A Report on the Role of SORHs with State Innovation Model (SIM) Programs

Seventeen states have received State Innovation Model (SIM) funding either in Round One or Two to test state-led, multi-payer health care payment and service delivery models. Round One Test Awards are in the final year of demonstration, while Round Two Test Awards are in the second year of funding. The National Organization of State Offices of Rural Health (NOSORH) reached out to State Offices of Rural Health (SORHs) to get an update on rural initiatives within state SIM plans in these states along with the involvement of SORHs in the implementation of these initiatives.

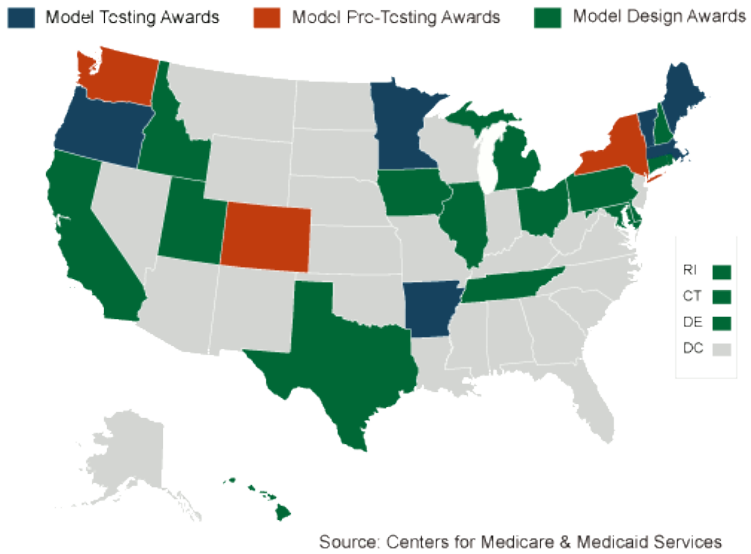
Background on SIM

The State Innovation Models (SIM) Initiative provides financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models. The SIM initiatives aim to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.

Awards to states are to design or test innovative health care payment and service delivery models in the form of Model Design, Model Pre-Test, and Model Test awards.

- Model "design" awardees - states/entities that are designing plans and strategies for statewide innovation.
- Model "test" awardees - states that are taking the next step from "designing" to "testing" and implementing comprehensive statewide health transformation plans.

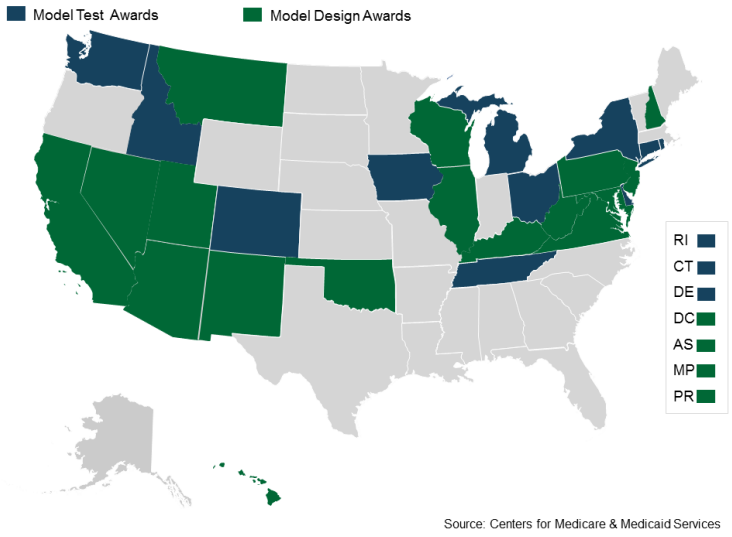
In Round One of the SIM Initiative, over $250 million in Model Test awards are supporting six states to implement their State Health Care Innovation Plans. Four-year awards began in February 2013 for the states of: Minnesota, Vermont, Massachusetts, Maine, Oregon and Arkansas. The first annual report for Round One Awards can be found here.



Source: Centers for Medicare & Medicaid Services

In Round Two, over $622 million in Model Test awards will support 11 states that are ready to implement their State Health Care Innovation Plans. These four-year awards began in February

2015 for the states of: Washington, Idaho, Colorado, Michigan, Iowa, Tennessee, Ohio, New York, Rhode Island, Connecticut, and Delaware.



A description of the overall state initiatives, the amount of the award, and the website for each state can be found on the CMS Innovation website.

ROUND ONE TEST AWARDS

Minnesota

NOSORH reported on Minnesota's SIM test award in September 2014 as a Promising Practice. In February 2013, Minnesota received $45 million to use across a three-year period ending October 2016 to test new ways of delivering and paying for health care using the Minnesota Accountable Health Model framework. The goal of this model is to improve health in both rural and urban communities, provide better care, and lower health care costs. Up to three million Minnesota residents are expected to receive care through this model over the three-year period.

The Minnesota Office of Rural Health and Primary Care's most direct involvement with SIM is through the Emerging Professions Integration Grant Program focusing on expanding the number of patients served by team-based integrated/coordinated care by supporting the adoption of emerging provider types. The Minnesota Accountable Health Model has identified three emerging professions to test for integration into the health care workforce; Community Health Workers, Community Paramedics and Dental Therapists/ Advanced Dental Therapists. Each emerging profession will be evaluated for how its integration into a team environment can change the team's overall capacity and the patient's outcomes.

The Program has issued three rounds of grant funding to support the integration of emerging professions into the health care workforce. A total of fourteen organizations were awarded 12 months of start-up funds to support salary and fringe of the emerging professional.

Grantees/organizations received approximately $30,000 each in funding. Each agency will also contribute funds toward the emerging professional they plan to hire. Round 1 awards were announced in July 2014, Round 2 awards were announced in October 2014, and Round 3 awards were announced in August 2015.

The State convened a workgroup for each of the new emerging professions which consisted of 6-8 individuals who are immersed in the field and have connections to other stakeholders to identify the type of data to collect. The workgroups met quarterly for one year which provided staff with the opportunity to share information about the grant projects and collect feedback.

Role of Minnesota SORH
Minnesota's Office of Rural Health and Primary Care (ORHPC) has been involved with the state's SIM grant from day one, primarily in work around Emerging Professions. In Minnesota, Community Health Workers, Community Paramedics, and Dental Therapists are all emerging professions at various stages of development and integration in the health care marketplace. Medicaid coverage has been established for all three of these professions, but gaps and barriers exist.

ORHPC pushed to include Emerging Professions in its SIM grant, because these professions can bridge many of the same coordination and information gaps between health care, population health, and other stakeholders -- which SIM is designed to foster through broader adoption of ACOs. ORHPC has been engaged in three main activities: placement grants for Emerging Professions in new or innovative roles; development of Toolkits for potential employers of Emerging Professions; and sharing information and best practices within other SIM-related projects that use Emerging Professionals.

Oregon

The Centers for Medicare and Medicaid Innovation awarded a SIM grant to the Oregon Health Authority in September 2012 for up to $45 million through September 30, 2016. Oregon was one of six states to receive the grant for testing innovative approaches to improving health and lowering costs across the health delivery system, including Medicaid, Medicare, and the private sector. The grant supports the state's ongoing health system transformation and provides opportunities for Oregon to share what it learns with other states. Oregon's health reform to its Medicaid program started with the creation of coordinated care organizations (CCOs) in 2013. The SIM grant is an opportunity for Oregon to strengthen and support the coordinated care model and to begin to make its key elements, such as best practices to manage and coordinate care, available to others such as PEBB, OEBB, and Medicare beneficiaries.

The SIM grant focuses on innovation in three areas:

Innovation and Rapid Learning, which provides:

- Resources and technical assistance to Oregon's CCOs
- Facilitated learning collaboratives and rapid improvement cycles
- Promotion of health equity across sectors and payers including private payers, long-term care, community health, and education systems

Delivery Models

- Evaluation of methods for integrating and coordinating between primary, specialty, behavioral and oral health
- Improvement of community health through promotion and prevention activities
- Support CCOs collaborations with long-term care, community health and social services

Payment Models, tested at two levels:

- Global budget for CCOs
- A "starter set" of promising alternative models for provider payment and models that focus on the value, rather than the volume, of services provided.

Role of Oregon SORH

In October 2014, the Oregon Health Authority partnered with the Oregon Office of Rural Health (OORH) to request telehealth pilot project proposals that improve care coordination; increase individuals' access to their own health data and engagement in their care; expand system capacity; and achieve efficiencies in health care delivery. Proposed projects were required to be innovative, scalable, and align with SIM grant purposes:

1 Support Oregon's coordinated care model and health care transformation;
2 Identify and spread health care innovation and/or;
3 Promote the triple aim of better health, better care, and lower costs.

Sixty-seven letters of intent were received from all areas of the state and across all types of organizations. Scott Ekblad, Director of the OORH, noted, "This was an incredibly valuable process in so far as understanding the telehealth needs across Oregon. Proposed projects ranged from rural facilities looking to expand access to specialist services to Coordinated Care Organizations looking at new ways of using technology to improve population health. It demonstrates the ongoing importance of collaboration and innovation." OORH used this information to identify where CCOs and CAHs identified the same technology solutions to address population health needs and created a grant opportunity for CAHs to partner with their CCO on innovative solutions under the Flex grant.

Thirteen applicants were invited to submit full proposals, and five awardees were selected. "We are excited to partner with these organizations and support their efforts to improve coordination and access to care through telehealth technologies," said Susan Otter, Director and State Coordinator for Health Information Technology. "Each of these pilot projects will work to address a unique population and system challenge in areas such as behavior health, youth dental, dementia care, HIV services and connecting paramedics to clinics in rural areas. We look forward to lessons learned through these pilots and sharing best practices for improving care and increasing access in local communities." Projects began in June 2015 and will run through June of 2016. OORH will be sharing the grant administration process with the Idaho Department of Health and Welfare in June and will facilitate a presentation of these projects at their annual rural health conference in September 2016. For more information on the Telehealth Pilot Project grants, please visit the OORH website or contact Meredith Guardino at guardino@ohsu.edu.

Vermont

On February 21, 2013, Vermont was awarded $45 million for a four-year SIM grant named the Vermont Health Care Innovation Project. According to John Olson, Chief, with the Vermont Office of

Rural Health and Primary Care, "All health in Vermont is rural health," so many of the activities listed below stretch across the state.

Active Work Groups include:

Care Models and Care Management
The Care Models and Care Management (CMCM) Work Group examined current or planned care management programs and care delivery models. The group recommended mechanisms for assuring greater consistency and/or coordination across these programs and models in terms of service delivery, financial incentives, quality measurement or other key model or program components. The goal to maximize effectiveness of the programs and models in improving Vermonters' experience of care, reducing unnecessary costs and improving health, and minimizing duplication of effort or inconsistencies between the models.

Disability and Long Term Services and Supports
The Disability and Long Term Services and Supports (DLTSS) work group will build on the extensive work of the duals demonstration steering committee. The group will continue to develop recommendations regarding:

- A care model or models for dually-eligible Vermonters that improves beneficiary service and outcomes
- Provider payment models that encourage quality and efficiency among the array of primary care, acute and long-term services and support providers who serve dually-eligible populations
- Quality measures to be used to evaluate provider and overall project performance
- A financial model that allows for an assessment of the potential costs, benefits and risks of the project for the state, providers and beneficiaries
- Management structures necessary to administer the project at both the state and provider levels

Health Care Workforce
Specific to the Vermont Health Care Improvement Project, the Work Group will seek to gather the data necessary to assess supply and demand in order to ensure the appropriate number and type of health care professionals to achieve the Project's goals. Once the data is obtained and analyzed, the Work Group will utilize it to develop, recruit, and retain the workforce needed. This will require intense and well-coordinated work that engages the entire health care and educational community, including state entities and external stakeholders.

Health Information Exchange
The Health Information Exchange (HIE) work group strived to:

- Identify the desired characteristics and functions of a high-performing statewide information technology system.
- Explore and recommend technology solutions to achieve SIM's desired outcomes.
- Guide investments in the expansion and integration of health information technology, as described in the SIM proposal, including:
    - support for enhancements to EHRs and other source data systems
    - expansion of technology that supports integration of services and enhanced communication, including connectivity and data transmission from source systems

such as mental health providers and long-term care providers
- implementation of and/or enhancements to data repositories
- implementation of and/or enhancements to data integration platform(s)
- development of advanced analytics and reporting systems

The group also will advise the development of the state's health information technology plan with regard to the above activities and expenditures.

The HIE work group was responsible for the following deliverables:
- Recommendations to the Steering Committee regarding the HIE work plan.
- Recommendations on expenditure of SIM funds to support HIT investments.
- Recommendations on coordination of HIT/HIE related efforts across various agencies and organizations.
- Recommendations on prioritization of new initiatives such as EHR installations, interfaces, and other investments.

Payment Models
The Payment Models (PM) work group will build on the work of the ACO standards work group to date and:
- Continue to develop and recommend standards for the commercial shared savings ACO (SSP-ACO) model
- Develop and recommend standards for the Medicaid SSP-ACO model
- Develop and recommend standards for both commercial and Medicaid episode of care models
- Develop and recommend standards for Medicaid pay-for-performance models
- Review the work of the duals demonstration work group on payment models for dual eligibles
- Recommend mechanisms for assuring consistency and coordination across all payment models

Population Health
The Population Health (PH) work group will examine current population health improvement efforts administered through the Department of Health, the Blueprint for Health, local governments, employers, hospitals, accountable care organizations, FQHCs and other provider and payer entities. The group will examine these initiatives and SIM initiatives for their potential impact on the health of Vermonters and recommend ways in which the project could better coordinate health improvement activities and more directly impact population health, including:
- Enhancement of State initiatives administered through the Department of Health
- Support for or enhancement of local or regional initiatives led by governmental or non-governmental organizations, including employer-based efforts
- Expansion of the scope of delivery models within the scope of SIM or pre-existing state initiatives to include population health

Quality and Performance Measures
The Quality and Performance Measures (QPM) work group worked to build on the work of the ACO Quality and Performance Measures Work Group, and will recommend standardized measures that

will be used to:

- Evaluate the performance of Vermont's payment reform models relative to state objectives;
- Qualify and modify shared savings, episodes of care, pay for performance, and health home payments; and
- Communicate performance to consumers through public reporting.

The overarching goal of quality and performance measurement is to focus health care reform and quality improvement efforts to control growth in health care costs, improve health care, and improve the health of Vermont's population. The work group's deliverables will include recommendations on consolidated and standardized sets of all-payer quality and performance measures to be used to indicate improvements in performance, monitor adherence to quality standards, and qualify and modify payments to providers or provider organizations. When possible, the focus will be on nationally accepted measures that can be benchmarked. As needed, the work group will make recommendations regarding data resources for proposed measures, troubleshooting measurement barriers, and supporting measurement issue resolution. Performance measures will be reviewed on at least an annual basis, and will be revised, retired or replaced as appropriate.

Role of Vermont SORH

Vermont's SORH is involved with the workforce development workgroup and monitors SIM activities of the many other organizations, state agencies and networks that are actively leading initiatives.

ROUND TWO TEST AWARDS

Colorado

The Colorado Department of Health Care Policy & Financing was awarded $65 million in February 2015 to allow the state to develop a State Health Care Innovation Plan with a focus on improved integration of physical and behavioral health services. Colorado's plan, entitled "The Colorado Framework," creates a system of clinic-based and public health supports to spur innovation. The state will improve the health of Coloradans by:

1. Providing access to integrated primary care and behavioral health services in coordinated community systems;
2. Applying value-based payment structures;
3. Expanding information technology efforts, including telehealth; and
4. Finalizing a statewide plan to improve population health.

Colorado submitted a SIM Operational Plan in January 2016 outlining their vision for the next three years. The plan leverages practice transformation, payment reform, health information technology (HIT), and public health efforts to build upon the success of existing initiatives like the Comprehensive Primary Care Initiative (CPCI) and the Medicaid Accountable Care Collaborative (ACC). Furthermore, the plan details how Colorado SIM will engage consumers, develop workforce capacity, and utilize a range of policy and regulatory levers to address current systemic barriers and pave the way for future innovation and transformation. Finally, the document addresses how a dynamic evaluation plan, which aligns Clinical Quality Measures (CQMs) with population-based

data and focuses on rapid-cycle feedback, will allow Colorado SIM to identify areas that need improvement in real time and build on strategies that show particular promise.

Role of Colorado SORH
The Colorado SORH has been involved with the develop of SIM initiatives since the submission of the original application in March 2013 by participating in meetings, speaking up for the rural voice, and advocating for telehealth initiatives.

All Practice Transformation efforts and Health Information Exchange efforts will be handled collectively as a state. The CO SORH was approved to provide practice transformation and health information technology services to rural practices across the state. There will be four cohorts and 100 practices were selected to participate in the first cohort. The CO SORH will focus on assisting the practice complete a data quality assessment to identify the gaps in the practice's HIT resources and work to identify, prioritize, and implement strategies to address HIT needs including a link to resources available. Assist with making community connections, identifying best practices, identifying and implementing quality improvement priorities through use of the SIM Change Package/Building Blocks framework and Toolkit and sharing lessons learned throughout the state.

Connecticut

Connecticut was awarded a $45 million SIM test grant in early 2015. Connecticut's SIM design is the product of two years of intensive input from healthcare providers, government agencies, employers, consumers and payers through dozens of broadly representative workgroups, 25 consumer focus groups, commentary elicited from the general public, and deliberations by the Healthcare Innovation Steering Committee and the Healthcare Cabinet. SIM is being implemented with the same broad input and inclusion. The SIM Program Management Office (PMO), situated within the Office of the Healthcare Advocate, facilitates the execution of the SIM Test Grant and Innovation Plan.

The SIM Consumer Advisory Board (CAB) sponsored two community listening sessions in the Fall of 2015. A Rural Community Health Care Forum was held on October 15, 2105 at Generations Family Health Center in Willimantic. A Southeastern Asian American Community Listening Forum was held on October 20, 2015 at Elmwood Community Center in West Hartford. More information on these sessions can be found here and here. Most recently, a Behavioral/Mental Health Forum was held on May 19 and a Western CT Forum is scheduled for June 3.

Rural Health Care Forum highlighted the unrecognized healthcare disparities between rural and urban/suburban communities in CT. Rural communities comprise 40% of towns in CT and about 10% of the populations. Serious concerns were raised about healthcare workforce shortages in CT's rural communities particularly for psychiatry, behavioral health services and substance abuse treatment. Participants also noted that transportation presents a critical barrier to accessing health care. In the northeastern corner of CT, some towns have virtually no transportation at all and an ambulance may be the only way to access medical care.

The CT SIM Initiative seeks to transform the healthcare system to improve healthcare delivery and outcomes throughout the state. To achieve this in CT's rural communities, particular focus must be

given to the particular needs of these communities. Consumer Advisory Board recommends that SIM Steering Committee and Workgroups consider the following initial recommendations.

1. Geography should be considered a specific health equity factor in SIM's evaluation efforts, not just race and ethnicity. The CT SIM evaluation needs to include an assessment and plan to address geographic as well as racial and ethnic disparities.
2. Advanced medical home pilots and CCIPs that serve rural communities need to include strategies to address rural health care disparities as part of their planning process.
3. It is recommended that SIM undertake a specific process to address workforce shortages and transportation challenges particularly in rural communities. Without addressing these critical factors, progress cannot be achieved in rural communities.
4. Implementation and reimbursement for telehealth services across the state will significantly improve access to quality care for those in most need while reducing costs and addressing workforce shortages and transportation challenges.

The Southeastern Asian American Community Listening Session was the first time the Cambodian, Laotian, and Vietnamese communities in Connecticut came together to raise awareness of their unique history and healthcare needs. Southeastern Asian Americans experience a higher rate of diabetes and hypertension. Those who came to the United States to escape the regimes of Khmer Rouge and Pol Pt also experience high rates of post-traumatic stress disorder and depression. Physical and mental health care needs are strongly linked.

Challenges to improved health faced by these communities include limited access to interpreter services, lack of transportation, high medication costs and mental health services that are not culturally tuned to the needs of Southeast Asian refugees. Participants urged that SIM ensure that participating providers and health plans assess and effectively address language and cultural barriers for the communities they serve.

A fundamental goal of CT's SIM Initiative is to reduce racial and ethnic disparities in health outcomes. It has been noted by the SIM Program Management Office that the Community Clinical Integration Program will offer technical support and in some cases financial awards to Advanced Networks and health centers to assess and address health disparities, to provide care management to those with complex health needs, and better integrate behavioral healthcare into primary care practices. The Advanced Medical Home Program offers support to primary care practices to meet medical home standards such as assessing and addressing needs of diverse populations, interpretation or multilingual services and providing printed materials in the language of its population.

The Consumer Advisory Board recommends that SIM Steering Committee and Workgroups consider the following:

1. Advanced networks, advanced medical homes and CCIPs that serve diverse populations need to demonstrate to SIM how they plan to address the language and cultural barriers to health improvement, specifically how the need for translation, interpretation/multi-lingual services, and culturally relevant care in their communities will be met.

2. Behavioral health services need to be sufficiently attuned to the unique cultural experiences of those in their communities and demonstrate their linkages with community organizations expert in addressing these needs.
3. CT SIM needs to include in its evaluation and conduct ongoing monitoring to ensure the effective delivery of interpretation/multilingual services, access to culturally relevant services, as well as reductions in racial and ethnic disparities in health outcomes.

The Role of the Connecticut SORH
The Consumer Advisory Board (CAB) reached out to the Connecticut SORH for assistance in planning a Rural Health Forum. The CAB included 5 community forums in the state proposal. The goal was to do one rural forum in eastern CT and one in western CT. The eastern forum was held in October 2015 and was very successful. The western CT forum is scheduled for June 3, 2016. The CT SORH will continue to assist the CT SIM upon request.

Delaware

The Delaware Health Care Commission received a $35 million SIM testing award to support the implementation of the State Health Innovation Plan. The Delaware Center for Health Innovation (DCHI) was established to lead the implementation of the state's SIM goals. The DCHI has five standing committees – Healthy Neighborhoods, Clinical, Payment Model Monitoring, Workforce and Education and Patient & Consumer Advisory – as well as a Technical Advisory Group. A SIM Annual Progress Report was filed in May 2016.

The Role of the Delaware SORH
The SIM work is managed by the Delaware Health Care Commission, which is a sister agency to the Division of Public Health where the Delaware SORH is housed. The DE SORH attends the various committee meetings to keep abreast of the work and to provide a rural perspective when needed. Delaware has only three counties, so most activities are planned on a statewide level.

Idaho

In December 2014, the Idaho Department of Health and Welfare received a SIM grant for $39,683,813. The grant will fund a four-year model test that began in February 2015 to implement the Idaho State Healthcare Innovation Plan (SHIP). The first year of the award period was considered a pre-implementation year which was dedicated to getting project staff and contractors in place. During the grant period, Idaho will demonstrate that the state's entire healthcare system can be transformed through effective care coordination between primary care providers practicing patient-centered care, and the broader medical neighborhoods of specialists, hospitals, behavioral health professionals, long-term care providers, and other ancillary care services.

Idaho's plan identifies seven goals that together will transform Idaho's healthcare system.

Goal 1: Transform primary care practices across the state into patient-centered medical homes (PCMHs): Idaho will test the effective integration of PCMHs into the larger healthcare delivery system by establishing them as the vehicle for delivery of primary care services and the foundation of the state's healthcare system.

Goal 2: Improve care coordination through the use of electronic health records (EHRs) and health data connections among PCMHs and across the medical neighborhood: Idaho's proposal includes significant investment in connecting PCMHs to the Idaho Health Data Exchange (IHDE) and enhancing care coordination through improved sharing of patient information between providers.
Goal 3: Establish seven Regional Collaboratives to support the integration of each PCMH with the broader medical neighborhood: At the local level, Idaho's seven public health districts will convene Regional Collaboratives that will support provider practices as they transform to PCMHs.
Goal 4: Improve rural patient access to PCMHs by developing virtual PCMHs: This goal includes training community health workers and integrating telehealth services into rural and frontier practices. The virtual PCMH model is a unique approach to developing PCMHs in rural, medically underserved communities.
Goal 5: Build a statewide data analytics system: Grant funds will support development of a state-wide data analytics system to track, analyze and report feedback to providers and regional collaboratives.
Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value: Idaho's three largest commercial insurers, Blue Cross of Idaho, Regence and PacificSource, along with Medicaid will participate in the model test. Payers have agreed to evolve their payment model from paying for volume of services to paying for improved health outcomes.
Goal 7: Reduce healthcare costs: Financial analysis conducted by outside actuaries indicates that Idaho's healthcare system costs will be reduced by $89M over three years through new public and private payment methodologies that incentivize providers to focus on appropriateness of services, improved quality of care and outcomes rather than volume of service. Idaho projects a return on investment for all populations of 197% over five years.

Role of Idaho SORH
The Idaho SORH is very involved with the implementation of many Idaho SIM initiatives. Goals 3 and 4 are housed in the SORH. Here is a brief update on those Goals:

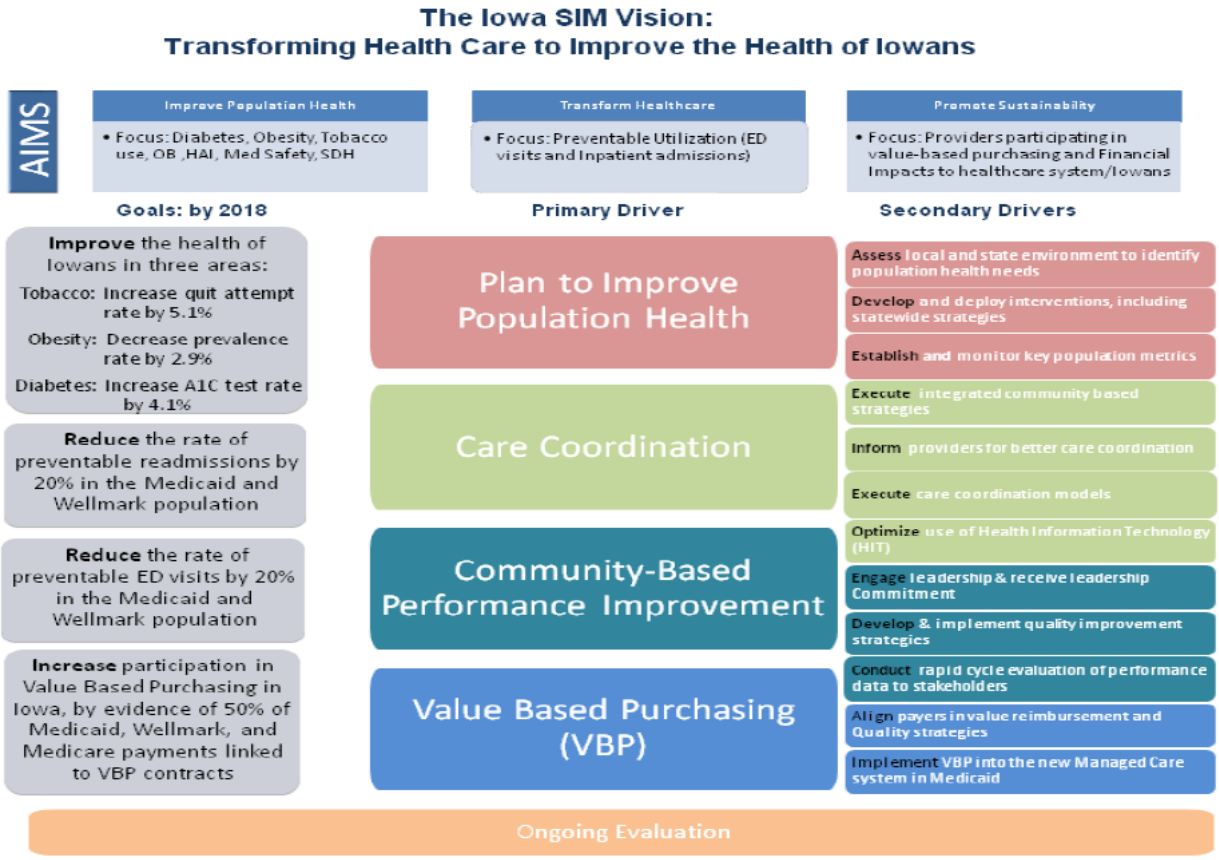
Goal 3: Idaho's seven local public health districts are each establishing a Regional Collaborative (RC) and each RC is chaired by two primary care physicians. Public health district staff are participating in training to provide on-site PCMH transformation support to primary care practices. The RCs and public health districts will also identify gaps and resource needs to strengthen the medical-health neighborhood.

Goal 4: The Idaho SORH convened workgroups to develop the "virtual PCMH" components. Each workgroup successfully created a plan to develop new statewide programs, including, telehealth expansion in rural primary care clinics, Community Health EMS, and Community Health Worker program models.

Iowa

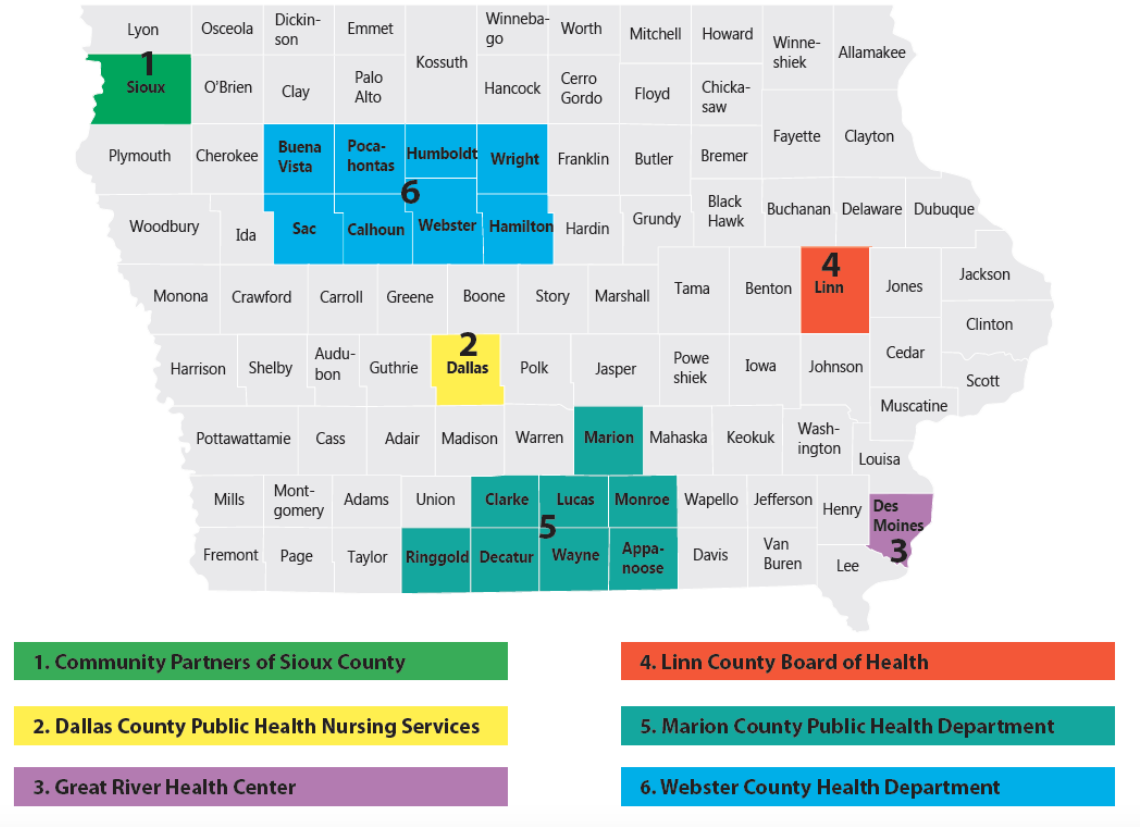
The Iowa Department of Human Services was awarded a SIM Test grant in early 2015 to support a statewide health system transformation. Iowa will use the SIM grant to implement and evaluate a sustainable health care delivery and payment system that will improve population health, improve patient care, and bend health care cost trends. Through the SIM program, Iowa will align and equip communities to address population needs by collaborating with payers, providers and public health

entities. The SIM Test aligns Iowa payers in payment reform that focuses on value; equips Iowa providers with tools to perform in value based, population focused models; and aligns and integrates public health strategies into how health care is delivered.



A portion of the SIM funding is focused on creating six Community Care Coalitions (C3s), spanning 20 counties; the majority being rural counties, to engage in broad-based health care system reform over the next three years that will lead to better health outcomes and lower costs. C3s are locally-based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. The C3s will have two primary functions: addressing social determinants of health through care coordination and implementing population-based, community- applied interventions related to the Iowa SIM Statewide Strategies. C3s began work on March 7.

State Innovation Model Community Care Coalition Initiative Grantees



Role of Iowa SORH

The Iowa SORH has no direct involvement in the Iowa SIM. However, Gloria Vermie, who previously worked for the Iowa SORH, is now the SIM Program Manager for the Iowa Health Care Collaborative (IHC), which is a state SIM subcontractor. To assist C3 communities in accomplishing effective solutions, IHC will convene Learning Community education sessions, provide online learning resources, and ensure technical assistance. IHC provides each C3 with a Quality Improvement Advisor, access to IHC faculty and training resources. Additionally-- to document and sustain C3 efforts-- IHC coordinates data collection, submission, and analysis. IHC is committed to providing Iowa communities with the tools and necessary depth of understanding needed to improve outcomes, increase patient safety, and decrease the cost of healthcare for all Iowans.

Michigan

The Michigan Department of Health and Human Services (MDHHS) received a $70 million grant from the U.S. Department of Health and Human Services to develop and test the models that were outlined in the Blueprint for Health Innovation over the next four years. MDHHS will work with community partners and stakeholders to develop and test these models in the following five pilot regions in Michigan: Jackson County; Muskegon County; Genesee County; Northern Region; and the Washtenaw and Livingston counties area.

Role of Michigan SORH
The Michigan SORH has no direct involvement in the State of Michigan SIM, at this time. Regions have been identified and the MI SORH will continue to monitor activities.

New York

The New York State Department of Health was awarded a $99.9 million Round Two SIM Test Award. The state's official project period of the grant began February 1, 2015 and will continue for four years. They have divided into 3 workgroups: Integration of Care, Access to Care and Workforce.

SIM/DSRIP Workforce Workgroup noted the significant importance of developing core competencies and/or training standards for workers in care coordination titles. As a result, they are convening three targeted subcommittees to meet over the coming months and report back to the full workgroup in February.

The 3 subcommittees that will be convened are as follows:

1. **Subcommittee 1: Identification of key care coordination functions and regulatory barriers that can impede effective care coordination**
   Charge: To delineate key care coordination competencies and functions, recognizing that associated activities may vary, based on the needs of the patient population, the services to be provided, and the skills and competencies of the care coordination staff. To identify all regulatory barriers that could potentially impede the provision of care coordination services.
2. **Subcommittee 2: Identification of curricular content for educating the health workforce in core concepts in care coordination (embedded in health professions education curricula and for continuing education of existing health care professionals).**
   Charge: To describe the recommended curriculum to use for educating health professions students and the existing health workforce in the core concepts of care coordination. The curriculum should be designed to provide a basic understanding of what care coordination is and the roles that health workers can play to support effective care coordination in their patient population. The initial focus will be on the following health professions: registered nurses, physicians, physician assistants and nurse practitioners. Subsequently, strategies for training other professions and occupations will be considered, including social workers, pharmacists, and medical assistants, among others.
3. **Subcommittee 3: Identification of recommended core curriculum for training workers in care coordination titles**
   Charge: To review curricula used by groups across the state for training workers in care coordination titles, to examine overlap in core content of these training programs and to identify key curricular components that should be included in all basic training programs for workers in care coordination titles. It is recognized that care coordinators may need additional disease-specific training, depending on the patient population served (e.g., working with diabetic patients, people with asthma, the chronically mentally ill, etc.)

Role of the New York SORH
Karen Madden, the Director for the NY SORH, sits on the Workforce Committee and is excited about

two projects that will have an impact in rural areas:

1. An initiative to provide start-up funds to create new residency programs in rural communities; and
2. A pilot to provide medical students and residents with exposure to professional, social and culture activities in upstate rural communities.

Rhode Island

Rhode Island received a $20 million award to test its health care payment and service delivery reform model over the next four years. The SIM model design will be operationalized through a "value-based care" paradigm. This paradigm integrally includes patient care quality measurements and strategies for engaging patients in their own health care. As part of SIM Round Two, the value-based care paradigm includes the following six components:

1. Developing a population health plan (Rhode Island baseline measures);
2. Developing and refining clinical outcome measures;
3. Expanding the state's health information technology infrastructure;
4. Establishing multi-disciplinary teams of health care providers to link provider practices with the communities that they treat (creating more effective relationships);
5. Identifying effective strategies for actively engaging patients in their own health care;
6. Achieving alternatives to fee-for-service arrangements, such that by the end of the grant period, 80% of insured Rhode Islanders will be in health insurance arrangements that link payment to value or quality of care.

The SIM Measure Alignment Work Group completed its work in February 2016, at which time the Work Group recommended a menu of performance measures and core measure sets for ACOs, hospitals, and PCMHs. The menu and ACO core set have been developed. Michael Bailit will present on the results of the measure alignment process at the SIM Steering Committee meeting on March 10.

HealthFacts RI will have the first release of HealthFacts RI data to the public in February. This public launch included release of public use data, such as state-generated reports, and interactive graphics available on a new HealthFacts RI data release webpage on the Department of Health website. Additional reports will be released regularly. Starting in March, interested parties will also be able to access standard data extracts through an electronic data request process, and the HealthFacts RI team will begin accepting requests for restricted data extracts and research requests.

The Provider Directory is currently undergoing internal testing and validation by RIQI staff using 4 different provider data sources. Additional provider data sources will be added over the coming year, including data from medical licensure, several hospital systems, etc. Data extracts of mastered provider data are anticipated to be available starting July 2016.

The agency continues the Accountable Entities (AEs) certification process. AEs are integrated provider organizations that have the opportunity to share in savings created by better managing for the total cost of care and healthcare quality and outcomes of an attributed population. Currently

four pilot AEs have been certified. AE names will be announced upon contract completion. As Medicaid adopts these value-based contract components, it is aligning its strategies and measures with OHIC, as part of the overall SIM effort to drive Rhode Island toward a value-based health system.

The Executive Office of Health and Human Services (EOHHS) and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) are jointly administering and monitoring the Integrated Health Home initiative, which commenced January 1, 2016. MCOs are now administering this benefit for all their enrolled SPMI members who will be assessed using a standardized and validated national screening tool to objectively measure their level of function and assign them to appropriate level of care and commensurate payment level. Quality measurement standards are in place to evaluate outcomes.

In collaboration with EOHHS and Medicaid, BHDDH has implemented a new Integrated Health Home and Assertive Community Treatment program for individuals with serious mental illness.

RI DOH is continuing the work of refining its Strategic Plan by reviewing the metrics associated with the established Population Health goals. Senior and Policy leadership staff have been meeting weekly to review the existing implementation/strategic plans for each programmatic area to identify the key initiatives (and short and intermediate term metrics) that will move the population health goals forward towards achieving the targets. We are prioritizing that review based on both Governor's priorities (e.g. infant Mortality and Drug overdose deaths) and SIM goals (e.g. Diabetes, Obesity, Tobacco); background/foundation documents have been shared with our new SIM vendors who are working on the SIM Population Health Plan.

RI DOH continues to explore opportunities for leveraging and aligning the work and infrastructure created with the Health Equity Zones. RI DOH has been diligently working with a group of public-private key stakeholders towards creating consensus on the core skills and competencies for Community Health Workers that would lead to certification and assurance of quality for this new workforce.

Role of the Rhode Island SORH

At present, the RI Office of Primary Care and Rural Health has no involvement in the SIM grant. The grant went to the EOHHS and the Department of Health has some role in the implementation, but efforts are really just starting. There are no specifically rural provisions in the grant. The RI SORH has relationships with the project through professional relationships with staff of the SIM grant. The RI SORH is keeping an eye on the project for anything that will impact rural stakeholders.

Tennessee

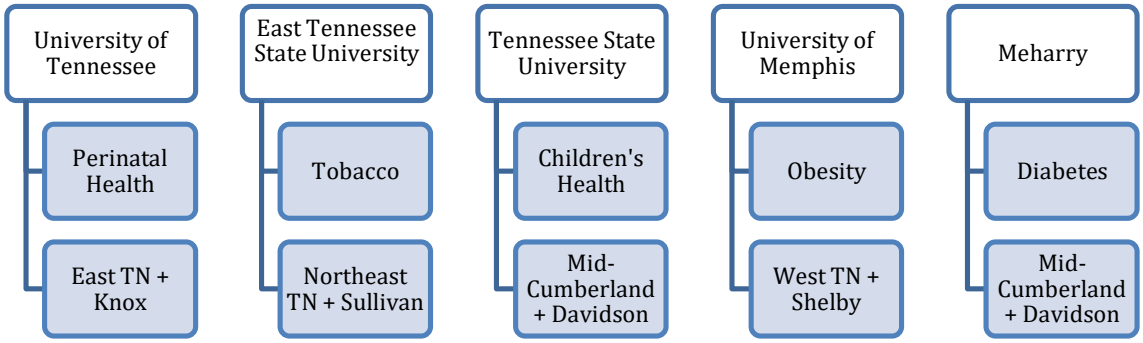
The Tennessee Department of Health Care Finance and Administration (F&A), which includes TennCare, received a SIM Grant in the Spring of 2015. The SIM Initiative Model Test Award provides financial and technical support over a four-year period for states to test and evaluate multi-payer health system transformation models. TennCare is utilizing the majority of this grant for work related to the Governor's payment reform initiative. F&A is convening clinical groups which are developing episodes of care and encouraging patient centered medical homes. The intent of these efforts is to fundamentally change how health care is reimbursed in Tennessee. The efforts

of the Governor and F&A have support from private insurers, the state employee plan and TennCare. You can view more details about the Tennessee Health Care Innovation Initiative at: http://tn.gov/hcfa/section/strategic-planning-and-innovation-group

A portion of the grant also funds the development of a State Population Health Improvement Plan (PHIP). The F&A has contracted with the Tennessee Department of Health for this work to be accomplished.

Regional Population Health Improvement Plan

The Tennessee Department of Health is contracting with five schools of public health to develop regional population health improvement plans. The Centers for Medicare and Medicaid Innovation identified five priority health topics on which these plans must focus: obesity, diabetes, tobacco cessation, perinatal health, and children's health. Additionally, each plan must be designed for a region of the state that includes both rural and urban counties and is comprised of a diverse demographic population mix. Each school has selected the region and health priority its plan will address. In order to develop an appropriate plan, the goal for each school is to collect and analyze relevant data, conduct informant interviews with regional service stakeholders and insurers, and organize focus groups or community meetings to identify causal factors associated with the health topic selected.



State Population Health Improvement Plan

Each school presented its finalized Regional PHIP at a statewide stakeholder meeting on March 3-4, 2016. TN SORH Director, Angie Allen, attended this meeting as a representative of the SORH. The Tennessee State Division of Health Planning will begin drafting a Statewide PHIP addressing all five priority health topics, which will be incorporated into the 2015 update to the Tennessee State Health Plan and submitted to the Governor in July 2016. Subsequent to this meeting, each school will submit updated finalized regional PHIPs and the State Division of Health Planning will begin drafting a statewide PHIP addressing all five priority health topics. This statewide PHIP will be incorporated into the 2015 update to the State Health Plan and submitted to the Governor in July, 2016.

From April 20, 2016 to May 6, 2016, the Division of Health Planning conducted public focus groups in nine cities across the state to gather additional feedback on the proposed framework for the State PHIP, the usage the Institute of Medicine/National Academy of Medicine's Vital Signs as measure of progress, and the regional applicability of different recommendations provided by our academic partners. These focus groups provided a forum for members of the general public, local health systems, non-profits, payers and other local health workers to provide input into the State

PHIP. For some attendees, it was an opportunity for them to see how the input they provided during the schools' stakeholder engagement process has been incorporated to date. These meetings were held in urban, suburban and rural cities across the state. Through this process, we were able to discuss, in a more intimate setting with open dialogue, many of the struggles of both care providers and recipients in the many rural regions of Tennessee.

The Role of the Tennessee SORH

In short, the SOHP is coordinating the PHIP component of SIM. The SORH has been involved as a resource and internal partner with the SOHP. For example, SORH reviewed the content of a SIM Update presentation for the annual Rural Health Association of Tennessee conference in November 2015. SORH gave input as to how Population Health and Tennessee Health Care Innovative Initiative would impact rural health care. SORH advised that rural residents would have better access to a PCMH where improved quality outcomes are driven by value-based payment incentives. Also, since episodes of care involve multiple providers, rural patients who have surgery performed or inpatient hospitalization at an urban hospital or health care entity will be able to access quality outpatient services, follow-up care or long term services and support from their local rural hospital or provider group associated with the episode of care. Additionally, SORH also participate in stakeholder meetings.

Washington

The Innovation Plan, now called Healthier Washington, received a $65 million federal award of a Round Two Model Test grant, which launched in February 2015 and makes targeted investments in five foundational areas to achieve health system transformation:

1. **Community empowerment and accountability**. Washington is driving local innovation through Accountable Communities of Health (ACHs), which develop a sustainable presence in their communities and partner with the State to achieve Healthier Washington goals. Regionally organized ACHs align the activities and investments of diverse sectors—providers, public health, housing, education, social service providers, health plans, county and local government, philanthropy, consumers, businesses, and Tribes—to drive integrated delivery of health and social services and improve population health. ACHs will be held accountable for performance results and rapid-cycle learning and improvement.
2. **Practice transformation support.** A Practice Transformation Support Hub will support providers across the state to effectively coordinate care, increase capacity, and benefit from value-based reimbursement strategies. Housed at the Department of Health (DOH), the Hub will capitalize on consultant and community expertise in clinical practice transformation. This investment area also supports shared decision-making tools to engage individuals and families in their health, and strengthens Washington's multi-disciplinary workforce.
3. **Payment redesign.** In partnership with purchasers, providers, and payers, Washington is leveraging its purchasing power to be the first mover in shifting 80 percent of the health care market from traditional fee-for-service to integrated, value-based payment models. Healthier Washington will implement four payment and delivery test models to integrate physical and behavioral health, pioneer new payment methodologies for the state's primary care and rural health delivery system, and apply the State's purchasing power to drive accountable delivery and payment models.

4. **Analytics, interoperability and measurement.** New analytical infrastructure for monitoring and reporting on health system performance will support broad deployment of common performance measures to guide health care purchasing. Healthier Washington invests in an innovative solution portfolio that builds analytic and measurement capacity and develops a diverse tool set needed for the translation and visualization of data from multiple sectors into actionable information.
5. **Project management.** Implementation is coordinated through a public-private leadership network with a dedicated interagency team and legislative oversight. Strategic investments in accountable project management ensure real-time evaluation and continuous improvement on all Healthier Washington initiatives.

Role of Washington SORH

The Washington State Office of Rural Health (SORH) met with the Washington State Hospital Association in September 2013 during the annual leadership team meeting and the two agencies determined there was a strong need for a clear proposal for how health care in rural communities could change to better meet the needs of each community while responding to healthcare reform.

"The New Blue H" project is Washington State's initiative to design a new rural community health system model and payment mechanism that meets the needs of individual communities, the goals of healthcare reform and the Triple Aim, and preserves healthcare services in rural areas. The "Blue H" refers to the road signs indicating the location of hospitals throughout WA. New models of care delivery will ideally cover the continuum of care from prevention and wellness to acute care and long term care to support health across the lifespan.

The Washington SORH also closely coordinates the Practice Transformation Support Hub, working to accelerate the availability of new and existing resources to support practice change.

Washington SORH is also assisting rural regions to understand and participate in Accountable Communities of Health to help them establish collaborative decision-making on a regional basis to improve health and health systems, focusing on social determinants of health, clinical-community linkages, and whole person care.

Finally, Washington SORH is working with stakeholders to develop a new payment delivery model for CAHs and one for RHCs/FQHCs. Seventy percent of RHCs are provider-based in Washington, and DOH wants to ensure that the independent RHCs don't get lost in the conversation.