COMMUNITY UTILITY DEVELOPMENT IN IOWA

TED BOESEN, CEO
IOWA PRIMARY CARE ASSOCIATION

HHS Appropriations Subcommittee Meeting
2/14/2013

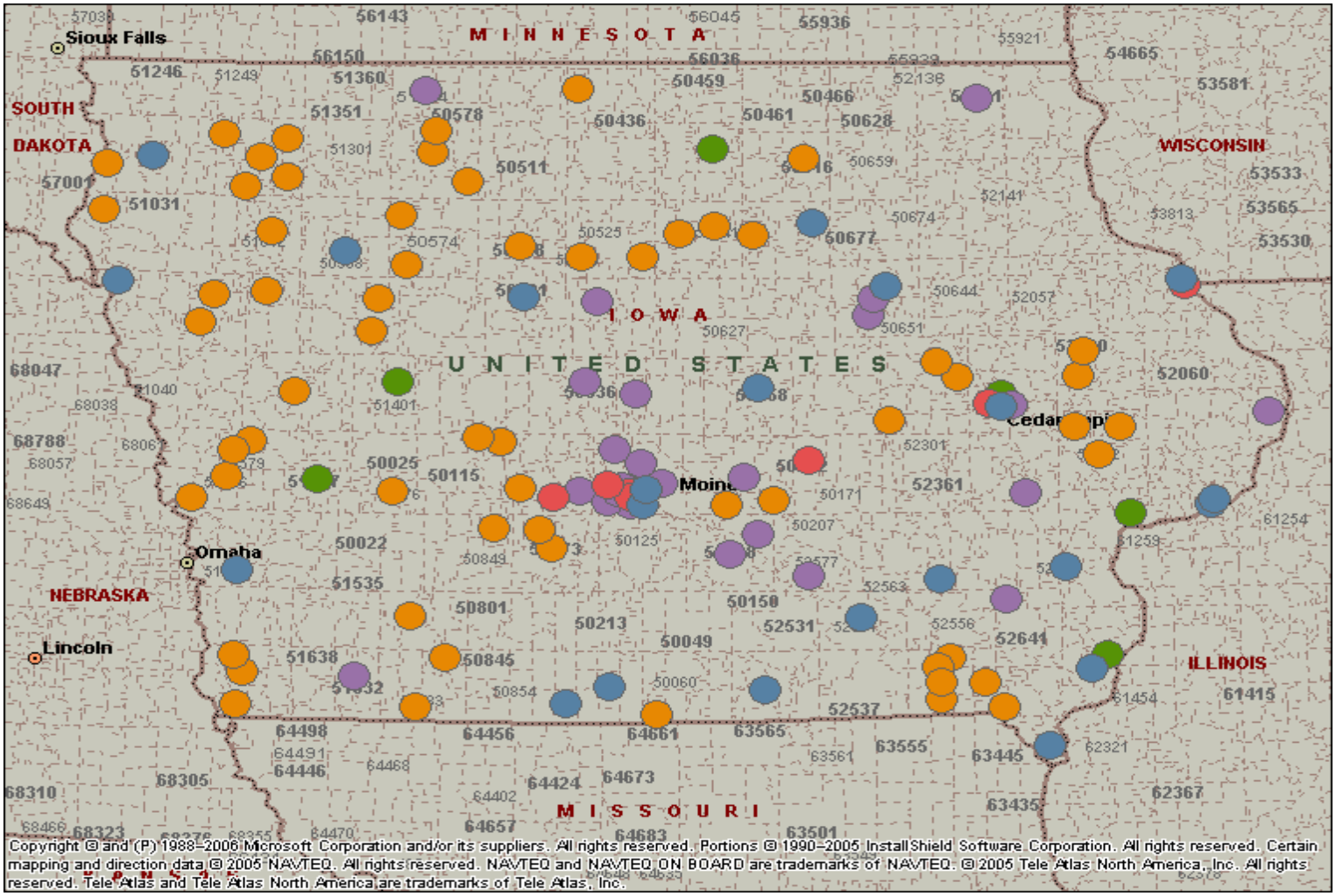
Why Community Utility in Iowa?

- Necessary infrastructure to reduce costs, improve quality
- Allows for risk adjusting that includes more than claims data to identify high acuity-high cost patients
- Ideal model to be included as part of Iowa's State Innovation Model planning and implementation particularly for the Medicaid patient population
- Provide necessary infrastructure and support to primary care providers and patients

Why Community Utility in Iowa?

- Result in a re-engineered health care delivery system that supports the Triple Aim (reduce costs, improve quality, improve access)
- Connect various other local organizations that support patients in achieving better health as part of a more efficient and effective health care system
  - "Orphan providers"
- Move Iowa's current health care system to more of a prevention-based system that better addresses patients' social determinants of health

Iowa's Safety Net Providers



Iowa's Safety Net Providers

- Federally Qualified Health Centers – 14
- Free Clinics – 45
- Rural Health Clinics – 138
- Family Planning Agencies - 14
- Also recognizes public health departments, maternal/child health providers, child health specialty clinics, and others as part of the safety net in Iowa

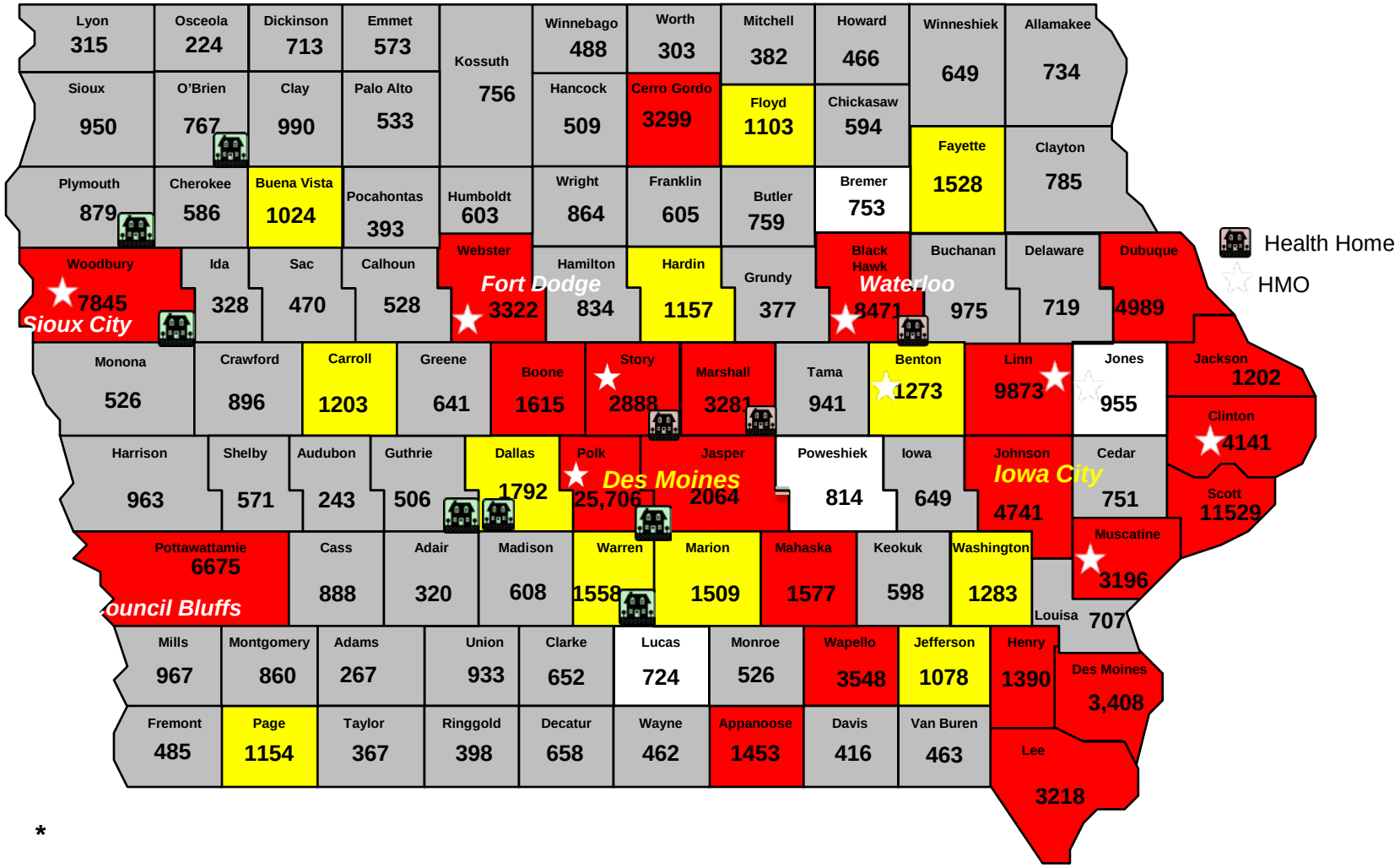
Where to Start (NC Experience)

- Asthma (1998 – 1st Initiative)
- Diabetes (began in 2000)
- Pharmacy Management
  - Prescription Advantage List (PAL) - 2003
  - Nursing Home Poly-pharmacy (piloted for the state 2002 - 2003)
  - Pharmacy Home (2007)
  - E-prescribing (2008)
  - Medication Reconciliation (July 2009)
- Emergency Department Utilization Management (began with Pediatrics 2004 / Adults 2006)

Where to Start (NC Experience)

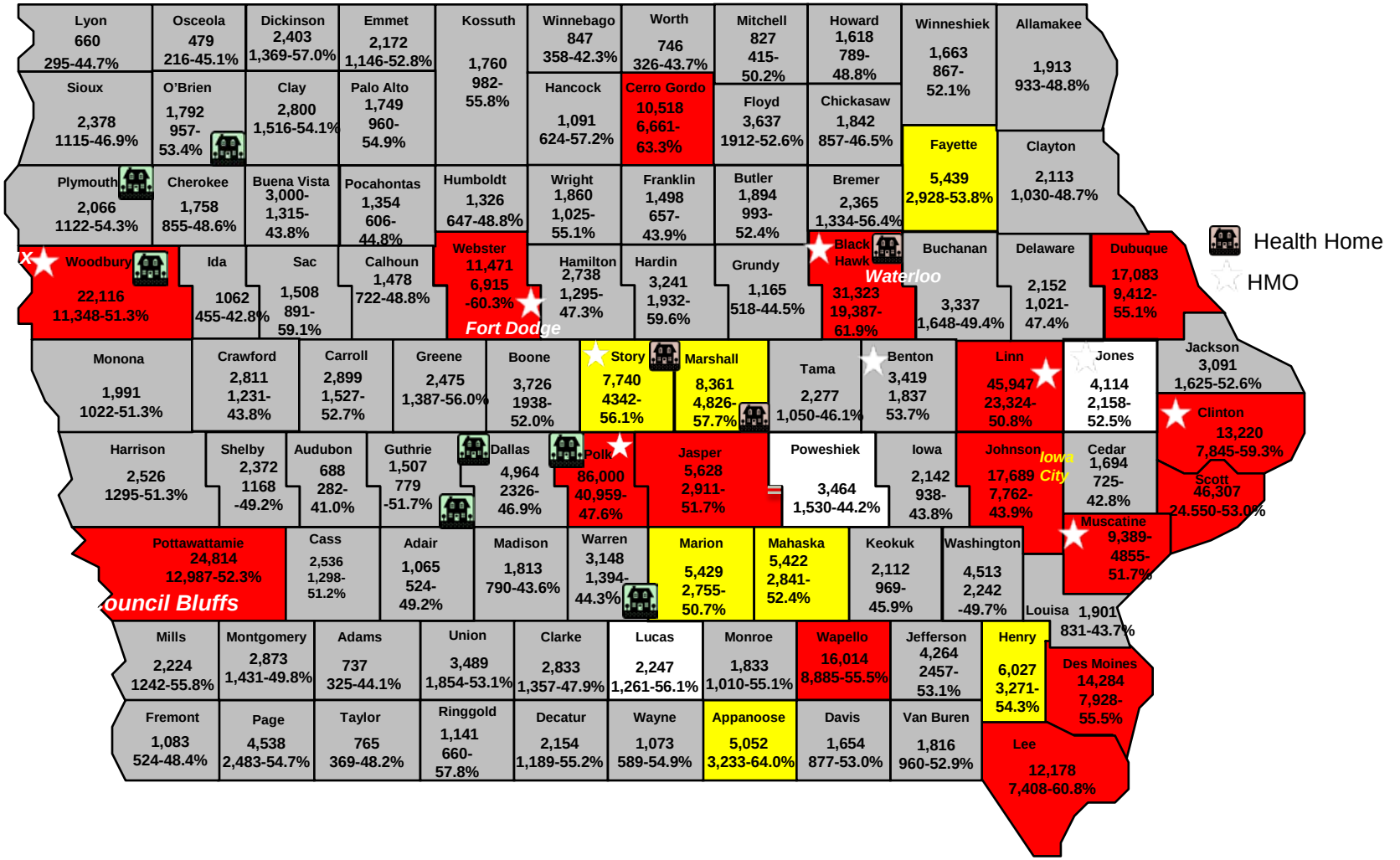
- Case Management of High Cost-High Risk (2004 in concert with rollout of initiatives)
- Congestive Heart Failure (pilot 2005; roll-out 2007)
- Chronic Care Program – including Aged, Blind and Disabled
  - Pilot in 9 networks 2005 – 2007
  - Began statewide implementation 2008 - 2009
- Behavioral Health Integration (began fall 2010)
- Palliative Care (began fall 2010)
- Pregnancy Home and Care Coordination for Children with Special Needs (began April 2011)

Potential Health Home Candidates



*

ER visits per County and Potential Health Home Candidates ER Visits-



First Patient Example

A mother brings her 2-year-old son in to a primary care provider for his well-child visit. The clinician and staff perform a typical well-child visit. They notice the mother seems to be stressed out and not able to focus on all of the information they are providing. They are unsure how to support the mother and worry some of their recommendations for the son may go unfilled.

Community Utility Solution

Solution: The primary care provider makes a referral through the regional entity to connect the mother with a care coordinator supported by the 1st Five program, who would contact the family and link them with appropriate support services available in the community. The care coordinator would provide information back to the primary care provider so the provider could follow up with the mother during subsequent visits. Because the primary care provider is participating in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, any results that are flagged after the assessment is conducted will be shared with the care coordinator who will work with the family to provide appropriate supports for the son.

Second Patient Example

A 56-year-old man has several chronic health care issues including diabetes, anxiety, depression, tobacco use, and obesity. He often misses appointments with his primary care provider and frequently shows up at the local emergency room seeking care, particularly when he is feeling anxious. His primary care provider has tried to help him access behavioral health services but the limited number of behavioral health providers in his rural community makes it nearly impossible to get a timely appointment. His primary care provider also just discovered the patient is currently homeless.

Community Utility Solution

The regional community utility effort uses data to identify this patient as high-risk and makes a case manager available to support the primary care provider office. The case manager assists the patient with transportation for his appointments and calls him to remind him about appointments. Through the regional entity, a behavioral health provider is made available to the primary care provider for consultation on the patient's behavioral health needs. The consulting behavioral health provider, primary care provider, and patient determine that tele-behavioral health appointments are appropriate given the patient's unmanaged and significant anxiety and depression. Through the state community utility entity, tele-health infrastructure has been made available to providers across the state.

Community Utility Solution, cont.

Once this health issue is better addressed, the primary care provider can manage this aspect of the patient's care with assistance from the regional behavioral health consultant. Additionally, the case manager connects the patient with a peer support resource available in a neighboring community and connects the patient with Iowa Legal Aid, which assists the patient in getting reestablished in subsidized housing. Finally, through shared claims and other relevant data made available from the state entity, the patient's overall health care costs are lowered due to a reduction in the duplication of services.

Upcoming Dates of Interest

- Safety Net Network Strategic Planning Session
  - March 6, 2013
  - Community Utility Development as Priority
- National Academy of State Health Policy Onsite Technical Assistance Session
  - April 25 – 26, 2013

Contact Information

Ted Boesen

CEO

Iowa Primary Care Association

515-333-5010

tboesen@iowapca.org