, Wren Withers, Cynthia York,

Staff: Casey Moyer, Meagan Graves, Shelby-Lyn Besler, Stephanie Sayegh, Elke Shaw-Tulloch, Dieuwke Dizney-Spencer, Ann Watkins

Guests: None

Status: 09/16/2019

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Summary of Motions/Decisions:

Motion:

Outcome:

Larry Tisdale moved to accept the minutes of the August 13, 2019 Payer Provider Workgroup meeting as modified.
Neva Santos seconded the Motion.

Passed

Cynthia York moved to accept the Payer Provider Workgroup Charter
Matt Wimmer seconded the Motion.

Passed

Agenda Topics:

Welcome and Opening Remarks; Roll Call; Introductions; Anti-Trust Statement; and Agenda Review- *Norm Varin and Dr. Kelly McGrath Co-Chairs of the Payer Provider Workgroup*

Norm Varin and Dr. Kelly McGrath introduced themselves as the co-chairs and welcomed everyone. Norm read the anti-trust statement and requested that this statement appear in all future meeting minutes of the Payer Provider Workgroup.

- ◆ Due to some department reorganization and changes in staffing assignments, the Office of Healthcare Policy Initiatives (OHPI) is now under the umbrella of the Division of Public Health, with Division Administrator Elke Shaw-Tulloch, Deputy Administrator Dieuwke Dizney-Spencer, and Bureau of Rural Health and Primary Care Chief Mary Sheridan. Kymberlee Schreiber and Ann Watkins have been transferred to the Division of Public Health.
- ◆ Due to limited budget resources for OHPI (e.g., only two full time positions were approved by the Legislature), September 16th is the last day of employment for Casey Moyer, OHPI Program Administrator and Meagan Graves, OHPI Administrative Assistant 2. Casey and Meagan worked very closely with Elke, Mary and Shelby-Lyn Besler, Administrative Assistant 2 (Division of Public Health and Bureau of Rural Health and Primary Care) to ensure a smooth transition of assigned duties. Their hard work will not go unnoticed.
- ◆ Elke explained that Lisa Hettinger took another position in the department, OHPI reported to her directly. Director Jeppesen is waiting to fill her position, which made for a smooth transition for OHPI to be incorporated with Rural Health and Primary Care. Mary Sheridan worked actively with the Statewide Healthcare Innovation Plan (SHIP) and provided support with staffing and implementation of SHIP.

Charter Review- *Casey Moyer, Office of Healthcare Policy Initiatives*

- ◆ Casey provided an overview of the charter structure and discussed the various components of the finalized draft charter.
- ◆ The members agreed there is a need to further define the metrics and whether they will be measuring total dollars, total number of payments, or total percent of beneficiaries in value-based arrangements.
- ◆ Following discussion, a motion was passed to accept the Charter with modifications.

Procurement Update- *Ann Watkins, Office of Healthcare Policy Initiatives*

- ◆ Request for Proposal developed to solicit bids for a financial analysis contractor to assist with collecting data from public and private payers to determine the percent of payments made in value-based models.
- ◆ HCP-LAN (Health Care Payment Learning & Action Network) framework provides a national standard for definitions of the levels of progress and assigned categories which can be utilized to measure progress toward paying for value.
- ◆ State procurement process can take up to 6 months.

Top 10 Project- Norm Varin and Kelly McGrath, Co-Chairs

- ◆ PPW members discussed areas where the group may have a unique ability to impact cost through collaboration between payers and providers.
- ◆ Discussion centered around how the PPW could identify methods for data collection to address this type of project. Further discussions will need to take place to establish baseline measurement processes, how to identify focus areas, how to implement standardized processes for data collection and data aggregation procedures as well as adherence to antitrust protections.
- ◆ Elke offered to share Division of Public Health data at the next meeting regarding the Division's statewide needs assessment and priority areas of focus, including behavioral/mental health, diabetes, obesity, and unintentional injury.

Closing- Norm Varin and Kelly McGrath, Co-Chairs

- ◆ The next meeting is Wednesday October 16th, 2019 from 9:30am – 11:30am Mountain Time.
- ◆ The following meeting is November 18th, 2019 from 1:30pm-3:30pm Mountain Time.

Meeting Adjourned: 03:27 pm

Author	Date	Version	Summary
Shelby-Lyn Besler	09/17/19	V1	
Ann Watkins	09/24/19	V2	
Mary Sheridan	10/7/19	V3	
Final Draft – submitted for approval		Final V1	
Final Approved		Final V2	

Payer Provider Workgroup Charter

Workgroup Summary:

Chair/Co-Chair	Norm Varin & Dr. Kelly McGrath
OHPI Staff Lead	Mary Sheridan
PPW Charge (from HTCI)	Assist in developing, promoting, and advancing initiatives that increase value-based payments while helping decrease cost and increasing quality.
HTCI Alignment	<ul style="list-style-type: none"> Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare. Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation. Recommend and promote strategies to reduce overall health care costs.

Driver Alignment and Measurement:

Driver Alignment	Desired Outcome	Measurement	Workgroup Role
Finance	1. Increase the number of value-based payments to 50% by 2023 (Target 50%)	Annual percentage (%) of payments made in value-based payment methodologies (using HCP-LAN framework)	Review vendor report (annually)
Finance	2. Identify cost drivers that can be improved through collaboration between payers and/or providers (Target: 3)	Number (#) of initiatives identified to be targeted for coordinated problem solving	Payers and Provider member participation.
Finance	3. Increase the number of value-based payments made in advanced APMs. (Target: TBD)	Annual percentage (%) of payments made in value-based payment methodologies within LAN categories 3B-4.	Review vendor report (annually).
Access	4. Review quarterly project updates and provide feedback on BH initiative (Target: 4).	Number of quarterly updates provided to PPW workgroup on BHI project.	Review project reports (quarterly).

Planned Scope:

Deliverable 1:

Description:	Develop an operational plan and methodology to routinely collect and report the percentage of payments made in value-based arrangements statewide.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	Sept - Oct 2019	Release RFP and selecting a vendor
	Nov - Jan 2020	Vendor secures data sharing agreements with payers
	Feb - Apr 2020	Data collection (CY 2018 & 2019)
	May 2020	Initial Draft presented to PPW
	June 2020	Revised Draft present to HTCI
	July 2020	Publication of findings (Legislature & Executive Branch)
Milestones:	<ul style="list-style-type: none">• Recruit and contract with vendor• Secure data sharing agreements with payers• Collect payer data• Calculate and report data findings by CY starting with 2018	

Deliverable 2:

Description:	Determine sub goals within each value based payment category to help inform initiative selection and gauge progress.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	June 2020	Review VBP Report (by breakdown)
	July 2020	Establish proposed sub goals and targets by LAN category
	August 2020	Seek HTCI approval of sub goal targets
	September 2020	Identify strategy(ies) to impact VBP sub goal target
	Oct-Apr 2021	Implement strategy(ies)
	May 2021	Review draft CY2020 financial analysis
	June 2021	Report findings to HTCI
Milestones:	<ul style="list-style-type: none">• Baseline and VBP updated report received and reviewed• Sub goals established by PPW• HTCI approval of sub goals• Identify strategies to influence and impact sub goal areas• Monitor and report progress related to sub goal areas	

Deliverable 3:

Description:	Identify cost drivers (by carrier) in which collaboration at the payer provider workgroup level could increase the value-based payment arrangements while decreasing cost and increasing quality.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	Sept 2019	Collect payer ideas and sharable data elements
	Oct 2019	Determine structure for initiative
Milestones:	<ul style="list-style-type: none">• Define which cost drivers will be advanced for targeted coordination	

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- Develop a strategy and timeline for each TBD target
 - Report progress to HTCI
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Deliverable 4:

Description:	To build upon the existing Idaho Integrated Behavioral Health Network (IIBHN) into an enduring structure to demonstrate a hub and spoke model. HTCI will support Idaho Rural Opioid Prevention and Pharmacy Education Stewardship (I-ROPPEs) demonstration project- Health Resources and Services Administration (HRSA) funded through the payer-provider workgroup to develop a value-based payment methodology for Team-Based Care. The demonstration project would leverage current and past integration projects initiatives.	
Timeframe:	<i>Anticipated Dates</i>	<i>Description</i>
	June 2019	Project Initiation
	May 2020	Project Conclusion
Milestones:	<ul style="list-style-type: none"> • Review of signed MOUs of Hub and Spokes • Review completed baseline data analysis • Recommendation BH &/or Team Based metrics • Recommendations data support based on baseline findings 	

Membership and Composition:

General Information	<p>Membership composition will consist of representatives from the following stakeholder groups:</p> <ul style="list-style-type: none"> • Medicaid • Medicare • Commercial Carriers <ul style="list-style-type: none"> ○ Blue Cross of Idaho ○ Regence ○ Select Health ○ Mountain Coop ○ Pacific Source ○ Aetna ○ United Health ○ Humana • Self-Funded Employer • 1 representative from each of the following organizations: <ul style="list-style-type: none"> ○ Idaho Hospital Association ○ Idaho Medical Association ○ Idaho Primary Care Association ○ Idaho Academy of Family Physicians • Physicians • Independent Clinic Physician • <additional slots>
Member Selection	Co-Chair Invitation.

Terms

Membership shall be extended to individuals and organizations by the co-chairs as needed to address the initiative(s) of the workgroup. There are no set terms or limits for this workgroup.

Expectations of Members

- Members must participate in 75% of all meetings scheduled within the calendar year.
 - Members' designee may participate in up to 25% of the meetings scheduled within the calendar year.
 - Members are encouraged to send the same designee to the meetings instead of different individuals.
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Change Management:

Changes to scope must be approved by HTCI.

Version Information:

Version	Author	Summary	Date
1.0	Moyer	Initial Drafting	08/02/2019
1.1	Moyer	Revision with PPW feedback	08/29/2019
1.2	Moyer	Addition of BH Deliverable	09/10/2019
1.3	Moyer	PPW Review and edits, Finalized	09/16/2019
1.4	Sheridan	PPW metric clarification	09/19/2019

Final Acceptance:

Name/Signature	Title	Date	Approved via Email
Norm Varin	Co-Chair PPW	09/17/19	X
Dr. Kelly McGrath	Co-Chair PPW	09/18/19	X
Dr. Ted Epperly	Co-Chair HTCI	09/19/19	<input type="checkbox"/>
Dr. David Pate	Co-Chair HTCI	09/19/19	<input type="checkbox"/>

Legend of Acronyms	
APM	Alternative Payment Model
BH	Behavioral Health
CY	Calendar Year
HCP-LAN	Health Care Payment Learning and Action Network
HTCI	Healthcare Transformation Council of Idaho
OHPI	Office of Healthcare Policy Initiatives
PPW	Payer Provider Workgroup
RFP	Request for Proposal
VBP	Value Based Payment

PAYER FINANCIAL AND ENROLLMENT METRICS FOR GOAL 6 THROUGH AWARD YEAR 3 (AY3)

September 6, 2018

INTRODUCTION

In calendar year (CY) 2017, Idaho's Statewide Healthcare Innovation Plan (SHIP) continued promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the Patient-Centered Medical Home (PCMH) model of care. To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits, LLC to analyze financial metrics for the State population's health in an effort to measure the progress in moving from fee-for-service (FFS) to value-based payments.

STRATEGIES AND METHODS FOR VALUE-BASED PAYMENTS

The State's multi-payer approach shifting from FFS payments to value-based payment strategies is expected to achieve a long-term, sustainable impact on the State's healthcare system. In AY3, payers continued to move away from FFS and towards value-based payment through several methods, including:

- Pay-for-Performance (P4P)
- Enhanced P4P
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments
- Episode-Based Payments

In addition to the Patient-Centered Medical Home (PCMH) model of care, payers are testing alternative models including accountable care organizations (ACOs) with many of the State's acute care hospitals.

Payers also support total-cost-of-care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits.

The multi-payer approach includes:

- Understanding each payer's need to design and implement payment models that they believe fit their organization's goals and are most effective for their beneficiaries and provider partners.
- Recognizing that system wide transformation to value-based purchasing will only occur across Idaho payers if payers are participating as leaders of the change rather than responding to mandates.
- Acknowledging that payment transformation may not occur quickly in the State but, through partnership with payers, new reimbursement models will emerge that have a positive impact on the system statewide. Implementation of new reimbursement models representing at least 80% of the beneficiary population is the goal for the State and is underway.

To collect payer data for tracking the State's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup. The model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

BASELINE FOR IMPROVEMENT COMPARED TO AWARD YEAR 3

The overarching aim of the State's integrated multi-payer PCMH model is to improve quality outcomes and beneficiary experience, which is expected to lower the cost of healthcare. Transforming from a FFS reimbursement model to payment models that incentivize quality outcomes and improved beneficiary experience is a key goal to achieve this aim. Evidence of the transformation from paying for volume to paying for value will be shown by comparing the enrollment and payment metrics from commercial, Medicare and Medicaid payers throughout the State for each award year.

Data Requests

To measure progress, the baseline of CY 2015 data was compared to CY 2016 and CY 2017 data. Payers were asked for both years to provide percentages of beneficiaries and percentages of payments in the following categories:

- Category 1: FFS — no link to quality and value. Example is FFS payments.
- Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.
- Category 3: Value methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.

- Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.

To assist in compilation, the data request also asked for total dollars paid for medical services in both years. The data request forms did not change from year to year.

Mercer’s Client Confidentiality Agreement was signed by commercial payers and Mercer to ensure their data was protected and kept private. The agreement covers all four award years. It was agreed that the data would be aggregated across payers so no individual payer data would be discernable.

Data Compilation

Upon receiving data from five of the State’s largest payers, including Medicare and Medicaid, Mercer collected comparison data from public documentation, including KFF.org and statutory filings in the National Association of Insurance Commissioners format. Data was weighted for both enrollment and payment information by payers to combine the data and protect the privacy of commercial respondents.

TABLE 1: PERCENTAGE OF BENEFICIARIES PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

CALENDAR YEAR	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	13%	13%	21%	22%	23%	8%	7%	6%	42%	15%	15%
Category 2: FFS with quality and value	0%	87%	87%	73%	71%	59%	72%	75%	78%	51%	77%	73%
Category 3: Methodologies built on FFS architecture	0%	0%	0%	4%	4%	13%	20%	18%	16%	6%	8%	11%
Category 4: Population-based payment	0%	0%	0%	2%	2%	4%	0%	0%	0%	1%	1%	2%

TABLE 2: PERCENTAGE OF PAYMENTS (PAID OR ACCRUED) PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

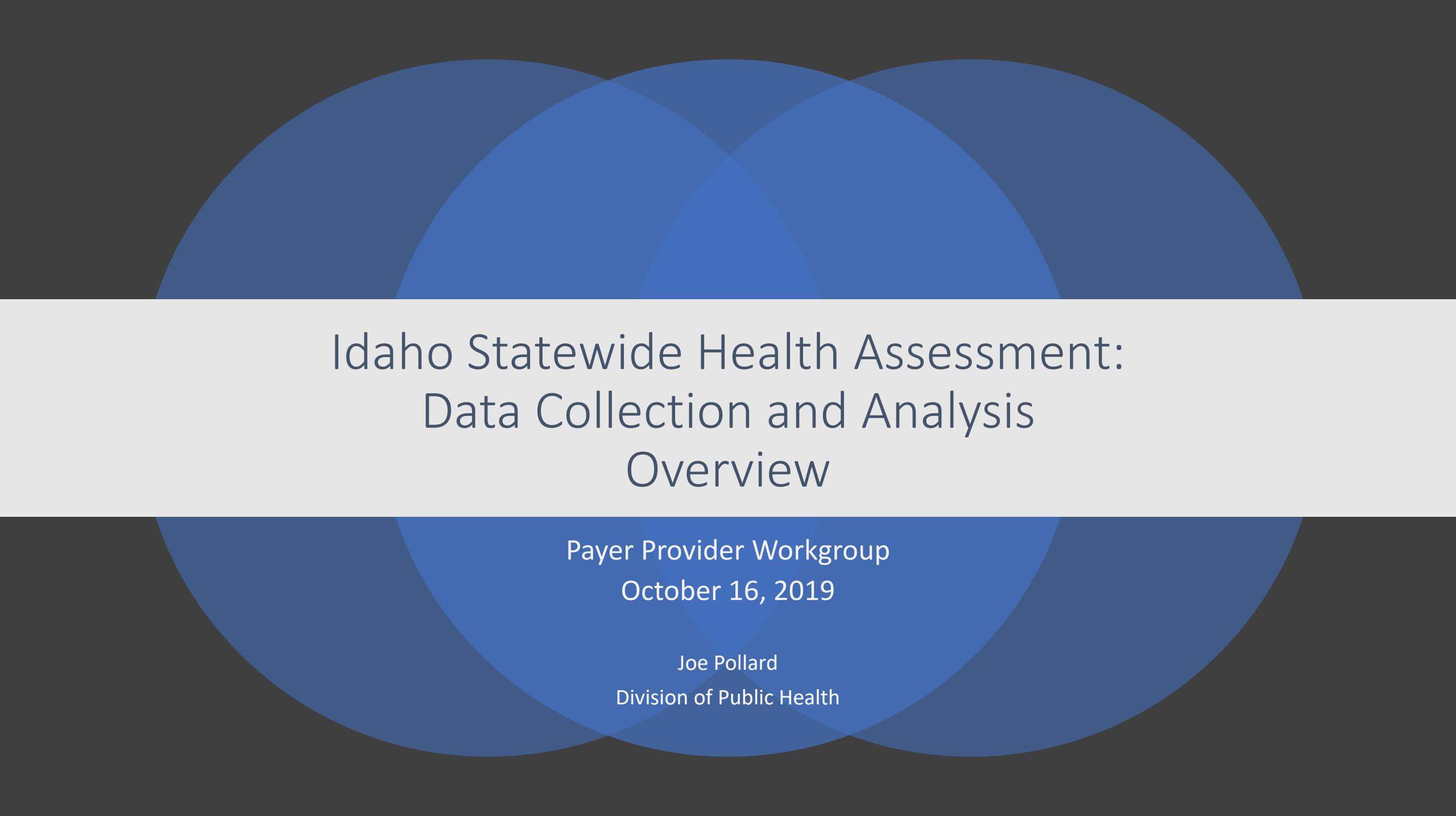
CALENDAR YEAR	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	99%	99%	71%	67%	61%	43%	45%	45%	76%	75%	71%
Category 2: FFS with quality and value	0%	1%	1%	19%	20%	18%	37%	37%	39%	16%	16%	17%
Category 3: Methodologies built on FFS architecture.	0%	0%	0%	7%	9%	12%	20%	18%	16%	7%	8%	8%
Category 4: Population-based payment.	0%	0%	0%	3%	4%	9%	0%	0%	0%	2%	2%	4%

Analysis

In CY 2017, all payer types remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain-sharing, risk-sharing and population-based payments were completing their second year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. While membership attribution remains strong, payments were still primarily FFS. However, the CY 2017 data improved slightly with gains in categories 2, 3 and 4 compared to CY 2016 and CY 2015, driven by commercial and Medicare.

Anecdotal evidence suggests that payers and providers are limited in their ability to accept quality-based payments due to system limitation and increased risk due to the lack of beneficiaries assigned to each provider or were waiting to see the outcomes of initial assignments. Some payers required minimum levels of beneficiaries, such as 1,000 beneficiaries, before quality or risk-based payment arrangements replaced FFS.

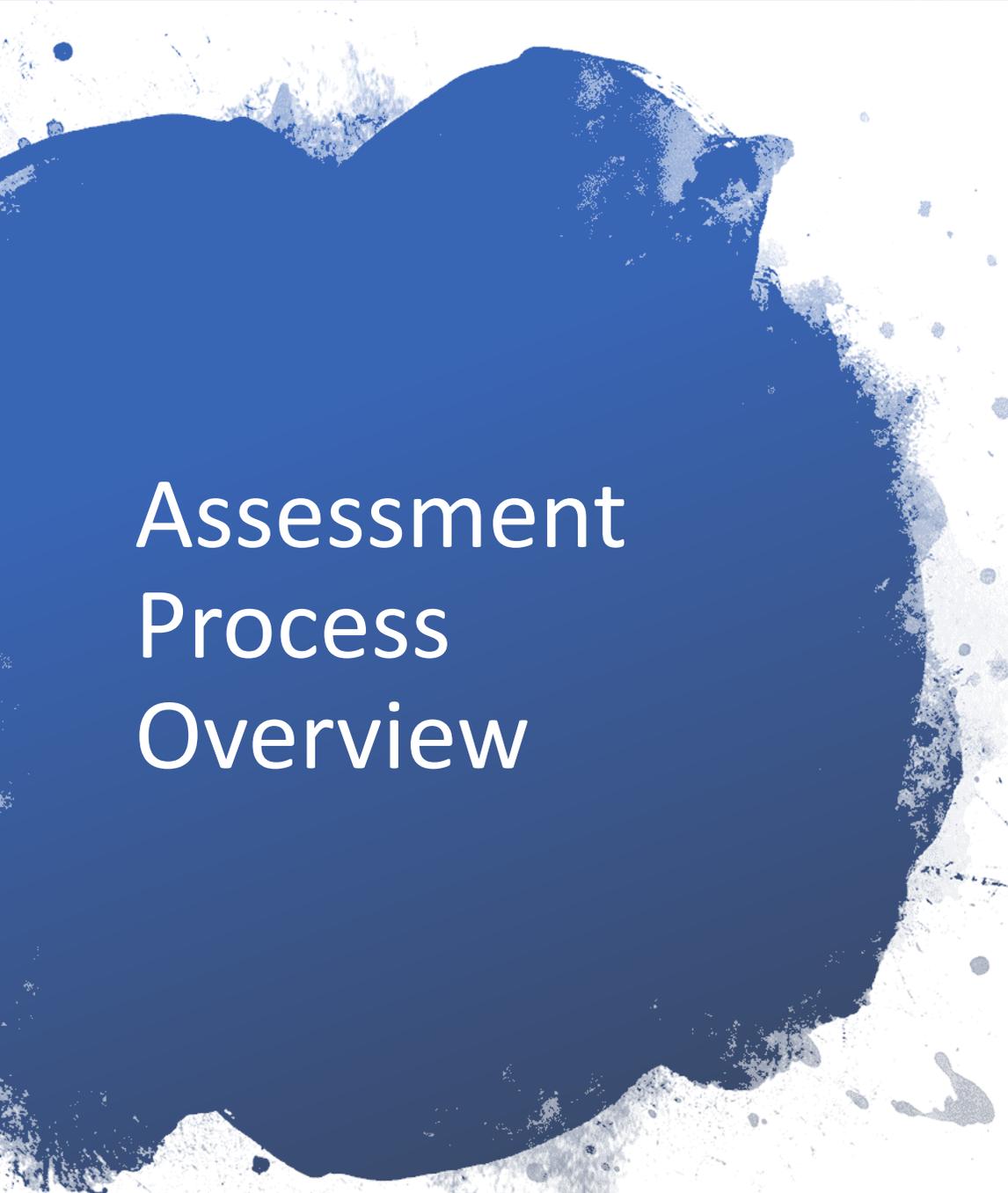
Medicaid continued the Health Connections PCMH program in CY 2017, although the design phase of the program was extended. The program includes four tiers with PMPM payments ranging from \$2.50 to \$10.00. While Medicaid members were attributed to primary care clinics, payments remained primarily FFS in CY 2017. At the request of providers, however, beginning July 1, 2019, Idaho Medicaid will expand Healthy Connections program to include shared savings for primary care practices and ACOs through direct contracts and through participation with regional care organizations. Medicaid is implementing several programs that cover a broad range of healthcare transformation activities and population-based care management initiatives. All Medicaid beneficiaries will be attributed to primary care, either through beneficiary choice or, if no choice is made, prior claims history or proximity to providers. In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the Advanced APM standard of “more than nominal financial risk”, allowing participating clinicians to pursue the APM with Medicare, as allowed under the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015. Medicaid expects to make the first shared savings payment in CY 2020.



Idaho Statewide Health Assessment: Data Collection and Analysis Overview

Payer Provider Workgroup
October 16, 2019

Joe Pollard
Division of Public Health



Assessment Process Overview

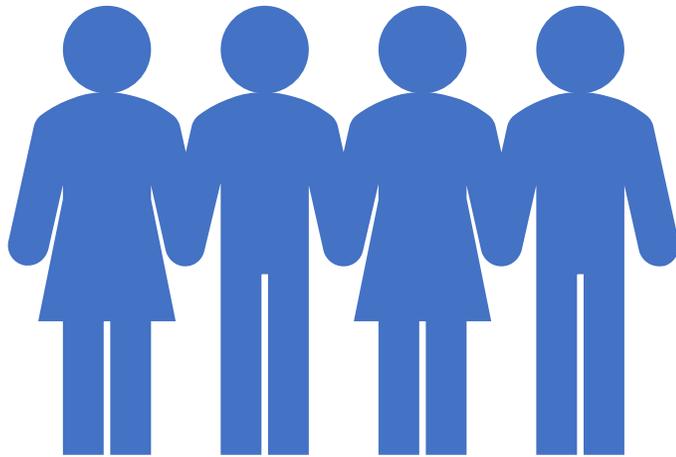
Assessment Cycle –

- 2015 – 2019
- Annual review of data and emerging data

Community Health Assessment Toolkit – Association of Community Health Improvement



2019 Assessment Data



- Leading health indicators
- Local/hospital Community Health Needs Assessments
- Key Informant Interviews

New Data – Key Stakeholder Interviews

Collecting Qualitative Data Through Community Engagement

- In conjunction with data collection and analysis
- Limitations of data – missing narratives from communities
- Goal: to surface prevailing themes and better understand the current context
- 10 key stakeholder interviews conducted over three weeks



Participants – Diverse Perspectives

- Boise State University
- Center for Community and Justice
- Community Health Worker Alliance
- Genesis Community Health
- Idaho Academy of Family Physicians
- Idaho Commission on Aging
- Idaho Foodbank
- Idaho Hospital Association
- Two Local Public Health Districts

Participants – Wearing Many Hats

- Advocacy
- Community health needs assessments
- Convening stakeholders and hosting meetings
- Direct clinical services
- Educating the public and decision makers
- Environmental health monitoring and inspections
- Home-based services
- Nutrition education
- Public policy formulation
- Relationship building
- Strategic planning
- Workforce – development, recruitment and capacity building

Questions Asked of Participants – Three Main Pillars

- Agency or organization's role in health-related issues
- Identifying top health issues – 3-5 particular issues
 - Critical and pressing health issues facing Idahoans
 - Dynamics and underlying issues contributing to health issues
 - Short- and long-term impacts of health issues
 - Populations most impacted
 - Biggest barriers to addressing health issues
 - Emerging or poorly understood health issues
- Addressing top health issues
 - Greatest assets around the state to leverage for developing effective solutions
 - Gaps to addressing health issues
 - Innovative projects, collaborations, etc. working to address health issues
 - Access to data
 - Levers state leaders can pull to improve the health of Idahoans

Highlighting Themes from Four Important Questions

- What are the most critical and pressing health issues for Idaho?
- What underlying dynamics contribute to these health issues?
- What are some of the short- and long-term impacts of these health issues?
- Which populations face the greatest risk for these health issues?

Most Critical and Pressing Health Issues (23 Identified, Some Condensed)

- Access to health care
- Affordable housing
- Chronic diseases
- Cost of health care
- Immunization rates
- Livable wages
- Mental health
- Obesity/diabetes
- Opioids and other substance use
- Social determinants of health
- Suicide
- Tobacco and vaping
- Workforce issues in health care/shortages

Underlying Dynamics Contributing to Health Issues

- Access to health care
- Disconnection across health care providers
- Economic inequality
- Education levels and health awareness
- Geography – rural vs. urban communities
- Increase in misinformation
- Independent culture of Idahoans
- Mental health incidences
- Adequate transportation
- Workforce shortages and issues

Impacts of These Health Issues

- Decreased life expectancy
- Decrease in the quality of life for Idahoans
- Fear/personal suffering – around costs and access of health care
- Health literacy not passed down through generations
- Higher rates of incarceration
- Individual isolation
- Mortality and morbidity
- Rising health care costs
- Substance abuse – and higher suicide rates

Populations at Greatest Risk for Health Issues

- Children
- Disabled
- Elderly
- LGBTQ
- Low-socioeconomic status
- Minority populations
- Rural communities

Thanks to Everyone that
Participated!

Additional Resources - Joe

- Data handout
 - Identified priorities
- Get Healthy Idaho website – assessment data
- Prioritizing today
 - Health outcomes or behaviors, determinants of health will be reviewed later
 - Criteria to think about
 - Review website, data handout and other sources you may have

Questions