

Health Quality Planning Commission Annual Report

Creating a Healthy Idaho

June 2016

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Acknowledgments

The Health Quality Planning Commission (Commission) wishes to thank Idaho's major healthcare stakeholders for their selfless contributions to this effort, which include their time and staff resources. Much of the work of the Commission would not be possible without the generous staff support provided by the Department of Health and Welfare, Saint Alphonsus Health System, Regence BlueShield, Blue Cross of Idaho, St. Luke's Health System, Kootenai Health, the Idaho Health Data Exchange, Boise State University, Angela Beauchaine, MD with Primary Health Medical Group, and Ted Epperly, MD with Family Medicine Residency of Idaho.

Foreword

This document is submitted to the Department of Health and Welfare's Director, Richard Armstrong; the Idaho Senate Health and Welfare Committee; and the Idaho House Health and Welfare Committee to meet the requirements set out in House Bill 375 passed by the 2016 Legislature.

Health Quality Planning Commission Members

Chair

J. Robert Polk, MD, MPH Executive Consultant, Saint Alphonsus Health System, Boise, Idaho

Vice Chair

(vacant)

Committee Members

| | |
|--|--|
| Scott Carrell | Executive Director, Idaho Health Data Exchange |
| David Pate, MD | President and CEO, St. Luke's Health System, Boise, Idaho |
| Zelda Geyer-Sylvia (retired 2.1.2016) | President and CEO, Blue Cross of Idaho, Meridian, Idaho |
| Tim Dunnigan | Dean of the College of Health Sciences, Boise State University |
| Ted Epperly, MD | Program Director and Chief Executive Officer Family Medicine Residency of Idaho, Boise, Idaho |
| Rich Rainey, MD | Medical Director, Regence BlueShield of Idaho, Boise, Idaho |
| Representative John Rusche | Idaho House of Representatives, Minority Leader |
| Casey Meza | Executive Director, Affiliated Health Services, Kootenai Health |
| Angela Beauchaine, MD | Pediatrician, Primary Health Medical Group |

Committee Staff

Michele Turbert Program Research and Development Analyst, Department of Health and Welfare, Boise, Idaho

Note: There are currently two vacancies on the Commission. A recommendation to the Governor to fill one vacancy has been moved forward and a recommendation on the second vacancy will be forthcoming.

Background

The Health Quality Planning Commission (Commission) was established by House Bill 738 during the 2006 legislative session, extended with House Bill 238 in the 2007 legislative session, and extended again in 2008 with House Bill 489. The purpose of the Commission is to “...promote improved quality of care and improved health outcomes through investment in health information technology and in patient safety and quality initiatives in the state of Idaho.”

The Commission is a committee of 11 individuals selected by the Governor’s office and currently led by Dr. J. Robert Polk. These 11 members all share an interest in improving the quality of healthcare in Idaho and in investment in health information technology to do so. They come to the Commission having experiences with the healthcare system at many different levels, and represent a broad sweep of stakeholders. Members include hospital CEOs, providers, private payers, an educator, and an Idaho legislator. The Director of the Department of Health and Welfare (DHW), Richard Armstrong, attends all meetings. The Commission also has the support of a staff liaison from DHW.

During the first two years of its work, the Commission focused on establishing a plan to implement a health information exchange for Idaho. To that end a 501(c)(6) not-for-profit corporation, the Idaho Health Data Exchange, was established. Its status as an independent, legally established entity that is responsible to a board of directors with members from a broad base of stakeholders help to ensure that its primary commitment is to the common good.

In 2010, with the passage of House Bill 494, the duties of the Commission were slightly modified. That legislation added responsibility for monitoring the effectiveness of the Idaho Health Data Exchange. House Bill 494 restates the Commission’s responsibility for making recommendations to the Legislature about opportunities to improve health information technology in the state, as well as recommending, “...a mechanism to promote public understanding of provider achievement of clinical quality and patient safety measures.”

House Concurrent Resolution No. 39 was also passed during the 2010 legislative session. That resolution encouraged the Commission to study stroke systems of care in Idaho and develop a plan to address stroke identification and management. As a result of the investigations that followed, the Commission sent a recommendation to the Legislature in October 2011 to empower DHW to develop a plan to establish a stroke system of care.

Attention then shifted to examining other time sensitive health issues such as trauma and heart attack. This revived ongoing discussions of how Idaho could access data to better understand the true scope and cost of various health issues in Idaho. The Commission’s interest in access to health data and its importance continue to be a focus of their work and are considered with all work initiatives the Commission explores.

In December 2012 the Commission recommended that the Legislature adopt a concurrent resolution on time sensitive emergencies in Idaho. This recommendation was introduced

during the 2013 legislative session. In support of that recommendation, House Concurrent Resolution No. 10 was passed. It empowered DHW to convene a workgroup to create an implementation plan and framework for a statewide system of care to address trauma, stroke, and heart attack. During the 2014 legislative session that plan was reviewed and Senate Bill No. 1329 was passed creating a time sensitive emergency system in Idaho. An update on that work is contained within.

Finally, during the 2015 legislative session the Commission supported the passage of Senate Concurrent Resolution No. 104. This resolution authorized the Commission to prepare an implementation plan for a comprehensive suicide prevention program. The Commission completed that work and presented the suicide prevention plan to legislators during the 2016 legislative session. The outcome and plan details are discussed below.

Areas of Focus for the Commission This Year

The Commission is continually working to stay informed about changes that are occurring within the healthcare environment in Idaho and nationally. This information is necessary to understand potential impacts to quality of care and to direct the Commission as it continues to pursue opportunities to promote improved quality of care and improved health outcomes. This year the Commission received updates on several current healthcare initiatives in Idaho and also heard from subject matter experts on recurring as well as new issues that impact the health and care of Idahoans. The subjects and information learned are summarized below.

Updates on Existing Initiatives

Medical Home Collaborative

Lisa Hettinger, Administrator for the Division of Medicaid, provided an update on the Medical Home Collaborative pilot project. That project was initiated in 2013 to assess methods for and the impact of implementing the person centered medical home model of care, which is a multi-payer project including Idaho Medicaid, Blue Cross of Idaho, Pacific Source, and Regence Blue Shield. The project established baseline requirements and provided both financial and technical support to 36 practices over the course of the next year. The state has now received the final report from TransforMED, LLC, an independent contractor selected under a competitive bid process to conduct a summative analysis of the pilot project. Highlights include:

- Medicaid was able to reduce the per member per month (PMPM) costs by \$22 for those who participated in the pilot. This was primarily a result of a reduction in emergency room visits, a reduction in inpatient admissions, and a reduction in prescriptions. Prescription duplication was also reduced. Medicaid experienced a 2.2 million dollar savings. The Medicaid pilot population fluctuated between 9,000 and 10,000 people.
- Patients responded quickly to improved care coordination. People with acute healthcare needs had better health outcomes when there was enhanced engagement from the primary care physician.
- Blue Cross also experienced savings demonstrating that both populations, commercial and non-commercial payers, responded well to the medical home model of care.

- National Committee for Quality Assurance (NCQA) recognition was achieved by most practices that participated in the pilot.
- Most practices reported that they have transformed in a way that is sustainable long term.
- Access to care was reported to have improved.
- The return on investment was 5 to 1.

There were a number of lessons learned and recommendations for the future, including:

- Use of the Idaho Health Data Exchange (IHDE) should be encouraged. The IHDE tools provide the necessary level of communication to do this work effectively. Improved use of electronic health records, exchange of information, and increased training for practices all enhance the benefits of a person centered medical home.
- The state is encouraged to establish community consensus guidelines for care of chronic diseases. It is important that these guidelines be offered as support, not as mandated practices.
- Having a physician champion for transformation within the practice is critical to the success of the person centered medical home model.

Medicaid plans to transform more practices into this model in the future using the lessons learned.

Suicide Prevention

The Commission began its examination of suicide prevention in May 2014. After much discussion and consideration over several meetings, the Commission concluded that suicide prevention is a healthcare issue the state should examine further. The Commission sent a letter in February 2015 to the Legislature to support a request for establishing a select committee of statewide stakeholders to develop a system of care for implementing the Idaho Suicide Prevention Plan across the state. Ultimately, Senate Concurrent Resolution No. 104 was passed authorizing the Health Quality Planning Commission to prepare an implementation plan for a comprehensive suicide prevention program such as the one described in the Idaho Suicide Prevention Plan and published by the Idaho Council on Suicide Prevention.

A core workgroup was convened. The group developed the plan which was supported by the Idaho Suicide Prevention Coalition. It was presented to the Senate and House Health and Welfare Committees and to JFAC during the 2016 legislative session. The plan included a request to the Legislature to establish an Office on Suicide Prevention in Idaho. That request was approved by the Legislature and signed by the Governor. It allocated \$971,000 to the Division of Public Health and includes funding for four staff.

The Office for Suicide Prevention will address 12 initiatives:

1. Develop public awareness campaigns
2. Training of youth: this funding will support training middle school and high school students on suicide prevention utilizing a well-respected suicide prevention program known as *Sources of Strength*. The mission of *Sources of Strength* is to prevent

suicide by increasing help seeking behaviors and promoting connections between peers and caring adults. There is a five year goal to train 50% of all students.

3. Gatekeeper training to those most likely to have the greatest impact preventing suicide: primary care physicians and staff, teachers and other school personnel, law enforcement, and first responders.
4. Train media on safe and effective reporting of suicide. There are ways to report on suicide that enhance help seeking behaviors and lower the risk of suicide contagion.
5. Sustainability for Idaho Suicide Prevention Hotline: 60% of the costs for operating the suicide prevention hotline have been appropriated.
6. Ensure training of behavioral health clinicians in suicide assessment and management through changes in university curricula and relicensing criteria.
7. Ensure effective, immediate follow up of suicidal patients following a visit to the emergency department, other healthcare visit, or a mental health facility discharge. This initiative is based on the fact that the greatest risk for suicide completion for a suicidal patient occurs in the 30 days after being seen in a healthcare facility.
8. Immediate coroner reporting of suicides. This is currently a voluntary program created by the Suicide Prevention Action Network of Idaho, with opportunity to improve.
9. Train and support more professionals who encounter survivors in the immediate aftermath of suicide loss: police, funeral home staff and healthcare staff. Currently they are trained on a volunteer basis.
10. Train and support facilitators of suicide loss support groups. Currently they are trained on a volunteer basis with no coordination of training or support groups.
11. Create an office of suicide prevention within DHW.
12. Overcome the barriers to accurate and adequate data reporting of suicide and suicidal behavior. The actual number of suicide attempts in Idaho is unknown. Fulfilling this initiative will require a statewide database.

The Suicide Prevention Program will begin July 1, 2016.

Time Sensitive Emergencies

The Idaho Time Sensitive Emergency System Council was created with the passage of Senate Bill No. 1329 during the 2014 legislative session. Its functions include implementing and monitoring a voluntary statewide system that includes trauma, stroke, and heart attack facilities to provide oversight of that system and to establish and manage regional time sensitive emergency committees throughout the state. The council is also responsible to designate hospitals as trauma, stroke, or heart attack centers when that hospital has been found to meet applicable level of trauma, stroke, and heart attack center criteria as established by the council.

Christian Surjan, Time Sensitive Emergency (TSE) Program Manager in DHW, provided an update on the current activities of the TSE Council. Activities currently in process include:

1. Regional quality assurance & process improvement activities: For example, as a result of a case study where communication was not effective during the transfer of a trauma patient, processes have now been put in place to improve communication and prevent future problems. Collaboration has improved significantly between all entities involved in a time sensitive emergency as a result of the regional committees and their work.
2. Education for emergency medical services providers: region-specific educational materials and trainings have been developed and presented to emergency medical services agencies by their peers around the state.
3. Local education utilizing the Rural Trauma Team Development Course (RTTDC): This is a national course for all levels of providers who see trauma patients. Idaho is fortunate to have a local physician who is an RTTDC certified instructor. Work is currently underway to arrange for three to four RTDDC trainings per year around the state.
4. To date, the council has received eight applications from hospitals for designation. Four have been approved and four are pending. They are:

Current Designations in Idaho

| Hospital | Designation |
|---|--|
| Saint Alphonsus Regional Medical Center Boise | Level II Stroke Center Level II Trauma Center Level I STEMI Center |
| Eastern Idaho Regional Medical Center | Level II Trauma Center |

Applications Pending

| Hospital | Designation |
|-----------------------------|------------------------|
| Lost Rivers Medical Center | Level IV Trauma Center |
| Clearwater Valley Hospital | Level IV Trauma Center |
| Teton Valley Medical Center | Level IV Trauma Center |
| Kootenai Health | Level II Trauma Center |

5. Finally, the Council has developed the logo below:



Continued Discussion on Healthcare Data in Idaho

Over the past several years the Commission has examined multiple health issues affecting Idahoans. These efforts have been continually frustrated by the lack of data available to

truly understand the scope and cost of these health issues in Idaho. The data required to bring about a thorough analysis and accurately identify needed improvements is just not available. For example, we know how many Idahoans die from stroke, but there's no data available about how many have a stroke and live, or how many die of complications from a stroke. We do not know how many Idahoans have diabetes or how many Idahoans attempt suicide and fail.

Collecting and distributing complete, uniform information would:

- Give policy makers the information they need to make informed decisions and target investments for state dollars effectively and efficiently.
- Provide the information necessary to assess the effectiveness of quality improvement initiatives in Idaho, even at the community level.
- Provide transparency of data which sheds light on it and the needed improvements.
- Support provider efforts to design targeted quality improvement initiatives at the community or practice level.
- Enable providers to compare their own performance with those of their peers.
- Help the public understand provider performance, clinical quality standards, and patient safety standards.

The Legislature has directed the Commission to enhance public health through means such as population-based epidemiological studies and the maintenance of statistical databases and registries. This includes the creation of a health data authority, if appropriate. The Commission has also been directed to recommend possible mechanisms to help the public understand how providers achieve clinical quality and patient safety standards.

The Commission continues to discuss how to best address these directives via improved access to healthcare related data. The Commission is undertaking this work understanding the importance of keeping in focus the benefits vs. the cost of gaining access to that data.

Currently Available Data

Joseph Pollard, B.S., the Health Data Analytics Program Manager in the Division of Public Health at DHW, gave a presentation to the Commission on what healthcare data is currently available to DHW and how that data is being used. Within the Division of Public Health there are roughly 45 systems collecting data. Some are simply registry systems; some collect public health data; some are older registries such as vital records, which provides mortality data; and some are newer systems such as Time Sensitive Emergencies, which provides data on traumas, stroke, and heart attacks. Data systems currently include an entire lifespan, meaning it includes children and adolescence health data, adult health data, and population health data.

Examples were provided on how data is being used and where public health data has impacted care delivery:

- Trauma registry data can be used to determine where the high volume of time sensitive emergencies (TSE) exist so resources might be deployed to that area.
- The regional TSE committees review de-identified data and determine what can be done at the community level to improve outcomes.
- Moving forward, TSE data will support areas where training efforts are needed for improved care and will help measure challenges and successes as comprehensive coordinated systems of care are implemented regionally and statewide.
- Chronic disease prevention programs use the Behavioral Risk Factor Surveillance System (BRFSS) data for program planning (e.g., defining priority populations, geographic targeting, etc.), setting targets, and evaluating long-term outcomes.
- Public health programs use mortality data for planning, setting targets, evaluating long-term outcomes, etc. (similar to BRFSS).
- Community health assessments use mortality data to understand what health-related issues represent the greatest burden to their service area population.
- Get Healthy Idaho was developed using health data to formulate its plan for improving population health.
- Public health programs like Project Filter and the Idaho Physical Activity and Nutrition Program use the Pregnancy Risk Tracking System data to identify priority populations, set targets, and evaluate program effectiveness. The goal here is to reduce smoking by pregnant women and mothers of newborn children, encourage breast feeding, etc.

The Non-STD (sexually transmitted disease) Reportable Disease Registry is used for real-time infectious disease monitoring through lab reports, case reports, etc. This information can be used to identify where an outbreak may be occurring that would not be identified by local public health officials and how to prevent the disease from spreading.

The Division of Public Health is working to identify better methods for health data to be used by health systems to improve patient care at the clinic/health system level.

What We Know About the Health Status of Idahoans

Next, the Commission wanted to learn more about what the health status of Idahoans is today. Dr. Kelly McGrath, Medical Director for Quality and Safety Initiatives with Qualis Health, provided the Commission with an overview of what is known.

Dr. McGrath began with a presentation on the results of a Keiser Family Foundation national survey conducted November 10-17, 2015. This survey asked people to identify what the possible priorities should be for their state's governor and legislature. The

number two priority, following improving public education, was making healthcare more accessible and affordable. The sixth priority, also a health related priority, was to reduce prescription drug and heroin abuse.

The Commonwealth Fund Health System State Ranking found that Idaho ranked 31st in the nation in 2015 for overall health. The three areas where Idaho ranked lowest are: access, prevention treatment, and healthcare equity.

Additional information on the health status of Idahoans included:

- Access – is care affordable and available?
Idaho ranks 50th out of 51 states (includes District of Columbia) for adults with low or moderate out-of-pocket costs relative to their income and 38th overall for access to physician care. Idaho is 49th in the nation for the number of active physicians per 100,000 people, 46th for access to primary care providers, and 51st in the nation for access to psychiatrists. Insurance coverage is still a concern in Idaho. Forty-four percent of those in Idaho who are not insured are ineligible for financial assistance.

Prevention and Treatment – how effective is the care? When accessed, is there preventive care? What are the outcomes of the treatments received?
Idaho ranks 50th for percent of children 0-17 with both a medical and dental preventative care visit in the past 12 months, 44th in the nation for percent of adults reporting poor mental health, and 51st in the nation for access to psychiatrists as well as state mental health agency per capita mental health services expenditures. It was also noted that there is a rising tide of prescription drug abuse nationally and in Idaho. Idaho's rate of drug overdose deaths more than doubled between 1999 and 2010 (5.3 to 11.8 per 100,000). Much of the increase was driven by prescription drug use such as opioids.

- Care Coordination
Good care coordination is dependent to a great extent upon the adoption and utilization of electronic health records. Adoption rates are relatively low in Idaho. In 2014 there was a 69% adoption rate in hospitals in Idaho and a 42% adoption rate in physician practices in Idaho. Small and rural hospitals lagged behind the most significantly.

Note about the timeliness of this data:

- Many ranking systems are updated once per year or less frequently.
- Some are based on data from as far back as 2010.
- Many of these measures have likely improved since that time due to policy and payment changes.

Next, the Commission heard from Joseph Pollard, B.S., the Health Data Analytics Program Manager in the Division of Public Health at DHW. Mr. Pollard gave a presentation on how the Division of Public Health utilizes data to gain a snapshot of the health status of Idahoans. The Health Data Analytics Program identified 10 topic areas and 31 leading health indicators to benchmark and trend. The indicators are being used to

assess the health status, facilitate collaboration, and motivate action at the state and local levels to improve the health of the Idahoans. These leading health indicators include such things as tobacco use, immunization rates, and the percentage of Idahoans who receive colorectal screenings. The indicators are benchmarked against national data to the extent possible and are believed to give a good picture of the health status of Idahoans.

The Health Data Analytics Program reviews the leading health indicators annually. Trends reveal that over the last 10 years about one third of the indicators tracked have improved, about one third have declined, and about one third have remained constant. A sample of the results is provided here:

- Significant improvement (2006-2013):
 - teenage smoking has decreased
 - death due to coronary heart disease and stroke has decreased
 - adolescent pregnancy rates have dropped by nearly 50%
- Significant worsening (2006-2013):
 - percent of overweight youth has increased
 - percent of obese adults has increased
 - infant pertussis has increased
 - Sexually transmitted diseases have increased
 - high school age suicide attempts have increased
 - adult diabetes diagnoses have increased
- Remained constant:
 - the suicide death rate remains markedly higher than the national rate
 - Idaho continues to have a significantly lower proportion of primary care physicians per capita than the national average

Get Healthy Idaho utilized the data from the leading health indicators to set and track four priority areas for improving population health: access to care, diabetes, tobacco use, and obesity. Currently there are programs in place within the Division of Public Health to address five-year goals set in each of the four priority areas.

How Data is Currently Being Used to Improve Quality

Chris Johnson, MPH, an epidemiologist with the Cancer Data Registry of Idaho (CDRI), gave the Commission an overview of the work done there and how the data from the registry is used to improve the quality of care. The CDRI is a statewide cancer registry that collects incidence and survival data on all cancer patients who reside in, are diagnosed with, and/or treated for cancer in the state of Idaho. Idaho has one of the oldest cancer registries in the country. The CDRI was established in 1969 and became population-based in 1971.

Cancer is a reportable disease under state law and operations of the registry are mandated by Idaho Code. The type of data collected includes demographics, cancer site and type, stage, biomarkers, comorbidities, treatment, and survival. The latest annual CDRI report (2013) is located at www.idcancer.org.

The goals of the CDRI are to:

- Monitor trends and patterns of cancer incidence over time.
- Identify high risk populations.
- Provide accurate cancer incidence and survival information so that cancer control efforts can best focus energies on appropriate cancer prevention, screening, and treatment priorities.
- Complete cancer cluster analysis work.

CDRI data are used for many purposes. Historically, population-based cancer registry data were used to describe cancer burden, trends, and survival. In the past two decades registry data have been used for cancer control efforts and assessing the effectiveness of early detection programs. Enhanced cancer registry data, especially molecular data and biomarkers, offer an opportunity for collaboration with clinicians on patient care and clinical management.

Mr. Johnson provided the Commission with the following statistics on cancer:

- Nearly one in two men and one in three women in the United States will be diagnosed with cancer sometime in their life.
- Cancer is the leading cause of death in Idaho. About 22% of deaths are from cancer.
- There are approximately 8,000 new cases and 2,700 deaths from cancer each year.
- Cancer is expected to become the leading cause of death in the U.S. within the next five years.

Idaho has one of the lowest cancer mortality rates in the U.S. This is strongly tied to our lung cancer mortality rate, which is related to the relatively low smoking prevalence. Idaho has the lowest, or among the lowest, screening rates in the country for cancers of the breast, cervix, colon, and rectum.

Mr. Johnson included in his discussion a review of the Idaho sources of population-based disease surveillance data. Idaho has access to information from death certificates, reportable communicable disease tracking, registries such as the cancer registry and trauma registry, as well as data from surveys such as the Behavior Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System. **Idaho does not have access to two primary data sources: a hospital discharge database or an all payer claims database. As a result, Idaho really lacks associated costs of disease.**

The Commission then heard from Brian Windau, the Director of Population Health and Analytics at Primary Health Medical Group. Mr. Windau provided an overview of Primary Health Medical Group's use of data to improve quality.

There are basically three types of data used by Primary Health Medical Group:

1. Clinical data - basic data from electronic medical records (most timely)
2. Claims data - from payers

3. Supplemental data – anything from other sources to help with performance measures and to identify patient gaps

A priority for Primary Health Medical Group when using data is to prevent provider information overload. This is achieved by handling data centrally and only pushing certain data down to the clinic for action. For example, quarterly they publish several diabetes and hypertension metrics sorted by primary care provider. This data is provided to the clinic. It shows the provider where he or she stands with the metrics in terms of meeting best practice. The data is then filtered by patient to identify those patients who are missing labs, who need a new appointment, etc. The clinic staff then reviews the patient's chart and, when appropriate, reach out to the patient to schedule an appointment for whatever the missing event or lab might be.

Data is also used to follow trends in the Primary Health Medical Group. For example they found that they were very poor at documenting foot exams for patients with diabetes. They looked closer and found that it took 30 clicks in the electronic medical record to complete that documentation. As a result, they were able to revise their foot exam template and improve their overall tracking of foot exams.

The Primary Health Medical Group is working with Proskriptive to integrate all their data and develop comprehensive dashboards on cost trends and risk scoring. Data will be aggregated at three levels: by company, by provider, and by patient. This will lead to predictive analytics and timely interventions.

Exploration of a New Topic

Prescription Drug Abuse in Idaho

The Commission heard two presentations this year on prescription drug abuse in Idaho. First, they heard from Alex Adams, the Executive Director at the Idaho State Board of Pharmacy, and second was Elisha Figueroa from the Idaho Office of Drug Policy. Ms. Figueroa is responsible for state-level drug policy and overseeing substance abuse prevention efforts throughout the state.

Some key points learned from these presentations include:

- Prescription drug abuse is increasingly getting national attention as demonstrated by President Obama's seeking \$1.1 billion to fight addiction.
- Nationally, deaths from opioid pain relievers exceed those from all other illegal drugs combined in all age groups.
- In 2012 in the United States, a baby was born suffering from opioid withdrawal every 25 minutes..

There is limited data available in Idaho specifically on prescription drug abuse. Here is some of what we do know:

- Idaho has five to ten deaths per 100,000 people per year from prescription drug medications.
- Idaho's death rate for prescription drug overdose has roughly tripled since 2000.

- In Idaho from 2010 – 2014 there were 324 unintentional deaths from prescription drugs and 133 unintentional deaths from non-prescription drugs.
- 16% of Idaho high school students report taking a prescription medication without a doctor's prescription at least once during their lifetimes.

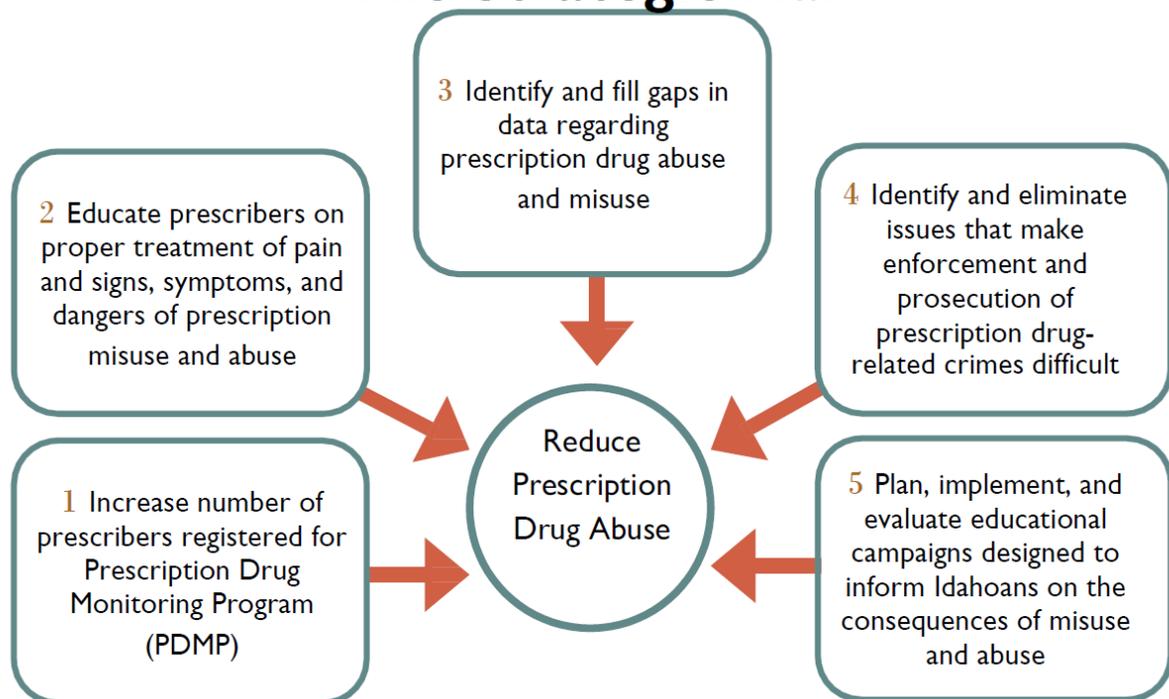
The prescription monitoring program was established in Idaho in 1997. All prescriptions dispensed in Idaho must be reported to the program within 24 hours, regardless of payer. The primary statutory purpose is for use by prescribers and pharmacists at the point of prescribing and dispensing. However, there is no requirement for all prescribers to check the database before prescribing or for pharmacies to check prior to dispensing; therefore, use of the prescription monitoring program for that purpose is low. As a result, Idaho is missing an opportunity to identify patients who are seeing multiple physicians to obtain large amounts of prescription drugs. To mandate use of the prescription monitoring program would require a statutory change.

Idaho participated in a national Prescription Data Mining Program. Idaho sends de-identified data to Brandeis University and they produce reports for Idaho. From this we know that Idaho has 215 opioid prescriptions per 1000 residents, which is slightly lower than the other six states reporting to Brandeis.

The prescription monitoring program uses this data and sends unsolicited reports to prescribers when a patient has had five or more prescribers issue a controlled substance prescription in a calendar month. There have been 636 patients reported as a result of this monitoring since January 2015.

In 2012 the Governor's Office and legislators recognized that prescription drug abuse in Idaho is an issue that needed to be addressed in the state. As a result a state Prescription Drug Workgroup was established. Members include physicians, licensing boards, law enforcement, treatment providers and families who have been touched by this problem. A strategic plan has been developed with a five pronged approach to addressing drug abuse in Idaho.

The Strategic Plan



The goals of this plan are to reduce the number of drug-induced deaths in Idaho by 10% by 2016 as measured by Vital Statistics and to decrease the number of Idaho students reporting prescription drug misuse by 3% by 2017 as measured by the Youth Risk Behavior Surveillance System.

After much discussion of the information presented, the Commission determined that this is an issue they would like to learn more about. The Commission chairman, Dr. J.R. Polk, will be attending the next Prescription Drug Workgroup meeting to learn more. Prescription drug abuse in Idaho will be an agenda item at future meetings.

Monitoring the Effectiveness of the Idaho Health Data Exchange

In 2010, House Bill 494 added monitoring the effectiveness of the Idaho Health Data Exchange (IHDE) to the Commission's responsibilities. To that end, the Commission has received a quarterly report from Scott Carrell, the Executive Director of the IHDE, on its current goals, progress toward meeting those goals, system utilization, and long-term plans. A written annual report about the IHDE is also submitted to the Commission for review. The 2016 IHDE Annual Report is attached for your reference.

Highlights of IHDE's Progress

Highlights of IHDE's progress over the last year include:

- Adoption activity: The IHDE enrolled more new participants in 2015. The current participant enrollment and/or connections consist of hospitals (15), laboratories (5), payers (3), providers/staff (465), and system access for 3,300+ provider/staff group

users. In 2015, they also enrolled a few new organization types (i.e., LTPAC, hospice, and more FQHCs).

The IHDE has been and will continue to be very involved in supporting State Healthcare Transformation Initiatives. The IHDE will continue to support the 55 recently enrolled participating clinics in the State Health Innovation Plan (SHIP). Furthermore, planning efforts are underway with the recently selected analytics vendor (HealthTech Solutions, LLC) in order to deliver quality metric data for this group. The IHDE will also continue to support the Patient Centered Medical Home (Healthy Connections) project as it seeks to move its clinics to higher tier reimbursement levels through participation with the IHDE.

- Several hospital groups continued to supply their radiological images through the IHDE image exchange service. To date, the IHDE has enabled 1,601,224 images to be viewed by IHDE users in their respective communities. This feature helps reduce the excess time and cost to deliver images to providers that have traditionally been burned onto a CD and hand-delivered to specific locations.
- As part of IHDE's transition to a new vendor, Orion Health, an Immunization Gateway was completed. This Immunization Gateway is intended to allow provider clinics a streamlined connection to Idaho's Immunization Reminder Information System in order to improve tracking and reduce the time required for provider reporting.
- Sustainability: The IHDE's revenues have been growing commensurate with its participant base over the years. Despite the long and costly transition project with Orion Health, the IHDE continues to manage its expenses diligently to keep pace for a strong, sustainable future. With the conclusion of the ARRA grant funding in March 2014 that provided a boost to its adoption rate and sustainability plan, the IHDE has continued to position itself for more revenue-generating opportunities. The SHIP project funding and its respective new enrollees will promote greater adoption of the IHDE services. Additionally, with the recent Medicaid announcement requiring its Healthy Connection participants to participate with the IHDE, these endorsements and statewide acceptance of the IHDE as a transformative solution for healthcare initiatives can enable the IHDE to experience greater financial strength through 2016 and beyond.

The IHDE's Next Steps

- To Support SHIP – 55 clinics to connect their EMR systems to IHDE.
- Deploy a "Direct" (secure e-mail) solution to broaden IHDE participation and further support meeting Meaningful Use objectives for current participants.
- Continue support of statewide health project initiatives (e.g., SHIP project plans, Medicaid's Healthy Connections, Telehealth Task Force, Statewide Trauma System, and Health Quality Planning Commission initiatives).
- Identify market opportunities in the health information exchange landscape for IHDE.

Evaluation Summary

Commission members are satisfied with the progress of the IHDE and support its plans for future work. The IHDE has been effective in meeting the needs of Idahoans in this ever changing medical environment and continues to provide a much needed service to Idaho.

Conclusion

Idaho is currently embarking on a number of initiatives that will shift how healthcare is provided. The SHIP is transforming Idaho's healthcare delivery system from a fee-for-service, volume-based system to a value-based system of care focused on improving health outcomes and reducing costs. We will soon see the implementation of a statewide suicide prevention program. New health issues are emerging such as abuse of prescription medications. Commission members are committed to maintaining a focus on this changing environment as they move forward with their work. They will continue to examine ways to best use the expertise and authority they hold to promote health and patient safety, planning, and improved quality of care and health outcomes.

Attachment: Idaho Health Data Exchange Annual Report to the Health Quality Planning Commission.



Annual Report to Idaho Health Quality Planning Commission

May 4, 2016

Background

The Idaho Health Data Exchange (IHDE) is a 501(c)(6) not for profit corporation, charged with the development and implementation of a statewide health information exchange in Idaho. Governor C.L. “Butch” Otter identified IHDE as the State designated entity to receive funds under Section 3013 of ARRA.

The IHDE is the work product of Idaho’s Health Quality Planning Commission (HQPC), which was created by Idaho’s Legislature in 2006. The HQPC was tasked with *promoting improved quality of care and health outcomes through investment in health information technology in the state of Idaho*. The HQPC was tasked with the creation of a plan for statewide health information exchange (HIE) in Idaho to facilitate improved quality and coordination of care by making more complete patient information available at the point of care. It was the priority of the HQPC to build a framework for consistent, secure, statewide HIE – within the broader national context – to rapidly build capacity for connectivity between and among health care providers.

Members of the HQPC included three major hospitals, a critical access hospital, a federally qualified health care center, physicians, a consumer, employer representation, a pharmacist and payers. The HQPC worked over a two year period to develop a comprehensive plan. As part of the planning process, the HQPC identified obstacles to the success of a statewide system including: developing a sustainable business model, defining the value that accrues to users, addressing privacy and confidentiality issues, accurately linking patient data and addressing organizational and governance issues.

The HQPC’s plan was released for public comment and the final plan submitted to Governor Otter in June 2008. IHDE was established to develop and implement the plan. IHDE is an independent legally established entity, responsible to a Board of Directors whose members come from a broad base of stakeholders that will help ensure its primary commitment is to the common good. The Idaho Health Data Exchange model offers significant short and long-term benefits to serve the public interest. The IHDE moves toward the HHS goal of developing a nationwide interoperable health information technology infrastructure to support significant and measurable improvements in population health through a transformed health care delivery system.

Since May 2011, IHDE board membership has changed its composition according to a pre-arranged design by the original board membership. Nearly half of the original board members have served their terms and newly elected board members continue a level of voluntary support necessary for IHDE’s future success. The Board includes representation from both the public and private sectors including health care providers, hospitals, public health, and payers. The IHDE has developed articles of incorporation and bylaws that govern the business of the IHDE. The day-to-day operations of the Corporation are the responsibility of an Executive Director who reports monthly to the Board of Directors. For guidance between Board meetings, the Executive Director consults with the members of the Executive Committee of the Board of Directors. The Executive Committee is comprised of the Chairman, Vice-Chair, Secretary and Treasurer of the Board of Directors.

To date, the IHDE has provided a solution for a statewide, interoperable HIE which can help hospitals and providers achieve meaningful use objectives. IHDE provides the necessary technical support to enable consistent and secure statewide HIE across health care provider systems. It protects a patient’s right to privacy and security of their health information while making healthcare safer, more effective and efficient. It supports hospitals and providers in Idaho and the surrounding region with meeting meaningful use of electronic health records.

Progress to Date

Sustainable Plan

Since last year’s annual report, the IHDE continued its strategic plan to achieve sustainability and to electronically connect Idaho providers, hospitals, and ancillary service providers across the state. During 2015, the IHDE completed its transition to Orion Health, moving several years of data. This transition project took longer than expected and was more costly than planned, but the end results and benefits of migrating to Orion’s HIE platform have already shown signs of being promising to our participants. As reported last year, this new system sets the foundation for IHDE’s sustainable future. It offers the capability for more flexible and dynamic technology solutions necessary for meeting future needs of this ever-changing Health IT environment in which the IHDE operates in. Examples of this are IHDE’s support of the SHIP project requirements and the newly announced Medicaid tier

requirements. More importantly, this Orion solution brings immediate value to our customer base with enhanced capabilities such as greater web portal access, clinical messaging, and alerts/notifications to name a few, that were not previously offered.

With the completion of transition project to Orion Health, the growth of its revenues over the last five years, proper management of its operating expenses and a contract in place with SHIP, the IHDE has positioned itself to strengthen its sustainable plan.

Adoption Activity

The IHDE enrolled more new participants in 2015 (see list below). The current participant enrollment and/or connections consist of hospitals (15), laboratories (5), payers (3), providers/staff (465), and system access for 3,300+provider/staff group users (see full participation list on Exhibit A). In 2015, we enrolled a few new organization types (i.e., LTPAC, hospice and more FQHCs) as mentioned below. Several participating providers use the Clinical Portal (Chart #1) and/or have their EMRs connected to receive results delivery through the IHDE and are using the exchange to communicate on consultations (Chart #2).

NEW enrollees

- Horizon Home Health & Hospice (Meridian)
- Spark M.D. (Boise)
- Meridian Pediatrics
- Thomas R. Huntington, M.D. (Boise)
- ID Minor Emergency/Family Practice (Meridian)
- Valley Family Healthcare (Payette)
- Genesis HealthCare (Boise)
- A New Leaf, Inc. (Boise)
- Vibra Hospital (Boise)
- Crosspointe Family Services
- Pocatello Children's Clinic
- Madison Memorial (Rexburg)
- Upper Valley Community Health Services (St. Anthony)
- Heritage Health (Coeur d'Alene)
- Unified Healthcare of Idaho (Idaho Falls)
- Benewah Medical Center (Plummer)
- Bonners Ferry Family Medicine
- Family First Medical Center (Idaho Falls)

Charts 1 (Utilization of the Virtual Health Record/Clinical Portal)

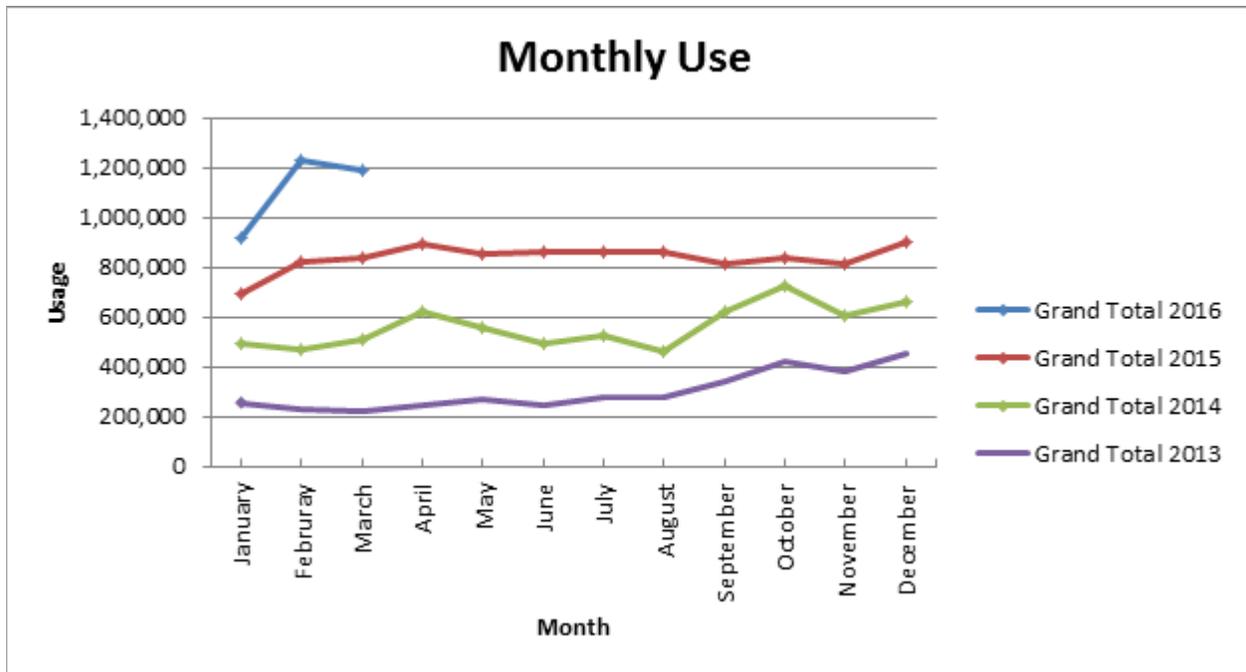
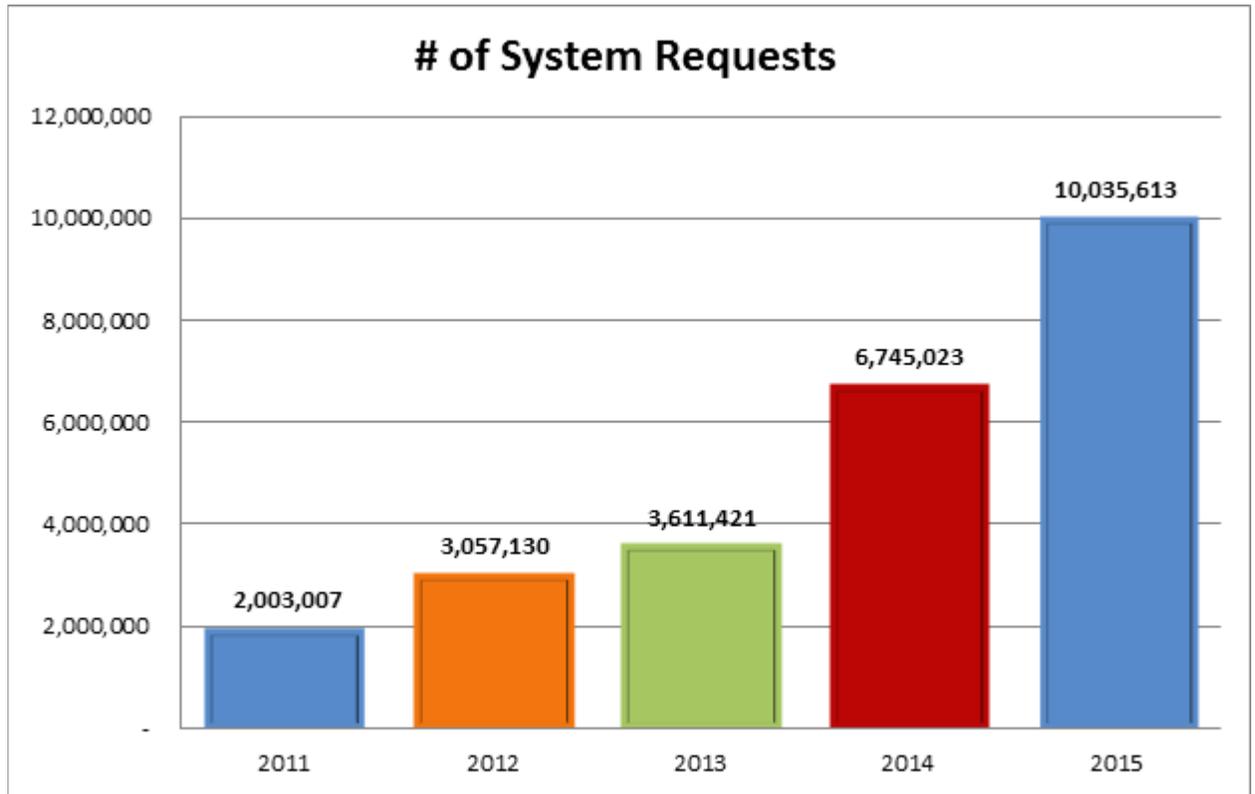
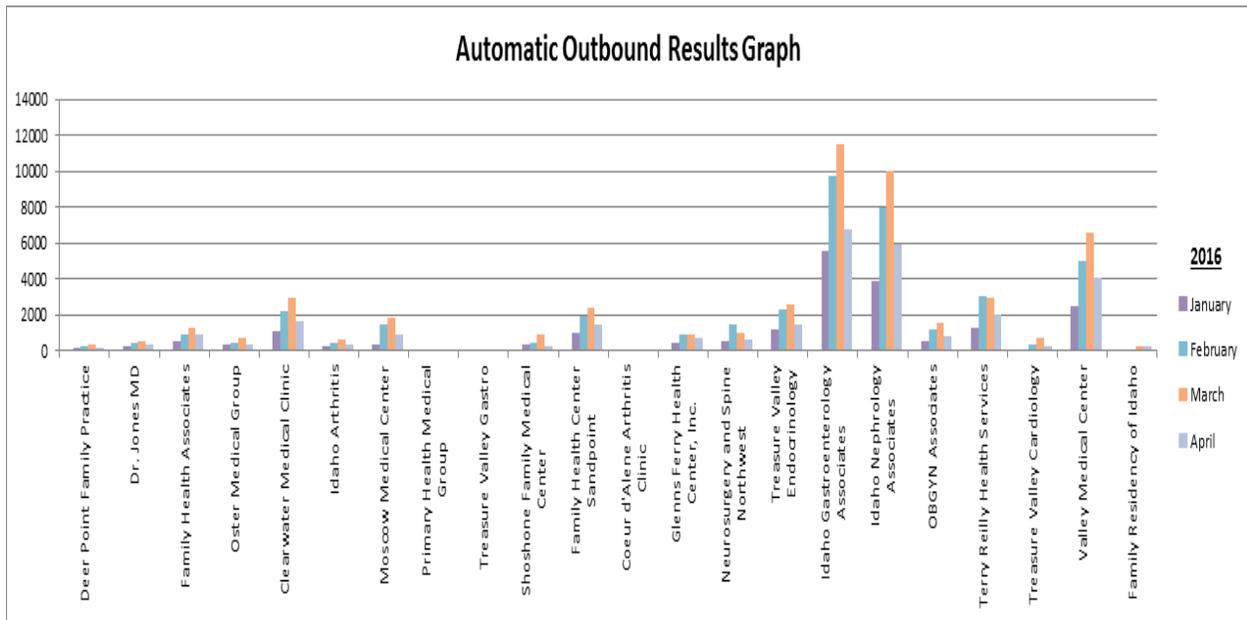


Chart #2 (Outbound Results delivery to connected EMR practices)



Supporting State Healthcare Transformation Initiatives

The IHDE is not only a solution for traditional provider practices to be “connected” or to view a universal clinical record, but the IHDE has also been much more involved with several state healthcare innovation projects. As the sole source contractor, the IHDE will continue to support the recently enrolled Cohort #1 participating clinics (“55”) in the State Health Innovation Plan (SHIP). It is planning to connect all clinics with bi-directional routes to enable both sharing and receiving of valuable clinical data. Furthermore, planning efforts are underway with the recently selected analytics vendor (HealthTech Solutions, LLC) in order to deliver quality metric data for the first cohort. Specifically, the IHDE will provide a means to access the clinical data it reposit with that of the analytics tool and reports (from HTS) in order to support the quality metric measurements set forth by the SHIP project.

The IHDE will also continue to support the Patient Centered Medical Home (Healthy Connections) project as it seeks to move its clinics to higher tier reimbursement levels through participation with the IHDE.

Several hospital groups continued to supply their radiological images through the IHDE image exchange service. To date, the IHDE has enabled 1,601,224 images to be viewed by IHDE users in their respective communities. This feature helps reduce the excess time/cost to deliver PACS images to providers that have traditionally been burned onto a CD and hand-delivered to specific locations.

Strategic/Operational Plans

In 2014, the IHDE began planning a connection project with the state’s immunization registry (IRIS). This Immunization Gateway is intended to allow provider clinics a connection to IRIS in order to enhance the needs of the healthcare community by reducing the number of interface connections (point to point) to IRIS. It will also serve as an interest for some providers who currently do not have a connection with IRIS. As part of the transition project to Orion Health, an Immunization Gateway was completed. Just recently, the IHDE connected its first practice (Primary Health Group) which now allows Primary Health to submit its immunization data on a

frequent, less cumbersome basis. Coupled with the 2015 legislative passage of Senate Bill 1121, the IHDE is positioned itself to allow providers to receive data back into their EMRs (from IRIS) as well as make the immunization data available to benefit the whole provider community.

Although last year's efforts to pursue another federal grant opportunity (to pursue a "Direct" solution offering) did not come to fruition, the IHDE Board just recently approved to engage a "Direct" vendor and solution to be offered to those groups/clinics who have not been engaged in "connecting" to the IHDE and/or have not had a means for being able to connect to the IHDE. Additionally, this solution will help support the IHDE participants seeking to meet their Meaningful Use exchange requirements.

Sustainability

The IHDE's revenues have been growing commensurate with its participant base over the years. Despite the long and costly transition project with Orion Health, the IHDE continues to manage its expenses diligently to keep pace for a strong, sustainable future. With the conclusion of the ARRA grant funding in March 2014 that provided a boost to its adoption rate and sustainability plan, the IHDE has continued to position itself for more revenue-generating opportunities. The SHIP project funding and its respective new enrollees will promote greater adoption of the IHDE services. Additionally, with the recent Medicaid announcement requiring its Healthy Connection participants to participate with the IHDE, these endorsements and statewide acceptance of the IHDE as a transformative solution for healthcare initiatives can enable the IHDE to experience greater financial strength through 2016 and beyond.

Next Steps

Follow strategic plan initiatives for 2016:

- Support SHIP – Cohort#1 enrollees (55 clinics) to connect their EMR systems to IHDE
- Deploy a "Direct" (secure e-mail) solution to broaden IHDE participation and further support meeting Meaningful Use objectives for current participants
- Continue support of statewide health project initiatives (e.g., Statewide Health Innovation Plan (SHIP) project plans, Medicaid's Healthy Connections, Telehealth Task Force, Statewide Trauma System, Health Quality Planning Commission initiatives)
- Identify/assess market opportunities in the HIE landscape for IHDE (e.g., Public Health, help support eligible providers and hospitals to meet Meaningful Use stage #2 and #3 objectives. s, interoperable solutions for constituents)

IHDE Testimonials

"I'm a believer. The Clinical Portal (CP) is different from the previous system and much more useful. I've been using it and have seen great benefits. The clinical value of the IHDE is clear. I'm just trying to spread the word, especially in my practice and with my partners. The full benefits will be realized once more people are using it."

"I have a couple of recent experiences where the CP has been extremely useful for me. The first was when I was treating a disoriented patient with a behavioral health history who was brought into the ER Dept. by law enforcement. She was unable to provide much history other than that she had been involved in a motor vehicle collision the previous day. She had symptoms that, with her disorganized thoughts, would likely need imaging to rule out injury from the motor vehicle collision. Through the IHDE, I was able to see that she had an extensive and complete workup at another hospital just the day before. This included extensive imaging with CT. With this information, I did not need to duplicate the imaging. This saved time in the ER Dept., avoided unnecessary radiation of the patient, reduced costs to the system by avoiding repeat CT scans, and allowed me to expedite the more pressing needs for the patient that day. It was better, safer care at a lower cost: the true "triple aim" of health care."

"The IHDE CP has also been of particular value with behavioral health patients. For such patients, particularly when in crisis, accessing their information in the IHDE helped me understand their history, get a sense of patterns, the management of their care, and come up with an overall treatment plan. Before, I would have had to gather this information independently which often is not possible. This situation also applies to other clinical conditions where history is incomplete or cannot be provided due to patient impairment. So, I've been using the IHDE more frequently to get a patient's recent progress notes. For example, earlier today, I logged into the CP to check up on a very sick patient who I transferred to a regional tertiary care facility. This was extremely valuable in the transition of care back to our community. When I saw the patient in the next follow-up visit, almost none of the hospital information had been sent to me. By accessing the CP, I had an even more complete set of information than usual. This made the care transition safer, efficient and more effective; another case where the IHDE supports the triple aim."

"When I'm working in the ER Dept., particularly over a weekend and I hear my colleagues needing their patients' data, I encourage them to check the IHDE and tell them that they can often get what they need from the IHDE. The most frequent response is that they don't have their log-on or that they didn't realize that the IHDE would be valuable. When more providers use the system, they will have more stories like mine to tell you. In fact, I think that there will be a flood of these stories to tell. How does having more information and imaging available from the IHDE not help us do our jobs better and positively impact health care?"

"You can get the information outside of the IHDE, but it's going to take a lot more energy and time, and will delay care for the patient. Where this is really going to be helpful is with a patient's transition of care. With the IHDE, providers can go in and select what they need and not have to sift through paper records or order duplicate, unnecessary tests or imaging which can expose patients to unnecessary radiation. What would be really helpful is if all providers were using the system, not just providers in hospitals, because it's the right thing to do for the patient."

*Kelly McGrath, MD
Clearwater Valley Hospital and Clinics*

"Primary Health Medical Group is pleased to be the first in Idaho to use the IHDE Immunization Gateway. This process will allow an automatic daily upload of immunization records to Idaho's immunization registry (IRIS). Previously, immunization records were manually uploaded bi-weekly. We are committed to providing our patients with convenient, high-quality health care and will continue to make strides for Idaho patients and our community partners."

*Paul Castronova
Director of Information Technology
Primary Health Group*