COMMUNITY CARE COORDINATION

Bringing together community partners as an improved approach to providing quality care to our patients

VISION

- To develop regional community care coordination entities across Iowa to coordinate care for high-risk patients and to support primary care providers.

GOALS

- Provide assistance to local primary care providers to meet the unique needs of their highest risk patients
- Deploy care coordinators and additional support to help assist practices in providing services for their highest need patients such as targeted disease and care management interventions, addressing gaps in care, education, self-management support, transitional care, connection to community resources, pharmacy management, and behavioral health management
- Improve quality, population health, and cost of care at local level
- Develop regional community care coordination entities that become extension of primary care teams

GOALS CONTINUED

- Engage practices in quality improvement initiatives
- Establish connections with other community resources to link patients to support systems that address social and behavioral needs
- Demonstrate value of community care coordination and linkages to community resource approaches to payors in meeting the Triple Aim goals
- Foster community innovation and response by building upon local champions and early adopters

SOCIAL DETERMINANTS OF HEALTH

- Social and economic conditions and their effects on people's lives determine risk of illness and impact the actions taken to prevent or treat illness
- The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of force such as: economics, social policies, and politics.
- Achieving health equity is the primary approach in addressing social determinants of health - where everyone has the opportunity to reach their full health potential

FACTORS RELATED TO HEALTH OUTCOMES

- How a person develops during the first few years of life (early childhood development)
- How much education a person obtains
- Ability to get and keep a job
- Type of work a person does
- Having adequate food or being able to get food (food security)
- Having access to health services and the quality of those services
- Housing status
- How much money a person earns
- Discrimination and social support

BENEFITS

- Safety net providers are accustomed to working with various community partners to ensure care, provided to high risk populations, is based on the needs of the patients including but not limited to financial barriers and other social determinants of health. This model allows for a coordinated comprehensive effort that will assist in minimizing the gaps to quality health care, thus reducing the overall total costs expended for care.

TARGET POPULATION

- Current and new Medicaid members and the uninsured population
- Definition of Safety Net population
  - Under 138% federal poverty level
  - Individuals without a medical home
  - Uninsured and underinsured
- Examples:
  - People showing up in the ER that do not require admission
  - People in need of pain management coordination and services

GOALS OF CARE COORDINATION

- The goal of care coordination is to make the primary care practice the hub of all relevant activity. Care must be coordinated not only within the practice, but between it and community settings, labs, specialists and hospitals

KEY COMPONENTS OF CARE COORDINATION

- Link patients with community resources to facilitate referrals and respond to social determinant of health needs.
- Integrate behavioral health and specialty care into care delivery through co-location or referral agreements.
- Track and support patients when they obtain services outside the practice.
- Follow-up with patients within a few days of an emergency room visit or hospital discharge.
- Communicate test results and care plans to patients/families.

DESIRED OUTCOMES

- To build an infrastructure through care coordination management within participating regions to provide better, more efficient and more cost-effective health care for our state's most vulnerable individuals.
  - Need to invest in infrastructure to support primary care and patients
    - Rural, independent, safety net
  - Need for care coordination among providers and with other community resources
  - Model developed based on experience of other states
  - Address risk profile and social determinants of health

TIMELINE FOR IMPLEMENTING THIS MODEL OF CARE

- The Iowa Primary Care Association will have a contract with the Iowa Department of Public Health to implement this model which includes the following:
  - Planning and Model Development: July – September 2013
  - Implementation of State Level Resources: October – December 2013
  - Regional Implementation: December 2013 – June 2014
- Below are several high-level phases of implementation for the model for care coordination entities:
  - Letter of Intent Released August 12, 2013
  - Letter of Intent Due September 13, 2013
  - Release of Request for Proposal September 23, 2013
  - Answers to Questions Posted As available
  - Proposals Due by 5 pm CT October 25, 2013
  - Contract Award Notification November 15, 2013
  - Begin Work December 2, 2013
  - Contract End Date June 30, 2014

LETTER OF INTENT

- Describe an activity in which your organization has engaged diverse community partners that has resulted in improved quality care to patients.
- Describe your organization's current participation with Patient Centered Medical Home recognition, Iowa Medicaid Enterprise's State Plan Amendment 2703 Health Home programs, and/or your intent to align with the health home concept going forward.
- List your organization's current partners both locally and regionally. What role does each of these partners play in your current or planned collaborative efforts?
- Which organization will serve as the lead agency for a regional community care team and how will this role be defined?
- The experience in other states supporting community care coordination or similar models cite the critical role that clinical leadership plays in the success of these efforts. Has a lead clinician been identified who would support this project? Please describe your strategy for engaging additional clinicians.
- What target population(s) of high risk patients do you feel could most benefit from further care coordination efforts?
- What are current barriers and/or challenges that you have experienced in your current efforts to improve the care of patients?

LETTER OF INTENT CONTINUED

- Describe how you would address the social determinants of health for your desired target population.
- Describe your relationship with local pharmacists/clinical pharmacists. Do you currently work with a 340b program? If not, please describe your intent to work with a 340b program.
- What information does your organization or your partner organizations currently track and monitor? Please provide a detailed example of data collected and the impact your collaborative work has had on this data?
- What software program(s) does your organization currently use to track data? What IT support do you have available to you to support care coordination efforts among several partner organizations?
- How do you feel your collaborative partners can best meet the needs of the following groups of patients? In addition, list your current ratios of the subsets below and how you anticipate these ratios will change when the Iowa Health and Wellness Plan is implemented.
    - Medicaid population
    - Uninsured population
    - Current payor mix
    - Primary care providers/patient ratio

CONTACT INFORMATION

Sarah Dixon Gale or Michelle Stephan
Iowa Primary Care Association
sdixongale@iowapca.org
mstephan727@icloud.com