Iowa Collaborative Safety Net Provider Network Community Care Coordination Progress Report

CONTRACT: 5884SN01

Iowa Collaborative Safety Net Provider Network

Community Care Coordination Planning and Development:

The Iowa Primary Care Association (PCA) is under contract with the Iowa Department of Public Health (IDPH) to direct and manage the Iowa Collaborative Safety Net Provider Network (Network). The following information serves as the progress report on Community Care Coordination (CCC) activities from July 1 – December 31, 2013. This report summarizes progress made in implementing the initiative based on the five deliverables within the contract with the IDPH, a budget indicating how the funds are being allocated, and information about remaining needs that exist in order to implement the initiative statewide. In addition, a summary of the customer satisfaction survey reports collected is also included, which serve as the performance incentive measure established by the IDPH.

Deliverable 1: Develop and execute a successful implementation plan for the statewide regionally based network.

The PCA submitted a final work plan to the state for approval in July 2013. Objectives within the work plan have been accomplished with minor changes noted. The PCA has been very successful in the implementation thus far and anticipates further success during the remainder of the contract period.

PCA staff reviewed material from other states and learned a great deal through colleagues in other states who have utilized the Community Care Coordination model. A link on the Primary Care Association website under Community Care Coordination provided access to this material in addition to a document which was kept up to date on frequently asked questions submitted to the PCA by interested organizations.

Several in person meetings were held with policymakers and key state level stakeholders that assisted with the promotion of the funding opportunity throughout August and September. Further, periodic updates were provided at appropriate meetings such as the State Innovation Model (SIM) workgroup meetings, Patient Centered Health Advisory Committee, Safety Net Network Advisory Group to list a few. Key stakeholders provided guidance about implementing the CCC model in Iowa and also shared additional ideas to leverage existing efforts in the state to ensure the full implementation plan was effective.

Due to the tremendous response during two community care coordination educational webinars (over 100 participants for each webinar) the PCA hosted and several additional one-on-one phone calls and emails with organizations interested in the concept, the PCA decided to initially request Letter of Intents for the regional funding. This was done so that only the best positioned organizations were invited back to submit a full application.

The Letter of Intent (LOI) was released the middle of August and 15 applicants submitted a Letter of Intent in mid-September. There were a wide variety of agencies that submitted a LOI

including, but not limited to, public health agencies, hospitals, behavioral health entities, family residency programs, and community health centers. All of the organizations submitting LOIs included several community agencies with well-formed partnerships designed to support the community care coordination model. Each LOI focused on supporting primary care providers and linking patients to community resources which are necessary to address social determinants of health to improve health outcomes. Applicants self-identified their regions and were asked to ensure that a minimum of 10 percent of their total patient target population of Medicaid and uninsured population would be impacted by the community care coordination model. Based on the LOIs submitted, 66 Iowa counties would have been supported by the community care coordination model if funding was available for all interested applicants. This speaks volumes about the level of interest local communities have in new health care delivery approaches to improve patient outcomes and lower the overall total cost of care.

A list of 15 organizations that submitted LOIs is provided below:

Invited to Submit Full Applications

- Webster County Health Department
- Mercy Medical Center - North Iowa, Cerro Gordo Department of Public Health, North Iowa Community Action
- Seasons Center for Behavioral Health
- Telligen, Dallas County Public Health
- Northeast Iowa Medical Education Foundation
- Methodist Jennie Edmundson Hospital
- Community Health Centers of Southeastern Iowa

Only LOI Submitted

- Primary Health Care, Inc. (invited back but elected to not submit full proposal)
- Centerville Community Betterment, Inc.
- Mid-Iowa Community Action, Inc.
- Edgerton Women's Health Center
- County Social Services
- Iowa Specialty Hospital
- ChildServe
- County Rural Offices of Social Services

An independent review committee evaluated the 15 LOIs and based on the scores, eight regions were invited back to submit a full proposal. A Request for Proposals (RFP) was developed by the PCA and sent to the eight regions the end of September. The RFP required that applicants submit information on the following topics: geographic area served, health care providers participating, target population(s), primary care provider leadership support, how social determinants of health would be addressed, the composition of the community care coordination team and their functions, community partners engaged, how an increase and/or improvement of pharmacy services would impact patient outcomes, and strategies for sustaining and expanding the CCC model post funding. On-site technical assistance sessions were held with each of the eight regions. These two-hour sessions were held with the lead agency and their community partners. PCA staff and Jon Rosmann, Executive Director of the Iowa Prescription Drug Corporation, were in attendance to provide technical assistance on the community care coordination model and pharmacy strategies to improve care for the

identified target populations. In addition, this was an opportunity for regions to ask questions about the RFP with the goal of strengthening their applications. The regions spoke highly of the collaborative approach the PCA utilized in the RFP process which the PCA believes contributed to the strong applications submitted.

Seven proposals were submitted the end of October. One region determined that while they very much support the CCC model, they would face challenges with the implementation stage as they had been recently awarded a large grant from the Health Resource and Services Administration. The selection process for the two funded regions is summarized under the third deliverable on page three of this report.

One change to the PCA's implementation plan was the decision the PCA made to not purchase care management software on behalf of the two funded regions. PCA staff evaluated several software programs and while there were several viable programs to consider, it was determined early on that both of the funded regions had internal robust software programs which could be used to track services provided by the CCC teams as well as for the evaluation of the initiative. The funds allocated for the software purchase are instead being used on a more comprehensive evaluation of the initiative and both regions selected were supportive of this decision. The evaluation process will be extremely valuable in informing the two funded communities, but equally as important in capturing both the implementation successes and challenges and the determination of outcomes for communities that will implement this model of care in the future.

Deliverable 2: Conduct community outreach and education sessions.

At the end of August, two educational webinars were held to introduce the Community Care Coordination model to safety net and other health care providers throughout the state. Several statewide list serves were utilized to share information about this training opportunity. The PCA received an impressive response with over 120 individuals participating in each of the webinars. Participants were provided with contact information for PCA staff to follow up with questions and the PCA also put together lists by region of the state with contact information for the organizations willing to be contacted by organizations in their area.

While the initial intent was to provide additional regional education sessions, after modifying the RFP process the PCA elected to hold on-site technical assistance sessions with the top eight regions. The PCA believes this was an effective approach and allowed the PCA staff to experience first-hand the level of engagement from not only the lead agency, but their community partners as well. A summary of the participant evaluation of the two webinars is included below.

Deliverable 3: Execute and monitor subcontracts for at least two and no more than three developmental regional community care coordination entities.

An external independent committee, comprised of 10 members, reviewed the seven proposals and scored them prior to the PCA holding an in person evaluation session with the entire group. Based on the scores from the review committee, two applicants were selected for funding. All applicants, including the five regions not selected, were notified via phone call on the final decision. A follow up email was then sent to each lead agency which included the reviewer comments as well as the strengths and opportunities for improvements for the proposed projects. Contracts were awarded to Webster County Public Health and Mercy Medical Center-North Iowa.

The Webster County initiative is comprised of a six county region including: Webster, Hamilton, Pocahontas, Calhoun, Wright and Humboldt Counties. In addition to primary care, participation by hospitals, behavioral health providers, dentists and pharmacists have been secured. One hundred percent of their primary care providers and hospitals have committed to participation in this project. This initiative seeks to target vulnerable populations at-risk for high utilization of health care resources and/or engaging in unhealthy behaviors. Income and access to health insurance are the social determinants of health that impact their target population's ability to seek timely or preventative healthcare. Through this funding, approximately 2,492 individuals will be targeted including their two most vulnerable populations of Medicaid or uninsured persons focusing on medically complex persons and/or persons with multi-occurring behavioral health conditions and children.

Mercy Medical Center's project concentrates on Cerro Gordo County. Funding will be specifically used to develop and measure success of patient-centered paths, focusing primarily on patients who fall under one or more of the following criteria: uninsured, no established primary care provider, have diabetes and/or heart failure, and/or are unable to afford their medications. Their team will focus on the following outcomes: identification and outreach of uninsured patients throughout Cerro Gordo County; development of a system to ensure uninsured patients can obtain insurance; creation of a "central hub" to assess patients for at-risk behaviors and social determinants of health; assist patients in identification of a patient-driven goal; and help establish patients with a primary care provider. This project grew out of collaboration between Mercy Medical Center North Iowa, Cerro Gordo County Department of Public Health and North Iowa Community Action Organization. The total number of uninsured and Medicaid patients within Cerro Gordo County equals 6,386 individuals. This project will strive to improve community care coordination efforts on approximately 15% of the target population.

Memorandums of agreement for $300,000 in funding have been executed for both regions with the contract award date beginning on December 2nd.

Deliverable 4: Develop state-level infrastructure to support regional community care coordination entities and local practices based on community outreach and education sessions and barriers identified through the RFP process.

After contract awards were announced, an additional on-site technical assistance session was held at each of the lead agency locations. These sessions were primarily focused on addressing any opportunities for improvement noted by the RFP review committee discussing what additional technical assistance and support the PCA will offer to further support the regions in their implementation process, and reviewing the evaluation plan for the initiative to ensure both regions are capable of collecting the appropriate data for analysis of the community care coordination model. These sessions included community partners which further demonstrated to the PCA that both regions have engaged the broader community in the CCC model implementation.

The Iowa Prescription Drug Corporation provided initial pharmacy technical assistance to the organizations invited back to submit proposals. The pharmacy technical assistance going forward will focus on increasing access to medications which improves medication adherence and patient outcomes, enhancing the role of the pharmacist as an integral member of the CCC team, providing Medication Therapy Management services for high risk patients, and

integration of a pharmacy home model for the target populations.

The behavioral health technical assistance will primarily focus on integration of care between primary care and behavioral health providers with special emphasis placed on helping primary care providers understand the role they can play to more appropriately address and manage behavioral health issues within the primary care setting. This will allow for better referrals from primary care providers to behavioral health providers to be made so that the limited behavioral health providers can be used for the most complex patients.

Both of these technical assistance areas were clearly identified as barriers to care for the target populations and thus the primary reason the PCA will provide ongoing technical assistance not only to the two regions selected but also those who initially submitted a LOI and request further guidance. The PCA lead staff will also continue to work with each region to ensure progress is made and that lessons learned are shared between the two regions and statewide as well.

Deliverable 5: Develop an evaluation plan for the regional community care coordination entities and statewide entity.

The PCA has engaged the services of three evaluation experts to assist in the development of an evaluation plan for the initiative. This plan covers a wide variety of key measures that will be utilized to showcase the success of the program implementation along with improved patient outcomes, patient satisfaction, appropriate referral outcomes, primary care provider satisfaction, pharmacy and behavioral health management, emergency room utilization, and a target goal to consider the impact on overall total costs of care. This evaluation plan was reviewed during the post award technical assistance session with the regions and both organizations expressed support for the evaluation plan noting that the deliverables are realistic and collection of this data is appropriate to highlight their success in transitioning their health care delivery model.

Rochelle Schultz Spinarski from Rural Health Solutions and Drs. Pete Damiano and Suzanne Bentler from the University of Iowa Public Policy Center have developed an evaluation plan for each region. Many of the targets are similar for the two regions, however depending on data available; each region may have one or two additional measures to track. The evaluation plan includes both process and outcome measures and will engage all local stakeholders and those served in the evaluation of the initiative.

Community Care Coordination Implementation Budget

The following table includes the implementation budget for the CCC funding for state fiscal year 2014 and is set up to show the funding allocated to the two regions as well as the funding being used to build state-level infrastructure to support communities from across the state in implementing this model of care.

Community Care Coordination	Regional Funding	State Funding	TOTAL
Salary/ Fringe	$0	$108,842	$108,842
Supplies/Equipment	$0	$7,150	$7,150
Contract	$600,000	$426,658	$1,026,658
Other	$0	$15,500	$15,500
TOTAL	**$600,000**	**$558,150**	**$1,158,150**
Salary/Fringe	n/a	CEO, CFO, Controller, Senior Program Director, Program Manager	
Supplies/Equipment	n/a	Internet/Data, Printing/Copying, Postage, Phone	
Contract	Grants and Subawards	State Director, Behavioral Health TA, Pharmacy TA, Evaluation	
Other	n/a	Office Supplies, Travel, Meetings, Conferences	
*Pharmacy TA - IPDC/IPA - pharmacy home (patient education, access to medications, medication therapy management, adherence, reconciliation)	**Behavioral Health TA - behavioral health integration, behaviorally enhanced PCMH model, role of telehealth	***Onsite technical assistance will be provided to the two funded communities beyond pharmacy and behavioral health. Also, the pharmacy and behavioral health TA will be made available to all communities who applied for the funding as the PCA is committed to spreading this model across the state.	

Remaining Needs to Implement the Initiative Statewide

The PCA continues to work to develop a strategy to expand the Community Care Coordination model to align with the SIM plan. With 15 total applications received encompassing 60 counties, there is considerable interest in this model across the state. Through the application process community partners pulled together to meet the common goals of improving health outcomes and reducing the overall cost of care for the state. In working with communities during the application process, it is clear that local partners are engaged and focused on collaborative efforts to change the current fragmented health care system.

Continued state funding will be crucial in the next state fiscal year as this will allow the PCA to provide ongoing support to the two regions and assist in the replication of this model as part of the PCA statewide strategy. Part of the development strategy is to research additional funding streams to help support the overall implementation plan including funding the remaining five RFP applicants. PCA staff continues to reach out to these applicants to develop a revised approach to implement the CCC model in their regions with either limited or no funds. Through the extensive evaluation plan, the regions will be able to serve as learning labs for delivering care in collaborative, non-competitive manner and will be able to easily showcase their successes and lessons learned. Expectations remain high that patient outcomes will be positively affected instantaneously and in short order, the state will see a direct impact on total cost of care.

Through lessons learned from the two regions, the PCA will work to continue to develop a statewide regional approach to grow the Community Care Coordination model to align with the SIM plan and implementation. PCA staff attended all of the SIM meetings and also submitted comments to the Iowa Department of Human Services on the draft state plan that was submitted to the Centers for Medicare and Medicaid Services in December, which are included as an attachment to this report. In addition, the PCA has met on several occasions with the Iowa Department of Human Services and Iowa Medicaid Enterprise staff to ensure that this project closely aligns with the SIM model and request their assistance in providing data to determine improvement in overall total costs of care.

Because the two communities have only started their efforts, outcome information is not yet available. However, based on other states' experiences, it is anticipated there will be a positive impact on health outcomes, while also achieving a reduction of overall costs through a decrease in inappropriate utilization of services. Initiatives such as the Community Care Coordination programs have the potential to make a significant impact on local health care delivery and on the State's overall health care transformation. We ask the Legislature to continue funding for the two initial communities and to support additional communities in initiating care coordination programs.

IDPH Contract Performance Measure

As part of the contract the PCA has with the IDPH, a performance incentive measure was included, which is: "The Department will withhold $10,000 from Budget C payment(s) during the first 5 months of the contract period, pending Contractor completion and submission of customer satisfaction surveys of attendees at community outreach and education sessions, showing a satisfaction rate of 70% or greater. With the submission of the December 31 program progress report the Contractor shall submit a written summary of results of community outreach and education sessions, including the customer satisfaction rate."

After the two webinars were held, an online evaluation was sent to participants. Over 90% of the participants who completed the evaluation agreed or strongly agreed the webinars were educational and worthwhile. Written comments were supportive of the community care coordination model and suggested a high level of interest throughout the state. In addition to this customer satisfaction, an online evaluation was also sent to those lead agencies that received onsite technical assistance. Seven of the eight agencies responded and one hundred percent of the respondents stated that the onsite technical assistance sessions either quite well or extremely well answered their questions about the initiative. Reponses again indicated that the PCA staff is knowledgeable about the model and understands how to effectively implement the model in each of their regions.

State Innovation Model State Healthcare Innovation Plan
Comments from Iowa Primary Care Association
December 18, 2013

Community Care Coordination Team Development

We commend Iowa Medicaid Enterprise's (IME) efforts to try to support the transformation of primary care practices into patient-centered health homes through the 2703 programs, Iowa Health and Wellness Plan implementation, and State Innovation Model (SIM) planning process. We ask that IME also support Community Care Coordination Team (CCCT) development in the state's SHIP as this infrastructure and inclusion in new payment models is necessary for small, independent, rural, and safety net primary care practices. These teams will be of benefit to all patient populations and providers, and is a very justifiable model with only the Medicaid population as the growing body of knowledge indicates from states implementing the model before us. The CCCTs have the ability to aggregate the broad array of community-based services necessary for Medicaid and uninsured patient populations, both of which are more impacted by determinants of health such as poverty, food insecurity, unsafe housing, and violence in the home, among many other issues. This aggregation of services is of benefit to all traditional medical delivery system providers and there is increasing recognition nationally of the need for this model, particularly for underserved populations.

Primary Care-Led Care Coordination Entity

We appreciate that IME remains open to having more than one Medicaid ACO in any given region in the state and that there is an openness for non-health system-based ACOs to contract with the state. The enrollment of patients into Medicaid ACOs is based on the primary care provider (PCP) they are assigned to having a contract with an ACO, and the Iowa PCA will be working to build a PCP network with Federally Qualified Health Centers, Rural Health Clinics, and other PCPs to build a Care Coordination Entity (CCE) that can hold a Medicaid ACO contract.

Selecting an appropriate infrastructure partner is part of the development of the PCA's CCE and most likely this partner will be a managed care company that is open to looking at new lines of business outside of traditional managed care contracts. Having such a managed care partner is both necessary and valuable given their experience managing complex, high-risk patient populations and their ability to bring the unique infrastructure to primary care providers such as analytics, provider network development, care management strategies, and a willingness to deploy strategies using local resources. The selected infrastructure partner will also have an ability to take on risk-based contracts as the payment methodology evolves.

The development and inclusion of a primary care-led CCE can be of benefit to health systems, hospitals, and specialists which may lack experience managing the needs of high-risk, complex populations, including the long-term care and behavioral health populations. The CCE will hold contracts with hospitals and specialists and can design and implement payment terms that benefit these organizations and allow them to share in savings, which may be more advantageous to them than holding an ACO contract with Medicaid themselves. Regardless, these organizations would be able to participate in an ACO as well as the CCE since the enrollment of patients is based on the participation of PCPs with either an ACO or the CCE.