COMMUNITY CARE COORDINATION PLAN

NASHP Learning Collaborative

Iowa's NASHP Learning Collaborative Goals

- Maximizing the participation of eligible safety net providers in the state's 2703 Health Home Program, and;
- Developing strategies to better integrate primary and behavioral health care for the population served through program, and;
- Exploring potential roles for safety net providers in accountable care organizations and other valuebased purchasing arrangements.

Learning Collaborative Members

- □ Ted Boesen, CEO, Iowa PCA
- Marni Bussell, Health Home Coordinator, IME
- Libby Coyte, PA-C, Past President, Iowa Association of Rural Health Clinics
- □ Dr. Pete Damiano, Director, Ul Public Policy Center
- Deb Kazmerzak, Director of Clinical Services, Iowa
 PCA
- Jennifer Steenblock, ACA Coordinator, Iowa Dept.
 of Human Services
- □ Jennifer Vermeer, Director, IME

Attraction of Community Care Coordination Model For Iowa

- □ Dr. Ed Schor, The Packard Foundation
- Recognized as Solution for Meeting PCMH
 Infrastructure Needs for Safety Net, Rural, and
 Independent Providers
- Determinants of Health
 - #1 Social/societal characteristics and total ecology
 - #2 Health behaviors
 - #3 Medical care
 - #4 Genes and biology

Why Community Care Coordination in Iowa?

- Provide necessary infrastructure and support to primary care providers and patients.
- 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 lowa's State Innovation Model planning and implementation particularly for the Medicaid patient population.
- Result in a re-engineered health care delivery system that supports the Triple Aim (reduce costs, improve quality, improve access).

Why Community Care Coordination in Iowa?

- Connect various other local organizations that support patients in achieving better health as part of a more efficient and effective health care system in a community-led, non-competitive manner.
 - "Orphan providers"
- Move lowa's current health care system to more of a prevention-based system that better addresses patients' social determinants of health.

Concept Development Opportunities in lowa

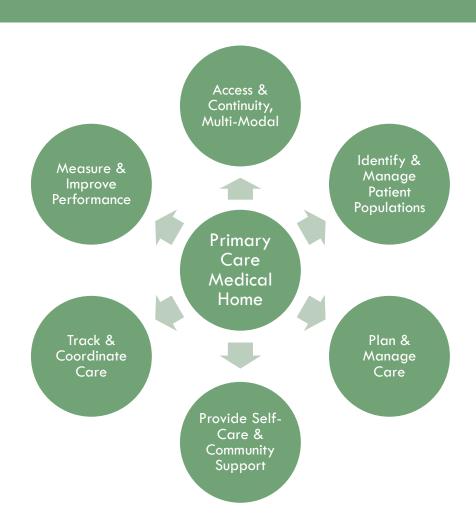
- National Academy of State Health Policy Medicaid-Safety Net Learning Collaborative Site Visit
- 2703 Health Home SPA Program
- ACO Development
 - State Innovation Model for multi-payer ACO
- Commonwealth Fund Project Re: Impact of ACA on Safety Net
- Community Transformation Grant
- Blue Zones Communities
- Healthiest State Initiative

Other States/Communities Doing This Work

- Alabama
- □ Camden, New Jersey
- Chicago, Illinois (Medical Home Network)
- □ Colorado
- Maine
- Maryland
- Minnesota

- Montana
- □ New Mexico (Health)
 - Commons Model)
- □ New York
- North Carolina
- □ Oklahoma
- □ Oregon
- Vermont

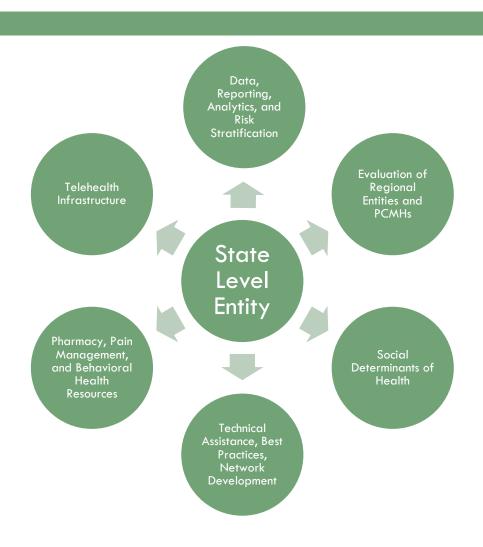
High-Level Primary Care Medical Home Functions



High-Level Regional Functions



High-Level State Functions



Partners in Community Care Coordination Model

- Primary care providers
- Public health departments
- Maternal/child health providers, inc. CHSCs
- Area Agencies on Aging
- Family planning agencies
- Community action organizations
- Patient/family advocates

- Specialists/hospitals
- Legal aid services
- Organ/cancer associations
- Behavioral health providers
- Oral health providers
- Long-term care providers
- HCBS providers

NASHP Site Visit

- National Academy of State Health Policy Onsite
 Technical Assistance Session
 - April 25, 2013, 10:00 a.m. to 3:00 p.m. at Embassy Suites Downtown Des Moines
 - Overview of Iowa's State Innovation Model Initiative
 - Why Community Care Coordination Works
 - Addressing the Social Determinants of Health
 - Rural and Urban Provider Perspectives on Community Care Coordination and Its Benefits
 - April 26, 2013, 9:30 to 11:30 a.m. at State Capitol
 - State Innovation Model Stakeholder Discussion

Care Coordination Legislative Activities

- Funding for community care coordination
 development included in HHS budget \$1,158,150
 - "Provide an integrated approach to health care delivery through care coordination that supports primary care providers and links patients with community resources necessary to empower patients in addressing biomedical and social determinants of health to improve health outcomes."
 - Must align with the SIM through work with DHS
 - □ Progress report due 12/31/2014
- Advisory Council for State Innovation Models Initiative

Vision

To develop regional community care coordination teams across lowa which coordinate care for highrisk patients and to support primary care providers regardless of the presence of Accountable Care Organizations.

Regional Team Work

- Support small, rural, independent, and safety net practices by employing a team of individuals to provide care management and coordination services.
- The team will support participating primary care providers with their most high-risk patients and will interface with community resources to improve the care for patients.

State Entity Work

- Support the regional community care coordination teams.
- The infrastructure built at the state level is a more efficient use of resources and will provide practices with:
 - Behavioral health consultative support
 - Pharmaceutical support
 - Support to share information among all of the partners,
 i.e. case management software

Implementation Steps

- Conduct community outreach and education sessions in partnership with an outside technical assistance provider from a state already engaged in building this type of infrastructure.
 - Bring together partners
 - Identify clinician champions
- Execute and monitor contracts for at least two and no more than three developmental regional community care coordination entities.

Implementation Steps, cont.

- 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 RFA process.
- Develop an evaluation plan for the regional community care coordination entities and statewide entity.

Contact Information

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