

Health Quality Planning Commission Annual Report

Creating a Healthy Idaho

June 2019

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Foreword

This document is submitted to the Department of Health and Welfare's Director, Dave Jeppesen; 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

Tim Dunnagan, EdD
Dean and Professor, College of Health Sciences,
Boise State University

Vice Chair

(vacant)

Commission Members

Richard Armstrong	Governor's Health Care Advisory Panel (HCAP)
Paul Brannan (PROXY - vacant) Brad Erickson (fmr)	Interim Executive Director, Idaho Health Data Exchange
Bart Hill, MD David Pate, MD (fmr)	VP and Chief Quality Officer, St. Luke's Health System, Boise, Idaho
Dan Meltzer, MD	SVP and Chief Medical Officer, Blue Cross of Idaho
Margaret A. Henbest, RN, MSN, CPNP	Community Representative, Boise, Idaho
Ted Epperly, MD	Program Director and Chief Executive Officer, Family Medicine Residency of Idaho, Boise, Idaho
Kenneth Bramwell, MD	Medical Director, Regence BlueShield of Idaho, Boise, Idaho
John Rusche, MD	Pediatrician, Lewiston, Idaho
Patt Richesin Casey Meza (fmr)	President, Kootenai Care Network
Angela Beauchaine, MD	Pediatrician, Primary Health Medical Group
Charles Davis, DO James Lederer, MD (fmr)	DO President, Saint Alphonsus Health System

Commission Staff

Robin Butrick
Policy Analyst, Project Coordination and Support
Department of Health and Welfare, Boise, Idaho

** (fmr) – Former member that has resigned

Background

The Health Quality Planning Commission (HQPC) was established by House Bill 738 during the 2006 legislative session, extended with House Bill (HB) 238 in the 2007 legislative session, HB 489 in 2008 and HB 375 in 2016. 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. Tim Dunnagan, Dean and Professor, College of Health Sciences, Boise State University and the former Director of Health and Welfare, Dick Armstrong, currently the Governor's Healthcare Advisory Panel (HCAP) Chair. These members all share an interest in improving the quality of healthcare in Idaho and in investment in health information technology. 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 senior administrators, providers, private payers, educators and community representatives. The Director of the Department of Health and Welfare (DHW), Dave Jeppesen, also attends the meetings. The Commission 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 HB 494, the duties of the Commission were slightly modified. That legislation added responsibility for monitoring the effectiveness of the Idaho Health Data Exchange (IHDE). 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. Because 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 discussion 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 in this document.

Additionally, 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.

Lastly, HB 375 was passed during the 2016 legislative session reauthorizing the Health Quality Planning Commission to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure, to improve the quality and efficiency of health care and the ability of consumers to manage their care, and to facilitate coordinated implementation of statewide patient safety standards, including identifying uniform indicators of, and standards for, clinical quality and patient safety as well as uniform requirements for reporting provider achievement of those indicators and standards. To this end the commission has focused on behavioral health in Idaho and the development of a robust web-based Advance Directives platform for residents and providers in Idaho. The remainder of this document outlines the progress with these two critical efforts during this past year.

Areas of Focus for the Commission

The Commission is continually working to stay informed about health care changes that are occurring in Idaho and the nation. By keeping informed, the commission members better understand potential impacts to quality of care and how to focus efforts to pursue opportunities to improve the quality of care and health outcomes. This year, the Commission took a deep look at several initiatives including advanced care planning, Idaho Health Data Exchange, Medicaid expansion and health insurance and behavioral health. Other areas include elder care, value based health care, graduate medical education, maternal mortality, dual eligible programming and telehealth. The Commission heard from subject matter experts who provided updates on diverse health issues. The initiatives and updates considered by the Commission are summarized below.

INITIATIVES

Advanced Directives - Advanced Care Planning in Idaho

In August 2018, Stephanie Bender-Kitz informed the HQPC that the advanced care volunteers were split up into two task forces to address advanced care directives. The first was a legislative task group and the other was the Honoring Choices Idaho funding group. The legislative group met to identify what funding source should be used. They initiated a plan for a general fund request to be submitted in 2019 for \$860,000 through the DHW budget. During the 2018-2019 timeframe, there was a gap in funding which was bridged through contributions of health and educational entities across the state. The financial contributions demonstrated strong support across the state for this initiative.

In the November 2019 HQPC meeting, Dr. Bender-Kitz and Ms. Elke Shaw from IDHW provided updates that included a letter supporting advanced care directives for the Legislature and Governor. The commission discussed:

- 1) an overview of how to introduce the HQPC to legislators during the new legislator orientation;
- 2) methods for data gathering to market the advanced care planning approach clearly;
- 3) the content of the letter and a one-page flyer describing advanced care planning initiative in Idaho;
- 4) a strategy to distribute advance care plan letter and flyer to the Governor elect and legislators;
- 5) timing for distributing the letters and flyer.

Through this approach the members were able to obtain support from many legislators along with community stakeholders representing all parts of the state. During the year the task force members and supporters were able to answer questions related to costs, sustainability, access for all Idahoans, governance and staffing to interested individuals and groups.

A summary of supplemental information can be found in the Advanced Directives documentation [Appendix A](#).

Idaho Health Data Exchange (IHDE)

In 2010, House Bill 494 added monitoring the effectiveness of the Idaho Health Data Exchange (IHDE) to the Commission's responsibilities. In August 2018, Jim Borchers discussed all the improvements Idaho Health Data Exchange (IHDE) has made during the past year. Mr. Borchers reported that IHDE had connections with almost 200 clinics, 18 hospitals and many EMR vendors. Their goal is to get 10 western states on the same platform so patients' information can be accessed outside their data home. This outcome would help with the sharing of needed information as patients from Idaho receive care in surrounding states.

In February 2019, Lisa Hettinger introduced Paul Brannan as the new interim director of the IHDE. Mr. Brannan presented to HQPC members IHDE's business development highlights that included customer engagement, customer service, training and sustainability. The exchange's strategic plan was also provided through a presentation that reviewed the vision, mission, values, and principles. Some of the strategic goals that IHDE proposed included best in class stakeholder engagement and services, best in class infrastructure and measurement, improving IHDE's performance by creating more meaningful metrics, and ensuring sustainability. Immediate next steps were to operationalize the strategic plan, identify and prioritize initiatives, commence with the improvement lifecycle to enhance quality/performance.

Mr. Brannan provided more updates in the May 2019 HQPC meeting to discuss using more organized focus groups, acquiring a new director, ensuring clean data, and how to change IHDE's role into services and value instead of vendor clinician role. He also brought up some organizational analysis that pointed out the need for cross training.

A summary of the presentation can be found in the IHDE presentation packet in [Appendix B](#).

Medicaid Expansion and Health Insurance Reform

In August 2018, Dick Armstrong reported that the state had received the needed signatures to get the Medicaid expansion on the ballot. He mentioned that workgroups have shifted their gears to education on what the Medicaid Expansion is and what it isn't (to try to avoid confusion). It was determined that HQPC could present a letter to the Governor and Legislature about what we believe is important for the overall good of healthcare for the state. The lack of medical coverage was a significant issue in Idaho and HQPC should take a strong stance on how important coverage is for all Idaho residents. It was motioned and seconded for HQPC to write and present a letter to the Governor and Legislature regarding the importance of coverage for the overall good of healthcare for Idahoans.

In the November 2018, Mr. Armstrong provided a presentation and overview of election results and next steps for discussion. Items discussed included:

- 1) pulling together Proposition 2 voting data by district;
- 2) the impact of this vote on waivers;
- 3) the need to look at other states to better craft work requirements for Idaho residents;

- 5) considering the role of HQPC 's role with Proposition 2 and Idaho health care;
- 6) the impact of the passing of Proposition 2 on Medicaid participants specifically as it relates to access and continuity of care;
- 7) efforts needed to educate the community and address fears about changes in Medicaid;
- 8) identifying an HQPC spokesperson for this topic to the Legislature and other interested groups.

The subsequent HQPC meeting in February 2019 considered the comments and insights provided by Lisa Hettinger about the constitutionality of Proposition 2. Hettinger also updated the committee on the IDHW next steps for submitting State Plan Amendments (SPAs) for Medicaid Expansion on February 15, 2019 and the anticipated requests for additional information and questions from CMS and the Legislature and Governor. Another update was provided during the HQPC meeting in May 2019 that covered additional Medicaid expansion discussions around project teams and outreach plans. The update also included that there will be approximately 90,000 new Medicaid participants due to expansion and that 70,000 potential participants had contacted the IDHW for other state assistance programs. The plan mentioned was the implementation of fast track enrollments in September 2019. Other topics discussed were primary care access and choice, suspension of care for incarcerated participants, recidivation of two-year utilization bumps in premiums and care management capabilities.

UPDATES

Graduate Medical Education (GME)

In August 2018, Dr. Ted Epperly provided updates regarding the Graduate Medical Education (GME) in Idaho. He reported to the HQPC that Idaho is ranked 49 out of 50 states in the number of active physicians per 100,000 population. This ratio has become an increasing problem due to Idaho's rapid growth. While the recruitment of specialists has been a concern, the recruitment of family practitioners has been particularly troubling. Overall, the issue throughout the US isn't the production of the number of medical students, it is the lack of graduate medical education programs that will ultimately be the driver for recruiting students to practice in Idaho. Conversely, Idaho ranks 10 out of 50 in the percentage of physicians retained in the state upon completing GME programs. Therefore, once they are placed in Idaho we do a good job of keeping students in Idaho.

In 2017, Idaho started to make a focused effort on how to improve this issue. Subsequently, Idaho put together a plan to increase GME program offerings from 9 to 21 students in various locations throughout the state by 2028. The plan also included offering more fellowships (an increase from four to nine) and to add one to two years of specific training to the GME curriculum. Furthermore, internal medicine programs will increase their class size from nine to twelve residents per year.

The methodology for residential funding has been broken down so that one-third of the costs will come from the program, one-third from the state, and one-third from the sponsoring institution. This will more effectively distribute the costs of \$180,000 per resident/fellowship per year. The state's investment in additional healthcare providers would be matched two-to-one by the programs and sponsors. In doing this, each physician would generate \$1.9 million per year of economic impact and potentially generate 12 new jobs annually. The total impact to Idaho is forecasted to be \$1.9 Billion and 12,000 new jobs. Following the presentation, HQPC made a motion to endorse the GME letter in support of the 10-year plan.

In May 2019, Dr. Epperly provided more GME updates to the HQPC and discussed current and new program growth. Some of the key points were that family medicine will increase from five to twelve programs, internal medicine from two to three programs, psychiatry from one to three programs, preliminary year internship will remain at one program, emergency medicine and general surgery will grow from zero to one program and

fellowships will have five additional programs/areas of focus. Other programs under consideration include fellowships in pediatrics, general surgery and behavioral health.

A summary of Dr. Epperly's presentation can be found in [Appendix C](#) of this document.

Medicaid Medicare Coordinated Plan (MMCP) and New Program for Dual Eligible Idaho Medicaid Plus (IM Plus)

In February 2019, Ali Fernandez discussed Idaho Medicaid Plus with an overview of the mandatory dual eligible participants in certain counties that have not enrolled in the Medicaid Medicare Coordinated Plan (MMCP). Idaho Medicaid Plus went live in Twin Falls County on November 1, 2018. Program Comparison of MMCP vs Idaho Medicaid Plus were provided. Contact information, facts and questions, and other informational materials were provided through the webpage at <http://MMCP.dhw.idaho.gov>.

A summary can be found in the Medicaid Dual Eligible Programs overview in [Appendix D](#).

Healthcare Transformation Council of Idaho and Telehealth

In February 2019, Mary Sheridan and Casey Moyer discussed the closure of the Statewide Healthcare Innovation Plan (SHIP) Grant and the transfer of telehealth initiatives to the Healthcare Transformation Council of Idaho (HTCI). The SHIP telehealth goals were:

- 1) to develop a roadmap to operationalize and expand telehealth in SHIP patient centered medical homes and community health and emergency medical specialists programming;
- 2) to gather Telehealth Council members and engage the 2015 Idaho Telehealth Access Act;
- 3) research the current telehealth landscape using Idaho Statewide Healthcare Innovation Plan (SHIP) efforts to some of the barriers/challenges and opportunities.

Spring boarding off the work of the Idaho SHIP grant, the presenters discussed the need to define telehealth gaps in policy (statute), examine reimbursement policies, and determine telemedicine payment models that would work in Idaho. The role of the council is to act in advisory capacity to regulatory boards and state agencies. The council requested the HQPC members consider supporting the idea of HTCI taking on the statewide lead for telehealth policy/expansion, to operationalize the telehealth strategic plan and to have the IDHW Office of Healthcare Policy Initiatives (OHPI) provide infrastructure and support for the council. It was requested that a member from the council provide a list of HCTI members to the HQPC members and continuously provide telehealth updates at future HQPC meetings.

During the May 2019 HQPC meeting, Dr. Ted Epperly and Lisa Hettinger expanded on the role of Healthcare Transformation Council of Idaho (HTCI). In addition to concentrating on telehealth they also addressed the need to explore the expansion of value-based contracting in Idaho. An advanced percentage of payments made in non-fee-for-service arrangements compared to the total payments made by Idaho payers will increase to 50% by 2023. The HTCI will be setting up a provider-payer workgroup to help establish goals, outcomes, and metrics to help achieve this 50% goal.

A summary can be found in [Appendix E](#) and [Appendix F](#).

Standard Quality Metrics

In May and August of 2019, Dr. Tim Dunnagan presented the idea of using a parsimonious set of common metrics that could be used to guide payers and providers as the health industry moves from fee for service to value-based contracts. Currently, there are a daunting set of metrics that vary across governmental entities, payers and providers. A common set of measures could bring governmental entities, payers and providers together as they collectively work to provide better care, better experience at a lower cost for patients.

To more deeply explore this topic, the HQPC membership discussed the need to invite external experts to talk about key measures and indicators of health. As part of the conversation, members of the HQPC suggested that the commission explore:

- 1) What do we mean by value in health care?
- 2) What is quality health care?
- 3) How can we collect accurate, consistent data across payers and providers?

This topic will be explored in greater detail during the next year.

Maternal Mortality and AIM Standards

In November 2018, Dr. Stacy Seyb and Dixie Weber provided a presentation on maternal mortality with the HQPC members. The key topics discussed were:

- 1) renewing the planned child mortality and maternal mortality program for 2020
- 2) sharing information with states that have data on Maternal Mortality Review Committees (MMRCs)
- 3) seeking HQPC support to help set up and provide letter of support for governmental entities
- 4) conducting peer reviews to provide de-identified data,
- 5) how legislators can help this effort through the engagement of workgroups
- 6) working with other states to enhance programming in Idaho

A summary can be found in the Maternal Mortality presentation in [Appendix G](#).

Suicide Prevention Programming in Idaho

During the November 2018 HQPC meeting, Elke Shaw-Tulloch provided a presentation and updates on Suicide Prevention in Idaho. Areas that were discussed included:

- 1) suicide prevention and HQPC's involvement;
- 2) the current success of suicide prevention programming to raising public awareness, implementing a suicide prevention hot line, providing education on “post-vention” (how to handle the aftermath of attempts/completed suicides);
- 3) the composition of letters of intent for legislators and amending the State Plan (August 15, 2018);
- 4) an update about the Idaho Coalition for Suicide Prevention (ICSP) that consists of 50 people attending regular meetings held every three weeks to refine the state plan;
- 5) the ICSP strategic map of four goals with 60 key prioritized objectives;
- 6) the budget request for one million to rebuild the suicide prevention system statewide and cover the costs for increases in staff, resources, hotline call volume and other operational items;
- 7) a planned community outreach with consistent messaging;
- 8) an overview of planned training and technical assistance for advanced responses;
- 9) a review of the sustainability plan created through research and federal information.

Membership Updates

Former Member:	Replaced By:	Agency/Role:
James Lederer	Charles Davis	Saint Alphonsus Health System DO President
Brad Erickson	Paul Brannan	Idaho Health Data Exchange (IHDE) Executive Director

Future Considerations

Idaho is currently embarking on several initiatives that will shift how healthcare is provided. Idaho's healthcare delivery system is shifting from a fee-for-service, volume-based system to a value-based system of care focused on improving health outcomes and reducing costs. Idaho has seen the implementation of a statewide suicide prevention program and is pursuing solutions to create an Advanced Directive system for all Idaho residents. Other health issues also need to be addressed including telehealth, quality metrics in value-based healthcare, graduate medical education, Medicaid expansion, and enhanced functionality and utilization of the Idaho Health Data Exchange. Commission members 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 for all Idahoans.

Appendices

APPENDIX A - Advanced Directives (AD)

ADVANCE CARE PLANNING | Value & Return on Investment

While there are many ways to consider return on investment, literature reviews and conversations with Idaho health care leaders indicate the two most critical: improving care and reducing unnecessary costs.

Improving Person-Centered Care

Advance care planning (ACP) helps people think through healthcare decisions that guide loved ones in tough times.

Talking about death is uncomfortable, but planning end-of-life decisions needs to happen before it's too late. Meeting with our ACP facilitator, we were able to find out what our options are, ask questions and complete our Advance Directives. She made it easy!
Aaron and Angie Day, Boise

The conversation was really helpful — making us think about what we would want and not want in the event of a serious accident. Also, we thought this was important enough to encourage our son to complete his advance directive.

Bernadette and JD Sexton, Meridian

Meeting with the ACP facilitator made us realize the importance of ACP. We believe that sharing and documenting what WE wish to happen pertaining to our end-of-life care, will minimize possible disagreements between our family and healthcare providers.

Herb and Marlies Winters, Eagle

ACP increases end-of-life discussions and completion of Advance Directives.^{xiii} Honoring Choices® Idaho data indicate 67% of ACP conversations result in a completed advance directive and over half of guided conversations include a health care agent.^{xiv}

ACP aligns care to patients' wishes. One study of nursing home residents showed that when people participated in ACP they were more likely to document their preferences (often for less aggressive treatment) and were more likely to receive care that aligned with their wishes stated in their advance directives.^{xv}

Improving Population Health & Costs

ACP reduces overall cost by helping people complete an advance directive that describes the care they do and do not want.

Idahoans are concerned that their end-of-life care will be a financial burden to family or friends (60%).^{xvi}

A study showed that in the 12 months before death, people who completed advance directives had 37% fewer inpatient admissions and 3.66 fewer days of inpatient admissions. **Medicare savings were \$9,500 for individuals who completed an advance directive.**^{xvii}

Among cancer patients who participated in end-of-life conversations, costs were about a third less than for patients who didn't. **Aggregate costs of care were \$1,876 for patients who had end-of-life discussions compared with \$2,917 for patients who did not.**^{xviii}

ACP programs offered by health systems reduces expenditures. A 3-year study of a large Accountable Care Organization analyzed ACP program development (costs to train facilitators and time spent in facilitation) and savings in Medicare expenditures. In the 3-year period, **the study concluded the net cost savings of the ACP program was \$1,572,330 (a 104% return on investment).**^{xiv} The ACP program spent \$1,515,170 and generated \$3,087,500 savings in Medicare expenditures.

ⁱhttp://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/2016-Reports/2016_Population.pdf

ⁱⁱ<https://www.census.gov/prod/cen2010/briefs/c2010br-09.pdf>

ⁱⁱⁱhttp://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/2016-Reports/2016_Mortality.pdf

^{iv}<https://www.kff.org/medicare/fact-sheet/10-facts-medicare-coverage-in-end-of-life-care/>

^v<http://www.dartmouthatlas.org/keyissues/issue.aspx?com=2944>

^{vi} Quality Health Communities for Safer Transition of Care Community Performance Report. 2017. http://medicare.qualishealth.org/sites/default/files/medicare.qualishealth.org/CmtyPerf_NorthCentral.pdf

^{vii} Pope, Thaddeus M. Legal Briefing: New Penalties for Ignoring Advance Directives and Do-Not-Resuscitate Orders. *J Clin Ethics*. 28 (1), 74-81. Spring 2017.

^{viii} Idaho Survey: Personal Preferences End of Life, Boise State University, 2018.

^{ix} Laklin, Joshua R. MD, Eric Isaacs MD, et al. "Emergency Physicians' Experience with Advance Care Planning Documentation in the Electronic Medical Record: Useful, Needed, and Elusive". *J Palliat Med*, 2016; 19.6: 632-638.

^x Thomas, Judy and Charles Sabatino. Patient Preferences, Policy and POLST. *Journal of the American Society of Aging*. Spring 2017, 102-109.

^{xi} Lamas, Danfela MD, Bernard Hammes, PhD, et al. Advance Care Planning Documentation In Electronic Health Records: Current Challenges and Recommendations for Change. *J Palliat Med*, 2018; 21.4: 522-528.

^{xii} Ibid.

^{xiii} C.H. Houben, M.A. Spruit, M.T. Groenen, E.F. Wouters, D.J. Janssen. Efficacy of advance care planning: a systematic review and meta-analysis *JAMDA*, 2014; 15(7): 477-489.

^{xiv} Honoring Choices® Idaho June 2018 Data report.

^{xv} Morrison RS, Chihin E, Carter J, et al. The effect of a social work intervention to enhance advance care planning, documentation in the nursing home. *J Amer Geriatr Soc*, 2005; 53(2): 290-294.

^{xvi} Idaho Survey: Personal Preferences End of Life, Boise State University, 2018.

^{xvii} Bond William F., Michul Kim, et al. Advance Care Planning In an Accountable Care Organization Is Associated with Increased Advance Directive Documentation and Decreased Costs. *J Palliat Med*, April 2018.

^{xviii} Baohui Zhang, et al. Health Care Costs in the Last Week of Life: Associations with End-of-Life Conversations. *Arch Intern Med*. 2009, 169(5).

^{xix} Bond, ACP In an ACO, 2018.

ADVANCE CARE PLANNING | Honoring Choices® Idaho Framework

Honoring Choices® Idaho provides a centralized infrastructure and dedicated staff who:

- ✓ **Coordinate and provide training and consultation to organizations to adopt the Respecting Choices® First Steps® Advance care Planning (ACP) program**

Training:

- ACP Program Design
- Conversation skills for ACP Facilitator
- ACP Instructor (to train future ACP Facilitators)

Consultation to support:

- Redesign workflow to initiate and guide ACP
- Target specific populations
- Store & retrieve ACP documents
- Improve participant experience
- Sustain & scale ACP program

- ✓ **Develop and distribute public education and outreach campaign**

- Distribute "I Choose for Myself" public campaign



- Promote and coordinate annual National Health Care Decisions Day events among participating organizations

- ✓ **Develop and distribute standardized advance care planning tools and materials**

- Honoring Choices® Idaho Advance Directive
- Education Guides
- Community and group ACP conversations
- Employer engagement



Advance Directive



Education Guides

- ✓ **Coordinate and advocate for system changes**

- Lead advocacy efforts for state registry improvement
- Promote consistent approach to ACP across Idaho

- ✓ **Coordinate standardized data collection and reporting**

- Prevalence of ACP conversations across participating organizations
- Completion rates of Advance Directives among participating organizations
- Engagement of health care agent
- Participant satisfaction with guided ACP conversation

Expected Results:

- ✓ Improve patient care
- ✓ Improve population health
- ✓ Decrease unwanted care



To learn more about Honoring Choices® Idaho contact:

Stephanie Bender-Kitz, Ph.D. Project Lead
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To learn more about state registry improvements contact:

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Elke.Shaw-Tulloch@dhw.idaho.gov / 208.334.5950

ADVANCE CARE PLANNING | Idaho Registry Solution

Current State

Currently Idaho, per the Medical Consent and Natural Death Act, IDAPA Title 39 Chapter 45, 39-4515 (2006) provides for a health care directive registry. This registry is housed in the Idaho Secretary of State's office. A person may register with the Secretary of State's office, have their advance directive documents placed in the registry, receive an identification card with a unique identification number and pin, and subsequently provide that information to their delegates and/or health care providers for use in end of life decision making. Additionally, a person may create an advance directive and request it be housed in his/her medical record at a single or multiple medical systems or facilities. These current practices create the potential for multiple locations for advance care planning documents that may be in conflict with one another.

Ideal State

Through the work of many stakeholders including but not limited to the former Idaho Quality of Life Coalition, the Honoring Choices® Idaho program and steering committee, hospitals, etc., it was determined that a more robust, integrated and accessible system is needed for advance directive storage and retrieval. In particular, it is important to have a single source of truth for advance care planning documents that meets the following criteria:

- Electronically accessible 24/7 to care providers, consumers, health care agents/proxies
- Provided through electronic access and ultimately integrated into the electronic health record
- Document security and HIPPA compliance
- Portability across organizations, providers, and geography so that all points of care have access such as EMS, skilled nursing, hospitals, etc.
- Authentication criteria and process
- Version control
- On-line form completion for advance directives and POST documents
- Easy to use and no financial barriers to users

Recommendation

The Idaho Department of Health and Welfare (IDHW), in partnership with the Idaho Secretary of State's office, Honoring Choices® Idaho and the Advance Care Planning Work Group seek funding and legislative support to move responsibility for the registry (including all current documents) from the Idaho Secretary of State's office to IDHW and develop a more robust registry structure and technology solution. With Honoring Choices® Idaho infrastructure supporting guided advance care planning discussions and training, utilization of the technology solution will ensure that Idahoans' wishes are communicated, respected, and supported by the system of care.



To learn more about Honoring Choices® Idaho contact:

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To learn more about state registry improvements contact:

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ADVANCE CARE PLANNING | The Proposal

Problem Statement

Seventy-five percent of people in life-threatening situations or nearing end of life cannot make or communicate decisions about the medical care they want.ⁱ Family members and health care providers face daunting decisions when a person's preferences are unknown. The default is to treat, leaving families and providers guessing if treatment is what that person wants. Eighty-five percent of Idaho adults say it is very important to choose their own treatment options at the end of life, but less than half have completed an advance directive identifying their health care agent and preferences for medical treatment.ⁱⁱ An even smaller fraction (less than 5%) of Idaho's adult population has submitted an advanced directive document to the Idaho Healthcare Directive Registry.ⁱⁱⁱ

Proposed Solution

Addressing these profound disconnects requires:

- (a) increasing the prevalence of advanced care planning conversations that include *discussions of goals and preferences for medical care in the event a person is unable to make his/her own health care decisions*;
- (b) documenting individual's informed preferences through advanced directives and Physician Orders for Scope of Treatment (POST) documents;
- (c) improving outdated, poorly utilized document registry technology; and
- (d) communicating individual's preferences across settings of care.

State-wide, systematic, standardized advance care planning and registry improvements will result in continuity of care, respect for the individual's freely-made informed decisions, matching of medical care to the individual's informed preferences, and prevention of harm and suffering by providing only medical care individuals say they want.

Recommendation

The Health Quality Planning Commission (HQPC) recommends that the generation of an effective advanced care planning system for all Idahoans be accomplished through meaningful partnerships between the Idaho Department of Health and Welfare (IDHW), other state agencies, and private stakeholders such as insurers, providers, businesses, nonprofits and others. The partnerships will focus on the development, funding, scaling, accountability, and sustainability of two objectives.

Objective 1: Establish the infrastructure and technology to support a web-based document registry.

Achievement of this objective will establish a secure, accessible, sustainable mechanism to ensure documented advance care plans (advanced directives and POST documents) are available wherever and whenever individuals and health care providers need them. The registry must be readily available to consumers, Idaho health care providers across settings of care, and Idaho emergency responders.

Objective 2: Integrate evidence-based advanced care planning practices statewide through the support of Honoring Choices® Idaho.

Achievement of this objective will create consistent, evidence-based advanced care planning practices within health care and community organizations statewide, enabling these organizations to:

- (a) increase the prevalence of high quality advance care planning conversations between individuals, family members, and health care providers;
- (b) promote completion of appropriate documents; and
- (c) increase utilization of the web-based document registry by consumers and providers.
- (d) Ensure goals and values of individuals are honored



To learn more about Honoring Choices® Idaho contact:

Stephanie Bender-Kitz, Ph.D. Project Lead
skitz@honoringchoicesidaho.org / 208.947.4286

To learn more about state registry improvements contact:

Elke Shaw-Tulloch, MHS, Administrator, Division of Public Health
1 Elke.Shaw-Tulloch@dhw.idaho.gov / 208.334.5950

ⁱ Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Institute of Medicine of the National Academies, 2014.

ⁱⁱ Idaho Survey: Personal Preferences End of Life, Boise State University, 2018.

ⁱⁱⁱ Personal communication with Idaho Secretary of State's Office.

ADVANCE CARE PLANNING | The Budget

The 3-year estimated costs for Objective #1 (web-based document registry technology and the staffing to support a system) is \$872,791 and for Objective #2 (statewide training, capacity building, and outreach) is \$1,609,661. These two features of an advance care planning system need to be orchestrated in order to maximize the success of each.

	Year 1 (SFY 20)	Year 2 (SFY 21)	Year 3 (SFY 22)	Justification
Objective #1: Establish the infrastructure and technology to support a web based document registry.				
Technology	\$244,000	\$56,650	\$58,350	Y1 ESTIMATES ONLY: Cost includes annual license (\$55,000 plus 3% increase per year based on industry standard), conversion of existing registry documents records to new system (34,000 records), one-time perpetual license (\$155,000).* Y2/3: Cost includes annual license.**
Personnel	\$167,874	\$170,550	\$175,367	This includes staff to support the registry contracts, use, hospital coordination, etc. Costs include salary and benefits for 2.0 FTP (\$155,874). It also includes \$2,000 in capital outlay for office furniture for staff (one time SFY 20), and \$10,000 ongoing for operating expenses and technology training. Salaries calculated at 3% increase each year.
SUBTOTAL	\$411,874	\$227,200	\$233,717	\$872,791
<p><i>*This cost is based on a bid of \$1 per record transferred from existing registry to new one (as of April 2018 there are 34,000 records to migrate). This cost could be higher. Personnel costs are based on costs of managing similar data systems but may be less depending on the requirements of the vendor.</i></p> <p><i>**There are options for 'subscription fees' for larger hospitals/health systems to integrate product to EHR based on annual Medicare discharges and for small hospitals to have documents 'pushed' to their EHR. Subscriptions not necessary as hospitals can use web-based product and not included in this cost.</i></p>				
Objective #2: Integrate evidence-based advanced care planning practices statewide.				
Honoring Choices® Idaho program to integrate advance care planning skills and practices within 200 health care and community organizations	\$348,138	\$378,588	\$382,935	HCI is currently funded by SAHS and SLHS and provides training, technical assistance, tools, and outreach to health and community organizations in the health systems' catchment areas. A statewide, detailed dissemination budget has been provided for this three-year scaling effort. The aim is to establish the HCI framework and infrastructure in two regions per year over the 3-year period (HCI is already established in Region 4). Subsequent years will focus on maintenance of tools/training repository.
Statewide outreach/marketing	\$100,000	\$200,000	\$200,000	These costs are for a marketing campaign targeting consumers and providers to participate in advance care planning conversations and complete ACP documents. The campaign will direct providers and consumers to use the registry, ensuring the investment in the technology results in high utilization.
SUBTOTAL	\$448,138	\$578,588	\$582,935	\$1,609,661
YEARLY TOTAL	\$860,012	\$805,788	\$816,652	\$2,482,452

APPENDIX A (continued) HQPC Letter of Endorsement

State of Idaho
- Health Quality Planning Commission -
Established 2006, House Bill 738

To: Governor Little and Honorable Members of the Idaho State Legislature
From: Health Quality Planning Commission (HQPC)
Re: HQPC Overview and Proposal to Improve Advance Care Planning in Idaho
Date: 12/6/18

Overview and progress of Health Quality Planning Commission

The Health Quality Planning Commission (HQPC) was established by House Bill 738 during the 2006 legislative session, extended with House Bill (HB) 238 in the 2007 legislative session, 2008 with HB 489 and 2016 with house HB 375. 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. Tim Dunnagan, Dean and Professor, College of Health Sciences, Boise State University and the former Director of Health and Welfare Dick Armstrong. These members all share an interest in improving the quality of healthcare in Idaho and in investment in health information technology including oversight of monitoring the effectiveness of the Idaho Health Data Exchange (IHDE). 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, educators and community representatives. The Director of the Department of Health and Welfare (DHW), Russell S. Barron, attends all meetings.

Notable accomplishments of the HQPC has been to be the catalyst behind the creation of a time sensitive emergency system in Idaho through Senate Bill No. 1329. Additionally, during the 2015 legislative session, the Commission supported the passage of Senate Concurrent Resolution No. 104 that 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. Subsequently, the legislature funded the suicide prevention program. Finally, House Bill 375 was passed during the 2016 Legislative session reauthorizing the Health Quality Planning Commission to provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure, to improve the quality and efficiency of health care and the ability of consumers to manage their care, and to facilitate coordinated implementation of statewide patient safety standards. To this end, the Commission has focused on behavioral health in Idaho and the development of a robust web based Advance Directives platform for residents and providers in Idaho. The remainder of this document discusses the need to support for advanced planning in Idaho.

Advanced Care Planning in Idaho

Advance care planning helps Idahoans think about, discuss, and document their goals and preferences for medical care in life-threatening situations and end-of-life, and ensures those freely-informed plans are available when and where they are needed.

The HQPC recommends the Idaho Legislature and Governor's Office approve and fund a proposal that will improve advance care planning opportunities and outcomes for Idahoans. This endorsement is the result of

HQPC identifying advance care planning as one of its two priority areas, followed by a lengthy process of information-seeking, stakeholder input, review, and vote by members of the HQPC. We urge your support for this important proposal that will benefit all Idahoans.

To address its mandate to “...promote improved quality of care and improved health outcomes...” the HQPC convened leaders from Idaho’s health care, public health, insurance, education, and nonprofit sectors to examine a critical problem across the state: **poor access to, prevalence, quality, and outcomes of advance care planning**. There is widespread agreement this problem must be addressed so Idahoans get the medical care they want in their most vulnerable moments, and that giving people this person-centered care will lead to better quality and lower health care costs.

The proposed solution, developed and supported by stakeholders¹ and endorsed by HQPC, involves a public-private partnership to achieve a coordinated, consistent, accountable advance care planning system statewide. Public funds appropriated to the Department of Health and Welfare will (1) disseminate a statewide training and outreach framework (Honoring Choices[®] Idaho) that weaves advance care planning services into health and community organizations and motivates individuals to participate in planning; and (2) establish within the Department the infrastructure, technology, and operation of a healthcare directive registry to ensure Idahoans’ advance care plans are available when and where they are needed across the continuum of care. Private funds will be invested by health care organizations statewide in internal infrastructure and operations to establish advance care planning services (using the Honoring Choices framework) and to link with the document registry. These mutual investments will achieve statewide, systematic, standardized advance care planning and a robust document registry that will result in continuity of care, matching medical care to an individual’s freely-made decisions and informed preferences, and prevention of harm and suffering by providing only the medical care Idahoans desire.

To arrive at this proposed solution, HQPC convened multiple stakeholder workgroups and discussions that examined (a) the evidence behind and support for the Honoring Choices[®] Idaho framework; (b) the elements needed for an effective, secure, accessible, bi-directional healthcare directive registry; (c) opportunities and challenges to integrate these registry elements with the Idaho Health Data Exchange; (d) challenges organizations may face to link with an external registry; (e) the need for extensive public outreach and education; and (f) the capacity and will of organizations to invest in an advance care planning solution. This solution-seeking process and extensive stakeholder participation demonstrates widespread commitment.

Additional stakeholder commitment is evident by collaborative private funding of the Honoring Choices[®] Idaho program (HCI). An initial \$1M pooled contribution in 2016 from Saint Alphonsus and St. Luke’s Health Systems established the Honoring Choices program at the nonprofit Jannus Inc. That seed funding is exhausted on December 31, 2018, and health care organizations from across the state committed a combined \$115K to fund HCI through June 2019 to guarantee its framework of training and consultation, tools, data, and public outreach continue until a legislative decision is made. Public support of HCI going forward will ensure its capacity to assist organizations and communities statewide and that the advancements made over the past 24 months are not lost.

The results of Honoring Choices[®] Idaho’s efforts over the past 24 months are impressive:

As of October 2018, more than 3,300 Idahoans have participated in advance care planning conversations guided by Honoring Choice’s partner organizations; 60% of those conversations included the individual’s health care agent; and 70% of conversations resulted in a completed, informed advance directive document.

Honoring Choices® Idaho extends an invitation to Idaho Legislators and Executive Office holders, along with your families, to participate in an advance care planning conversation with a trained HCI facilitator to experience firsthand the value of this work.

ⁱ **Stakeholder Organizations Involved**

Health Quality Planning Commission
Idaho Hospital Association
Idaho Medical Association
Idaho Health Continuum of Care Alliance
Saint Alphonsus Health System
St. Luke's Health System
Kootenai Health
Portneuf Quality Alliance
West Valley Medical Center
Eastern Idaho Regional Medical Center
BlueCross of Idaho
Regence Blue Shield of Idaho
Boise State University
Idaho Department of Health and Welfare
Idaho Secretary of State's Office
Qualis Health
Idaho Health Data Exchange
AARP
Honoring Choices® Idaho
Consumer representatives

APPENDIX A (continued) 39-4515 Proposed Changes



Idaho Statutes

TITLE 39
HEALTH AND SAFETY
CHAPTER 45

THE MEDICAL CONSENT AND NATURAL DEATH ACT

39-4515. HEALTH CARE DIRECTIVE REGISTRY. (1) The Director of the Idaho department of health and welfare shall administer a health care directive registry. The health care directive registry shall be accessible through a web-based platform. The information contained in such registry shall include: the full name of the person executing the health care directive as stated in the directive, a file identification number unique to the person executing the directive, and the date the directive was executed. The registry shall be made available twenty-four hours a day, seven days a week.

(2) A person may register a health care directive or a revocation of a health care directive by submitting the directive or revocation, completing and submitting an informational registration form as required by the Idaho department of health and welfare, and paying the director of the Idaho department of health and welfare the fee which the Idaho department of health and welfare may require for registering a health care directive. The person may register either on-line or by submitting the registration form through the postal services. The person who submits a document for registration with the director of the Idaho department of health and welfare pursuant to this section shall provide a return address.

(3) The Idaho department of health and welfare may charge and collect a fee not to exceed ten dollars (\$10.00) for the filing of a health care directive. All fees collected for the filing of a health care directive shall be deposited into the health care directive registry fund. No fee shall be charged for revoking a health care directive.

(4) The registry established under this section shall be accessible only by entering the unique identification file number and the person's assigned password for the health care directive registry.

(5) The Idaho department of health and welfare may promulgate such rules necessary to comply with the statute.

(6) The Idaho department of health and welfare and those granted access to the health care directive registry shall use information contained in the registry only for purposes prescribed in this section. No person granted access to the registry shall use the information for commercial solicitations or in any fraudulent or improper way. Any commercial solicitation, fraudulent or improper use of information contained in the registry shall constitute a violation of this section and a violation of the Idaho consumer protection act.

(7) The Idaho department of health and welfare is not required to review a health care directive or revocation thereof to ensure that the document complies with any applicable and statutory requirements. Entry of a document into the health care directive registry pursuant to this section does not create a presumption favoring the validity of the document.

(8) The Idaho department of health and welfare shall delete a health care directive and the informational registration form from the health care directive registry in the following circumstances:

(a) Upon receipt of a written revocation of a health care directive signed by the maker thereof or that person's legal representative along with the identification file number and assigned password; or

(b) Upon verification from the Idaho department of health and welfare's bureau of health records and vital statistics that the person who executed the health care directive is deceased. The deletion under this paragraph shall be performed not less than once every two (2) years.

(9) Neither the Idaho department of health and welfare nor the state of Idaho shall be subject to civil liability for any claims or demands arising out of the administration or operation of the health care directive registry.

(10) The health care directive registry fund is hereby created in the state treasury, the moneys of which shall be continuously appropriated, administered by the Idaho department of health and welfare and used to support, promote and maintain the health care directive registry. The fund shall consist of fees paid by persons registering health care directives under this section and income from investment from the fund, gifts, grants, bequests and other forms of voluntary donations. On notice from the Idaho department of health and welfare, the state treasurer shall invest and divest moneys in the fund, and moneys earned from such investment shall be credited to the fund.

APPENDIX B - Idaho Health Data Exchange (IHDE) presentations to HQPC

IHDE UPDATE

HEALTH QUALITY PLANNING COMMISSION

PAUL BRANNAN
INTERIM EXECUTIVE DIRECTOR



BUSINESS DEVELOPMENT HIGHLIGHTS

.....

 **CUSTOMER ENGAGEMENT** QTR 4 / 2018

Customer Engagement

- Following up on SHIP Cohort clinics
- Completing last 10 hospital visits
- 9 calls to clinics
- 14 new leads
- Reviewing the "Data Sharing Agreement" with Payers
- Requirements obtained from major payers and networks
- Idaho Dental Association with positive results

Customer Service

- 196 client services logged events in Dec
- Working a New Participant Agreement (PA) with the VA

Training

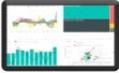
15 on site training sessions from 9/1/18 to 12/31/18



STRATEGIC PLAN

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 **STRATEGIC PLAN** 2019-2023

FOUNDATION	STRATEGIC GOALS	MEASUREMENT
<p>Our Vision Be the <u>Trusted Partner</u> for Health Information Exchange Across Our Region.</p> <p>Our Mission Lead Collaboration in the Healthcare Community to Improve Patient Care.</p> <p>Our Values & Principles</p> <ul style="list-style-type: none"> • Collaborative • Transparent • Accurate • Accountable • Secure • Innovative • Agile 	<p>Best in Class Stakeholder Engagement & Services</p> <ul style="list-style-type: none"> ❑ We will establish and maintain a shared vision for health information sharing across all leaders of healthcare in Idaho. <ul style="list-style-type: none"> ➢ We will facilitate semi-annual envisioning and strategy workshops for all leaders of healthcare in Idaho. ➢ We will provide online access to promote and facilitate continuous improvement of the vision and strategy for health information sharing. ❑ Our perceived value of each service will equal the cost of each service. <ul style="list-style-type: none"> ➢ We will develop and share clear and transparent value models for all service offerings current and planned. ❑ Our stakeholder satisfaction will exceed 90% each year. <ul style="list-style-type: none"> ➢ We will conduct surveys and facilitate workshops to determine and improve stakeholder satisfaction. <p>Best in Class Infrastructure</p> <ul style="list-style-type: none"> ❑ We will align and implement improvements to our capabilities and infrastructure based on industry and federal guidance for health information sharing. <ul style="list-style-type: none"> ➢ We will complete and maintain an assessment of our infrastructure based on federal guidance from OIG & ONC. ➢ We will establish model-based blueprints and model-driven engineering to assist in planning, defining and implementing our improvement initiatives. ❑ We will establish a formal Quality Management Program. <ul style="list-style-type: none"> ➢ We will manage and monitor our performance as it pertains to key initiatives and metrics managed through an enhanced collaborative governance process. 	<p>Our Performance</p>  <p>Our Metrics</p> <ul style="list-style-type: none"> • Governance • Participation • Use Case • Information Completeness • Information Quality • Security • HQF Alignment • Information Timeliness • Usability & Usage <p>Our Sustainability</p> 

 **STRATEGIC PLAN** 2019-2023

FOUNDATION

Our Vision

Be the Trusted Partner for Health Information Exchange Across Our Region.

Our Mission

Lead Collaboration in the Healthcare Community to Improve Patient Care.

Our Values & Principles

- Collaborative - Accurate - Innovative
 - Agile - Transparent - Accountable - Secure

ihde STRATEGIC PLAN 2019-2023

STRATEGIC GOALS

Best in Class Stakeholder Engagement & Services

- We will establish and maintain a shared vision for health information sharing across all leaders of healthcare in Idaho.
 - We will facilitate semi-annual envisioning and strategy workshops for all leaders of healthcare in Idaho.
 - We will provide online access to promote and facilitate continuous improvement of the vision and strategy for health information sharing.
- Our perceived value of each service will be at least equal the cost of each service.
 - We will develop and share clear and transparent value models for all service offerings, current and planned.
- Our stakeholder satisfaction will exceed 90% each year.
 - We will conduct surveys and facilitate workshops to determine and improve stakeholder satisfaction.

ihde STRATEGIC PLAN 2019-2023

STRATEGIC GOALS

Best in Class Infrastructure

- We will align and implement improvements to our capabilities and infrastructure based on industry and federal guidance for health information sharing.
 - We will complete and maintain an assessment of our infrastructure based on federal guidance from CMS & ONC.
 - We will establish model-based blueprints and model-driven engineering to assist in planning, defining and implementing our improvement initiatives.
- We will establish a formal Quality Management Program.
 - We will manage and monitor our performance as it pertains to key indicators and metrics defined through our collaborative governance process.

ihde OPERATIONALIZING STRATEGIC PLAN

- Semi-annual meeting of providers – awaiting assistance from external vendor
- Perceived value >= Cost & Stakeholder satisfaction > 90% - Listen and provide what is important to stakeholder
- Improve our infrastructure – building to deliver value to stakeholders
 - Vetting delivery and connectivity methods
- Established quality management program
 - Named Quality Director

STAFFING

.....

NEW INITIATIVES

- Director of Community Engagement
- Organizational Analysis
- New back end vendor (from Orion to Verinovum)

NEW HIE SYSTEM

.....

NEW INITIATIVES

- Vetted needed functionality
- SOW in evaluation
- Moving forward as soon as cost and funding are finalized

ihde **BARRIERS**



Costs – EMR & IHDE + Staff
 Confusion – How to achieve connectivity
 Continuity- Workflow integration

NEXT STEPS

.....

ihde **NEXT STEPS**

- Operationalize Strategic Plan
- Identify and Prioritize Initiatives
- Commence Improvement Lifecycle (Measurement)



IHDE Update

Health Quality Planning Commission

August 1, 2018

Jim Borchers, Director – Business Development



1

Content

- Journey over last year (Review)
- Connections
- Architecture 3.0
- Priorities and Focus
- Strategic Planning



2

IHDE – Progress over Past Year (Brief Review)

8/31/17	Category	7/31/18
-\$275K loss	Cumulative Net Equity	\$723K to \$448K
\$95K	Cash Balance	~10X to \$1M+
\$304K	Long-term Debt	\$0 - paid off
Low Engagement	Customer Engagement	Score: 85% >= Sat >140 customer visits
None	Project Mgmt Discipline	Strong: Executing, Organized, Accountability
2 Corrective Action Plans	Stakeholder Engagement	Strong Partnerships, Bringing new deals, \$2.5M+ new funding
Low Influence/Accountability	Vendor Management	\$550K OH remedies, data feeds, VN Contract
ZIKA VIRUS	Office/Team	

IHDE Highlights - Connections

- >200 Clinics**
 - 75 SHIP clinics; 70 more by end of Jan 2019
 - Target – connect 130 more next 2 year
 - Add more specialty clinics
 - SHIP & Medicaid funding to help drive
- 18 Hospitals (of ~50)**
 - 3 Acute Care hospitals remaining (WV, EIRMC, Portneuf)
 - ~31 Rural/Critical Access hospitals remaining
 - Target – connect 20 more next 2 years
 - SHIP & Medicaid funding to help drive
- Other Connections:**
 - Connect Dentists, Optometrists, Chiro, etc.
 - Target – 1000 with at least View Access next 2 years
- Most major labs and imaging centers connected**
- EMR vendor connections** (Epic, Cerner, Allscripts, Aprima, Greenway, eClinicalWorks, NextGen, Athena, GE Centricity, McKesson, etc.)

❖ Approximately 70% of Idaho Medical EHR's in repository

4

Regional & National Connections Patient Centered Data Home (PCDH) Initiative

- Idaho Exchanging Admission, Discharge, Transfer (ADT) Alerts currently with 10 Western States

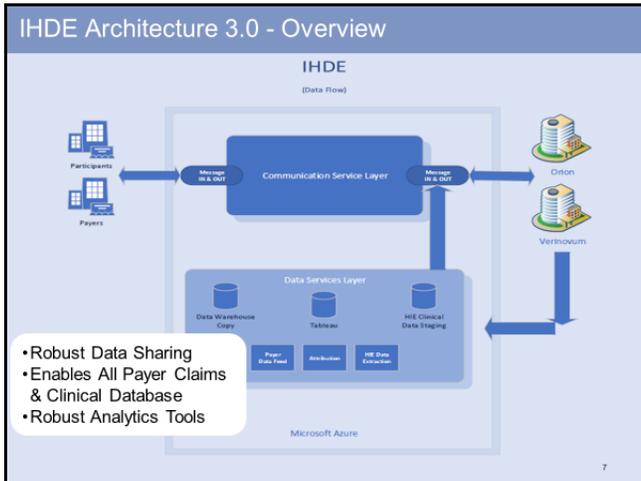


5

IHDE Technology - Architecture Overview

- IHDE 1.0 (2008) – Axolotl/Optum Insight
- IHDE 2.0 (2015) – Orion (current)
- IHDE 3.0 (2019) – Tiered Architecture (future)
 - Building strong internal team of developers (less vendor dependence, lower cost model)
 - Tiered to support stability, flexibility, reduce risk
 - Rather than single vendor dependence/failure point
 - Robust data sharing and analytics capabilities
 - Support payers, provider networks
 - Provide platform for All Payer Claims & Clinical DB





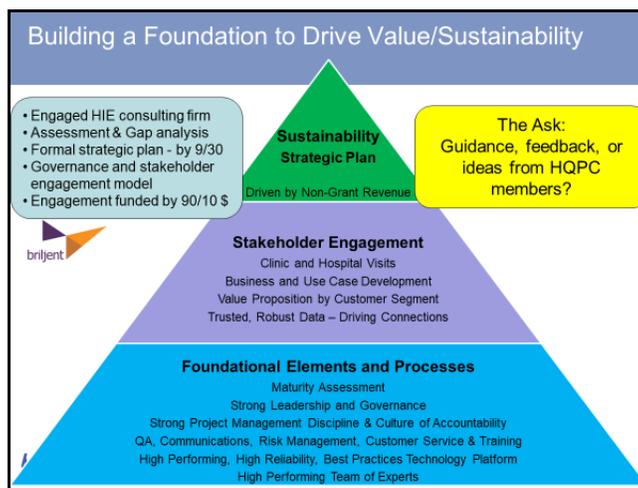
- ### 2018 Priorities & Focus
1. SHIP/Medicaid – Keep Driving Connections
 2. Drive Long-term Sustainability
 - Drive Value – Capitalize on New Business Opportunities
 - Complete Strategic Plan – Brilljent Engagement
 - Secure \$2M additional SHIP funding; \$6M FY2020 Medicaid funding, but don't depend on grant funding
 - Develop and institute formal processes/procedures missing
 3. IHDE 3.0 Technology Platform Upgrade
 - Orion to Verinovum HIE Platform - Migration Key Component
 - Move from single vendor to tiered architecture
 - Communication Services Layer
 - Data Services Layer
- Clinic & Hospital Connections

Operations and Technology Infrastructure

Customer Engagement

Build a High Performing Team

Strategic and Sustainability Planning
- ihde**



APPENDIX C - Graduate Medical Education (GME) presentation to HQPC

Idaho's Ten Year Graduate Medical Education (GME) Strategic Plan

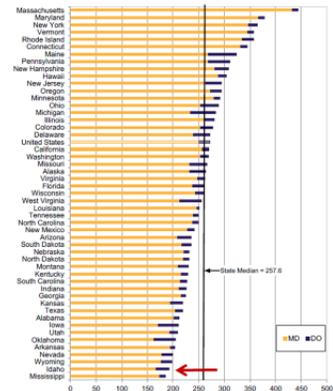


Health Quality Planning Commission
May 8, 2019

Ted Epperly, MD

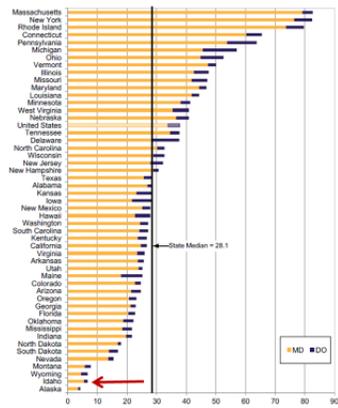
CEO / DIO | Family Medicine Residency of Idaho
Past President and Board Chair America | American Academy of Family Physicians
ACGME | Past Board of Directors
COGME | Council Member
Idaho State Board of Education | GME Coordinator

Active Physicians per 100,000 Population



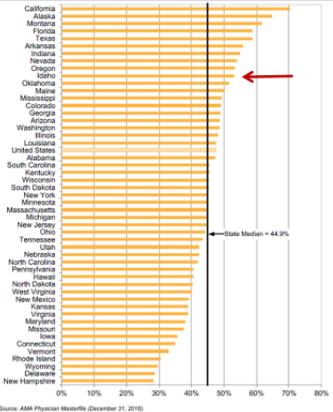
Sources: July 1, 2016, population estimates are from the U.S. Census Bureau (released December 2016). Physician data are from the 2017 AMA Physician Masterfile (December 31, 2016).
Note: Physicians whose school type was unavailable (n = 30) are excluded.

Residents and Fellows on Duty as of December 31, 2016



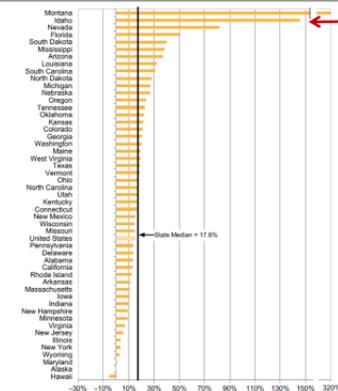
Sources: July 1, 2016, population estimates are from the U.S. Census Bureau (released December 31, 2016). Resident physician data are from the National GME Census in GME TracSM as of August 2017.

Percentage of Physicians retained from Graduate Medical Education (GME) 2016



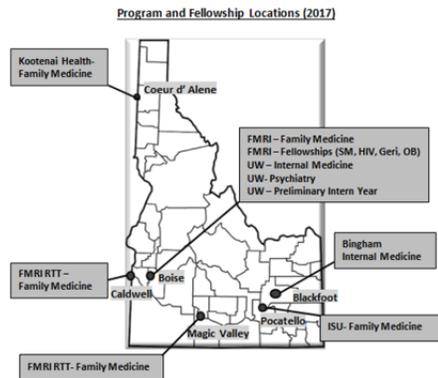
Sources: AMA Physician Masterfile (December 31, 2016).

Percentage Change in Number of Residents and Fellows in ACGME-accredited programs, 2006-2016

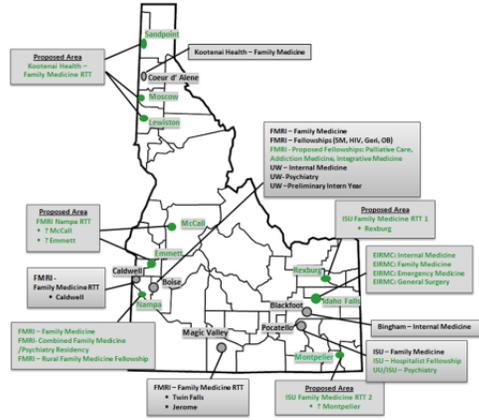


Sources: 2006 and 2016 National GME Census in GME TracSM as of August 2017.

Programs Specialties and Locations in Idaho (2017)



Program and Fellowship Locations (2028)



Current and New Program Growth

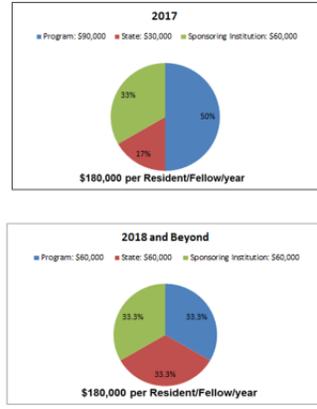
Program Types	2017	2028
Family Medicine	Five Programs • FMRI-Boise (33) • FMRI - RTT Caldwell (9) • FMRI - RTT - Magic Valley (6) • ISU - Pocatello (24) • Kootenai - Coeur d'Alene (18)	Twelve Programs • FMRI Boise (42) • FMRI RTT Caldwell (12) • FMRI Magic Valley (12) • FMRI Nampa (18) • FMRI Nampa RTT (6) • FMRI Nampa Combined Family Medicine and Psychiatry * (10) • ISU Pocatello (27) • ISU Pocatello - RTT #s (Rexburg) (6) • ISU Pocatello RTT #2 (Idaho Falls) (6) • Kootenai Coeur d'Alene - RTT (Landsport, Moscow or Lewiston) (6) • EIRAC Idaho Falls (18)
Internal Medicine	Two Programs • UW - Boise (25) • RVU - Bingham - Blackfoot (11)	Three Programs • UW - Boise (36 Residents & 3 Chief Residents = 39) • RVU - Bingham - Blackfoot (15) • EIRAC - Idaho Falls (16)
Psychiatry	One Program • UW - Boise - Psychiatry (7)	Three Programs • UW - Boise - Psychiatry (24) • ISU/ISU - Pocatello (12) • FMRI Nampa - Combined Family Medicine/Psychiatry* (10 listed above)
Preliminary Year Internship	One Program • UW - Boise (4)	One Program • UW - Boise (4)
Emergency Medicine	(0)	One Program • EIRAC - Idaho Falls (16)
General Surgery	(0)	One Program • EIRAC - Idaho Falls (15)
Fellowships	• Sports Medicine (1) • HIV/Viral Hepatology (1) • Obstetrics (1) • Geriatrics (1)	• Sports Medicine (2) • HIV/Viral Hepatology (2) • Obstetrics (1) • Geriatrics (1) • Palliative Care (1) • Addiction Medicine (1) • Integrative Medicine (1) • Rural Family Medicine (1) • Hospice/Medicine (1)
Total	Nine Programs (137) Four Fellowships (4)	Twenty One Programs * (147) Nine Fellowships (9)

Other Programs Under Consideration

- Pediatrics – Boise
- General Surgery – Boise
- Behavioral Health Fellowships – Coeur d'Alene, Nampa
- Others



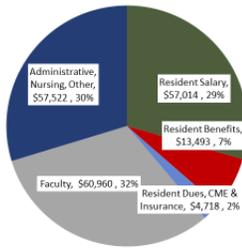
Resident Funding Per Year by Institution



- NEJM | 2016 – Regenstein, et al
 > \$244,730
- Family Medicine University of Washington | 2018 – Pauwels, et al
 > \$179,353
- FMRI | 2017
 > \$194,000

COST OF A RESIDENT

Cost of a Resident FY17: \$194K



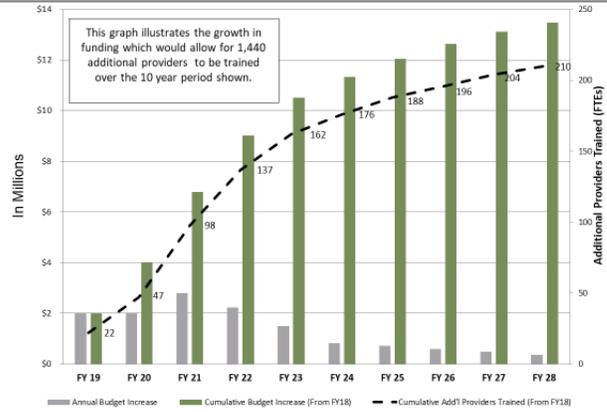
IDAHO CURRENTLY CONTRIBUTES:

Amount	Program	% of Cost
\$30,000	GME Resident/Year (Now)	17%
\$37,000	WWAMI Student/Year	50%
\$44,000	UU Student/Year	53%
\$45,000	Vet Student/Year	72%
\$50,000	Dental Student/Year	65%
\$60,000	GME Resident/Year (New)	33%

WWAMI STATES GME SUPPORT PER RESIDENT

Washington	\$49,383
Wyoming	?
Alaska	\$55,000
Montana	\$7,353 (?)
Idaho	\$30,000

10 Year GME Growth and Additional Providers Trained



Ten Year Growth in Graduate Medical Education Programs, Residents and Fellows, and Cost to Idaho's Legislature

	2017	2028	% Increase
GME Residency Programs	9	21*	233%
GME Fellowship Programs	4	9	225%
Residents and Fellows Training in Idaho/year	141	356	252%
Number of Graduates Each Year from Idaho's GME Programs	52	124	237%
GME Residents per 100,000 Citizens in Idaho	6.7 (National Average is 28.1)	17.7 (Assuming Idaho's Population grows to 2 Million People by 2028)	276%
State Support of GME and Additional Healthcare Programs in Idaho	\$5,138,700/year	\$16,349,000/year	318%

* The Nampa combined Family Medicine/Psychiatry program is being counted as both a family medicine and psychiatry program as it is producing physicians that will be Board Certified in Family Medicine and Psychiatry.

The state's investment in additional healthcare providers is matched 2-to-1 by the programs and sponsors. Each physician will generate \$1.9 Million per year in economic impact and 12 jobs—total impact to Idaho will be \$1.9 Billion and 12,000 new jobs—and quality healthcare for citizens throughout Idaho. Return on investment (ROI) 15.9 to 1

Summary of Idaho's Journey to Transform Healthcare and GME

- Complicated
- Not been easy but is vitally important
- Starts with a vision, communication, a team, support, resources and plan
- Persistence
- Right thing to do!

TEN YEAR GME STATUS/UPDATE

- Idaho Legislature Funded \$2.1 Million for Year One (FY 2019)
- Idaho Legislature Funded \$1.82 Million for Year Two (FY 2020)
- FY 2021 Request - \$2.8M
- GME Council/Committee
 - Oversees 10 Year Strategic Plan
 - 10-15 Members (Guests as needed)
 - Program Directors/Medical Schools/Hospitals/ IMA/IHA/OSBE
 - Housed in Idaho State Board of Education
 - Modifies/Innovates/Collaborates/Adjusts

“NEVER, NEVER, NEVER, GIVE UP.”



Winston Churchill



APPENDIX D – Idaho Dual’s Programs (MMCP & IM Plus) presentation to HQPC



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Idaho Duals’ Programs HQPC Update

FEBRUARY 6, 2019



Remember...



Idaho has **two** programs for duals:

1. Medicare Medicaid Coordinated Plan (MMCP) - *existing*
2. Idaho Medicaid Plus (IMPlus) – *new*

Dual eligible participants are eligible for Medicare A and B, in addition to full Medicaid

Medicare Medicaid Coordinated Plan (MMCP) – Overview

- Voluntary participation
- Medicaid and Medicare benefits administered by a single health plan
 - **Exceptions:** Non-emergency medical transportation, dental services, and services under the Adults with Developmental Disabilities Waiver program
- Care Coordination is available to every member

Idaho Medicaid Plus - Overview

- Mandatory for dual eligible participants in certain counties that have not enrolled in the **MMCP**, and are **not**:
 - Tribal members
 - Pregnant women
 - Participants on the Adults with Developmental Disabilities Waiver
- **Idaho Medicaid Plus** will only manage the member’s Medicaid benefits (no impact to Medicare coverage)
- Care Coordination is available to every member



Idaho Medicaid Plus went live in Twin Falls County on November 1, 2018!

- The Centers for Medicare and Medicaid Services (CMS) formally approved the program
- Idaho Administrative Code rules are in effect authorizing the program

Program Comparison

	MMCP	Idaho Medicaid Plus
Medicare Included	Yes	No
Mandatory Enrollment	No	Yes
Premium	No	No
Participant Chooses	Yes	Yes
Available Today	Yes	Only in Twin Falls County
Care Coordination	Yes	Yes
Supplemental Benefits	Yes	No
Plan Choices	<ul style="list-style-type: none"> • Blue Cross of Idaho • Molina Healthcare of Idaho 	<ul style="list-style-type: none"> • Blue Cross of Idaho • Molina Healthcare of Idaho

APPENDIX E – Idaho Telehealth presentation to HQPC

Idaho Department of Health & Welfare

Telehealth Presentation to the Health Quality Planning Commission

FEBRUARY 6, 2019

Casey Moyer, Office of Healthcare Policy Initiatives
Mary Sheridan, Bureau of Rural Health & Primary Care



Why Telehealth Matters

By complementing its existing health care system with telehealth capacity, Idaho can better serve patients and better support providers

- Telehealth services enhance access to health care, make delivery of health care more cost-effective and distribute limited health care provider resources more efficiently.
- Citizens with limited access to traditional health care may be diagnosed and treated sooner through telehealth services than they would be otherwise, resulting in improved health outcomes and less costly treatments due to early detection and prevention.
- Telehealth services address an unmet need for health care by persons who have limited access to such care due to provider shortages or geographic barriers.
- Telehealth services can provide increased capacity for appropriate care in the appropriate location at the appropriate time to better serve patients, providers and communities.
- When practiced safely, telehealth services result in improvement in health outcomes by expanding health care access for the people of Idaho.

IDAHO State of Idaho Telehealth Council

The Idaho Telehealth Council was created in 2014, under House Concurrent Resolution 46, and was committed to the advancement of telehealth in Idaho by coordinating and developing a comprehensive set of standards, policies, rules, and procedures for the use of telehealth in Idaho.

Telehealth Council Goals

1. Define Telehealth and gaps in policy (statute)
2. Examine reimbursement policies and determine telemedicine payment models
3. Act in advisory capacity to regulatory boards and state agencies

SHIP Telehealth Goals

1. Develop roadmap to operationalize and expand telehealth in SHIP PCMH and CHEMS programs

IDAHO State of Idaho Telehealth Council

Representatives to the Council included representatives from Blue Cross of Idaho, the Idaho Hospital Association, the Idaho Medical Association, the Idaho Primary Care Association, Kootenai Health, OptumHealth, Select Health, St. Luke's and various Idaho state departments. The work of the group heavily informed the content and passage of the 2015 Idaho Telehealth Act.

2015 Idaho Telehealth Access Act

- Patient-provider relationships can be established without an in-person visit using 2-way audio and video and maintained using electronic communications
- Prescription drug orders can be issued using telehealth services with some parameters
- Supports multi-disciplinary collaboration
- Decreases healthcare fragmentation; increases continuity of care

Current Telehealth Landscape

Telehealth plays a vital role as Idaho strives to achieve the triple aim to improve: 1) quality of care; 2) population health; and, 3) affordability of healthcare.

Idaho Administrative Code allows Medicaid to cover specific services delivered via telehealth technology, which help ensure all participants receive the best possible care regardless of geographic location.

Idaho does not have any parity laws for private insurance coverage for telemedicine.

ID Medicaid published new rules to allow coverage of primary care, OT, PT, speech therapy, language, and sign language interpretive services via telehealth.

Telemedicine in Idaho: Report Card on Coverage & Reimbursement

From the American Telemedicine Association, 2017

PARITY:

Private Insurance	F
Medicaid	B
State Employee Health Plan	F

MEDICAID SERVICE COVERAGE & CONDITIONS OF PAYMENT:

Patient Setting	A
Eligible Technologies	F
Distance or Geography Restrictions	A
Eligible Providers	C
Physician-provided Services	B
Mental/behavioral Health Services	B
Rehabilitation	A
Home Health	F
Informed Consent	F
Telepresenter	A

Idaho Statewide Healthcare Innovation Plan (SHIP)

SHIP is a statewide plan that aims to improve the health of all Idahoans. Private insurers as well as Medicaid and Medicare are meeting together to design healthcare reimbursement methods that pay providers for keeping people healthy. The SHIP was funded through January 31, 2019.

The SHIP was developed to redesign Idaho's healthcare system to improve Idahoan's health by:

1. Strengthening primary and preventive care through the PCMH, and
2. Evolving from a fee-for-service, volume-based payment system of care to a value-based payment system that rewards improved health outcomes.

Timeline of Activities (Clinics and Telehealth):

Award Year 1	Award Year 2	Award Year 3	Award Year 4
<ul style="list-style-type: none"> • Cohort 1 planning, recruitment and selection • Establishing program infrastructure and governance (IHC) 	<ul style="list-style-type: none"> • 55 Cohort 1 clinics receiving TA • Cohort 2 planning, recruitment and selection • Planning for Telehealth Grants began 	<ul style="list-style-type: none"> • 56 Cohort 2 clinics selected and receiving TA • Cohort 3 planning, recruitment and selection • 12 Telehealth grants awarded statewide (\$25k each) • Telehealth TA contract established 	<ul style="list-style-type: none"> • 54 Cohort 3 clinics elected and renewing TA • Telehealth grantees receiving TA and implementing programs

Current Telehealth Landscape

35 of Idaho's 44 counties are rural or frontier and many areas have limited access to specialty care.

In addition to the current health care system in place, telehealth holds the potential to increase access for patients and reduce burden on providers.



Idaho Statewide Healthcare Innovation Plan (SHIP) Telehealth

The Idaho Telehealth Council SHIP Subcommittee was charged with developing a telehealth expansion plan to operationalize and expand telehealth services in rural communities as part of the SHIP. SHIP telehealth goals for the 3 years of the model test include establishing rural telehealth capacity across a range of behavioral health and specialty services.

Efforts included:

- Development of a telehealth toolkit
- Series of educational webinars
- Two rounds of grants to support new or expanding telehealth programs resulting in twelve sub-grant awards
- Technical assistance contract to support telehealth grantees
- Stakeholder meeting on May 23, 2018 to set priorities for the future of telehealth

Efforts to Move Forward

On May 23, 2018, IDHW hosted a telehealth planning meeting and convened a diverse set of telehealth stakeholders to identify and discuss barriers, challenges, and opportunities for advancing telehealth in Idaho.

Barriers and Challenges

- Complex reimbursement landscape with inconsistent and restrictive reimbursement
- Lack of an operational coordinating body
- Lack of training and workflow processes
- Technology requirements
- Telehealth Council lacks capacity and resources

Opportunities

- Potential to overcome challenges of provider shortages and rural/frontier isolation
- Improve access to primary care and specialists
- Support patient and provider education
- Share real time actionable data
- Partnership with the IHC and HQPC to help identify resources to support telehealth

Next steps

Ask of HQPC:

1. Leverage existing entity/organization to own and lead telehealth policy and expansion.
 - Operationalize the telehealth strategic plan
2. IDHW Office of Healthcare Policy Initiatives (OHPI) can provide infrastructure and support for the coordinating body.

APPENDIX F – SHIP to HTCI: Future of Healthcare Transformation in Idaho presentation to HQPC

Orientation Overview

- Objective 1: Provide background on Idaho's transformation efforts to date
- Objective 2: Provide an overview of the Healthcare Transformation Council of Idaho (HTCI)
- Objective 3: Members, membership expectations and logistics
- Objective 4: Introduction to Office of Healthcare Policy Initiatives (OHPI) and its staff members
- Objective 5: First Initiative

Objective 1:

Provide background on Idaho's transformation efforts to date

Background

- 2007: Gov. Otter convenes Health Care Summit
- 2008: Idaho Health Data Exchange established
- 2008: Gov. Otter tasked Select Committee on Health Care
- 2010: Idaho Medical Home Collaborative established
- 2013: Idaho awarded CMHC Planning grant to develop SHIP
- 2014: Gov. Otter establishes Idaho Healthcare Coalition (IHC)
- 2015: Idaho begins 4 year CMHC Test Model Care implementing SHIP
- 2019: SHIP concludes; HTCI begins

for more information please visit www.SHIPIdaho.gov

Statewide Healthcare Innovation Plan

- GOAL 1: Transform practices into PCMHs
- GOAL 2: Improve care coordination through EHRs and health data connections
- GOAL 3: Establish 7 regional collaboratives to support integration with the medical-health neighborhood
- GOAL 4: Improve rural patient access through virtual PCMHs
- GOAL 5: Build a statewide data analytics system
- GOAL 6: Align payment mechanisms
- GOAL 7: Reduce overall health-care costs

for more information please visit www.SHIPIdaho.gov

Idaho Healthcare Coalition (IHC)

- Provided oversight of SHIP in implementing initiative goals
- Provided subject matter expertise for the implementation of plan deliverables
- Chartered workgroups and advisory groups for specific activities
- Enhanced member, stakeholder, and public understanding of the system change through educational topics

for more information please visit www.SHIPIdaho.gov

What Were The Outcomes of SHIP/IHC?



- 165 Practices transformed to PCMH's (825,000 Patients)
- IHDE supported/grown (73% of PCMH; 48% of Hospitals)
- CHW program established/training performed (103 CHW's, 13 CHEMs Programs)
- Public Health Departments Empowered/Regional Collaboratives
- Project ECHO funded
- Value based payments – (All Payers) ↑ 25% to 29%
- \$213 Million in avoided cost
- 510% ROI
- Process established to approach transformational Health Care change in Idaho

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Objective 2:

Provide an overview of the Healthcare Transformation Council of Idaho (HTCI)



Aligning with Gov. Little's vision



"...we should ... do what we can to make affordable, accessible, quality healthcare available to all Idahoans."

"We must pursue strategies that contain healthcare costs. I intend to continue developing Idaho solutions that bring healthcare costs down for all Idahoans."

Governor Brad Little
State of the State Address
January 7, 2019

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HTCI Mission



- Convene Idaho stakeholders with a wide range of healthcare delivery system expertise to work together to champion accessible, high-quality, affordable healthcare
- Identify opportunities and barriers for change, and develop strategies and activities to address obstacles and advance healthcare transformation
- Examine how to influence environmental, cultural, and social factors that will improve people's health

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HTCI Charter



- The governor will appoint members and co-chairs (Proposed Executive Order)
- The co-chairs will convene and preside over the HTCI meetings (Ted Epperly and David Pate)

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.



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HTCI Functions



- Identify opportunities for innovation that will help shape the future of healthcare
- Utilize accurate data to identify strategies and drive decision making for healthcare transformation
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health
- Support the efforts in Idaho to provide a workforce that is sufficient in numbers and training to meet the demand
- Identify barriers that are preventing transformation 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
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans

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Governance and Workgroups



- As initiatives are prioritized, selected and resourced, HTCI will provide the framework and monitoring of implementation and healthcare system transformation
- Workgroups will be needed at various times to include expertise and stakeholders beyond the ranks of HTCI
 - Each workgroup will establish a charter, deliverables, timeline and membership
 - HTCI approval of the charter is required
 - Routine updates to HTCI are expected from the Chair or co-chair of the workgroup
- As key deliverables are produced, the workgroup chair/co chair will work with the OHPI team and co chairs of HTCI to get these on the meeting agenda
- If there is a specific topic you wish to see on the agenda for HTCI, simply reach out to the OHPI team; it will be included in routine planning meetings with the co-chairs of HTCI

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Objective 3:

Members, membership expectations and logistics

HTCI Membership Composition



- Two co-chairs
- Payers:** three of Idaho's private payers, as well as a self-funded plan and Medicaid
- Clinicians:** representatives from primary care, behavioral health, and medical/surgical sub-specialties
- Hospital representatives:** from a health system, a community hospital, and a critical access hospital
- Association representatives:** Idaho's medical association, hospital association, nursing association, primary care association and family physicians
- A **public health district** representative
- A **consumer member**
- A representative from Idaho's Department of Health and Welfare (**IDHW**)
- At-Large members (three)

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2019 HTCI Membership Structure



- Co-Chairs**
 - Ted Epperly, Family Medicine Residency of Idaho
 - David Pate, St. Luke's Health System
- Payers, Medicaid, Self-Funded**
 - Matt Bell, PacificSource Health Plans
 - Kenny Bramwell, Regence-BlueShield of Idaho
 - Drew Hobby, Blue Cross of Idaho
 - Matt Wimmer, Idaho Division of Medicaid
 - Kathy Brashear, Self-funded Insurance Plans
- Primary Care Clinicians**
 - Keith Davis, Shoshone Family Medical Center
 - Scott Dunn, Family Health Center of Sandpoint
 - Karl Watts, St. Alphonsus Medical Group
- Behavioral Health Representative**
 - Andrew Barsz, Terry Reilly Health Services
- Hospital Representatives**
 - Patt Richesin, Kootenai Care Network
 - TDD, Critical Access Hospitals
- Medical/Surgical Sub-Specialist**
 - Mike Hajar, Neurosurgeon
- Public Health District**
 - Nikki Zogg, Southwest District Health
- Consumer Representative**
 - Denise Chuckovich
- Organizations**
 - Lisa Hettlinger, Idaho Department of Health & Welfare
 - Larry Tisdale, Idaho Hospital Association
 - Susan Poullot, Idaho Medical Association
 - Yvonne Ketchum-Ward, Idaho Primary Care Association
 - Neva Santos, Idaho Academy of Family Physicians
 - Randy Hudspeth, Nursing Leaders of Idaho
- Up to 3 At-Large members (TRD)

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HTCI Membership Logistics



- Monthly meetings (3rd Thursday of month) 3:00 - 5:00pm
- Open to public
- Membership Attendance Requirements
- Staffed by Office of Health Policy Initiatives (OHPI) of IDHW

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Website



HTCI.dhw.idaho.gov



The Healthcare Transformation Council of Idaho webpage is hosted on the Department of Health and Welfare website under the Office of Healthcare Policy Initiatives

The page contains helpful information including:

- Downloadable copies of core documents (charter, functions, business case)
- Calendar of upcoming meeting (HTCI & subcommittees)
- HTCI Meeting documents (agenda, minutes and attachments)
- Helpful links to other resources

The page information will change and be enhanced over time. It is recommended you bookmark this page.

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Objective 4:

Introduction to Office of Healthcare Policy Initiatives (OHPI) and its staff members



Office of Healthcare Policy Initiatives 



IDAHO DEPARTMENT OF HEALTH & WELFARE
OFFICE OF HEALTHCARE POLICY INITIATIVES

- HTCI will be supported by the Idaho Department of Health and Welfare – Office of Healthcare Policy Initiatives (OHPI)

OHPI logistic functions include:

- Scheduling
- Email communications
- Agenda publication
- Meeting minutes
- Action item follow-up (if applicable)

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Website Links



OHPI.dhw.Idaho.gov



The OHPI webpage is hosted on the Department of Health and Welfare website. It is the parent page of the HTCI webpage.

The page information will change and be enhanced over time. It is recommended you bookmark this page.

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Office of Healthcare Policy Initiatives
ohpi@dhw.idaho.gov
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Objective 5:

First Project



Value Based Payment 

- Advance percentage of payments made in non-fee-for-service arrangements compared to the total payments made by Idaho payers from 29% to 50% by 2023
- HTCI will be setting up a provider-payer workgroup to help establish goals, outcomes and metrics for this
- HCP-LAN Categories 1-4

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Questions?



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APPENDIX G – Maternal Mortality presentation to HQPC

Maternal Mortality

IDAHO HEALTH QUALITY PLANNING COMMISSION
WEDNESDAY, NOVEMBER 7, 2018

Hospitals know how to protect mothers. They just aren't doing it.

Gathering of maternal mortality experts in Pittsburgh seeks 'momentum'
One day symposium followed by two-day conference on women's health

Do You Know Someone Who Died or Nearly Died in Childbirth? Help Us Investigate Maternal Health
By many measures, the United States has become the most dangerous international country in which to give birth.

Study: Maternal mortality rates are rising and not enough Texans realize it
The report says only 17 percent of Texans knew the state's maternal mortality rate has increased in recent years.

With Maternal Mortality Rates On The Rise, Senator Gillibrand Issues New Legislation

Efforts to reduce maternal mortality stalled on Capitol Hill
The statistics are alarming.

The Tragedy of Maternal Death and the Healthcare Provider's Role in Prevention

OB/GYN

Maternal Mortality

DEADLY DELIVERIES

Maternal Mortality in the US 1999-2014

Deaths per 100,000 births

9.8/100,000 births (1999)

21.5/100,000 (2014)

Source: www.cdc.gov/nchs/data/healthstats

- Maternal mortality rates in the U.S., unlike other developed nations, have been increasing over the last 30 years.

Between 2000 and 2014, maternal death rates increased more than 25%

Odd one out
Maternal-mortality rate, per 100,000 live births

- United States:**
 - Highest Maternal Mortality rate of any high resource country
 - only country outside of Afghanistan and Sudan where the rate is rising.

Source: Kassebaum et al., Lancet

July 17, 2015

Between 2000 and 2014, maternal death rates increased more than 25%

Odd one out
Maternal-mortality rate, per 100,000 live births

- United States:**
 - Highest Maternal Mortality rate of any high resource country
 - only country outside of Afghanistan and Sudan where the rate is rising.

Source: Kassebaum et al., Lancet

July 17, 2015

BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS

MMRIA REVIEW IN ACTION

Leading Underlying Causes of Pregnancy-Related Deaths

Cause	Percentage
Hemorrhage	14.0
Cardiovascular and Coronary Conditions	14.0
Infection	10.7
Cardiomyopathy	10.7
Embolism	8.4
Preeclampsia and Eclampsia	7.4
Mental Health Conditions	7.0

Amniotic fluid embolism- 4.2%
Homicide- 3.3%
Cerebrovascular accidents- 2.8%

Unintentional injury- 2.8%
Anesthesia complications- 2.3%
Autoimmune disease- 2.3%

Pregnancy Related Deaths: Timing



38%
While pregnant



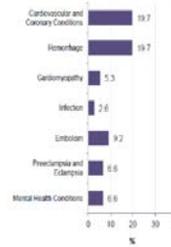
45%
Within 42 days



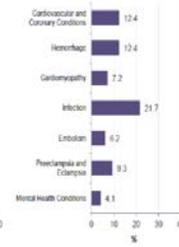
18%
42 days to 1 year

<http://reviewtoaction.org>

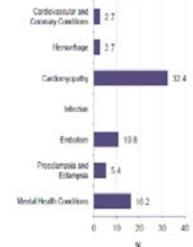
WHILE PREGNANT



WITHIN 42 DAYS



42 DAYS TO 1 YEAR



<http://reviewtoaction.org>

What about Idaho?

Number of Deaths and Death Rate per 100,000 Live Births, 2007-2016

	TOTAL	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Total Deaths	48	5	4	3	5	2	3	9	3	8	6
Death Rate Per 100,000 Live Births	20.6	20.0	15.9	12.6	21.5	9.0	13.1	40.3	13.1	35.0	26.7

Pregnancy Status at the Time of Death, 2007-2016

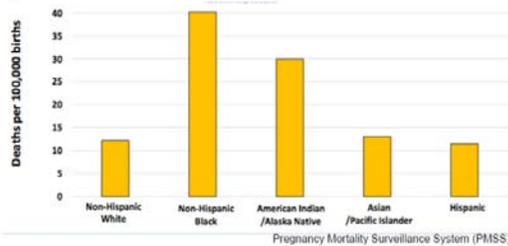
	TOTAL	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Pregnant at time of death	29	2	2	3	2	1	3	8	1	5	2
Not pregnant, but pregnant within 42 days before death	19	3	2	-	3	1	-	1	2	3	4

What about Idaho?

Cause of death, 2007-2016

	TOTAL	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Pregnancy with abortive outcome	-	-	-	-	-	-	-	-	-	-	-
Other direct obstetric deaths	28	3	2	3	2	1	2	4	-	5	6
Eclampsia and pre-eclampsia	2	-	-	-	1	-	-	-	-	-	1
Hemorrhage of pregnancy and childbirth, placenta previa	3	2	-	-	-	-	-	-	-	-	-
Complications predominately related to the puerperium	3	-	1	1	-	-	-	-	-	-	1
Obstetric embolism	4	-	-	-	-	-	-	1	-	3	-
All other direct obstetric causes	17	1	1	2	1	1	2	3	-	2	4
Obstetric death of unspecified causes	-	-	-	-	-	-	-	-	-	-	-
Indirect obstetric causes	20	2	2	-	3	1	1	5	3	3	-

As with all diseases, race and social issues play a part in the risks and outcomes.....



Furthermore.....

- 40-50% of maternal deaths are estimated to be preventable
- For every maternal death, there are 50 women with near-death complications

AIM works through state seams and health systems to align national, state, and hospital level quality improvement efforts to improve overall maternal health outcomes.

Any U.S. hospital in a participating AIM state or hospital system can join the **growing and engaged AIM community** of multidisciplinary healthcare providers, public health professionals, and cross-sector stakeholders who are committed to improving maternal outcomes in the U.S.

AIM STRATEGIES

- Broad Partnership
- Tools & Technical Assistance
- Implementation Training
- Real Time Data
- Build on Existing Initiatives
- Incremental Bundle Adoption

Expectations of AIM States and Birth Hospitals

- Collaborate with AIM Leadership to develop a maternal safety bundle implementation workplan.
- Collaborate with AIM Leadership to develop state and hospital level data plans.
- Share hospital level data to track progress of maternal safety bundles implementation and outcomes.
- Participate in monthly scheduled conference calls with AIM Leadership.
- Host a state AIM Kickoff Meeting to promote the AIM program in hospitals and the community.
- Disseminate AIM resources, including newsletter, to staff in participating hospitals and state organizations.
- Assist AIM Leadership in sharing implementation strategies and lessons learned with incoming AIM states.



STATES THAT CURRENTLY ARE INVOLVED WITH AIM

Maternal Mortality Review Committees (MMRC's)

- Surveillance and death certificate data is only so useful.
- Maternal Mortality Review has become the standard.
- Six Key Decisions MMRC's make for each death reviewed:
 1. Was the death pregnancy related
 2. What was the underlying cause of the death
 3. Was the death preventable
 4. What were the factors that contributed to the death?
 5. What are the recommendations and actions that address those contributing factors?
 6. What is the anticipated impact of those actions if implemented?

CDC • Reproductive Health • Maternal and Infant Health • Evidence-Based Practice

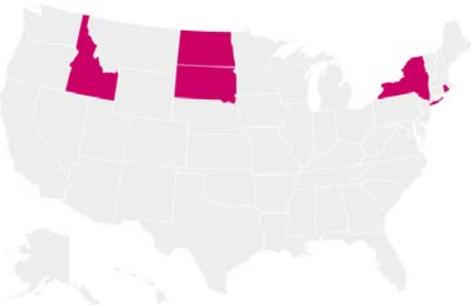
Pregnancy Mortality Surveillance System



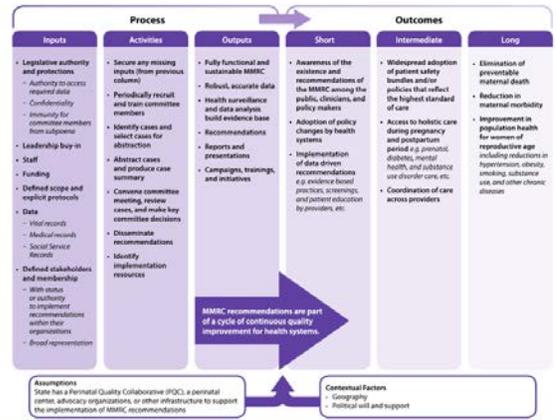
On This Page

- When did CDC start conducting national surveillance of pregnancy-related deaths?
- How does CDC define pregnancy-related death?
- How are the data collected and coded?
- How are the data used?
- How is data confidentiality protected?
- What is the pregnancy-related mortality ratio?
- Trends in Pregnancy-Related Deaths
- Causes of pregnancy-related death in the United States, 2011-2014

MMRJA BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS **REVIEW IN ACTION**



STATES THAT CURRENTLY DO NOT HAVE A MATERNAL MORTALITY REVIEW COMMITTEE IN PLACE OR IN PROCESS



Current Support

- Idaho Medical Association House of Delegates passed a resolution supporting the creation of a MMRC in Idaho
- Idaho Department of Health and Welfare representatives agree to coordinate these efforts

Needed Support

- Peer Review Protection
- De-identified Discharge Data
- Coordination and Organization

Conclusion

- AIM National Collaborative
 - <http://safehealthcareforeverywoman.org/how-does-aim-work/>
- Maternal Mortality Review
 - <https://www.reviewtoaction.org/>

Thank You!

