C3
Community & Clinical Care Initiative

Program Highlight

Project Period May 1, 2017 - April 30, 2018

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) 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 & Clinical Care Initiative Overview

Community and Clinical Care (C3) Initiatives are multi-sector groups of stakeholders implementing innovative strategies and referral processes to meet the clinical and social needs of the target population, which is individuals at risk for, or having, diabetes, through person-centered, coordinated care across a range of providers. The C3s 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.

These initiatives are intended to enhance care coordination and transitions for both providers and patients by identifying population risks and addressing barriers to health such as social determinants by connecting patients (and providers) to community resources, and developing and/or implementing strategies to address diabetes.

Iowa Department of Human Services

IDPH

Iowa Healthcare Collaborative

IOWA SIM
State Innovation Model of Iowa

October 2017

C3 Required Objectives and Tactics

All C3s are required to address predetermined tactics from Iowa's Statewide Strategy Plans. The tactics are divided into six objectives, outlined below, and each C3 developed activities to support the required tactics within the target population. Refer to each individual C3 overview for specific activities supporting objectives 1-6 (individual overviews do not include objective 7, as those specifics are outlined in the ACH table below).

Objective 1	Identify Target Population by Risk
Objective 2	Improve Diabetes Management
Objective 3	Link to Community Resources and Clinical-Community Programs and Services
Objective 4	Improve Healthcare Transitions
Objective 5	Decrease the Incidence of Diabetes
Objective 6	Address Community-Wide Prevention
Objective 7	Develop and maintain the C3 structure (see table below)

Accountable Communities of Health (ACH) in the C3s

The structure and function of a C3 includes all of the elements of an Accountable Community of Health (ACH):

ACH Element	C3 Requirement
Ability to perform basic financial and administrative functions	Grant management requirements of the C3 applicant organization
Integrator Organization	Community-based organization like local public health to convene partners; carry the vision of the C3; build trust among collaborative partners; convene meetings; recruit new partners; shepherd the planning, implementation, and improvement efforts of collaborative work; and build responsibility for these elements among collaborative members
Established Governance Structure	Steering Committee
Multi-sector Partnerships	Community Care Coalition
Sustainability Planning	Utilize supporting Health Information Technology (HIT); remove policy and regulatory barriers; and develop local commitment and long-term framework
Identified community engagement activities/ interventions	Utilize community-based care coordinators to provide community-clinical linkages and link to social services and supports
Population-based Prevention Activities	Implement tactics from Statewide Strategy Plans covering clinical, innovative patient-centered care, and community-wide health

Community & Clinical Care Initiatives
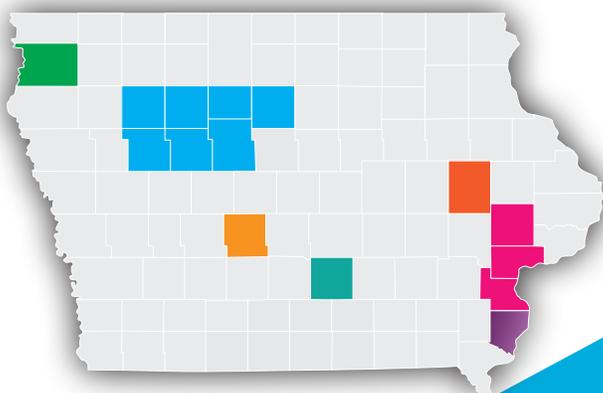
- » **Community Health Partners of Sioux County**
- » **Dallas County Public Health Nursing Services**
- » **Great River Medical Center**
- » **Linn County Board of Health**
- » **Marion County Public Health**
- » **Trinity Muscatine**
- » **Webster County Health Department**

Community Health Partners of Sioux County

Project Director:	Angela Kroeze-Visser, Community Health Partners of Sioux County
Project Director Contact:	angela.kroezevisser@siouxcountychp.org; 712-737-2971
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. CHP is a non-profit agency governed by a board comprised of administrators of the four hospitals in the countyas 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.

CHP serves as the Integrator Organization and 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 and build on established trust, 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 secure 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.

Activities

Objective 1
- » Improve provider Hemoglobin A1C screening and testing and educate providers on diabetes risk factors.
- » Work with primary care providers to develop a process to identify individuals in the target population with comorbidities through the use of electronic medical records (EMR); and implement processes for primary care providers and diabetes education coordinators to refer identified individuals for community care coordination.
- » Implement the AssessMyHealth Risk Assessment with all individuals in the target population referred for community care coordination.

Objective 2
- » Enhance diabetes management by assessing current diabetes interventions and encouraging providers to align with evidence-based practices.

Objective 3
- » Maximize the use of diabetes self-management education and training (DSME) by educating providers and improving clinic referral processes.

Community Health Partners of Sioux County (cont'd)

» Promote care coordination by implementing procedures to ensure inpatient discharges with a diagnosis of diabetes are referred for community care coordination and using the Iowa Health Information Network (IHIN) for referrals and closing the feedback loop to providers.

» Ensure providers refer patients for social needs by updating a resource directory, promoting the use of Lifelong Links to healthcare and community-based organizations, and educating providers on social determinants of health and community care coordination.

Objective 4

» Define care coordination roles by developing a referral flow chart, using the IHIN to communicate with partner organizations, and conducting performance improvement activities with the steering committee on care coordination processes.

» Educate providers and engage patients in glycemic management best practices through provider champions.

» Use appropriate health information technology (HIT) to support healthcare transitions and care coordination, including the IHIN and EMRs.

» Identify and transition to an electronic system for community care coordination referrals.

» Encourage all hospitals in the service area to send admissions, discharge and transfer data (ADT) to the Statewide Alert Notification (SWAN) system. Assist in the use of SWAN alerts at the hospital level once available.

» Address healthcare associated infections through identification of agency contacts for infection control and educating partners on infection prevention for the target population.

Objective 5

» Ensure implementation of evidence-based interventions to enhance overweight and obesity identification and treatment by identifying a provider champion, promoting educational opportunities, and promoting the adoption of established treatment algorithms from the American Association of Clinical Endocrinologists (AACE).

» Increase participation in diabetes primary prevention programs by educating providers and consumers about the purpose and locations of Diabetes Prevention Programs (DPP) in the service area and encouraging the development of EMR referral systems or prompts.

Objective 6

» Educate and equip employers for obesity prevention by collaborating with Healthy Sioux County and promoting the use of a workplace toolkit from the Healthy Hometown initiative.

» Improve health at the community level by contributing to a newspaper column and revising and disseminating brochures related to gardening and health.

Dallas County Public Health

Project Director:	Beth Frailey, Dallas County Public Health
Project Director Contact:	beth.frailey@dallascountyiowa.gov
Service Area:	Dallas County
Population:	84,516

The Dallas County C3 Initiative is led by Dallas County Public Health (DCPH). DCPH provides leadership and direction in the development and implementation of a community health improvement plan which promotes and conserves the health of the public. DCPH assumes responsibility of identifying and addressing the health needs of the community. As the Integrator Organization, DCPH facilitates a steering committee to provide leadership in coordinating services between local clinical providers and a community coalition, which implements community projects to address barriers that residents face.

DCPH 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. 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.

Activities

Objective 1

» Identify high-risk patients (Hemoglobin A1C>9) by reviewing clinical data for trends and exploring social screen processes and standardized referral processes.

» Prevent and address comorbidities (vascular diseases, tobacco use, etc.) in the target population by identifying clinic processes to address comorbidities, disseminating educational materials to patients on managing comorbidities, and implementing standardized referral processes for individuals in the target population with comorbidities to other clinicians, social services, and community-based organizations.

» Promote the use of the AssessMyHealth Risk Assessment by all C3 Steering Committee members, including standardizing the process for providing assessment results and action plans to primary care providers, and standardizing referral processes for clinical and social needs.

Objective 2

» Enhance diabetes management by identifying trends and risk factors of high emergency department (ED) utilizers and readmissions, and piloting a clinic/pharmacy program to increase medication compliance and reduce adverse drug events.

» Implement a referral process for emergency services, assisted living facilities, skilled nursing facilities, and long-term care providers to refer high ED utilizers to Health Navigation and utilize person and family engagement tools and strategies for care coordination within the target population.

Objective 3

» Identify existing diabetes self-management education and training (DSME) and assess barriers to attending and completing DSME programs. Utilize the Health Navigation program to address barriers, and establish referral processes with providers to connect individuals to DSME programs. Educate providers on DSME program availability and criteria for eligibility.

Dallas County Public Health (cont'd)

» Promote care coordination by aligning payer-supported educational strategies with prioritized population health and clinical strategies to avoid duplication, collaborating with providers to identify the most effective way to close the referral loop, and providing care coordination for social needs to the target population.

» Ensure providers refer patients for social needs by educating providers on the social determinants of health, promoting Health Navigation, and increasing awareness of health literacy.

Objective 4

» Define care coordination roles by identifying current clinical, community, and payer care coordinators and aligning roles across the clinical and community setting.

» Pilot a pharmacy collaboration with clinics to address glycemic management and best practices and promote DSME to providers prescribing diabetes medication.

» Use appropriate health information technology (HIT) to support healthcare transitions and care coordination by identifying current uses of the Iowa Health Information Network (IHIN), Statewide Alert Notification system (SWAN) alerts, and other secure messaging capabilities; and promoting the use of the IHIN for communication between care teams and piloting Health Navigation referrals through electronic health records.

» Address healthcare associated infections through increasing access and referrals to podiatrists to promote better foot care in the target population.

Objective 5

» Ensure implementation of evidence-based interventions to enhance overweight and obesity identification and treatment by identifying current wellness programs and promoting obesity prevention programs to providers.

» Increase participation in diabetes primary prevention programs by identifying existing programs; educating providers and consumers about the purpose and locations of National Diabetes Prevention Programs (NDPP) in the service area; and encouraging employee-based programs.

Objective 6

» Promote referrals to nutrition programming, community gardens, healthy options at food pantries, and walking groups by convening partners and facilitating systems-level changes to increase access to these resources.
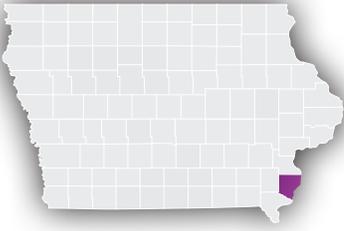
Great River Medical Center

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

Great River Medical Center (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.

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.

GRMC contracted with DMCPH to serve as the Integrator Organization. Through this role, DMCPH serves as a neutral C3 partner to assist in convening partners and building trust. DMCPH provides community-based care coordination to the C3 target population.

Activities

Objective 1

» Work with GRMC to implement a process to identify high-risk patients (Hemoglobin A1C>9) and alert providers. Educate providers on screening and addressing diabetes risk factors.

» Identify toolkits to improve diabetes management and the use of best practices in addressing comorbidities.

» Collaborate with the Community Health Centers of Southeastern Iowa (CHC/SEIA) to improve screening, referrals and follow-up for comorbidities in the target population.

» Promote the use of the AssessMyHealth Risk Assessment by aligning existing health risk assessments, encouraging the use of AssessMyHealth by providers, and including AssessMyHealth in community-based care coordination at DMCPH.

Objective 2

» Enhance diabetes management by identifying provider education needs and opportunities, developing care plans to address readmissions and emergency department (ED) visits, and disseminating toolkits to ensure the use of best practices for diabetes management.

» Evaluate current workflow processes within clinics for diabetes management.

Objective 3

» Assess existing diabetes self-management education and training (DSME) program for capacity for increased referrals and promote provider referrals to DSME during provider education opportunities.

» Promote care coordination by leveraging an existing group to address social determinants of health (SDH) concerns; and facilitate the development of a closed-loop referral system.

» Ensure providers refer patients for social needs by implementing a closed-loop referral process for SDH, developing process maps to facilitate SDH referrals, identifying a system for clinical and community providers to communicate and track referral data, and promote SDH resources to providers.

Great River Medical Center (cont'd)

Objective 4

» Define care coordination roles by ensuring C3 representation on care coordination committees at GRMC and promoting collaboration between patients and primary care providers during the development of care plans.

» Promote SafeNetRx services to improve access to medication for glycemic management and offer education to providers on best practices for glycemic management.

» Use appropriate health information technology (HIT) to support healthcare transitions and care coordination by partnering with DMCPH and CHC/SEIA to utilize the Iowa Health Information Network (IHIN) for direct secure messaging and working with GRMC staff who are developing EHR shared-use agreements. Work with GRMC to submit admissions, discharge and transfer (ADT) data to the Statewide Alert Notification (SWAN) system, and explore application of SWAN alerts for care coordination.

» Address healthcare associated infections by improving pre-surgery consultation processes for patients with a Hemoglobin A1c>7.5 and reviewing diabetic foot care practices.

Objective 5

» Ensure implementation of evidence-based interventions to enhance overweight and obesity identification and treatment by piloting and distributing a toolkit for providers and supporting development and implementation of process changes for referrals to the Diabetes Prevention Program (DPP).

» Promote referrals and participation in DPP through provider education and provider outreach events.

Objective 6

» Promote access to active transportation through education of current resources and development of new projects to improve infrastructure.

» Provide opportunities for the target population to receive education on social determinants of health and discuss barriers resulting from social determinants of health with providers and community organizations.

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

As the C3 Integrator Organization, Linn County Public Health (LCPH) is a neutral convening agency for community wide health efforts. As the lead entity for the CHA-CHIP (Community Health Assessment/Community Health Improvement Plan - CHNA/HIP) process and the Linn County C3, LCPH facilitates the C3 Steering Committee and Coalition, works with primary care providers to improve health outcomes in the target population, and ensures communication between providers and community-based organizations to address social determinants of health. This is primarily accomplished by managing the community-care coordination software that allows providers and community-based organizations to engage in ongoing communication and feedback loops.

Activities

Objective 1
» Identify high-risk patients (Hemoglobin A1c>9) by identifying existing clinic processes and areas for improvement and implement process improvements based on clinic needs.

» Support clinic identification of individuals in the target population with comorbidities (tobacco use, vascular diseases, tobacco use, etc.) through collaboration with the Iowa Healthcare Collaborative Quality Improvement Advisors based on clinic needs.

» Promote the implementation of AssessMyHealth by identifying current use, use of other health risk assessments by clinical providers, and identifying processes to increase the use of AssessMyHealth. Build an activity into the community care coordination software to promote the use of AssessMyHealth.

Objective 2
» Use community care coordination software to identify and disseminate provider information to connect to essential services.

» Assess current protocols for A1c management within local health systems and free clinics and encourage use of best practices and standardization within participating clinics to address adverse drug events, readmissions and emergency department (ED) visits.

Objective 3
» Maximize the effectiveness of Diabetes Self Management Education (DSME) and Chronic Disease Self-Management Program (CDSMP) by building referrals into the community care coordination software and increasing provider referrals to local programs. Assess current DSME and CDSMP availability and existing referral systems and process to identify opportunities for process improvement.

» Implement community care coordination software in participating community-based organizations and healthcare providers to support care coordination across a community of providers.

» Educate providers on social determinants of health and the community care coordination software to increase patient referrals by primary care providers for social needs.

Objective 4
» Designate care coordination roles within the community care coordination software and identify responsibilities of clinics, practices, and organizations.

Linn County Board of Health (cont'd)

» Engage providers and patients in glycemic management and best practices by facilitating a diabetes subcommittee to engage providers and encouraging the use of best practices.

» Use appropriate health information technology (HIT) to support healthcare transitions and care coordination by utilizing the Iowa Health Information Network (IHIN) for direct secure messaging and implementing community care coordination software with providers across the community. Assess current use of the IHIN and the Statewide Alert Notification (SWAN) system and provide training on the use of the IHIN and SWAN alerts where applicable.

» Address healthcare associated infections by assessing current referral flow processes specific to diabetic foot care.

Objective 5

» Implement strategies to enhance overweight and obesity identification and treatment by supporting providers through education and providing resources on best practices.

» Increase participation in local Diabetes Prevention Programs by assessing program capacity and building referral capabilities into the community care coordination software.

Objective 6

» Provide community outreach for diabetes education and screening through a diabetes subcommittee.

Marion County Public Health Department

Project Director:	Larissa Van Donselaar, Marion County Public Health Department
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Service Area:	Marion County
Population:	33,248

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 and serves as the "no wrong door" entity for care coordination for a variety of programs. MCPHD will continue to serve as this entity for all individuals with social needs in the service area. In addition to serving as the "no wrong door" entity, MCPHD works closely with Marion County's two health systems; Knoxville Hospital & Clinics (KHC) and Pella Regional Health Center (PRHC).

The primary focus has been to develop in-home care coordination by providing home visits from the Community Based Care Coordinator (CBCC) to diabetic patients referred by the diabetic educator. The CBCC will identify social determinants of health in the home to support optimal patient health. Each health system has taken a differing approach to care coordination: KHC utilizes MCPHD staff to act in the CBCC role, while PRHC utilizes pharmacy staff to make home visits. Using pharmacy staff allows PRHC to focus on patient medication management in the home as they assess patient living situations and barriers to care.

Activities

Objective 1

» Identify high-risk patients (Hemoglobin A1c>9) by exploring existing technology to promote screening and referral of high-risk patients.

» Promote the implementation of AssessMyHealth by identifying current use, use of other health risk assessments by clinical providers, and identifying processes to increase the use of AssessMyHealth.

Objective 2

» Enhance diabetes management by ensuring both medical facilities in the service area follow the ACO Diabetes Care Model and refer patients based on the IDPH Prediabetes and Diabetes Referral Flow Chart.

Objective 3

» Maximize the effectiveness of Diabetes Self Management Education (DSME) by working with providers to ensure referrals into State Certified DSME programs and working with the Steering Committee to promote local DSME programs and resources for individuals in the target population.

» Partner with the Area Agency on Aging to train local staff for provision of referrals to DSME and the Chronic Disease Self Management Program (CDSMP) and work with Telligen to implement Everyone with Diabetes Counts program to fill gaps in DSME access.

» Facilities utilize the embedded care coordinators to work with the clinical care team and the care coordinator at MCPHD to address social needs. Embedded care coordinators will utilize the care coordination software to assist in closing the feedback loop to the provider.

» Provide training to primary care providers, hospital based health coaches, transition nurses and care coordinators to improve implementation of the existing referral system for social needs.

# Marion County Public Health Department (cont'd)

Objective 4

» Designate care coordination roles through an existing care coordination work group. The work group will identify gaps, training needs, and implement quality improvement activities.

» Promote glycemic management best practices by training care coordinators to work with primary care provider (PCP) identified patients regarding glycemic medication management. The steering committee will improve glycemic management in the target population by promoting the use of evidence-based tools and implementing quality improvement activities for medication reconciliation and structured discharge communication.

» Promote the use of appropriate Health Information Technology (HIT) by working with hospitals in the service area to connect to and actively use the Iowa Health Information Network (IHIN) and send Admission, Discharge and Transfer (ADT) data to the Statewide Alert Notification (SWAN) System. The steering committee will engage ACOs in the service area to identify processes to utilize SWAN alerts for care coordination.

» Address healthcare associated infections by sharing infection surveillance data with the steering committee and implement quality improvement activities to address healthcare associated infections.

Objective 5

» Implement evidence-based interventions to enhance overweight and obesity identification and treatment by implementing standard Hemoglobin A1c testing at annual physical appointments for adults ages 40-70 years who are overweight or obese. The steering committee will also work with providers to implement evidence-based intervention for providers to screen for obesity and create referrals to care coordination.

» Provide training to providers on risk factors for diabetes, and increase provider referrals to Diabetes Prevention Programs (DPP) through the use of Electronic Health Records and improving referral processes.

Objective 6

» Increase access to healthy food by providing eligible farmers market produce to individuals enrolled in WIC and SNAP weekly at Marion County Public Health Department and working with providers to increase referrals for access to fruits and vegetables.

» Work with the Iowa Healthiest State Initiative to support community activities to increase access to healthy foods and walkable communities.

» Explore housing needs in the target population, particularly in relation to accessing diabetes care.
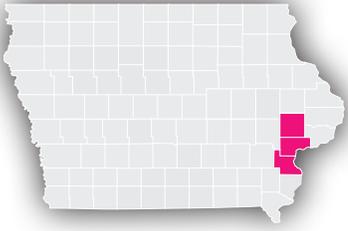
Trinity Muscatine

Project Director:	Grace Bowling, Trinity Muscatine
Project Director Contact:	grace.bowling@unitypoint.org; 563-264-9514
Service Area:	Muscatine, Cedar, and Louisa Counties
Population:	72,559

Trinity Muscatine provides a full continuum of services that includes a network of physicians, inpatient and outpatient diagnostic care and treatment, home health, hospice, public health, occupational medicine, nutrition and diabetic services, and substance abuse services. Unique to Trinity Muscatine is the partnership with the local public health department that was created when the Muscatine County Board of Supervisors and Board of Health contracted with Unity HealthCare (now called Trinity Muscatine) to provide the essential public health services.

Trinity Muscatine is committed to working collaboratively and collectively with a cross section of community referral partners and clinical care infrastructures to develop an improved coordinated care effort for patients diagnosed with diabetes. The Trinity Muscatine C3 will utilize an existing steering committee and coalition to drive the project. Trinity Muscatine has identified Muscatine County Public Health Department to serve as the Integrator Organization.

Activities

Objective 1
» Identify high-risk patients (Hemoglobin A1c>9) by identifying electronic medical record processes to identify high-risk patients and examining work flows within clinics in the service area.

» Promote the implementation of AssessMyHealth by identifying current use, use of other health risk assessments by clinical providers, and identifying processes to increase the use of AssessMyHealth.

Objective 2
» Enhance diabetes management by educating providers on the American Diabetes Association (ADA) criteria, developing a standard referral process with clinics that includes a diabetic care plan, and engaging providers in glycemic management and best practices.

Objective 3
» Maximize the effectiveness of Diabetes Self Management Education (DSME) and Chronic Disease Self-Management Program (CDSMP) by using program data to increase referrals and successful completion of the program.

» Promote care coordination across a community of providers by educating clinic care coordinators on available services to address social needs in the target population.

» Provide community-based care coordination for clinics within the service area and provide training and education to clinics to increase referrals to community-based care coordination for social needs.

Objective 4
» Designate provider roles for care coordination by identifying existing roles and educating providers on the role of the community-based care coordinator.

» Engage providers and patients in glycemic management and best practices by developing diabetic action plans for all individuals identified as high risk (Hemoglobin A1c>9) and promoting referrals to DSME.

Trinity Muscatine (cont'd)

» Promote the use of Health Information Technology (HIT), including the Iowa Health Information Network (IHIN) and EHR view only functionality, to allow mutual access to patient care information from all members of the care team.

» Address Healthcare Associated Infections (HAI) by educating clinic care coordinators, providers, patients, diabetes educators and community partners on diabetic foot care.

Objective 5

» Decrease the incidence of diabetes by educating clinics on evidence-based methods to identify patients who are overweight or obese and assessing community-wide evidence-based programs to reduce obesity.

» Increase participation in the National Diabetes Prevention Program (NDPP) through provider education and outreach and assess the need for additional NDPPs to ensure access within the entire service area.

Objective 6

» Improve utilization of community resources and services by improving referrals to reduce/remove social determinant barriers (housing, transportation, financial).

» Educate community partners and clinics on pre-diabetes and diabetes risk factors.

» Collaborate with C3 partners to explore and implement primary prevention efforts.
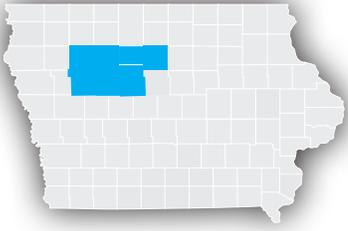
Webster County Health Department

Project Director:	Kari Prescott, Webster County Health Department
Project Director Contact:	kprescott@webstercountyia.org; 515-573-4107
Service Area Counties:	Buena Vista, Calhoun, Humboldt, Pocahontas, Sac, Webster, and Wright
Population:	107,554

The Webster County Health Department (WCHD) C3 includes a seven 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.

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.

Activities

Objective 1
» Identify high-risk patients (Hemoglobin A1c>9) by identifying electronic medical record processes to identify high-risk patients and examining work flows within clinics in the service area.

» Address comorbidities by collecting and using data to identify health behaviors that contribute to poorer outcomes for diabetic patients with comorbidities.

» Promote the implementation of AssessMyHealth by reviewing existing C3 health assessments and implementing the use of AssessMyHealth in the target population.

Objective 2
» Enhance diabetes management by standardizing patient engagement, diabetic care plan use, and physician oversight across clinics and partner agencies. The C3 will also utilize telephonic care coaches to manage diabetes in the target population, and work with the emergency room care coordination conference to address potentially preventable admissions and readmissions.

Objective 3
» Maximize the effectiveness of Diabetes Self Management Education (DSME) and Chronic Disease Self-Management Program (CDSMP) by increasing program availability through the ACO and Local Public Health (LPH) and promoting DSME to all individuals with diabetes accessing services from the C3 who have not received diabetes education.

» Promote care coordination across a community of providers by working with the ACO to support provider collaboration and existing care coordination strategies.

» Ensure social needs of individuals in the target population are addressed through the use of a psycho-social assessment within the C3 and developing and expanding system-level changes, such as policy change and community engagement, to support referrals for social needs.

Objective 4

» Designate provider roles for care coordination by improving the C3 community care coordination strategy across all counties in the service area and supporting training to ensure connections between clinics, hospitals and public health.

» Engage providers and patients in glycemic management and best practices by standardizing the wellness lab panel to identify diabetes, developing diabetic action plans for all individuals in the target population with a Hemoglobin A1c>8 and supporting process improvement around glycemic management.

» Promote the use of Health Information Technology (HIT), including the Iowa Health Information Network (IHIN) and Statewide Alert Notification (SWAN) system, by promoting these platforms to partners and requiring the use of IHIN direct secure messaging by local public health subcontractors.

» Address Healthcare Associated Infections (HAI) by providing HAI and foot care education to the Area Agency on Aging and at least one skilled nursing facility in each county in the service area.

Objective 5

» Decrease the incidence of diabetes by assessing current community-based efforts related to overweight and obesity and expanding and improving referral processes to existing evidence based interventions.

» Increase participation in the National Diabetes Prevention Program (NDPP) by increasing referrals to these programs from public health, clinics, the UnityPoint Health Diabetes Center, and community-based education and outreach opportunities.

Objective 6

» Promote community-wide prevention by educating C3 navigators, health coaches and care coordinators on local resources that support healthy eating habits and physical activity, educating the community on existing opportunities and resources for physical activity, and promoting overweight and obesity screenings.