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Submit your entry by **January 31, 2017**.

## Applicant Information

**Name:** Stephanie Heaton, MPA

**Organization Name:** Health West, Inc

**Email:** sheaton@healthwestinc.org

**Website:** www.healthwestinc.org

## Contact Information

**Address:** 500 South 11<sup>th</sup> Ave, Suite 400

**City:** Pocatello

**State:** ID

**Zip:** 83201

**Phone:** 208-232-7862 X 1129

## Grant Information

**Organization's Annual Operating Budget:** ██████████

**Dollars awarded from your winning proposal:** \$61,000

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*I hereby authorize GrantStation to use my submitted information for*  
**THE WINNING GRANT PROPOSAL COMPETITION.**

*Name and Date:* Stephanie Heaton, 1/06/2017

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Submit your entry by **January 31, 2017**.

*Have any questions?*

Contact Jill Cochran, Marketing Administrative Specialist, at [jill.cochran@grantstation.com](mailto:jill.cochran@grantstation.com)



# Community Health Excellence (CHE) Grant Program Cover Sheet

Name of Organization Health West, Inc.  
Address 500 South 11th, Suite 400  
City, State, Zip Pocatello, Idaho 83204

Organization Tax ID# 82-0324100

Payment Address \_\_\_\_\_  
(if different) \_\_\_\_\_  
\_\_\_\_\_

Project Title Transforming Health Care One Patient at a Time  
Project Sponsor Stephanie Heaton, MPA  
Address (if different) Director of Grants and Special Programs  
Phone 208-232-7862 x1129  
E-mail sheaton@healthwestinc.org

Organization CEO/CFO/  
Executive Director  
submitting  
Letter of Support Mindy Benedetti, CEO

Funding Requested \$150,000  
Funding Category Continuous patient care improvements

Project Summary To expand the Care Coordinator approach to Collaborative Care between the patients, primary care teams, behavior health providers, local hospitals and other medical providers, and the local community.

## Community Health Excellence (CHE) Strategic Grant Program 2016-2017 Application Narrative

### HEALTH WEST, INC - ORGANIZATIONAL BACKGROUND

Health West's (HW) mission is to empower our patients and communities by proactively providing quality, affordable, patient-centered healthcare. Established in 1976, Health West, Inc. (HW) is a not-for-profit, Federally Qualified Health Center with clinics located in Aberdeen, American Falls, Chubbuck, Downey, Lava Hot Springs, Pocatello, and Preston. HW is the major primary care provider for medically underserved and uninsured persons in this area. HW has 12 providers, 21 residents, and about 10-15 preceptors on staff. HW provided affordable family medicine to over 17,000 patients in 2015, of which 32% had no health insurance, 92% of all patients have a family income below 200% of the Federal Poverty Level (FPL). For patients whose income is below 100% of the FPL, there is a nominal charge of \$20 for a basic office visit. Patients whose income is between 100% and 200% of the FPL pay an amount base upon a sliding fee schedule. The organization consists of 103 staff members and has a 15 person representative community Board of Directors.

Health West, Inc. is dedicated to providing high quality health care for all, regardless of a patient's ability to pay. We believe in:

- The human dignity and rights of each individual.
- The delivery of comprehensive ongoing care of the "Whole Person."
- Quality care which is defined as having concern for patient satisfaction delivered by appropriately licensed and certified clinical personnel.
- The need to provide services which are responsive to the cultural, clinical, and linguistic needs of the communities.
- The individuality of each employee and the need to foster an environment in which creativity and productivity are encouraged, recognized, valued, and rewarded.
- Conducting business practice with integrity and in accordance with recognized ethical standards as set forth for community centers.

The primary patient population can be described as low income, uninsured, medically underserved residents, and migrant/seasonal farm workers and their families, the elderly, persons with language and/or cultural barriers, and anyone else who has difficulty accessing quality health care. Health West offers an array of comprehensive primary and preventive care, diagnostic lab and radiology services, immunizations, obstetrical care, preventive dentistry, behavioral health, and limited pharmaceutical services. Health education, case management, prescription and eligibility assistance, outreach, and translation services support primary care delivery. Each clinic has the capability to provide bilingual primary health care, counseling, and health education services. Acute care with same day appointments for basic emergency services is provided, along with HIV/STD screening and family planning services. Immigration, sports, migrant head start, and DOT physicals are also performed at Health West. At Health West our greatest strength is our capacity to reach out and serve the local communities within our service area with a high standard of care. In the last 3 years, HW has been awarded 2 New Access Point grants to expand services to needy individuals in SE. The organization is in the transformational change process toward a more pro-active, team-based, and evidence-based model of care that works with its patients to achieve optimal health. In 2012, Health West became the first medical clinic in Idaho to have

all six clinics receive National Committee on Quality Assurance (NCQA) recognition for patient-centered medical care 2008 standards--level 3. In the last year Health West has achieved 2011 Level 3 National Committee on Quality Assurance (NCQA) recognition for patient-centered medical care for eight clinics. Health West is continually striving for quality improvement and continues to work towards each new level of NCQA Recognition for patient-centered medical care as they become available as a way to exemplify quality of care.

Being a FQHC, HW receives 330 Grant funding from Health Resources and Service Administration (HRSA) which account for about 30% of Health West's funding needs. This project: "***Transforming Health Care, One Patient at a Time***" will be co-managed by Stephanie Heaton, MPA, Director of Grants and Special Programs and Hilary Humpherys, RN, Director of Quality Improvement under the direct supervision of the Chief Medical Officer--Dr. Mark Horrocks. Both of these individuals have extensive back grounds in project implementation and quality improvement. (See Attachment 1: Biographical Sketches).

### **PROJECT DESCRIPTION**

At Health West our greatest strength is our capacity to reach out and serve the local communities within our service area with a high standard of care. In the last 3 years, HW has been awarded 2 New Access Point grants to expand services to needy individuals in SE Idaho. Health West is continually striving for quality improvement and continues to work towards improving the quality of care received at Health West. The organization is in a transformational change process moving toward a more pro-active, team-based, and evidence-based model of care that works with its patients to achieve optimal health. As we expand and move forward in providing our patients the most optimal healthcare, we have discovered two huge unmet needs—Patient Involvement and Care Coordination. Patients tend to believe going to the doctor will fix all their problems and in reality this is not the case. Collaboration between patient, primary care and behavior health care providers are necessary for the patient to achieve the highest level of overall health. Care Coordinators can help meet both of these needs. To ensure a close collaboration in a fully integrated system, Health West will hire two additional staff (licensed practical nurse, Medical Assistant, Social worker, or other qualified individuals) as Care Coordinators. These additional staff members will work with patients to help them navigate the existing Primary Care and Behavior Health system.

Currently at HW, each clinic has multiple teams made up of at least three members working toward total patient care (provider, nurse, medical assistant). Each patient is assigned to a specific provider who is responsible for the patients care coordination and oversight. The provider ensures that wellness and medical reconciliation needs are addressed by the health care team and monitors care coordination, as necessary. The provider utilizes evidence-based CPGs and engages patients actively in their health care, ensuring that self-management instructions are given at all appropriate opportunities and referrals are made to Health West behavior health providers or outside agencies when needed. Currently there are only four (4) care coordinators on staff to help the patient follow through with recommended treatment plans where we really need at least 12. The Health West Aberdeen and American Falls clinics need a bilingual Care Coordinator as at this time the existing 4 care coordinators are trying to help out those clinics when they can. Our hope it to hire enough care coordinators to add one to each primary care team at some point in the future. This funding opportunity will allow the addition of two (2) new care

coordinators to expand services currently offered at Health West. One bilingual care coordinator will work in the American Falls and Aberdeen Clinics and one care coordinator will manage ER diversions with three (3) local hospitals.

Over the past year the Director of Quality Improvement (DQI) has been working diligently with the local hospital PMC (Pocatello Medical Center) to get current information on ER visits of HW patients. In the last month this has become a reality. HW Care Coordinators receive not only HW patient's information but anyone in the community without a designated provider. Care Coordinators receive up to 50 notifications each day and efforts to contact individuals requires about 25% of their time. What this means is, they now have 25% less time to spend coordinating patient care for preventative screenings, health education, community service assistance, huddling with the care teams and just getting to know their patient panel. The ER diversion care coordinators will take over the ER diversion process and will triage the incoming ER notifications. Serious health issues of existing patients will be sent to their Care Coordinator to implement follow-up with the patients care team. The remaining notifications of ER visits will be handled by the new Care Coordinator in charge of ER diversion. This Care Coordinator will call the HW patient's and schedule a follow-up appointment and any other necessary needs these patients may have including an explanation of what type of services are best served in the ER and what type of services are best served in the clinic; why it is important to see your PCP and care team; and how patient involvement in their own care plan can improve their overall health. For those patients who are not HW patients, the care coordinator will make two (2) attempts to contact the patient by phone and then they will mail a letter telling the patient about HW and the services provided at HW including extended hours of service and same day appointment availability. The bilingual care coordinator will take over the American Falls and Aberdeen clinic needs.

The Centers for Medicare & Medicaid Services (CMS) has a separate payment under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services under Current Procedure Terminology (CPT) code 99490. CCM services are non-face-to-face care management/coordination services for certain Medicare beneficiaries having multiple (two or more) chronic conditions. At this time, HW is unable to collect these payments due to the inability to implement the electronic care plan module of SuccessEHS (HW current EMR). It is anticipated about 200 hours of IT work is needed to get this module up and running. HW is asking for 200 hour of IT salary to help get this module up. Once this module is working, providers can detail the electronic care plan necessary to meet CMS requirements. This additional module has the capacity to track the time spent with patients to be able to bill for the CPT code 99490. CMS recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. Being able to implement the electronic care plan and the time tracking system will enable HW to sustain the new care coordinators at the end of the project period through additional payments from CMS. Other benefits of this implementation will include minimizing provider time and increasing the ability of care coordinators to better manage patient care.

The third and final piece of the “**Transforming Health Care One Patient at a Time**” project will be to implement two (2) all staff meetings. These all staff meetings will assist in educating staff on the new processes, helping staff to understand changes in healthcare, helping staff to understand how important care management is the patient outcomes, and how each member of the team has an important in achieving these outcomes. Each meeting will have group activities, informational presentations, self-development workshops, highlights of HW accomplishments, and overall team building. Everyone will

leave feeling energized and excited about the changes in healthcare as the healthcare system moves from a pay for volume standard to a pay for performance and outcomes.

The new “**Transforming Health Care One Patient at a Time**” grant will expand healthcare teams. These teams include at least a provider, nurse, medical assistant, care coordinator, a mental health provider, front desk staff, and access to a whole community of opportunities. Each patient is assigned to a care team which is responsible for the patients care, coordination, and oversight. With the help of PacificSource Foundation, HW will add two Care Coordinators to complement the existing four Care Coordinators, improve HW’s existing EMR, and educate HW staff to achieve the following goal:

***GOAL: To expand the Care Coordinator approach to Collaborative Care between the patients, primary care teams, behavior health providers, local hospitals and other medical providers, and the local community.***

Outcome 1: Reducing ER visits thereby reducing overall health costs

Outcome 2: Engaging patients and their caregivers/families in patient care

Outcome 3: Change treatment according to evidence-based algorithm if patient is not improving

Outcome 4: Systematic diagnosis and outcomes tracking by care coordinators

Outcome 5: Improve outcomes and quality of life for HW patients all of Southeastern Idaho

There is growing recognition that many health problems are affected by behavior health problems. Primary care clinicians see a significant proportion of common symptoms such as fatigue, abdominal pain, and back pain for which can be identified by common mental and behavioral conditions such as depression, anxiety, and substance use. Integrating behavior health care and primary care enhance a more patient-centered approach to care. In an integrated system the care coordinator would see patients for 5 to 15 minutes discuss behavior health issues, which may be affecting the patient’s chronic health problems. This process can occur using a Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Community Health Centers provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

This same process can be used for many different types of medical and/or behavior issues patients might have while working with their care coordinators. With the additional of two care coordinators, Health West will nearly double the number of patient encounters. During these visits, the care coordinators will help patients to determine not only their roll in achieving better health, but other community opportunities available to gain a healthier life style. As we know, depression is an independent cause of

morbidity can co-occur with chronic disease and potentially worsen its effects. Health risk behaviors such as smoking or leading a sedentary lifestyle are associated with increased morbidity and mortality from chronic diseases. Depression can be associated with health risk behaviors, potentially contributing to chronic disease risk. For example, overeating may cause weight gain, a major risk factor for diabetes. Fatigue or feelings of worthlessness may cause you to ignore a special diet or medication plan needed to control your diabetes, worsening your diabetes symptoms. Studies have shown that people with diabetes and depression have more severe diabetes symptoms than people who have diabetes alone. In addition to possibly increasing the risk for depression, diabetes may make symptoms of depression worse. The stress of managing diabetes every day and the effects of diabetes on the brain may contribute to depression. In the United States, people with diabetes are twice as likely as the average person to have depression.

Armed with these results, the patient's primary care physician will work with a care coordinator to develop and implement a treatment plan (medications and/or brief, evidence-based psychotherapy when needed). The care coordinator will assist the patient in following through treatment plans on behavior health and chronic health care services to improve patient outcomes. At this time, nearly all Health West clinics have behavioral health staff on site. The integration of behavioral health and primary care into a *coordinated model of care* is essential for Health West patients to truly take control of their own quality of life.

### Challenges

The biggest challenges facing Health West is funding to implement the needed changes and finding just the right people for the care coordinators and the funding to pay for them. Health West will continue to look for funding opportunities to grow this program and our plan is to hire the right people to become our team care managers. The care managers will need to possess several qualities to be the appropriate 'fit'. First, they will need to have familiarity with the medical system, work well in a team context, and be committed to serving our patients. They will need to be highly motivated and with a persistent nature in seeking the information needed. They will need to be highly organized and possess strong communication skills. As for the funding challenges, Health West will continue to look for support to implement and expand the program at Health West. We can also hope for changes in the payment structure and the expansion of Medicaid in Idaho to help support this closely collaborated and fully integrated style of healthcare making the patient the most important member of the healthcare team and fully engaged in their healthcare outcomes.

### Innovation

The most innovative aspect of a *coordinated model of care* is the roll of the patient. The patient is the most important member of the team. Coordinated healthcare requires building and strengthening relationships among all those involved in the patient's care: between patient and primary care provider, patient and behavioral health provider, patient and care coordinator, and between providers. At its most fundamental, the integrated model of care is collaboration between primary care provider, behavioral health provider, and the patient. HW is a functioning Patient Centered Medical Home (PCMH) where our goal is to coordinate all of our patient's health care needs into one successful and understandable plan.

- HW is committed to the “Whole Person” and uses a Team approach to each individual patients health care needs where the patient and their physician work together
- Quick access to appointments, with easy-to-understand answers to patient health care questions
- Help with patient concerns about health care costs, tests, prescriptions, insurance coverage, and referrals to specialists
- Helpful information to help manage patients health care issues at home

The Care Coordinator will work to keep the patient highly motivated and ensure the patient is involved with the care team as the patient is the most important member of the team. By learning new behaviors, through education and motivational learning, and with medication management; each patient will take charge of their own healthcare and improve their quality of life. This is a very innovative approach to care and it will open doors to new services and opportunities for the future at Health West. Currently in Southeastern Idaho there are a very limited number of services available for low income and uninsured individuals. This project will bring to light the need for additional services needed for this population and will assist Health West care teams in patient management.

### **Collaboration**

Collaboration is critical for the delivery of healthcare services in rural areas. Health West has a community advisory board, which was formed to provide insight and oversight for the development and implementation of the integrated model of primary and behavioral health care. Health West has negotiated agreements with all the local hospitals in our service areas. We have a long standing relationship with Portneuf Medical Center, Bingham Memorial Hospital, Franklin County Medical Center, and Power County Hospital District. We will be working on ER diversion with all local hospitals through care coordination.

- **What the project is trying to accomplish?**

Health West is trying to improve care for Southeastern Idaho by expanding care coordination as described above in the Goal and Outcomes listed above.

- **What changes are being proposed by the project?**

As described above, HW will add 2 care coordinators to 1) expand care coordination services to American Falls and Aberdeen, 2) Implement ER diversion, and 3) Add SBIRT screening; Enhance existing EMR to assist in care management and care management sustainability; Educate HW staff on the changing health care system and improve team based care.

- **Who is the targeted patient population?**

The primary patient population can be described as low income, uninsured, medically underserved residents, and migrant/seasonal farm workers and their families, the elderly, persons with language and/or cultural barriers, and anyone else who has difficulty accessing quality health care.

- **How will the project benefit the lives of the patient population?**

The project will improve overall patient health by improving care coordination for chronically ill patients, increase preventative screening and services, increase EMR utilization, reduce healthcare costs, and help the patient to take control of their own health by becoming more involved in their healthcare.

- **What are the emerging best practices and / or evidence-based guidelines upon which the project is based?**

Developed more than a decade ago, the Chronic Care Model (CCM) is a widely adopted approach to improving ambulatory care that has guided clinical quality initiatives in the United States and around the

world. Accumulated evidence appears to support the CCM as an integrated framework to guide practice redesign. CCM is cost-effective and leads to improved patient care and better health outcomes.

- **What are the known existing collaboratives or initiatives of which this project is similar?**

In Calendar Year (CY) 2015, CMS began making separate payment under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services under Current Procedure Terminology (CPT) code 99490. CCM services are non-face-to-face care management/coordination services for certain Medicare beneficiaries having multiple (two or more) chronic conditions.

- **What are the unique traits and capabilities of the organization that will be employed for success related to this project?**

Health West is unique in that as an FQHC, HW has access to many of the needy individuals in Southeastern Idaho with clinics, providers, policies, and processes already in place which will make implementing this project easy. HW has over 40 years of experience providing healthcare and implementing projects to improve access and care for all community members.

- **What are the ways different clinicians, hospitals, or other members of the community will share in the learning of your project?**

Health West has existing collaborations with all local hospitals and clinicians in the area. HW also is part of the Idaho SHIP grant cohort and works with providers and other FQHC's across the state. Several times a year HW meets with IPCA, SHIP, and other agencies to discuss best practices and grant projects each organization is implementing or participating in. These interactions will help with the dissemination of outcomes of this project.

### **Ambulatory Care Patient Categories**

As mentioned above the project will improve overall patient health by improving care coordination for chronically ill patients, increase preventative screening and services, increase EMR utilization, reduce healthcare costs, and help the patient to take control of their own health by becoming more involved in their healthcare. Improved care coordination will assist all ambulatory care patients in receiving better overall healthcare. This project will address: Newborns, Children, including those with asthma, diabetes, or other chronic conditions, Pregnant women, Adults with diabetes, asthma, CHF, COPD, or other chronic disease conditions, Adults in need of mental health or chemical dependency services, and Adults in need of preventative care services.

### **Measurements**

- **What are the measurements that will provide an indication that the project objectives have been met?**

HW will monitor two (2) chronic disease management measures: diabetes and hypertension and two (2) preventative screening measures: cervical cancer screening will increase from 42.7% to 50% by the end of the project and colorectal cancer screening will increase from 31.3% to 40% by the end of the project. Health West feels confident we can reach a goal of 75% of diabetic patients whose HbA1c levels are less than 8 percent, less than or equal to 9 percent, or greater than 9 percent will maintain a controlled HbA1c level. (Baseline 67.42% -2015 UDS data report.) Through care coordinators efforts, HW patients diagnosed hypertension whose most recent blood pressure was less than 140/90 will raise from 61.36% to 65% by the end of the project. Current baseline data was obtained from the 2015 UDS report submitted to HRSA 2/2016)

- **Are the measures to be used process measures or outcome measures?**

The four (4) measures to be tracked are outcome measures that can be affected by processes and changes in those processes. The Director of Quality Improvement gathers and reports the data on indicators and compliance within these goals. This continuous monitoring enables HW to identify trends, successes, and/or problems in a timely manner. Then, using quality improvement processes such as Plan-Do-Study-Act cycles, improvements can be made. This allows for rapid cycles with improvements reported to the monthly organization Quality Team meeting.

- **Are the measures relatable to any best-practice or evidence-based care guidelines?**

Yes all measures are relatable to best-practice and evidence-based care guidelines as required by HRSA for receipt of 330 grant funding.

- **What method and tools will be used to collect data?**

Health West’s EMR-SuccessEHS and a data management system-i2i are used to collect data. Both systems are validated and approved for data reporting by CMS for Meaningful Use reporting and by HRSA for UDS reporting.

- **Who will collect the data?**

Data is collected by the HW data analyst and the DQI both have significant training in data collection.

- **What are the dependencies (consultants, outside staff, systems, planned system upgrades, etc.) upon which data collection is reliant?**

Health West’s EMR-SuccessEHS and a data management system-i2i are used to collect data. Both systems are up dated regularly by both vendors and it is HW policy to implement new upgrades as soon as they are available.

**Timeline**

Award:	November 1, 2016
Begin search for Care Coordinators:	November 1, 2016 –December 31, 2016
New Care Coordinators begin work:	ASAP completed by December 31, 2016
Begin IT work on new care plan:	November 1, 2016 – January 15, 2017
Implement training for new electronic care plan:	January 15, 2017- February 15, 2017
Implement new electronic care plan:	February 15, 2017 –March 15, 2017
1 <sup>st</sup> All Staff Meeting	February, 2017
Ongoing progress reports	As required
Mid-year progress report with data	May, 2017
Review data monthly and make adjustments to Work plan	As needed
2 <sup>nd</sup> All Staff Meeting	August 2017
Final Report	November 2017
Collaboration Conference with Presentations	January-February 2018

**Sustainability**

The Centers for Medicare & Medicaid Services (CMS) has a separate payment under the Medicare Physician Fee Schedule (PFS) for chronic care management (CCM) services under Current Procedure Terminology (CPT) code 99490. Being able to bill for the CPT code 99490 will generate enough income to sustain the two care coordinator positions and possible allow HW to add additional care coordinators. Care coordination is the key to implementing change in the way providers deliver healthcare. Health West is transforming into a more pro-active, team-based, and evidence-based model

of care that works with its patients to achieve optimal health which will match the payment structure changes being implemented by CMS. In addition, HW will continue to apply for additional funding opportunities to help supplement and sustain this program.

### **Organizational Strategic Plan**

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. It is a main element in Health West's Strategic Plan (Goal5: Ongoing Quality Initiatives) to improve the quality of services given to our patients and to help diminish **Health disparities** in the populations we serve. Health West will transform the health care experience through a culture of caring, quality, and patient-centered service. We will be recognized by employees, providers, patients and the community as the best place to work, practice medicine and receive care. We will be an organization of people working together to do the right thing every day to improve the well-being of our communities.

### **Success Dependencies**

Funding is critical to making this project a reality. Although the program changes described in this application will happen at some point, the sooner funds are acquired the sooner this higher level of quality services can make available. Patients will begin to take part in their care and achieve a higher quality of life.

The biggest challenges facing Health West is funding to implement the needed changes and finding just the right people for the care coordinators. Health West will continue to look for funding opportunities to grow this program and our plan is to hire the *right people* to become our team care coordinators. The care coordinators will need to possess several qualities to be the appropriate 'fit'. First, they will need to have familiarity with the medical system, work well in a team context, and be committed to serving our patients. They will need to be highly motivated and with a persistent nature in seeking the information needed. They will need to be highly organized and possess strong communication skills.



July 27, 2016

PacificSource Charitable Foundation  
110 International Way  
Springfield, Oregon 97477

Mr. Peter McGarry:

I would like to express our gratitude to the PacificSource Charitable Foundation for taking the time to review Health West's application for the Community Health Excellence Program. This application will fit well within the organization mission of Health West to providing high quality health care for all regardless of an individual's ability to pay. Health West is dedicated to providing the highest quality of care to all patients and the goals of this funding opportunity will align well with our Strategic Plan in the area of Quality Improvement as we work towards meeting the Healthy American 2020 standards of health for all Americans.

It is Health West's goal to significantly improve patient outcomes in all Health West clinics and participating in the grant opportunity will help us get there. I am in full support of Health West's application for the Community Health Excellence Program.

Sincerely,



Mindy Stosich-  
Benedetti, MBA Chief  
Executive Officer  
Health West, Inc.

ATTACHMENT 1: BIOGRAPHICAL SKETCHES

Director of Quality Improvement, Hilary Humpherys, RN

Director of Grants and Special Programs, Stephanie Heaton, MPA

ATTACHMENT 2: CMS CODE 99490

Additional information found at:

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

## Biographical Sketch

<b>Stephanie Heaton</b>		<b>Director of Grants and Special Programs</b>	
Education /Training			
Institution & Location	Degree	MM/YY	Field of Study
<b>Idaho State University</b>	<b>MPA</b>	<b>2009</b>	<b>Master of Public Administration emphasis in State, Local, and Non-Profit Administration</b>
<b>Idaho State University</b>	<b>BBA</b>	<b>1994</b>	<b>Business Administration with emphasis in Finance and Accounting</b>

### Personal Profile:

Stephanie has 10 years of experience in grant management and project implementation with a passion for Health West’s mission and a desire to inspire others to advance that mission. Stephanie has a proven record of accomplishment in project management by leading comprehensive program strategies in support of organizational goals and objectives. She has strong analytical and planning skills which, when combined with self-motivation and high energy, makes her an articulate communicator and a verifiable talent for maintaining successful operations. With an eye for details and reaching the highest goals, Stephanie is key to Health West meeting program goals.

### Positions:

<b>Director of Grants and Special Programs</b>	2013-Present
Health West Inc., Pocatello, ID	
<b>Grant Specialist</b>	2011-2013
Family Health Service, Twin Falls, ID	
<b>Grant Project Coordinator</b>	2008-2011
Institute of Rural Health, ISU, Pocatello, ID	
<b>J &amp; M Contracting, Pocatello, ID</b>	1995-2009
Pocatello, ID	

### Awards and Certificates

- NCQA Certified Content Expert for Patient Centered Medical Home
- Certified CDBG Grant Administrator 2014-18
- Certificate in Proposal Preparation –State Offices of Rural Health, 2012
- Certificate in Proposal Writing – Fort Hays State University, 2012

## Biographical Sketch

<b>Hilary Humpherys</b>		<b>Director of Quality Improvement</b>	
Education /Training			
Institution & Location	Degree	MM/YY	Field of Study
<b>Eastern Idaho Technical College</b>	<b>LPN</b>	<b>2010</b>	<b>Practical Nursing</b>
<b>Eastern Idaho Technical College</b>	<b>ADN</b>	<b>2012</b>	<b>Registered Nursing</b>

**Personal Profile:**

Hilary has 20 years of experience in health and human services. Hilary has always chosen positions where she could make a difference. Her work experiences include: adult med/surgery, urgent care, clinical cardiology, behavioral health, pain management, and primary care. She joined Health West in 2014, and found working in a community health center to be the most challenging and rewarding position yet. Over the past year in Quality Improvement, her duties have included increasing HW’s chronic disease management program through the development of a care coordination program which is working to improve the quality of care for HW patients. In addition, Hilary has been working to building strong relationships with local hospitals and providers in the HW service area to help defer emergency room visits, and building an overall healthier community in Southeastern Idaho.

**Positions:**

<b>Director of Quality Improvement</b>	2015-Present
Health West Inc., Pocatello, ID	
<b>Registered Nurse</b>	2014-2015
Health West Inc., Chubbuck, ID	
<b>Licensed Practical Nurse / Registered Nurse</b>	2010-2014
Portneuf Medical Center, Pocatello, ID	
<b>Licensed Practical Nurse / Registered Nurse</b>	2011-2013
Mountain View Hospital, Idaho Falls, ID	
<b>911 Dispatcher</b>	2000-2014
Bingham County Sheriff Office, Blackfoot, Idaho	
<b>Certified Nurse Assistant</b>	1996-2000
Pocatello Regional Medical Center, Pocatello, Idaho	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



## Chronic Care Management Services

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.

**Please note:** The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for **non-face-to-face** care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. CPT 99490 is defined as follows:

99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:



- ▶ Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- ▶ Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- ▶ Comprehensive care plan established, implemented, revised, or monitored.

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## **Stephanie Heaton**

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**From:** Peter McGarry <Peter.McGarry@pacificsource.com>  
**Sent:** Wednesday, September 21, 2016 11:19 AM  
**To:** Stephanie Heaton  
**Subject:** FW: CHE program HealthWest  
**Attachments:** Health West, Inc. CHE applicaiton 2016-17.pdf

Stephanie,

Congratulations, your application was approved for funding via the PacificSource Community Health Excellence program. The approved funding amount is \$61,000 ... significantly less than the amount you requested in your application and consistent with the thought of our funding 1 of your Care Coordinators. I'd like to get your confirmation that you'd be able to move forward based on this grant amount. Please let me know and again, congratulations for this successful application.

Peter

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**From:** Stephanie Heaton [mailto:[Sheaton@healthwestinc.org](mailto:Sheaton@healthwestinc.org)]  
**Sent:** Friday, July 29, 2016 1:58 PM  
**To:** Peter McGarry <[Peter.McGarry@pacificsource.com](mailto:Peter.McGarry@pacificsource.com)>  
**Subject:** CHE program HealthWest

Peter,  
Please find Health West's application for the CHE program. If you have any problems with the attachment or if you have any questions about our proposal, please do not hesitate to contact me.  
Thank you for supporting healthcare initiatives in our community.

Sincerely,  
Stephanie

Stephanie Heaton, MPA  
Director of Grants and Special Programs  
Health West, Inc.  
500 South 11<sup>th</sup>, Suite 400  
Pocatello, ID 83201  
208-232-7862 ext. 1129