Community & Clinical Care Initiative

Success Stories August 2018

Overview

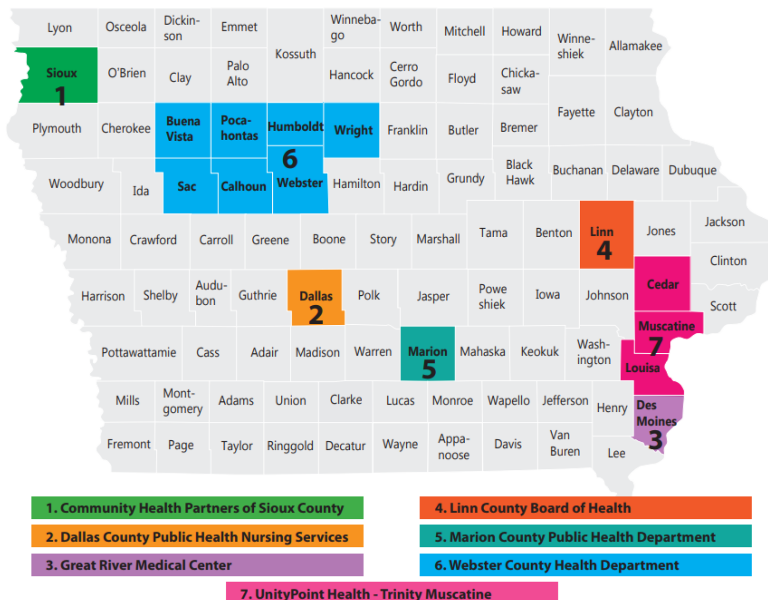
Seven Community and Clinical Care (C3) initiatives were established through the State Innovation Model (SIM) grant. SIM is a four-year federal grant through the Center for Medicare and Medicaid Innovation (CMMI). Iowa's SIM grant focuses on the following aims:

- Improve population health
- Transform health care
- Promote sustainability

C3s are community-level, multi-sector groups of stakeholders implementing innovative strategies and referral processes to meet the clinical and social needs of the target population through person-centered, coordinated care. The target population for Iowa's SIM grant are individuals at risk for, or having diabetes. 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.

C3s enhance care coordination efforts and improve transitions of care for providers and patients by identifying social determinants of health and addressing barriers. This is done by connecting patients (and providers) to community resources, and developing and implementing strategies to address barriers. The map below shows the C3 service areas for Award Year 3.



Overarching Key Success

A key success for all of the C3s is the continued convening and engagement of their community-level steering committees and communication with their coalitions on a regular basis (see below for description). A main barrier in many other communities is that their organization does not have a "seat at the table" to discuss healthcare transformation in their communities, or there may not even be a "table" in existence. The C3s in the seven communities are the convening organization and have successfully engaged and brought the key players to the table in their community.

Engaging the key stakeholders in a community is an essential foundational step for any healthcare transformation initiative. Bringing together these partners on a regular and ongoing basis will reduce silos, streamline efforts and encourage innovative ideas for future transformation efforts. All of the C3s have had individual successes beyond this which are summarized on the following pages, but this is a success that involves established, ongoing relationships that could likely continue after the SIM grant has ended.

Steering Committee

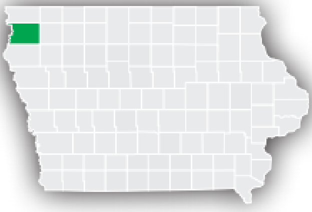
C3s convene steering committees on a regular basis. The steering committee, at a minimum, has representation from local public health agencies or boards of health, ACOs, hospitals, and a primary care provider from each involved health system or hospital. The steering committee is responsible for:

- Identifying the health strategies for the C3 initiative
- Providing leadership in coordinating and integrating services between a range of providers
- Ensuring community resources and providers that serve the target population(s) are included in the decision-making processes
- Facilitating understanding of health issues that impact the target population(s)
- Aligning responsibilities to develop and implement strategies

Coalition

The coalition serves as a source of communication and collaboration to drive implementation of the project. Organizations represented on the coalition implement tactics from the statewide strategy plans as applicable. The following are examples of coalition organizations:

- *Area Agencies on Aging (AAAs)*
- *Behavioral and Mental Health Providers*
- *City Planners*
- *Community Action Organizations*
- *Community-Based Nonprofit/For-Profit Organizations*
- *Community Members/Advocates*
- *Community Wellness Programs*
- *Dental Providers*
- *Diabetes Educators*
- *Emergency Medical Services*
- *Faith-Based Organizations*
- *Federally Qualified Health Centers*
- *Food Systems*
- *Health Plans/Third Party Payers*
- *Home Health Organizations and Nurses Housing*
- *Large and Small Businesses*
- *Law Enforcement and Correctional Agencies*
- *Local Governments*
- *Long-Term Care System*
- *Managed Care Organizations*
- *National Diabetes Prevention Programs*
- *Pharmacies*
- *Primary Health Care Providers*
- *Private Foundations*
- *School and Educational Institutions*
- *Social and Human Services*
- *Tobacco Community Partnership*
- *Transportation Services*
- *Tribal Governments*



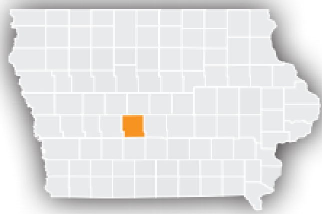
Community Health Partners of Sioux County

A major success for the Sioux County C3 is the strengthened partnership among their partner health systems and clinics and the local public health agency. Sioux County's four partner health systems and the Federally Qualified Health Center have engaged in a variety of activities related to diabetes prevention and treatment (including improving diabetes screening and referral, diabetes management and a diabetes prevention program) and have also collaboratively addressed preventing overweight and obesity.

The Sioux County C3 serves as a neutral space for generating and sharing ideas among community partners. While many activities occurring within individual health systems are related to other programs and initiatives, the Sioux County C3 serves as the space for integration among organizations and within the community. For example, several partner organizations developed health coaching projects related to participation in ACOs, but the SIM C3 expands the focus beyond the ACO population to serve the community and has involved diabetes educators in the system. While much of the work to improve care happens at the clinic level, the Sioux County C3's key role is to integrate efforts in the community.

Sioux County C3's Community-Based Care Coordinators have made 298 referrals, which is a 380 percent increase since last year. Referrals have been received from a variety of sources, including providers, self-referrals and community partners. Referrals have been made to address a wide variety of needs with insurance, food assistance, housing, community and social context, and other health care representing the most common referral categories.

Another positive outcome of the Sioux County C3 is a countywide partnership to deliver the National Diabetes Prevention Program (NDPP). The fourth cohort will start in August. The C3 facilitated a community directed workplace wellness event that promoted a variety of community wellness resources, including workplace policies directed at promoting physical activity and plans to reach out to businesses in the community to encourage them to support employee participation in the NDPP program.



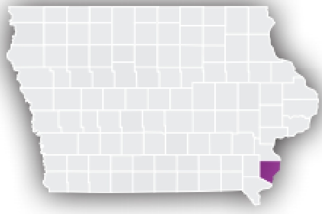
Dallas County Public Health

The Dallas County C3 features a Health Navigation program that continues to evolve. The Health Navigation program works in partnership with physicians, care coordinators and health coaches to address social needs of patients who are at risk for, or living with diabetes or other conditions. Health navigation is an extension of medical care, but focuses on transportation, food, housing, employment and other community resources. Navigators work closely with the patient's medical home to share progress, barriers and connections to resources that may influence the patient's plan of care. Using health navigation as the hub, the clinical delivery system is better prepared to meet the needs of residents, in addition to potentially reducing preventable emergency department (ED) visits and readmissions, which will affect payment. Data from the Health Navigation program is used to inform systems-level changes in the community.

Another success for the Dallas County C3 is Dallas County Public Health's (DCPH) role in facilitating communication between care coordinators in clinics, hospitals, public health and payer organizations. This allowed the C3 to better understand existing referral processes, designate defined care coordination roles, and avoid duplication of services among partners. DCPH also invited two individuals from the target population to attend the community coalition meeting and conducted follow-up interviews with these clients. Through this process, DCPH learned more about which resources individuals with diabetes thought would be helpful for them to manage the disease, benefits and barriers to attending DSME classes, barriers to taking diabetes medications as prescribed, and perceptions of care in a clinical setting.

During Award Year 3, DCPH collaborated with Sumpter Pharmacy and Mercy Family Clinic in Adel to implement a pharmacy pilot project. The partners worked together to identify patients, gather baseline data (A1C, recent ED/hospitalization, patient confidence level, medication adherence), and implement strategies to improve health outcomes. The Registered Nurse Health Navigator is uniquely equipped to visit patients in their home, ask questions about their medications, connect them with additional services they may need, and report back to the pharmacist and clinic. The clinic, pharmacy and health navigator have regular case conferences to discuss findings, next steps, and how each partner can reinforce patient safety and education to help improve medication adherence.

DCPH also implemented a new Health Navigation database through the Health Leads REACH software, which has the ability to screen patients, track successful connections to resources and assist in evaluating the program's return on investment. The platform also has the ability to interface with an EHR if health systems wish to invest in the social needs program in the future. The database updates allow for greater efficiency as the Health Navigation program continues to grow.



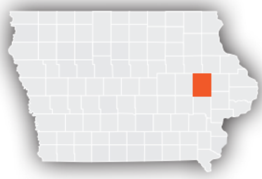
Great River Medical Center

The Great River Medical Center C3, located in Des Moines County, has had great success in building unique collaborative initiatives and partnerships in its community. These partnerships were built through the C3's Steering Committee and coalition and resulted in many successes.

The community received a Wellmark Foundation Grant that relied heavily on a unique group of stakeholders from regional planning, city administration, local bicycle advocates and a concerned physician. The focus of the community grant is to establish and expand local active transportation resources such as bike racks, bike repair stations, a water fountain and information stations. The local community college is interested in starting a bike share program for its students and is working with the group that helped bring the Wellmark grant to the area. The local Chamber of Commerce and the Corporate Wellness Department of Great River are seeking to collaborate and to support Des Moines County Living Well, which is Great River Medical Center's C3s Community Coalition. Through alignment and collaboration, all groups involved hope to reduce the potential overlap and to strengthen these relationships.

Another success is that Des Moines County Public Health, in concert with C3 stakeholders, worked closely with different groups to help address local concerns in skyrocketing sexually transmitted disease infection (STI) rates, and to provide a free disposal site for sharps for members of the community. Des Moines County Public Health now offers free STI testing clinics and coordinates a STI stakeholder meeting to discuss local issues and to formulate strategies to address these issues. In 2017, average follow-up A1c levels for patients who received support from Great River Medical Center Diabetes Education reduced 12 percent from their initial visit (8.73% -> 7.58%). Diabetes education patients with an initial A1c greater than 9% had, on average, a 19 percent reduction in A1c (10.46% -> 8.4%) where 26 of the 40 (65 percent) patients were able to drop their follow-up A1c below the high-risk cut off of 9% A1c. Separately, both Great River Medical Center's Diabetes Education and Des Moines County Public Health have shown success in working with patients and working with the community.

As a result of local collaboration of stakeholders who participate within the C3 initiative, the City of Burlington successfully applied for and will be receiving a $17 million TIGER (Transportation Investment Generating Economic Recovery) grant from the U.S. Department of Transportation. In tandem with the Wellmark Foundation grant, built environment changes have been prioritized that will positively impact safety and physical activity.

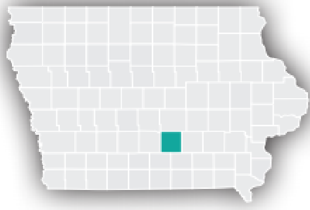


Linn County Board of Health

Linn County C3 increased cross-sector engagement and launched a shared care coordination technology platform. In June 2017, with the support of 14 community partner agencies, Linn County contracted with TAVHealth to launch TAVConnect for local use. Partners worked closely with one another and Linn County's SIM C3 staff to design and implement a single technology system to support inter-agency referrals and document social determinants of health (SDH) needs of clients. A social needs screening (SDH) survey with 10 high-level SDH questions was identified and built into the TAVConnect system to facilitate conversations with clients regarding their social needs. The screening tool also allowed for a uniform client assessment and data collection tool among all partner agencies utilizing the TAVConnect system. Multiple trainings were conducted with partner organizations to prepare for the launch of Linn County's TAVConnect platform. Since the launch in late fall/early winter, over 500 clients have completed a release of information and have been entered into TAVConnect. In addition, more than 5,000 SDH surveys have been completed in their community both within and outside TAVConnect system use. In 2018, this work was awarded national recognition through the National Association of County and City Health Officials (NACCHO).

The Linn County C3 also focused on improving its healthcare system related to diabetes and the health outcomes of pre-diabetic and diabetic individuals in Linn County. In June 2017, the first Diabetes Subcommittee meeting occurred. Participation is robust with representation from hospital systems, the federally qualified health center, clinics, dieticians, community health and diabetes educators and education programs, pharmacists, drug companies and diabetes related organizations. Diabetes clinical assessments were conducted shortly after the launch of the group and resulted in improved awareness and connection of clinical programs to community-based programs such as YDPP and CDSMP, and the creation of the Linn County Diabetes Healthcare System Map, a diabetes resource guide. Focused outreach and A1C testing with appropriate follow-up care was also a function of this group. During FY18, the Diabetes Subcommittee conducted various community screenings and education events in which participants were screened, A1C tested, and, if appropriate, referred to educational or medical resources. Medication management and safety was another focus of the Diabetes Subcommittee this year. A Medication Management Workgroup formed to identify strengths and weaknesses in the current healthcare system for medication education, communication and transitions of care. The workgroup identified a need to better understand patient barriers to medication adherence and through a partnership with Iowa Primary Care Association and Linn County's SIM C3 staff, were able to conduct three patient focus groups. Information will be utilized in FY19 to create complimentary surveys for healthcare providers, adjust clinical policies, improve inter-organizational communication and decrease patients' adverse events related to medication management.

Through a SIM C3 clinical subcontract, UnityPoint Health Diabetes and Kidney Center launched a clinic roadshow to increase provider education and referrals to their own services and classes. The roadshow took place at 12 UnityPoint clinics and has already shown a large uptick in patient referrals from primary care physicians to center services.



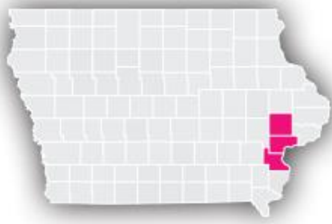
Marion County Public Health Department

The Marion County C3 has seen great success with its patient pilot project. The C3's Steering Committee identified the need for care coordination of patients who had A1C levels greater than 8% for six months or longer. Care Coordination would be conducted by Community Based Care Coordinators (CBCC) within pilot patients' homes. The pilot group, comprised of patients from Knoxville Hospital and Clinics and the Pella Regional Health Center, has seen a 67 percent reduction in A1C levels within the first three months of beginning the program. The CBCC makes home visits to the pilot participants and identified the following: food insecurity, financial insecurity, intellectual disability, mental illness, lack of primary care provider, lack of medical care, lack of friend/family support, lack of a support system and ongoing legal trouble. The CBCC assists participants with scheduling appointments, securing transportation, applying for financial services and food stamps and linking them to food pantries. Knoxville Hospital & Clinics (KHC) began with 20 non-ACO patients with A1C levels of 8% or higher for six months or longer. KHC has given read-only access of their EHR (Cerner) to CBCC. A process was developed to ensure and has proven to close the referral and communication loop to providers. Pella Regional Health Center's (PRHC) referrals come from their Pharmacy Department, with follow-up conducted through a home visit with a pharmacist, in partnership with CBCC, to provide medication management and reconciliation, as many patients see multiple physicians.

Another success for the Marion County C3 was the creation of a new mission statement: "The purpose of the Marion County C3 is to work together to consistently serve the whole person by communicating, coordinating, collaborating, and connecting community resources to the client's needs. This will be done by using clear and simple pathways, as one team coming together from multiple agencies, reducing duplication for the best possible outcome."

Additionally, the Marion County C3 collaborated with Central College to organize a poverty simulation to identify a process of care coordination with patients with diabetes and social determinants of health needs. The poverty simulation is the first one to be held in Marion County. A total of 67 people, representing organizations in the public, clinical, social and private sectors, participated and identified gaps in coordination services between providers to better serve clients. Organizations were able to collaborate. For instance, a church food pantry identified, via the simulation, referrals weren't made from local school district nutrition directors (who complete free and reduced lunch forms for families) to food pantries. This allowed partners to develop resources for school districts to provide to families and identify ways to discuss whole person care coordination.

After identification of food insecurity as the top barrier across Marion County, a Food Coalition was created where food pantry partners met monthly to discuss food insecurity in Marion County and pantry access. A monthly food pantry calendar has been created and distributed to grocery stores, bars, restaurants, email lists, schools, first responders and libraries. The food pantries have partnered to learn about each other's processes and how to improve process when serving clients with chronic disease.



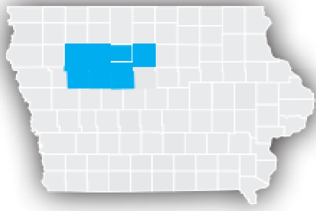
Trinity Muscatine

The Muscatine C3, the newest C3, completed the first year of the C3 grant and celebrates multiple successes. The Muscatine C3 brought together and convened its initial steering committee, established their subcontracts, and has begun capturing AssessMyHealth data. During this time, they have experienced some challenges with staff transitions in the project. Despite this, they have made great progress in establishing the project.

The National Diabetes Prevention Program (NDPP) was conducted with Trinity Muscatine Public Health and the Muscatine Diabetes Project. Ten persons were enrolled in the first cohort. The Muscatine Walk Project sent two representatives for lifestyle coach training from the American Association of Diabetes Educators and has applied for program startup with the CDC. The Muscatine Walk Project, Iowa State Extension Services and 1st Five initiative are part of "The Healthy Behaviors Committee," a collaborative group that interacts at planned meetings, working towards population education for prevention of diabetes, obesity reduction and reducing the burden of social determinants of health.

The Muscatine C3 successfully educated the providers in its area on social determinants of health. Providers were engaged in the topic and were eager to become a part of the process. Referrals to the Diabetes and Wellness Center have tripled in the past three months. Individual and group education sessions and a diabetes support group are components of the American Diabetes Association Recognized Diabetes Self-Management program.

Factors already in place that have set the Muscatine C3 up for success include a very strong community involvement in partnerships that make Muscatine a healthier community. The Muscatine Diabetes Project has been in existence for four years with strong leadership and community partner involvement. Through this, over 160 UnityPoint hospital employees, along with over 10 other business and community partners, with a grand total of over 500 walkers, participated in the Muscatine Diabetes Walk on May 4, 2018. A “Diabetes Busters” curriculum has been taught in the district to all third graders for the past two years. Additionally, Muscatine has been designated a BLUE ZONE community, receiving assistance from experts to develop and implement a Blueprint for making permanent environmental, social and policy changes that transition people into healthier behaviors that can lead to longer, happier lives.



Webster County Health Department

The Webster County C3 includes Buena Vista, Calhoun, Humboldt, Pocahontas, Sac, Webster and Wright Counties. A key success of the Webster County C3 is the implementation of a centralized intake process and a standardized process for collecting social determinants of health information across the C3 region. The C3 region utilizes this data to organize ways to integrate strategies between the local public health agencies and primary care providers. The Webster County C3 embedded a health risk assessment tool, AssessMyHealth, into the data collection process. The goal is to assist and provide guidance to providers by offering clinical preventative care, health promotion and disease management strategies. Ultimately, this will assist in improving health outcomes by identifying patients' modifiable health risks.

The regional partners are actively implementing strategies focusing on inappropriate emergency room usage and readmissions to the hospitals. Local public health agencies and community service providers meet routinely to enhance care coordination efforts in order to provide collaboration around a Common Care Plan. Through formulating a Common Care Plan, role responsibilities can be identified and transitions of care can be streamlined. The intent is to include strong community partners to coordinate referral strategies and processes, creating a more efficient and cost effective care delivery system. The Common Care Plan is a tracking tool that is located within the electronic health record of the hospital system in Webster County- UnityPoint Health. The tool includes information about demographics, diagnosis, primary care, medications, allergies, advanced care planning, ED visits, hospitalizations, action plans, fall risks, social determinants of health, community resource involvement, future appointments, labs, immunizations, pharmacy, and social supports.

The Webster County C3 is working on quality improvement activities and stronger referrals with the Webster County Unity Point Community Paramedicine Program, Fort Dodge Fire Department, Law Enforcement Center and City of Fort Dodge. Webster County is implementing processes in order to enhance collaboration and care coordination with these community partners. The objective is to work with these community partners to identify risks. Roles and responsibilities are identified to address the identified risks and needs. This coordinated referral system also strengthens the community in addressing the overall community health needs of the jurisdiction.

Additionally, the Webster County C3 is taking a proactive approach around mental health and substance abuse, particularly around opioid addiction. A task force has been formulated and plans are being put in place to educate schools and the community around the opioid crisis. The objective of the task force is to decrease the incidence of opioid use and substance abuse.