C3

Community Care Coalition Initiative

Program Highlight

Project Period March 7, 2016 - April 30, 2017

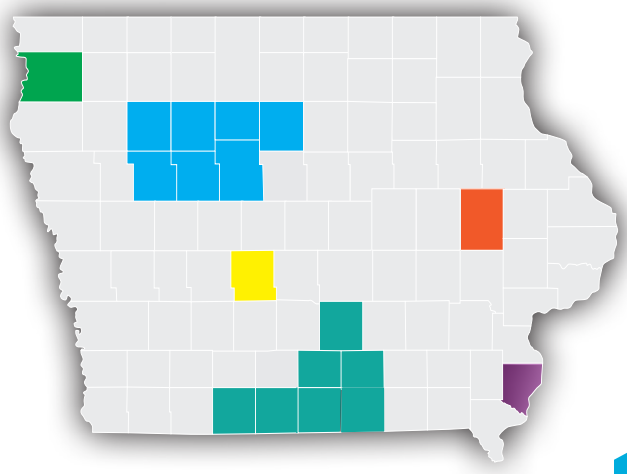
State Innovation Model Overview

The goal of the State Innovation Model (SIM) grant is to assess whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored Health Care Innovation Plan. This plan must improve health; improve the quality of care; lower costs for citizens through a sustainable model of multi-payer payment and delivery reform; and deliver the right care, at the right time, in the right setting. The Center for Medicare and Medicaid Innovation (CMMI) has created the SIM initiative for states that are prepared for or committed to planning, designing, testing and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. Iowa's SIM grant focuses on the following three aims:

- Improve population health
- Transform health care
- Promote sustainability

Community Care Coalition Overview

Six Community Care Coalitions (C3s), spanning 19 counties, engage in broad-based health care system reform to improve 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 to prepare their community and the health care delivery system for payment reform. Click on each link to learn more about the C3s!



Community Health Partners of Sioux County
Dallas County Public Health Nursing Services
Great River Medical Center
Linn County Board of Health
Marion County Public Health
Webster County Health Department

Iowa Department of Human Services

IDPH

Iowa Healthcare Collaborative

IOWA SIM
State Innovation Model of Iowa

July 2017

Grant Information: Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

Community Health Partners of Sioux County

Project Director:	Kim Westerholm, Community Health Partners of Sioux County
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Service Area:	Sioux County
Population:	34,937

The Sioux County C3 is led by Community Health Partners (CHP) of Sioux County, the local public health agency for Sioux County and non-profit agency led by administrators of the four hospitals in Sioux County as well as additional community members with expertise in nursing and business. This arrangement makes partnerships and collaboration on a county wide level the primary approach for responding to health needs.

C3 Structure

CHP provides a neutral, non-competitive environment in which the hospitals come together to work on issues that are of concern to their facilities, their employees and the communities they serve. As a result of this collaborative leadership, CHP subcontracts SIM funds for an embedded community care coordinator at 0.4 FTE at each hospital. To ensure sustainability, most embedded care coordinators were already a part of the health care team at each hospital, and all care coordinators have a variety of other roles within the healthcare system outside of community care coordination.

The C3 steering committee is led by CHP, as a neutral partner outside the clinical health care delivery system. The steering committee includes members from each of the four hospitals, the Latino Health Coalition, Promise Community Health Center and a member of the community. CHP has been very strategic in regards to adding Steering Committee members to ensure the appropriate member from each organization is identified to ensure maximum engagement from each partner. In addition to the Steering Committee, the CHP C3 maintains an active role in existing coalitions, including a social services provider coalition and community coalitions.

Year 1 Major Projects

» Training was provided to community care coordinators in each of the four hospitals. Embedded care coordinators in each hospital and public health attend monthly meetings to discuss best practices, develop pathways for making referrals and share resources. This communication has helped to improve referral processes within all four hospitals. Attending the same training and monthly meetings ensures a standardized process for addressing clinical and social needs in Sioux County. Additional initiatives with the embedded care coordinators include:
  - Data reporting and tracking processes to ensure consistent reporting for the C3;
  - Process improvements in workflow within each health system to identify referrals to the embedded care coordinators through hospital discharge processes;
  - Processes to monitor and follow up on readmissions and emergency room visits;
  - Processes to screen for body mass index (BMI), and develop action plans and provide resources to patients referred for obesity;
  - Processes to record A1c values in individuals with diabetes and assure access to resources for diabetes management as applicable

» CHP increased referrals to the National Diabetes Prevention Program (NDPP) through the C3 Initiative. Two of four hospitals have developed referral plans to use within their care systems and one community significantly increased referrals through media coverage and increased awareness. The NDPP will begin to collect referral source with participant registration information to assess additional ways to increase referrals.

» A quality improvement cycle was initiated on routine BMI assessments and communication with patients about health risks associated with increased BMI.

Community Health Partners of Sioux County (cont'd)

Data Collection, Use, and Analysis

Community-level data

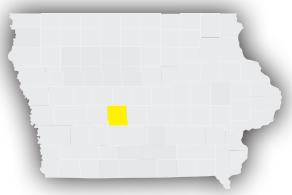
CHP uses community level data from a variety of secondary data sources such as the Iowa Public Health Tracking System, County Health Rankings, and the U.S. Census Bureau to track health issues of concern to the community including obesity and diabetes rates.

Clinical data

Use of clinical data is limited to within each of the four health systems in the service area. Because each hospital utilizes a different electronic health record (EHR) and belongs to a larger health system, access to data specific to the C3 that is comparable across all hospitals is not possible at this time.

Population health management

Currently CHP and the embedded care coordinators utilize a paper tracking system, as the initial referrals were quite low. As referrals and workloads have increased for the care coordinators, CHP will be researching potential information technology systems to track referrals for social needs.



Dallas County Public Health Nursing Services

Project Director:	Jennifer Walters, Dallas County Public Health Nursing Service
Project Director Contact:	jennifer.walters@dallascountyiowa.gov
Service Area:	Dallas County
Population:	80,133

The Dallas County C3 Initiative is led by Dallas County Public Health Nursing Services (DCPHNS). DCPHNS provides leadership and direction in the development and implementation of a community health plan which promotes and conserves the health of the public. DCPHNS assumes responsibility of identifying and addressing the health needs of the community.

C3 Structure

DCPHNS implemented the Health Navigation program in 2010. Health Navigation serves as a single point of entry to connect residents of Dallas County to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education or ethnicity. The Health Navigation program serves as the hub to bridge the gap between clinical care and community resources to meet the health and social needs of residents.

DCPHNS facilitates a steering committee to provide leadership in coordinating services between local clinical providers and provides leadership to a Community Coalition, which implements community projects to address barriers that residents face. Clinical partners and community based organizations refer clients to the Health Navigation program for assistance in accessing additional resources and services, including but not limited to health insurance, food, housing, employment, transportation, parenting/childcare, medical home and behavioral health services. Residents may also self-refer to the program.

Dallas County Public Health Nursing Services (cont'd)

Year 1 Major Projects

» DCPHNS Implemented and/or sustained a variety of projects to promote community access to healthy food and physical activity, including:

- Increased access to local food pantries through expansion of service area, assessment of hours and availability, and enhanced marketing;
- Promotion of healthier concession stand offerings, implementing healthy corner stores, and piloting the Double Up Food Bucks program; and
- Implementation of a Walking School Bus, educated municipal leaders on the importance of shared-use agreements, and the referral of clients to specific physical activity programs.

» Access to transportation was increased by implementing a voucher program and supporting a new volunteer driver program, *SAIL-DC*, which now provides free transportation services to Dallas County residents.

» Implementation of systems-level changes to reduce smoking, including policies within the volunteer driver program, local pharmacy, and tobacco-free parks ordinance in West Des Moines.

» DCPHNS offered and promoted community-based diabetes education programs, including Everyone with Diabetes Counts (Telligen) and Diabetes Prevention Program (YMCA Healthy Living Center) when applicable.

» Increased availability of community resources and established processes for identifying and referring Health Navigation clients, including adding a Health Navigator at the food pantry/free clinic in Waukee, developing communication methods with care coordinators at several clinics, and serving over 400 unduplicated clients through the Health Navigation program.

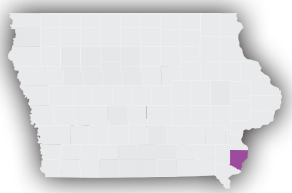
Data Collection, Use, and Analysis

Clinical data

Clinical data was collected directly from Unity Point, Mercy, Primary Healthcare, and The Iowa Clinic for Dallas County residents to assess needs and inform interventions. Specifically, Hemoglobin A1c, body mass index (BMI), blood pressure, tobacco use, zip code, and insurance information was collected, aggregated,and shared with the C3 steering committee.

Population health management

DCPHNS utilizes a custom made Health Navigation Database developed by Salesforce to capture, track, and report all Health Navigation data. The database captures barriers identified by clients to leading healthy lives, and is used to inform community programs and initiatives. The database has a provider-facing component in which providers can directly enter referrals for Health Navigation; however to date, providers prefer to fax referrals per their own clinic flow and processes.



Great River Medical Center

Project Director:	Jake Tanumihardjo, Great River Medical Center
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Service Area:	Des Moines County
Population:	40,055

Great River Medical Center (cont'd)

Great River Medical Center (GRMC), a part of Great River Health Systems (GRHS), is a community-based, not-for-profit, regional referral hospital in West Burlington, Iowa, that has served the area for 120 years. GRMC, Des Moines County Public Health (DMCPH), and the Southeast Iowa Regional Planning Commission (SEIRPC) are the three anchor organizations collaborating to lead the C3 Initiative.

C3 Structure

GRMC, DMCPH and SEIRPC recognize the community's health issues, seek to understand the needs of the target populations, and are committed to working together to achieve a "culture of health" in Des Moines County. GRMC, DMCPH and SEIRPC act as the anchor agencies for Des Moines County Living Well, which serves as the foundation for the C3 Steering Committee, vision and mission.

In year 1, the Des Moines County C3 focused on establishing a framework for community collaboration, including a focus on leadership and partnership building. The C3 is comprised of a primary steering committee with community partners, and several subcommittees to address each of the target areas of the C3 and those highlighted in a joint Community Health Needs Assessment between GRMC and DMCPH.

Year 1 Major Projects

- Subcommittees were developed address each SIM target area and focus areas highlighted in the Community Health Needs Assessment
- The C3 supported DMCPH in implementing a National Diabetes Prevention Program.
- Two trainings were provided on Social Determinants of Health from the University of Iowa College of Public Health: one to community members and one to medical providers. Both trainings were well-attended and greatly enhanced the knowledge and understanding by medical providers and community leaders of the impact of Social Determinants of Health on all health outcomes.
- With assistance from the Iowa Primary Care Association (IPCA) and the University of Iowa College of Public Health, a focus group of service providers and health care staff was organized by C3 staff to develop feasible action plans to address local social determinants of health concerns. Educators, community service providers, hospital and FQHC staff were in attendance.
- GRMC staff and C3 staff participated in a Kaizen event facilitated by the Iowa Healthcare Collaborative to discuss preventable readmissions. The event resulted in planned process changes, including pharmacy access, care access, inclusion of social determinants of health into care, and adoption of patient-centered medical home model for high risk patients.
- The need for community resource coordination was assessed, and potential information technology systems were identified to support this as well as supporting community care coordination.
- Compiled and updated a standardized resource matrix of community-based services and updated an existing community resource directory available at the local public library. A process to keep the resource matrix updated is being discussed.

Data Collection, Use, and Analysis

Community-level data

Census data was mapped and shared with community partners. Data from County Health Rankings was presented at multiple community venues including steering and subcommittee meetings. School district data on disparities in the local school system was made available for presentation use by C3 partners.

Clinical data

GRMC has direct access to clinical data within the health system and the ChimeMaps system.

Population health management

GRMC has reviewed several data systems to coordinate population health management and referrals for social determinants of health. To date, a usable system has not been identified, though the C3 continues to engage in discussions regarding the most efficient way to collect this information.

Linn County Board of Health

Project Director:	Cynthia (Cindy) Fiester, Linn County Public Health Department
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Service Area:	Linn County
Population:	219,916

Linn County Public Health (LCPH) is a neutral convening agency for community wide health efforts. As the lead entity for the CHNA/HIP process and the Linn County C3, LCPH used an existing steering committee from a previous project as a starting point for the C3, and has continued to add new members throughout the project period.

C3 Structure

The primary challenges faced in Linn County are the wide variety of community and health care resources and lack of a centralized system, process, or entity to monitor gaps and duplication. The main priority for the LCPH C3 during year 1 was to build a single coalition of all providers, develop and strengthen partnerships, and identify a process or system to ensure a coordinated system of care for Linn County residents.

The C3 is currently working to determine the most effective structure for community care coordination. This structure will need to work for all community partners and two local major health systems.

Year 1 Major Projects

- An engaged coalition was established with representation from community-based organizations, competing health care systems and safety net healthcare providers.
- A system to coordinate care for individuals with social needs was identified. The identified system has support and buy-in from a variety of community members who will use the system. LCPH continues to work with community partners to secure sustainable financial support for the system outside of the C3 grant.
- A sustainability subcommittee was developed, which will help with implementation and adoption of the care coordination system right away, and beyond the C3 grant period.
- A partnership with the local YMCA Diabetes Prevention Program was established to increase referrals to the program.
- Community assessments were conducted to determine the availability of tobacco, obesity and diabetes programs in the service area. The results of these assessments were shared with community partners, prompting discussion of the most effective way to increase referrals to and knowledge about these resources.

Data Collection, Use, and Analysis

Community-level data

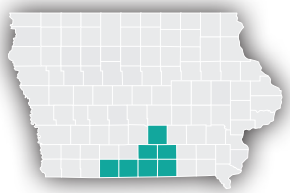
LCPH utilizes a variety of community data sources, including community assessments and the Behavioral Risk Factor Surveillance System (BRFSS).

Clinical data

Access to clinical data has been a barrier for LCPH due to restrictions from hospitals and lack of access to data beyond the zip code level.

Population health management

The LCPH C3 will be implementing TAVhealth for population health management and care coordination for social needs. Selecting this system was led by the C3, however all community partners and health care systems are on board with using the system and supporting sustainability of the system beyond the C3.



Marion County Public Health Department

Project Director:	Larissa Van Donselaar, Marion County Public Health Department
Project Director Contact:	lvandonselaar@marionph.org; 641.828.2238 ext. 226
Service Area:	Marion, Lucas, Monroe, Ringgold, Decatur, Wayne, and Appanoose Counties
Population:	82,151

Marion County Public Health Department (MCPHD) has a long history of serving families and the community at large. MCPHD is a comprehensive public health department, whose philosophy defines health broadly, and recognizes the strong influences of the social determinants of health. MCPHD focuses on public health.

C3 Structure

The MCPHD C3 service area includes the surrounding six counties and coincides with the Mental Health Redesign region. Each county within the service area has a critical access hospital and their own individual public health and health care system. MCPHD serves as a neutral partner to provide infrastructure and resources to each county in the service area and assist in breaking down silos and communication barriers to promote a coordinated system of care.

The MCPHD C3 Steering Committee includes clinical and community-based organization representatives from all seven counties in the service area. The MCPHD C3 director and care coordination staff also attend existing coalition and provider meetings in each county to assure consistent communication and engagement in the C3 initiative. This allows MCPHD to continue building and strengthening partnerships with providers and community resources while utilizing an existing infrastructure within each county in the service area.

MCPHD serves as the "no wrong door" entity for care coordination for a variety of programs, and will continue to serve as this entity for all individual with social needs in the service area. Milestones Area Agency on Aging (AAA), Decatur County Hospital and Public Health, Community Health Centers of Southern Iowa, and Knoxville Hospital and Clinics also provide this service for specific counties within the service area.

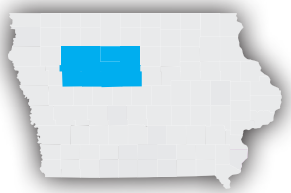
Year 1 Major Projects

- The Marion County C3 hosted a Social Determinants of Health Workshop with 60 attendees and representation from many disciplines and all counties in the C3 service area. The training was successful in identifying needs specific to the service area.
- A variety of partners throughout the service area began operating as a "no wrong door" entity for care coordination, including the AAA, multiple hospitals, and a Community Health Center.
- The use of Marion County Public Health Department's existing population health management system, TAVhealth, was enhanced by increasing the number of partners utilizing the system and improving the existing resource directory to include resources for all counties in the C3 service area.
- Partners in the service area were supported in their efforts to launch National Diabetes Prevention Programs (NDPP). Two NDPP sites were initiated, with each site facilitating two cohorts.

Data Collection, Use, and Analysis

Population health management

MCPHD has utilized TAVhealth since 2015 and will continue to utilize this software to coordinate social needs for individuals in the service area. MCPHD can obtain aggregate reports on identified needs in the service area and gaps in services.



Webster County Health Department

Project Director:	Kari Prescott, Webster County Health Department
Project Director Contact:	kprescott@webstercountyia.org; 515-573-4107
Service Area Counties:	Buena Vista, Calhoun, Hamilton, Humboldt, Pocahontas, Sac, Webster, and Wright
Population:	121,929

The Webster County Health Department (WCHD) C3 includes an eight county region in Central Northwest Iowa. These counties are included in the Next Generation Accountable Care Organization (ACO), which brings together health professionals, social service, business, government and other entities to improve health outcomes. In addition to working closely with providers in the ACO, the WCHD C3 works with the critical access hospitals, Federally Qualified Health Centers and other community-based organizations.

C3 Structure

The WCHD utilizes a tri-navigational model in coordinating care. This model recognizes that individuals may have different health/social determinant needs, which consequently require different medical homes with distinct supports – public health, primary care or behavioral health. For high-risk individuals, the primary need often requires supports from all three disciplines. Navigators specializing in each discipline provide expert coordination and timely referrals to maximize patient outcomes and community resources.

This coordination model wraps around the patient to provide holistic assessment and services regardless of whether they present at their primary health visit or at a community support service. This model also respects patient choice and existing relationships with trusted providers. Physical health outcomes are improved through a care coordination model while extending medical home infrastructure by leveraging behavioral health and public health resources.

Year 1 Major Projects

- Established new and enhanced existing agency processes to ensure all clients referred to WCHD are assessed for social needs, referred to all appropriate social and health services, and documented in the population health data system.
- Developed a referral flow chart to streamline the outcome of social needs assessments.
- Trained all staff providing care coordination services in motivational interviewing to improve patient engagement and effectiveness of coordination.
- Established standardized screening for all clients accessing resources from WCHD to assess, when appropriate, hemoglobin A1c, tobacco use, and BMI.
- Implemented processes to ensure all clients with a Hemoglobin A1c of 6 or higher are referred for diabetes education.
- Implemented processes for clients with an A1c of 8 or higher to have a diabetic action plan developed. WCHD is in the process of monitoring this process for quality improvement opportunities.
- Implemented processes to ensure clients with a BMI of 30 or higher receive education and a care plan for obesity.
- Implemented processes for new parolees exiting into the community to automatically receive coordination for physical and behavioral health services and resources for social needs. This has been fully implemented in Webster County, and the other seven counties will be using the model for implementation.

Data Collection, Use, and Analysis

Clinical data

WCHD has a strong working relationship with UnityPoint and is able to access limited clinical data through EPIC-CARE link. This allows WCHD read-only access to pertinent medical information to enhance care coordination. WCHD closes the referral loop based on the individual provider's request - either through fax or phone call.

Population health management

WCHD utilized Champs software to track referrals for social needs. Several of the other public health agencies in the service area also utilize Champs to manage referrals for social needs, which allows for streamlined data collection and reporting processes for the C3. Counties who do not use Champs or utilize a different software system have a separate data collection and reporting process to WCHD for all C3 data.