



**Community Care
Coalition Initiative**

Program Highlight

State Innovation Model Overview

In 2015, the Center for Medicare & Medicaid Innovation (CMMI) announced Iowa was one of 11 states awarded a \$43 million federal grant over four years to participate in the SIM Initiative's Phase Two Test States. The SIM 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. By 2018, the Iowa SIM project will:

- **Increase** the percentage of adult smokers who have made a **quit attempt**
- **Decrease** the **adult obesity** prevalence rates
- **Increase** the percent of adults with diabetes having two or more **A1c tests**
- **Reduce** preventable **ED Visits**
- **Reduce** preventable **Readmissions**
- **Increase** amount of healthcare **payments linked to value**

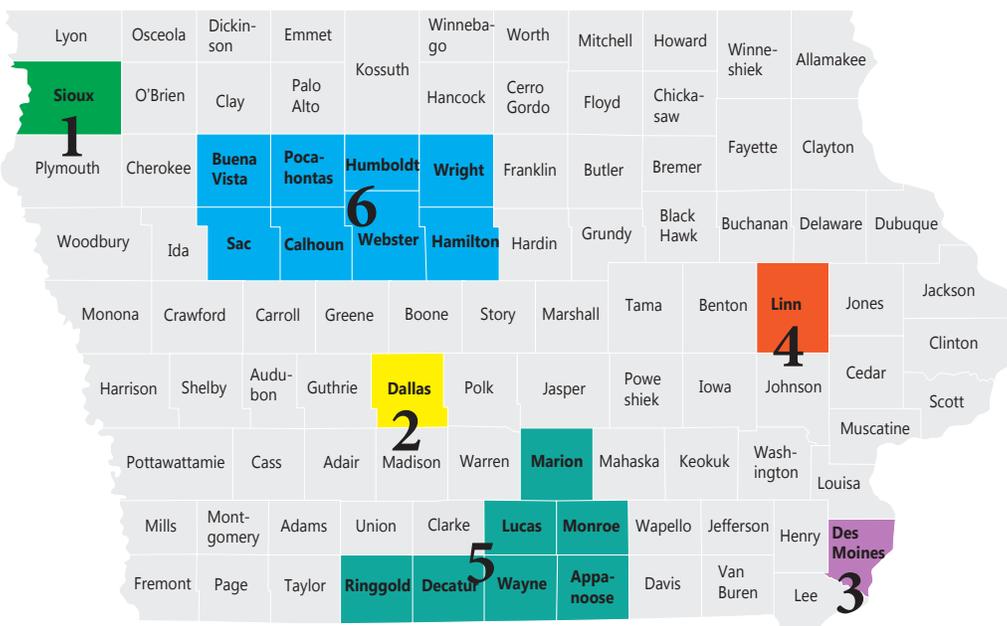
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Community Care Coalition Overview

Six Community Care Coalitions (C3s), spanning 20 counties, will 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: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community-applied interventions related to the Iowa SIM Statewide Strategies.

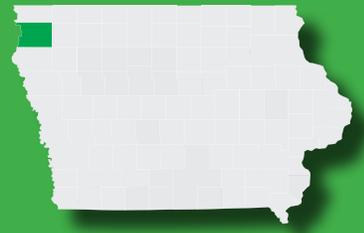
State Innovation Model Community Care Coalition Grantees



1. Community Health Partners of Sioux County
2. Dallas County Public Health Nursing Services
3. Great River Medical Center
4. Linn County Board of Health
5. Marion County Public Health Department
6. Webster County Health Department



Community Health Partners of Sioux County



Project Director: Kim Westerholm, Community Health Partners of Sioux County

Project Director Contact: kim.westerholm@siouxcountychp.org; 712-737-2971

C3 Type: Implementation

Service Area: Sioux County

C3 Steering Committee

The Sioux County C3 Steering Committee is comprised of individuals from each of the 4 hospitals in the county, community stakeholders and committed community members.

Planned Year 1 Activities

Community Health Partners of Sioux County will be implementing the following activities in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Increase the number of providers assessing patients for tobacco use at each visit through collaboration with the local Community Partnership, partnering with primary care providers, and conducting a provider survey.
- Link C3 participant referrals for tobacco users to cessation services, including referrals to classes, counseling, primary care providers, and fax referrals to QuitLine.
- Increase fax referrals to QuitLine by providing training and developing a referral process for all C3 care coordinators.
- Facilitate 2As and R training for providers and follow up to ensure implementation.
- Ensure assessment of BMI for all C3 participants, and lower participant BMI, increase physical activity through Complete Streets and Joint Use policies, and increase breastfeeding knowledge in providers.
- Increase participation in county diabetes prevention programs, hold diabetes screening events, and increase the number of C3 participants with an A1c value equal to or less than 7.0 through screenings and referrals to diabetes education, and self management.

Social determinants of health activities include:

- Educate providers on the Lemonade for Life tool to address Adverse Childhood Experiences in the service area.
- Promote utilization of health literacy based tools.
- Increase access to physical activity and recreation resources.
- Reduce stressed housing by collaborating with community leaders and the Community Health Needs Assessment task force to provide support to communities.
- Initiate the development of a county-wide intra-community transportation system through the use of a committee and administrative support.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/new-SIMhome>.



Dallas County Public Health Nursing Services



Project Director: Jennifer Walters, Dallas County Public Health Nursing Service

Project Director Contact: jennifer.walters@dallascountyiowa.gov

C3 Type: Implementation

Service Area: Dallas County

C3 Steering Committee

- 4RKIDS ECI
- American Diabetes Association
- American Lung Association
- AmeriGroup
- AmeriHealth Caritas Iowa
- Bluebird Integrative Health
- CareMore Care Ctr
- Citizens
- Crisis Intervention/Advocacy
- Dallas County Board of Health
- Dallas County Community Services
- Dallas County Conservation
- Dallas County EMS
- Dallas County Habitat for Humanity
- Dallas County Hospital
- Dallas County Public Health
- Dallas County Public Health
- Des Moines University
- Des Moines MPO
- Eat Greater Des Moines
- HIRTA
- HomeCare
- Hunger-Free Dallas County Coalition
- Iowa Chronic Care Consortium
- Iowa Clinic
- Iowa Community Health AmeriCorps Program
- Iowa Department of Public Health
- ISU Extension
- Juvenile Court Services
- Mercy
- Mid Iowa Health Foundation
- Municipalities
- New Opportunities
- Primary Health Care
- SAIL-DC (volunteer driver program)
- Sumpter Pharmacy & Wellness
- Telligen
- United Way of Central IA
- Unity Point Clinic
- Unity Point Health Des Moines
- Waukee United Methodist Church
- West Des Moines EMS
- YMCA Healthy Living Center

Planned Year 1 Activities

Steering Committee

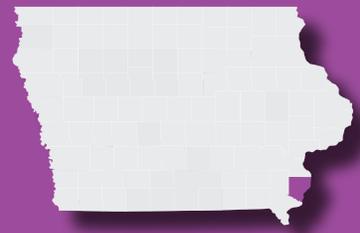
- Promote coordination of care across systems through regular meetings, resource mapping, data sharing, and intervention planning
- Implement referral systems and provide care coordination to address diabetes, obesity, and tobacco
- Connect residents with resources, education, and social supports through utilization of the existing Health Navigation Program
- Collaborate with the C3 coalition to identify and implement other community-applied policies and strategies to support health

C3 Coalition

- Collaborate with the Transportation Advisory Group (TAG) and Supporting Active Independent Lives in Dallas Center (SAIL-DC) to improve transportation options – including hosting town halls, providing HIRTA ride vouchers to low-income residents, and piloting a volunteer driver program
- Collaborate with Hunger-Free Dallas County to increase access to healthy foods through continued implementation of a healthy corner store initiative in Perry, improving concession stand and pantry options, and increasing access to healthy foods in communities
- Increase physical activity through alignment with existing statewide programs, connecting residents to physical activity programs and resources, implementing a volunteer-led walking school bus, and educating municipal leaders on evidence-based strategies and policies
- Host community summits and training opportunities to increase community awareness around social connection, poverty, and cultural competence



Great River Medical Center



Project Director: Sue Ferguson, Great River Medical Center

Project Director Contact: sferguson@grhs.net

C3 Type: Developmental

Service Area: Des Moines County

C3 Steering Committee

The Great River Medical Center C3 Steering Committee is comprised of individuals from the hospital, stakeholders from public health and a variety of community resources, and committed community members.

Planned Year 1 Activities

Great River Medical Center will be implementing the following activities in year 1 to address the required target areas of tobacco, diabetes, and obesity, and other CHNA/HIP priorities of mental health, poverty, and violent crimes:

- Sub-committees will be developed to assess resources, identify needs, develop action plans and begin to implement action plan for each area to improve population health.

Social determinants of health activities include:

- Host workshops for providers to educate how social, economic, and environmental factors impact health. These workshops will be provided by the University of Iowa's Community & Behavioral Health Department.
- Educate C3 Steering Committee members on community resources available in the service area.
- Identify ways to improve collaboration to ensure community members have access to services and resources by reviewing evidence-based policies, systems, or environmental changes and creating and implementing an action plan.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/new-SIMhome>.



Linn County Board of Health



C3 Awardee:	Linn County Board of Health
Project Director:	Cynthia (Cindy) Fiester, Linn County Public Health Department
Project Director Contact:	cindy.fiester@linncounty.org; 319-892-6081
C3 Type:	Developmental
Service Area:	Linn County
Blue Zones Communities:	Cedar Rapids

C3 Steering Committee

- Linn County Community Services
- United Way of East Central Iowa
- Linn County Public Health
- CarePro Health Services
- Heritage Area Agency on Aging
- UnityPoint Health, St. Luke's Hospital
- Abbe Center for Community Mental Health
- Mercy Medical Center
- Eastern Iowa Health Center (FQHC)
- Care Initiatives
- Community Health Free Clinic; His Hands Free Clinic
- Transportation Advisory Group & Horizons/ Neighborhood Transportation Services
- Four Oaks

Plans are underway to integrate with the Community Health Needs Assessment/ Health Improvement Plan steering committee. SIM Steering Committee members will be added to assure representation from the key SIM areas of tobacco, obesity, diabetes, and social determinants of health.

Planned Year 1 Activities

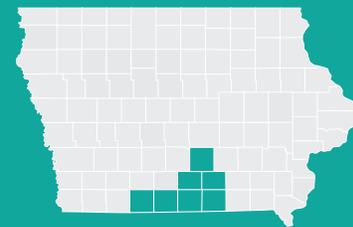
The Linn County Board of Health, in collaboration with the two local hospitals and a multitude of other community partners, completed an in-depth assessment of Linn County's community health needs in 2015. As a result, three strategic issues have been chosen for the 2016-2019 Community Health Improvement Plan: Health Promotion, Behavioral Health, and Social Determinants of Health. The Linn County SIM project will assist with addressing these community needs by:

- Conducting comprehensive assessments to identify populations at risk of or engaged in tobacco use; or at a higher risk for developing obesity or diabetes.
- Compiling a database of stakeholders providing prevention, control or referral programs in the areas of diabetes, tobacco and obesity.
- Analyzing and modifying current referral practices for addressing social determinants of health.
- Updating the Community Health Profile to add increased focus on Access to Care and Social Determinants of Health.
- Identifying Community Care Coordination software to address social determinants of health in collaboration with community partners.
- Expanding an existing workgroup that focuses on diabetes and investigating opportunities to address medication safety in persons having diabetes.

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Marion County Public Health Department



Project Director:	Kim Dorn, Marion County Public Health Department
Project Director Contact:	kdorn@marionph.org; 641-828-2238
C3 Type:	Developmental
Service Area Counties:	Marion, Lucas, Monroe, Ringgold, Decatur, Wayne, and Appanoose

C3 Steering Committee

- Ginny Krichau, Knoxville Hospital and Clinics
- Jill Sage, Knoxville Hospital and Clinics
- Ilene Johnson, SIEDA Community Action
- Vondale Tonelli, Domestic Violence and Abuse, DODDS
- Cheryl Garland, Integrated Counseling Solutions
- Stephanie Gehlhaar, Tenco
- Shelly Bickel, Decatur County Public Health
- Angie Mitchell, Knoxville Schools, School Nurse
- Karna Alexander, Community Member
- River Hills FQHC
- xlst, Behavioral Health
- Kendra Fries, Hy-Vee Dietician
- Milestones Area on Aging
- Angela Nelson, CROSS Mental Health Region

Marion County Public Health intends to add additional members to the C3 Steering Committee, including the Health Coach and Ambulance Director from Wayne County Hospital, an ARNP, and representatives from Monroe County Public Health, SCICAP, Mercy ACO, HIRTA Transportation, and Delta Dental Foundation.

Planned Year 1 Activities

Marion County Public Health Department will be working to strengthen existing partnerships and build new relationships with a variety of providers throughout the first year. The following activities will be implemented in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Engage partners throughout the eight-county service area in the coalition through partner agreements, quick wins, and workgroups.
- Develop and promote a region-wide standardized screening and referral process for tobacco, diabetes, and obesity. Evidence-based training and resources will be provided to all C3 Partners on care coordination and population health initiatives. TAV software will also be utilized to share data and ensure consistent communication.
- Work with school district nutrition directors and physical education directors, the University of Iowa Obesity Research and education Initiative, Mercy and UnityPoint ACOs, and local pharmacies to build and strengthen the coalition and referral processes.

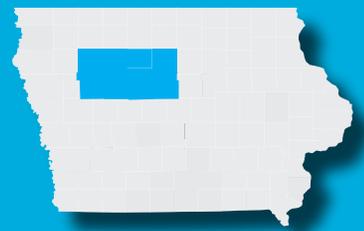
Social determinants of health activities include:

- Ensure C3 Partners utilize the TAVHealth software for all community care coordination referrals.
- Develop and promote a region-wide standardized screening and referral process for Social Determinants of Health.

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Webster County Health Department



Project Director: Kari Prescott, Webster County Health Department

Project Director Contact: kprescott@webstercountyaia.org; 515-573-4107

C3 Type: Implementation

Service Area Counties: Buena Vista, Calhoun, Hamilton, Humboldt, Pocahontas, Sac, Webster, and Wright

C3 Steering Committee

- Aaron McHone, Berryhill Mental Health Center
- Kelli Wallace, UnityPoint Family Medicine
- Pam Halverson, ACO UnityPoint
- Kari Prescott, Webster County Health Department
- Jane Condon, Calhoun County Public Health
- Diane Ferguson, Pocahontas County Public Health
- Michelle Hankins, Humboldt County Public Health
- Shelby Kroona, Hamilton County Public Health
- Tiffani Toliver, Wright County Public Health
- Rhyan Wing, Community Representative
- Jennifer Wuebker, Webster County Health Department
- Jackie Duffy, Sac County Public Health
- Pam Bouge, Buena Vista County Public Health
- Kathy Nicholls, Wright County Public Health
- Sherri Richardson, Pocahontas County Public Health
- Renae Kruckenberg, Fort Dodge Community Health Center

Planned Year 1 Activities

Webster County Health Department will be working with seven other county health departments, local health systems, community resources, and the Accountable Care Organization to implement the Community Care Coordination Initiative. The following activities will be implemented in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Standardize wellness lab panels to identify the presence of diabetes, provide diabetic education to diabetic clients, and develop diabetic action plans for diabetic clients.
- Promote awareness of QuitLine to community partners, and increase smoke-free and tobacco-free policies in the community.
- Obtain BMI scores of clients and develop an outreach strategy for clients. Education will be provided to clients with a BMI of 30 or more. Develop resource inventories for healthy eating and physical activity and distribute to C3 navigators, health coaches, and care coordinators.

Social determinants of health activities include:

- Assess clients for needs through a basic assessment and psycho-social assessment
- Refer clients for appropriate and available services both from medical and behavioral health appointments as well as from assessment results. Analyze gaps on a quarterly basis.
- Increase the rate of referral follow-ups through patient engagement, motivational interviewing, transportation assistance, and financial assistance. Analyze gaps on a quarterly basis.

Other CHNA/HIP priorities include:

- Coordinate care for asthmatic children and children with complex diagnoses through primary care providers, schools, daycare, and families.
- Complete high-risk assessment on WIC children and connect to community resources.
- Conduct high-risk assessments on incarcerated persons with multiple chronic conditions as well as adults with multiple chronic conditions, and persons with a mental health condition.

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