

Idaho

Advancing the Medical Home Model for Children and Youth Created in Collaboration with the National Academy for State Health Policy

The National Academy for State Health Policy (NASHP) is collaborating with the National Center for Medical Home Implementation (NCMHI) on the development of state profiles designed to highlight how public health programs are implementing and advancing the medical home model in pediatric populations. These updates are part of a formal partnership between NASHP and the NCMHI that focuses on exchanging information to improve medical home access for children and youth in medically underserved populations. If you have any questions about the information included in the updates, contact medical_home@aap.org. The NCMHI is a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

The Idaho Statewide Healthcare Innovation Plan (SHIP) aims to build a robust primary care system for both children and adults by enhancing access to the patient-centered medical home (PCMH) model. Support for the plan comes from the State Innovation Model (SIM) grant awarded in 2014 to fund a four-year test period. SHIP is overseen by the governor-appointed Idaho Healthcare Coalition (IHC), which includes representation from the Idaho Health Care Council and the Idaho Medical Home Collaborative, family physicians, private and public health insurers, policymakers, public health districts, and consumers. The goals for SHIP include providing access to a PCMH for 80% of the state's population, expanding provider connectivity through electronic health data exchange, integrating primary care and behavioral health care, and aligning public and private payers to advance practice transformation.

For the goal of expanding access to a PCMH, SHIP builds on lessons learned from Idaho's previous medical home initiatives:

- The Idaho Medical Home Collaborative (IMHC) was formed in 2010 to facilitate medical home transformation among family medicine and pediatric practices in rural communities. The IMHC included primary care physicians, health insurers, health care organizations, the Idaho chapter of the American Academy of Pediatrics (AAP), and the state's Medicaid program. The IMHC ended in 2013, but was reconvened in 2014 as a member of the IHC to advise on PCMH transformation efforts statewide.
- The Idaho Medical Home Demonstration project launched in 2013, through a partnership between the Idaho Title V Maternal and Child Health program and the state Medicaid Children's Healthcare Improvement Collaborative (CHIC) project. The goal of the demonstration project was to examine whether medical home coordinators could successfully utilize the PCMH model to improve care for children and youth with special health care needs. Local public health departments recruited urban and rural clinics for participation in the project, and supported employment of medical home coordinators to facilitate PCMH transformation. Medical home coordinators worked with clinics to educate patients, coordinate referrals, and manage workflows to help implement the pediatric medical home. The CHIC demonstrated successful collaboration between rural primary care practices and local public health districts, and improved population health management and care coordination for pediatric patients with special health care needs.

SHIP is coordinating with other health initiatives in the state, particularly with respect to Long Term Services and Supports (LTSS). This includes the two Section 1915(c) waivers Idaho Medicaid currently operates to provide home- and community-based services to children with special needs: the Act Early waiver and Children's Developmental Disabilities waiver.

PROGRAM COMPONENTS

The SHIP program includes the following goals related to Idaho's health care system:

1. Transform primary care practices across the state into PCMHs.



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2. Improve care coordination by using electronic health records and health data connections between PCMHs and the “medical-health neighborhood,” a term used to describe coordination across community services and supports, specialty services, behavioral health, and other organizations.
3. Establish and maintain seven Regional Collaboratives to support the integration of each PCMH with the broader medical-health neighborhood.
4. Develop virtual PCMHs, which utilize telehealth technology, community health workers, and community health emergency medical services personnel to provide rural communities access to a PCMH.
5. Build a statewide data analytics system.
6. Align payment mechanisms across payers to transform payment methodology from volume-based to value-based.
7. Reduce healthcare costs.

Practices participating in SHIP receive one-time practice support from a PCMH transformation consultant to develop their practice plan and complete an assessment for PCMH readiness. Ongoing support is provided to help practices achieve the following:

- Development of patient registries
- Health information technology system changes
- Clinic workflow and staffing pattern improvements
- Time spent out of clinic for training and coaching team members

As a rural state with a shortage of healthcare professionals, Idaho is also developing innovative strategies to maximize the capacity of the health care workforce through the use of multi-disciplinary PCMH teams. In particular, the state is working to ensure family physicians are trained to provide the following services in rural communities: pediatric care, emergency care, and behavioral and mental health care.

Regional Collaboratives in the seven participating local public health districts will foster connections within the region and encourage collaboration among stakeholders. For example, Regional Collaboratives will work with community partners to promote dental health for children and increase access to nutritious foods and promote physical activity in elementary schools. Stakeholders represent a variety of interests in Idaho’s healthcare system including: physicians, private and public payers, legislators, and the Idaho Academy of Family Physicians.

PAYMENT MODEL

The SHIP payment model provides PCMH practices with significant financial support to facilitate practice transformation. SHIP offers participating practices a reimbursement payment of up to \$10,000 to cover costs of transforming the practice, as well as financial assistance with accreditation and connectivity to the Idaho Health Data Exchange.

Practices participating in Medicaid that meet tier designation criteria are eligible for tiered per member per month (PMPM) payments. To achieve higher PMPM payments, PCMHs may be required to complete evidence-based education and training in chronic care models and behavioral health programs. Over the four-year period of SHIP, payers will be updating their payment models to incorporate value-based compensation into their arrangements with clinics. Payers will also implement quality incentives as part of their contractual arrangements with PCMHs. The quality incentive program initially will provide additional payments to providers for reporting on specific quality metrics, and will eventually evolve into “pay for performance” payments.

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OUTCOMES

SHIP is currently determining the metrics and tools needed to collect clinical and performance data across multiple payers to better understand the impact of community-specific and regional population health issues, such as childhood obesity. For the 2016 SHIP grant year, four clinical quality measures were selected for the collection of data from the first cohort of practices. These quality measures directly align with the comprehensive 2015 Get Healthy Idaho: Measuring and Improving Population Health state health improvement plan. Additional clinical quality measures are under development. The current quality measures focus on:

- Preventive care and screening
- Tobacco use screening and cessation intervention
- Weight assessment and counseling for nutrition and physical activity for children and adolescents
- Diabetes (hemoglobin A1c control)

Of the 55 practices involved in Cohort 1 of SHIP, one practice specialized in mental and behavioral health, three practices specialized in pediatrics, and 44 practices specialized in family medicine. Cohort 2 of SHIP, with an additional 55 practices, is currently underway, and Cohort 3 will begin in February 2018. Idaho aims to have 165 practices transformed into well-integrated, coordinated PCMH models, representing 1,650 providers and reaching 825,000 Idahoans, by the end of 2019.

Idaho Medicaid, as well as several partners, will be evaluating SHIP over the course of the project period. The evaluation will examine progress made on achieving the goals and objectives of the program by utilizing evaluation measures in four focused areas: outcomes, costs, structure, and care experience. The evaluation of Idaho SHIP will shed light on lessons learned in implementation.

FAST FACTS:

213,903: The number of children enrolled in Medicaid and CHIP in Idaho as of 2017.

93.3%: The participation rate for children eligible for the Idaho Medicaid and CHIP programs in 2015.

93.1%: The national participation rate for children eligible for the Medicaid and CHIP programs in 2015.