December 2, 2013
This webcast will begin at 1:00 pm Eastern.

Please hold until Larry Hinkle starts the conference.

The audio portion of this event will be broadcast through your computer speakers. You may also access it by dialing 800 768 2481
Why IMPaCT?

- A robust primary care system is the foundation for a health care system that delivers high-quality, affordable health care.
- The primary care system needs infrastructure to support practice transformation and quality improvement.
- Section 5405 of the ACA authorizes AHRQ to establish a national primary care extension program.
What is IMPaCT?

- Support for model state-level initiatives that provide infrastructure to small and medium sized primary care practices
  - New Mexico, **North Carolina**, Oklahoma, Pennsylvania
  - Practice transformation and ongoing quality improvement

- Dissemination of models to other states and the federal government
  - NC IMPaCT: Learning Community comprised of Idaho, Maryland, Montana, and West Virginia
# Today’s Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 – 1:15 pm</td>
<td>Welcome &amp; Introductions</td>
</tr>
<tr>
<td></td>
<td>Jill Rosenthal, Senior Program Director, National Academy for State Health Policy (NASHP)</td>
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<tr>
<td>1:15 – 1:30 pm</td>
<td>Building Models to Support Primary Care Transformation: Lessons from Idaho</td>
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<td>Denise Chuckovich, Deputy Director, Idaho Department of Health and Welfare</td>
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<tr>
<td>1:30 – 1:45 pm</td>
<td>Learning Community Reactions: How the IMPaCT Experience Affected Key Areas of Transformation</td>
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<td>Jonathan Griffin, MD, Family Physician, St. Peter’s Medical Group</td>
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<tr>
<td></td>
<td>Nancy Sullivan, Assistant to the Cabinet Secretary, West Virginia Department of Health and Human Resources</td>
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<td>Niharika Khanna, MD, Associate Professor, University of Maryland School of Medicine</td>
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<tr>
<td>1:45 – 2:00 pm</td>
<td>Improving on a Nationally Recognized Model: North Carolina’s IMPaCT Project</td>
</tr>
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<td>Darren DeWalt, MD, Associate Professor of Medicine, University of North Carolina – Chapel Hill</td>
</tr>
<tr>
<td>2:00 – 2:25 pm</td>
<td>Facilitated Discussion</td>
</tr>
<tr>
<td></td>
<td>Jill Rosenthal, Senior Program Director, NASHP</td>
</tr>
<tr>
<td>2:25 – 2:30 pm</td>
<td>Wrap-Up</td>
</tr>
</tbody>
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Idaho State Healthcare Innovation Plan (SHIP)

Building on NASHP IMPaCT Project to Transform Primary Care

Denise Chuckovich, Deputy Director
Idaho Department of Health and Welfare
Overview

Idaho has leveraged multiple initiatives over the past several years, building towards a shared vision of a transformed healthcare system. The patient centered medical home is the foundation of this vision. Other key design elements include:

- network development
- data/IT systems development
- quality improvement
- multi-payer participation in a value-based reimbursement model
Idaho Background

- **Environment**: 1.6M population. Rural, frontier, geographically diverse.

- **Resources**: Strong stakeholder community, good relationships. History of working together. PCMH development underway in public and private clinics.

- **Challenges**: Very rural population. 97% of Idaho is federally designated Health Professions Shortage area in primary care. Ranks 48th in primary care workforce. 18% population is uninsured.
Recent Developments in Idaho Health Care

- Fall 2007 Governor Otter convenes Healthcare Summit to identify outstanding issues in Idaho.
- 2008-2009 Governor’s Select Committee on Healthcare continues to refine focus during statewide meetings.
- October 2010 Governor Otter establishes Idaho Medical Home Collaborative (IMHC) to refine PCMH model for Idaho and study multi-payer methodology.
- 2012 Idaho participates in NASHP IMPaCT project and Idaho team travels to N. Carolina to learn first hand regarding NC network model.
- 2012 Idaho implements Health Home PMPM payments for PCMH care for Medicaid members with certain chronic conditions.
- January 2013 IMHC multi-payer medical home pilot launched with 4 major payers and 27 primary care practices from around the state participating.
- March 2013 State receives six month planning grant from CMMI to develop proposal for healthcare delivery system redesign-The State Health Innovation Plan (SHIP).
- December 2013 Idaho SHIP will be submitted to CMMI. Idaho will submit a model testing proposal when announced in early 2014. Idaho proposal to focus on statewide primary care transformation, shared quality measures, statewide and regional transformation support, and redesigning payment from volume to value.
In 2011 stakeholder group representing major provider groups began meeting regularly to discuss how to move Idaho towards primary care transformation. Includes key leaders from the Idaho Hospital Association (IHA), Idaho Medical Association (IMA), Idaho Academy of Family Physicians (IAFP), Idaho Primary Care Association (IPCA), Medicaid, and State Office of Rural Health.

Group identified certain core areas for healthcare system transformation that needed focus/resources:

- PCMH transformation
- Network development
- Information technology and data sharing
- Quality improvement
- Multi-payer models
The Opportunity--Joining NASHP IMPaCT Project

- Joining the NASHP IMPaCT Project offered numerous opportunities to Idaho including:
  - Opportunity to strengthen stakeholder partnership through shared experience.
  - Opportunity to fine-tune Idaho’s identified core issues.
  - Opportunity to study with other states interested in practice transformation.
  - Opportunity to visit N. Carolina and learn first-hand from NC experts how their network was formed, history, current issues.
  - Opportunity to adapt NC concepts to Idaho environment.
  - Opportunity to refine Idaho primary care transformation plan and submit to CMMI for SIM planning grant.
  - Opportunity to access tailored TA to assist Idaho planning
Stakeholders Spread the Word and Build Support

- Fall of 2012 stakeholders presented plan outline to their interest groups to begin to build support/buy-in for transformation direction and core concepts.
- This broad communication was linked to requests for letters of support for Idaho’s SIM planning grant.
- Fall of 2012 State of Idaho submits SIM grant application for 6 month planning grant.
- Idaho receives SIM award March 2013.
Idaho SHIP Builds on NASHP IMPaCT Initiative

- Stakeholders takes core IMPaCT plan elements and build application to CMMI.
- Key stakeholders continue to be involved while expanding the spread/buy-in. All members of Idaho IMPaCT team participating in SHIP development.
- SHIP leadership hold individual meetings with stakeholders to identify their specific interests and concerns.
Challenges Encountered

- Maintaining strong communications with stakeholders.
- Helping stakeholders understand each others’ interests.
- Private payer buy-in.
- Inclusivity—healthcare system impacts so many.
- Shift of perceived power to primary care from hospitals, specialty, payers.
- Role of state vs private. Balance. DHW will be responsible for grant management.
Where have we come?

- Idaho’s original NASHP IMPaCT application reflects same key initiatives proposed in SHIP Plan:
  - Transform Idaho primary care practices to PCMH
  - Integrate PCMH with medical neighborhood
  - Create state and local support networks
  - Identify shared quality measures across payers
  - Support and further develop Idaho HIT systems
  - Shift payment methodology from volume to value
Next Steps

• Idaho SHIP will submit to CMS 12/2013.

• Idaho will submit model testing proposal when CMMI grant opportunity released Winter 2014.

• SHIP Steering Committee to continue to meet to develop Idaho Healthcare Alliance, NFP 501c3.
Key Lessons Learned

• Pressure from ACA and concerns re healthcare system future provide impetus to bring stakeholders together.

• Build strong coalition of stakeholders and keep them engaged/informed.

• Take advantage of what you have in place (initiatives, partnerships, relationships) and leverage those resources to continue to build.

• Message ‘Big Picture’ context to connect these efforts.

• Share leadership--Identify strong, respected primary care physician leaders and others outside state government to lead the effort. Give them lots of support!
Questions?

Denise Chuckovich
Deputy Director, Idaho Department of Health and Welfare

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West Virginia Health Care Innovation Initiative
Engaging Stakeholders

- **Start at the Top**
  - Governor, Cabinet Secretary, Legislators
- **Call on your old friends**
  - Established alliances, other pilots and initiatives
- **Reach out to people headed in the same direction**
  - Strong Start, CMS Innovation

- **Go where large groups of people are gathered**
  - WV Family Care Conference
- **Make new friends wherever you can**
  - Share your vision
- **Open the door**
  - Public meeting

*Communicate, Collaborate, Coordinate*
Montana’s Statewide Health Information Management Infrastructure

Jonathan Griffin, MD, MHA
Montana PCMH Advisory Council
## Montana State Comprehensive Health Information Management & Exchange Suite (CHIMES)

<table>
<thead>
<tr>
<th>Cross-Organizational Connectivity &amp; Comm.</th>
<th>Capable of Reporting &amp; Advanced Analytics</th>
<th>Patient Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Claims</td>
<td>Clinical quality</td>
<td>Portal</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Performance</td>
<td>Personal health management</td>
</tr>
<tr>
<td>Patient-derived</td>
<td>Financial</td>
<td>Education</td>
</tr>
<tr>
<td>Care team communication</td>
<td>Clinical research</td>
<td>Pt-family-care team communication</td>
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<td></td>
<td>Epidemiology</td>
<td>Electronic outreach</td>
</tr>
</tbody>
</table>
Maryland Multi-Payer Program for Patient Centered Medical Home Practice Engagement and Supports

Niharika Khanna, MBBS, MD, DGO
Associate Professor Family and Community Medicine
Director Maryland Learning Collaborative
Maryland Multi-Payer Program for Patient Centered Medical Home Learning Collaborative

Commercial Payers: Aetna, CareFirst, Cigna, Coventry, United and Medicare Advantage
Public Payers: Medicaid and Tricare

Financial Model
- Fixed Transformation Payments
- Shared savings

Educational Engagement
- Embedded care management
- Primary care teams

Quality Metrics and Evaluation
- 21 NQF metrics for quality improvement
- External evaluator

Health information exchange for real time transitions data

Learning Collaborative
- Within practice coaching
- Workforce training using multi-media
Enhancing NC Practice Support

Darren DeWalt, MD, MPH
University of North Carolina
NC IMPaCT Principal Investigator
NC Healthcare Quality Alliance
Convening organization with board representing NC healthcare leadership, including CCNC, AHEC, physicians, hospitals, insurers, academic medical centers, business and the non-profit community.

NC AHEC Program Office

9 regional NC Area Health Education Centers

REC Improvement networks Practice coaching

Community Care Program Office

14 Regional CCNC Networks

Network level care management and QI support

Per member per month payment to practices to support practice level tools

Primary Care Practices
Primary Care Practice Support Elements

- Quality improvement facilitation
- Practice systems (EHRs, PCMH, Meaningful Use)
- Collaboration across practices

- Informatics for Measurement
- Informatics to support care provision (population level and individual level)
- Care Management

- Payment reform
- Leadership/collaboration/trust in integrating activities across organizations
Enhancements via IMPaCT

- Regional Leadership Collaborative
- Care Transitions for Primary Care Collaborative
Regional Leadership Collaborative Goals

- Increased capability to lead ongoing local improvement in primary care
- Shared vision for clinical quality improvement at a regional level
- Improved coordination and communication with other improvement leaders in region team
- Increased influence and effectiveness as leaders
- Strengthened network of relationships and resources to support future improvement initiatives
Curriculum

- Project-based
- Improvement project design—regional level
- Leading system change
- Supporting practice teams
- Measurement and analytics
- Spread of improvements
- Developing practice leaders
Structure

- 3 learning sessions (1-day)
- Monthly webinars
- Prework and reporting each month
Results

- Improved QI leadership skills
- Substantial alignment between AHEC and CCNC
- Use of data for improvement
- 1/3 of teams had demonstrable improvement in project measures
  - Reduced ED visits,
  - Greater use of care alerts
  - Increased follow-up after hospitalizations
North Carolina IMPACT
Regional Leadership Collaborative
Enhancing leadership to spread primary care transformation

April 2012-August 2013
What worked and what didn’t?

- Excellent engagement from across the state
- Structure of bringing AHEC and CCNC together helped to facilitate collaboration
- Teams sometimes had difficulty defining their improvement project (not used to a self-driven collaborative)
- Different projects not comparable for results
Care Transitions for Primary Care Collaborative

- 9 practices participated
- Coaches from AHEC and/or CCNC with each practice
- Monthly webinars and reporting
- Used IHI Care Transitions Guide as model

Goal: understand process of equipping primary care practices and role of coaching
Results

- Substantial changes in several practices
  - Prepared for hospital f/u visits
  - Seeking records from hospitals
  - Getting patients contacted and into practice
- Connections with hospitals (difficult)
- Planned visits
- After hours care

- Generated ideas for how to implement
- Several coaches got experience
As we went through the process, we kept track of what we learned

Adjusted the plan of implementation

Recorded in a change package full of resources for care transitions
Overall Approach to Enhancements

- Built on current infrastructure to make it better (not creating a new program)
- Identified current needs and addressed with program design
- Increased improvement capacity across the state
- Improved collaboration across organizations
- Created new and timely areas for primary care practice support (transitions)
Enhancing Your Program

- Any program ought to seek ways to become more effective
- Organized approaches to increase skills and capacity can help to advance large scale programs
- New product line development is often needed to meet new demands
- We have demonstrated two approaches toward enhancing NC’s program
Facilitated Discussion

Please listen to the operator for directions on how to ask a question, or type your question into the chat box.
Additional Resources


• NASHP Report: Building Infrastructure to Promote Primary Care Transformation: Lessons from a Four-State Learning Community

• NASHP Issue Brief: North Carolina’s IMPaCT Initiative: Enhancing Primary Care Practice Support

• NASHP Blog: Lessons in Primary Care Extension from Four States

• NASHP Blog: Building a Statewide Support System to Transform Primary Care

• Health Extension Toolkit
Thank You!

Your opinion is important to us. After the webinar ends you will be redirected to a web page containing a short survey. Your answers to the survey will help us as we plan future NASHP webinars.