

Scope of Work

Background

The mission of the RCs is to help practices transform to the PCMH model and provide high quality care in an efficient and cost-effective manner through the model. The RCs will be a regional extension of the IHC and in this capacity larger healthcare system. RCs will play a critical role in establishing and will facilitate, at the local level, the integration of PCMHs in the referral and communication protocols between the PCMH and other providers in the medical/health neighborhood, e.g., specialty care, hospitals, behavioral health, IHS and tribal programs, elder care services, social service organizations.

Regional Collaborative Development, Implementation, and Transition:

1. The PHD will provide leadership and convene, promote, and facilitate, a Regional Collaborative stakeholder group, with representation from PCMHs and the medical/health neighborhood, to promote learning, sharing of best practices, and peer support, among PCMHs and partners to improve population health within the region. Identify a Regional Collaborative representative that will participate on the Idaho Healthcare Coalition (IHC). The RC representative to the IHC will:
 - a. Advise the IHC on issues and initiatives within the region and seek programmatic support to address challenges, as needed.
 - b. Provide status reports on project progress and population health improvement strategies.
 - c. Seek resources through the IHC to address unmet technical assistance needs and resources for PCMHs and the medical/health neighborhood through the IHC.
2. The RC will use regional data to identify key public health initiatives to reach a broad spectrum of the region's population.
3. The RC will use community health needs assessment results to identify additional activities, services, and practice improvements needed to improve the community's health.
4. All RCs will share data, program efforts, successes, and challenges across all RCs through established IHC structures and communication pathways to identify evidence-based practices, improvement strategies, and educational resources.
5. The RC will evaluate community and regional data analytics reports provided by the data analytics contractor to identify population health issues develop improvement strategies and plans to address identified challenges, and reevaluate the data on an on-going basis to monitor progress and promote a system of on-going quality improvement.
6. All RCs will assist under-resourced primary care practices that need help in fulfilling the requirements of a PCMH by identifying opportunities for shared resources and serving as a communication facilitator across PCMHs.
7. All RCs will begin the process of creating a sustainability plan with input from all partners.

Patient Centered Medical Home (PCMH) Practice transformation support:

1. PHD staff will participate in training provided by the PCMH contractor to develop subject matter expertise in PCMH model requirements.
2. PHD staff will work closely with SHIP contractors to coordinate the support PCMHs receive in the region.
3. PHD staff will support primary care practices identified by the PCMH contractor not currently recognized by a PCMH certifying body and encourage adoption of the PCMH model through physician, practitioner, and medical/health neighborhood education.
4. PHD staff will identify NCQA recognized primary care practices and meet with staff to learn about and document best practice models for transformation.
5. PHD staff will meet with primary care practice staff and leadership at the PCMH to share information and resources available through the SHIP and promote opportunities to increase the PCMH recognition level.
6. PHD staff will collaborate with SHIP contractors to identify resources and technical assistance they provide to PCMHs to support transformation and quality improvement. This may include training and toolkits related to clinical quality improvement, evidence-based strategies, PCMH transformation, health information technology (HIT), and data analytics.
7. PHD staff will support PCMH data collection and reporting by connecting the PCMH to resources and expertise available through the HIT and data analytics SHIP contractor and IHDE or equivalent.
8. PHD staff will coordinate and support PCMH implementation by assisting PCMH contractor in the coordination of regional in-person training sessions.
9. PHD staff will assess the opportunity and need for Community Health Workers (CHW), Community Health Emergency Medical Services (CHEMS), and telehealth.
10. PHD staff will provide information to the PCMH about the behavioral health integration, resources and opportunities available through SHIP.

Medical/health neighborhood:

1. PHD staff will assume a key role in connecting the medical/health neighborhood to identify existing medical/health neighborhood resources for PCMHs and any unmet health, behavioral health, wellness and social service needs.
2. PHD staff will facilitate coordination and integration of services between the PCMH and the medical/health neighborhood.
3. PHD staff will educate PCMHs about CHW and CHEMS opportunities and link the practice to available resources. Follow-up and assess program development and implementation of CHW and CHEMS programs.
4. PHD staff will support CHW program implementation by assisting in the coordination of regional in-person training sessions at the RC.
5. PHD staff will promote the establishment and expansion of telehealth programs in rural PCMHs by providing information about available telehealth resources and on-site monitoring available through SHIP.

6. PHD staff will promote best practice strategies for the use of telehealth services and coordinate the sharing of specialty and behavioral health services among multiple PCMHs.