SAFETY NET OVERVIEW & COMMUNITY CARE TEAM MODELS

Health and Long-Term Care Access Advisory Council – 11/7/2012

Presentation Topics

- Overview of the Safety Net Network
- Commonwealth Fund Project Description
- Community Care Team Models

Overview of the Safety Net Network

Safety Net Network

- Iowa Collaborative Safety Net Provider Network
- Legislatively created in 2005; expanded in 2008 and in 2012
- Leadership Group and Advisory Group
- Representatives from Safety Net Network named to health care councils
- Provide funding to support various initiatives identified as priorities by safety net providers
- Safety net definition: At or under 200% of the FPL and un- or under-insured

Provider Award Funding

- Free Clinics
  - Total funding available: $274,050
- Rural Health Clinics
  - Total funding available: $142,192
- Federally Qualified Health Centers
  - Total funding available: $75,000

Other Initiatives

- Pharmaceutical Initiative
  - Total funding available: $320,000
- Specialty Care Initiative
  - Total funding available: $310,000
- Medical Home Development Initiative
  - LBH: Total funding available: $77,609
  - MCH: Total funding available: $95,582
- Sexual Assault Response Team Initiative
  - Total Funding Available: $50,000

Key SFY12 Outcomes

- 87.8% of funding allocated supported direct services to safety net patients from across the state
- Provided funding to 115 clinics or grantees
- 10,600 patients received direct services from the 10 grantees
- Over $3.1 million in free care was provided by four grantees

Annual Data Collection

- Data is collected annually
- Request for 2012 data will be made in early 2013
- In 2011, the clinics that make up the Network are serving their intended safety net population:
  - Low income, uninsured, underinsured, and racial and ethnic minorities

SFY12 Provider Awards and Survey Respondents

- Provider Awards
  - Free Clinics – 38 of 43 (88%)
  - Rural Health Clinics – 66 of 140 (47%)
- Survey Responses
  - Community Health Centers – 14 of 14 (100%)
  - Family Planning Agencies – 14 of 14 (100%)
  - Free Clinics – 42 of 38 (over 100%)
  - Rural Health Clinics – 72 of 66 (over 100%)

Data Challenges

- Ability to collect and report data as requested
  - Unduplicated patients versus encounters
- Ability to report information in the same categories or ranges
- Caution should be used when generalizing these data across the Network

Overall Patient Demographics

- 12% of safety net patients belong to a racial minority
- 17% identify as being Hispanic/Latino
- Women are using Network clinics at far higher rates than men among all clinic types
- Children and young adults, ages 0 to 34, make up 60% of the safety net patient population
- Compared to the state of Iowa's 22% combined uninsured and Medicaid population, the Network has a combined uninsured and Medicaid population of 61%
- Majority of patients are being seen for treatment of chronic diseases (encounters)

Total Unduplicated Patients and Encounters

2010

- Unduplicated Patients – 398,449 (n=96)
- Encounters – 1,502,806 (n=130)

2011

- Unduplicated Patients – 411,543 (n=113)
- Encounters – 1,493,616 (n=138)

Community Health Centers

2010

- Unduplicated Patients – 172,312
  - Uninsured – 39%
  - Medicaid – 33%
  - Non-White/Non-Caucasian – 16%
  - Hispanic – 18%

2011

- Unduplicated Patients – 181,458
  - Uninsured – 35%
  - Medicaid – 38%
  - Non-White/Non-Caucasian – 28%
  - Hispanic –21%

Community Health Centers

2010

- Patient Encounters – 602,001
- Provider FTEs
  - DOs/MDs – 66
  - PAs/NPs/ARNPs – 63

2011

- Patient Encounters – 635,046
- Provider FTEs
  - DOs/MDs –70
  - PAs/NPs/ARNPs –67

Family Planning Agencies

2010

- Unduplicated Patients – 82,633
  - Uninsured & Medicaid – 70% (combined)
  - Female – 95%
  - Non-White/Non-Caucasian – 11%
  - Hispanic – 8%

2011

- Unduplicated Patients – 79,579
  - Uninsured & Medicaid – 72% (combined)
  - Female – 96%
  - Non-White/Non-Caucasian – 19%
  - Hispanic – 18%

Family Planning Agencies

2010

- Patient Encounters – 220,942
- Provider FTEs
  - DOs/MDs – 6
  - PAs/NPs/ARNPs – 37

2011

- Patient Encounters – 241,923
- Provider FTEs
  - DOs/MDs – 5
  - PAs/NPs/ARNPs – 26

Rural Health Clinics

2010

- Unduplicated Patients – 124,886
  - Uninsured & Medicaid – 23%, 20% (combined)
  - Medicare – 31%, 29%
  - Non-White/Non-Caucasian – 3%, 2%
  - Hispanic – 8%, 4%

2011

- Unduplicated Patients – 126,353
  - Uninsured & Medicaid- 21%, 19% (combined)
  - Medicare – 27%, 31%
  - Non-White/Non-Caucasian – 7%, 32%
  - Hispanic – 2%, 0%

Rural Health Clinics

2010

- Patient Encounters – 587,874
- Provider FTEs
  - DOs/MDs – 85
  - PAs/NPs/ARNPs – 74

2011

- Patient Encounters – 557,960
- Provider FTEs
  - DOs/MDs – 85
  - PAs/NPs/ARNPs – 74

Free Clinics

2010

- Unduplicated Patients – 18,618
- Patient Encounters – 91,989
  - Uninsured – 94%, 86%
  - Non-White/Non-Caucasian – 28%, 25%
  - Hispanic – 13%, 22%

2011

- Unduplicated Patients – 24,153
- Patient Encounters – 58,687
  - Uninsured – 89%
  - Non-White/Non-Caucasian – 18%
  - Hispanic – 13%

Free Clinics – Volunteer Hours 2011

Physician	5741
ARNP, PA	5331
Pharmacist	2479
Chiropractor	294
Dentist	605
Dental Hygienist/Dental Assistant	143
Health Professional Student (Medical)	2413
Health Professional Student (Nursing)	1627
Health Professional Student (Pharmacy)	1432
Health Professional Student (Other)	197
Social Worker	2575

Nurses (RN, LPN)	12001
CNA	496
CMA	6066
EMT	126
Administrative	13834
Interpreter	1210
Medical Transcriptionist	228
Ancillary	6093

Enabling Services 2011(Encounters)

Community Health Centers

Interpretation	17,923
Case Management	12,025
Patient Education	4,979

Family Planning Agencies

Transportation	125
Interpretation	732
Eligibility Assistance	3,492
Outreach	597
Referrals	1722
Patient Education	30,783
Patient Assistant Programs	4,144

Enabling Services 2011 (cont.)

Free Clinics	
Transportation	73
Interpretation	1,921
Eligibility Assistance	57
Food	1,673
Employment Assistance	3
Case Management	860
Outreach	197
Referrals	924
Patient Education	2,070
Patient Assistant Programs	1,113
Other	523
Do Not Track	4,465

Rural Health Clinics	
Transportation	1
Interpretation	16
Eligibility Assistance	557
Food	1
Employment Assistance	1
Case Management	800
Outreach	1
Referrals	3,498
Patient Education	8,554
Patient Assistant Programs	184
Other	17
Do Not Track	17,847

Top Five ICD9 Codes

CHCs

- Diabetes Mellitus
- Hypertension
- Routine Infant /Child health check
- Depressive Disorder
- Hyperlipidemia

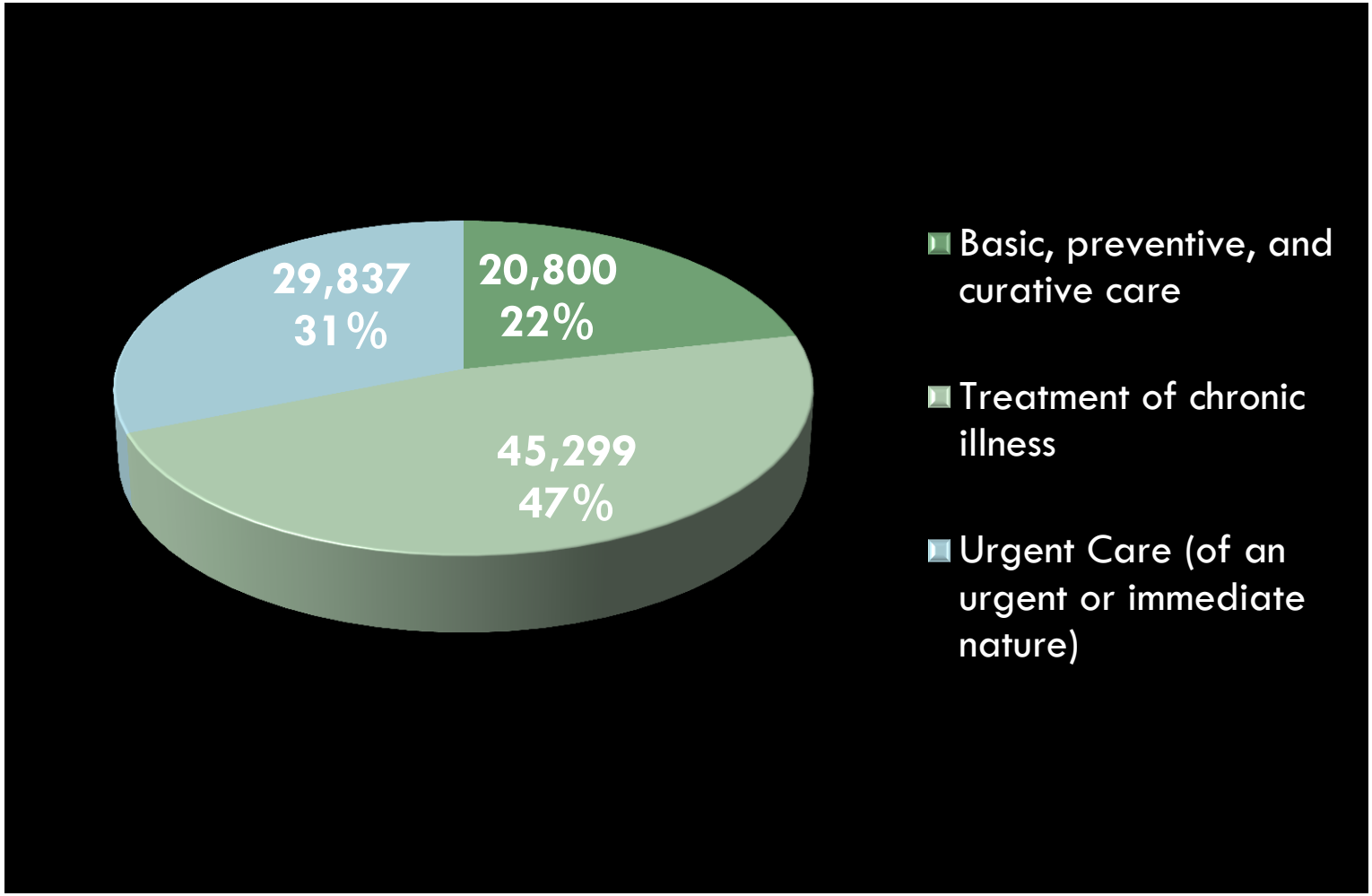
RHCs

- Hypertension
- Diabetes Mellitus
- Acute Upper Respiratory
- Hyperlipidemia
- Allergic rhinitis

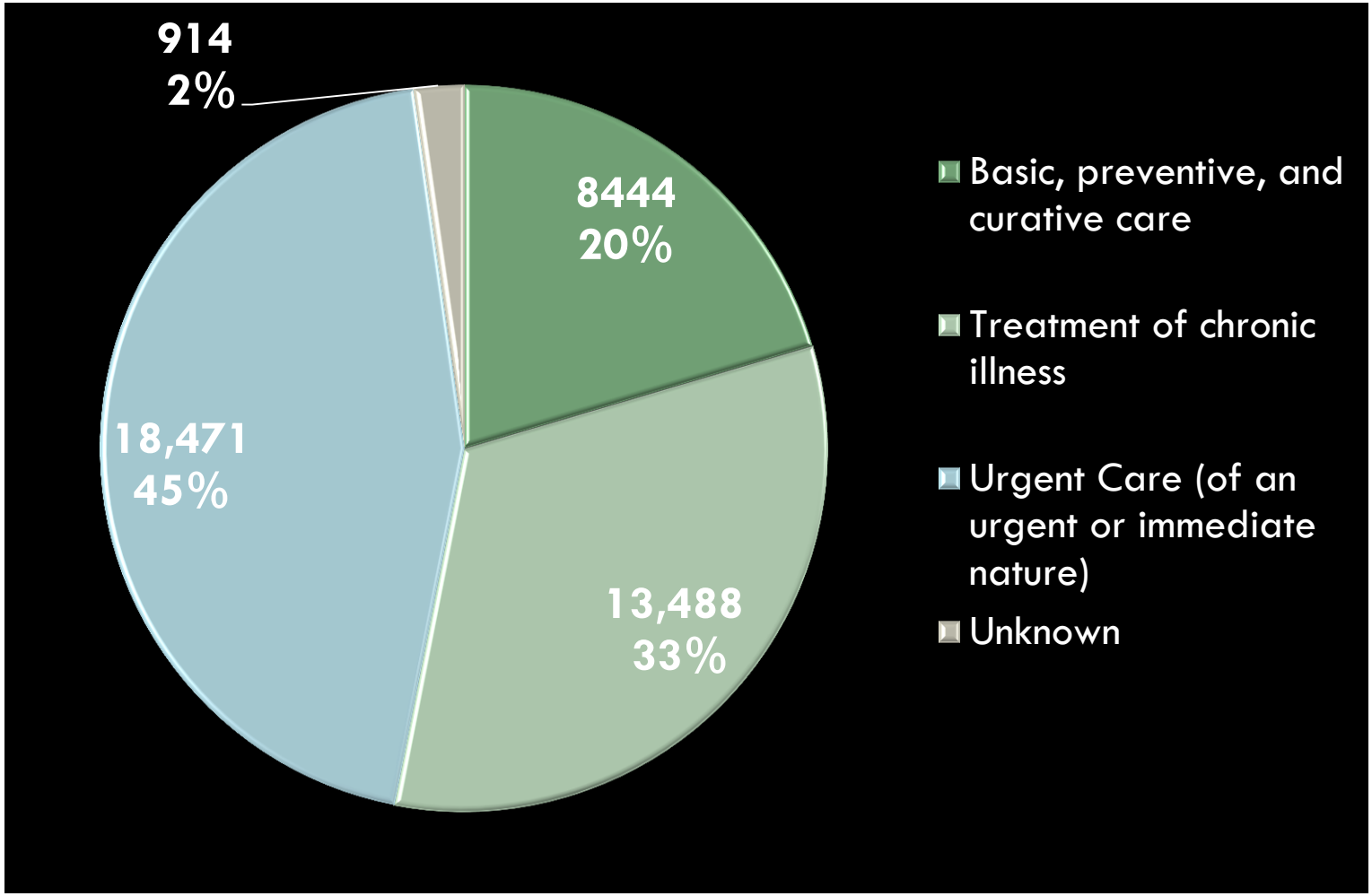
FPAs

- OB global visits
- Comprehensive Preventive Medicine exam
- Comprehensive Preventive Services (18 to 39 years)
- Surveillance; Contraceptive Pill
- Gynecologic Exam

Level of Service Provided – Free Clinics 2010



Level of Service Provided – Free Clinics 2011



Network Mission

Through collaboration, innovation, and advocacy, the Iowa Collaborative Safety Net Provider Network improves access to health services, quality of patient care, and the health of underserved patients in Iowa.

Goal A: Access

- Increase the underserved population's access to health services.
  - Objective 1: Identify and assess the capacity of and demands for safety net services.
  - Objective 2: Support efforts to provide access to a standard behavioral health pharmaceutical benefit.
  - Objective 3: Continue developing and expanding the work of the Iowa Prescription Drug Corporation.
  - Objective 4: Develop a protocol to connect and/or refer persons transitioning out of the corrections system with a safety net provider within 30 days of release.
  - Objective 5: All safety net patients have access to a diabetes care program.

Goal B: Finances

- Improve the financial viability of safety net providers.
  - Objective 1: Develop a financial model to quantify the financial impact of health system changes on the safety net and the population it serves.
  - Objective 2: Develop a baseline fiscal impact report of safety net organizations' combined services by service provider, focusing on revenues and expenditures.
  - Objective 3: Identify models for value-based purchasing/care (i.e. Accountable Care Organizations) or others as determined.

Goal C: Health System Integration

- Increase health system integration and collaboration across the continuum of care with a focus on safety net services.
  - Objective 1: Identify barriers for health care providers and safety net providers to participate in federal and state health information technology (HIT) opportunities.
  - Objective 2: Demonstrate the benefits of a functional community utility in Iowa encompassing patient centered medical home (PCMH) through a pilot project.
  - Objective 3: All safety net patients have a medical home.
  - Objective 4: All safety net patients have access to specialty care services.

Goal D: Communications and Education

- Enhance the Iowa Collaborative Safety Net Provider Network's communications and education efforts.
  - Objective 1: Safety net stakeholders and decision makers in Iowa are aware of the Safety Net Network.
  - Objective 2: Maintain data collection and reporting for all safety net providers, increase data reporting by rural health clinics (RHCs), and expand data collection and reporting to behavioral and oral health providers.
  - Objective 3: Collaborate with the UI PPC and other organizations to develop reform-related recommendations.

Health Care Reform Impact on Safety Net System in Iowa Project

- Grant funded by The Commonwealth Fund to The University of Iowa Public Policy Center
  - Support from Wellmark too
- Study impact of health care reform (access to care, financing, health system integration)
- Safety Net Network serving as key partner
  - Existing structure and partnerships make analysis and recommendations easier
- Completing analysis phase with a series of data reports on specific safety net providers and payors

Health Care Reform Impact on Safety Net System in Iowa Project, cont.

- Legal and Economic Review of the Affordable Care Act by UI team
- Subcommittee Work
  - Safety Net Providers – RHCs and FQHCs
    - Access, finances, health system integration, and communications (4 Network Goals)
  - Safety Net Payor – Medicaid
    - Population characteristics, basic health plan, benchmark plan, access and provider capacity, etc.
  - Primary Care Service Area – Oral Health
    - Access, capacity of providers, implications of reform

New Partnerships

- Iowa Department of Public Health
  - Community Transformation Grant
    - Funding from the Centers for Disease Control and Prevention
    - Serving on Leadership Team for project
    - Working to better connect primary care and public health at the local level
  - Health Benefits Exchange Outreach
    - Outreach targeted to providers and patients
      - Information about health insurance and the exchange
    - Dependent on Iowa's design and implementation plan

Commonwealth Fund Project Description

Background

ACA creates changes and opportunities for safety net providers-currently uncertain environment

- Increasing public and private coverage
- Funds for FQHCs
- Establishment of ACOs
- Funds for HIT, HIE, EHRs and meaningful use
- Funds for prevention
- Medical home development

Major Goals

- Assist policymakers and safety net providers to plan for change-financial and organizational
- Conduct large scale strategic planning effort not otherwise possible
- Using national and state-level experts with academic assistance to evaluate the potential impacts of ACA on states
- Identify opportunities for integration and coordination in the health care delivery system.

Project Background

Why Iowa:

- Iowa Safety Net Network was established
  - Legislatively mandated organization that already brought all safety net providers together into a loose confederation
  - Made communication and collaboration much easier
- IowaCare program for low income, uninsured adults
  - Adults up to 200% FPL
  - Provides experience with population that will be Medicaid eligible in 2014

Objectives

- Determine the current funding, expenditures, and infrastructure of the health care safety net at the state level, using Iowa as an example.
- Evaluate the potential implications of PPACA on funding, expenditures and infrastructure of safety net-related activities at the state level.
- Develop strategies for improving integration and coordination of safety net providers and organizations within the health care delivery system using Iowa as a model for change.

Emphasis on Primary Care

- Medical
- Preventive
- Dental
- Mental health
- Pharmacy

Background Being Collected- Providers

Primary Care Safety Net Providers in Iowa

- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)
- Free Clinics
- Family Planning Clinics
- Mental Health/Substance Abuse Treatment Centers

Background Being Collected-Payers

Payers of Primary Care Safety Net Services in Iowa

- Medicare
- Medicaid
- Children's Health Insurance Program (CHIP)
- Public Health Block Grants
- Ryan White

Contributions

- Provides a state-level demonstration, informed by experts on a key delivery system question
- Identifies implications of ACA on financing and operations of safety net providers
- Focuses attention on an issue often overlooked
- Develop recommendations for improving coordination and integration.
- Contributes to the knowledge of policymakers, providers and the public

Oral Health Subcommittee: Expected Deliverables

- Activity #1: Current state of access to oral health services in Iowa:
  - Inventory reports
  - Policy briefs

- Activity #2: Public dental delivery system capacity assessment:
  - Peer reviewed manuscripts with survey results
  - Policy briefs with interpretation

Oral Health Subcommittee: Expected Deliverables, cont.

- Activity #3: Private dental delivery system capacity assessment for Medicaid patients:
  - Report & peer reviewed manuscript- Medicaid participation survey
  - Report & peer reviewed manuscript- Conjoint analysis

- Activity #4: Collaboration with key stakeholders

FQHC/RHC Subcommittee

- Investigating funding opportunities for continuing activities
  - Would like to continue capacity study of FQHCs/RHCs paralleling oral health subcommittee activities
  - Exploring funding options:
    - Some Wellmark Foundation funds remain
    - Negotiating with CMWF for small amount

Medicaid Subcommittee

- First meeting on 11/9
- Looking specifically at community care team development as part of Iowa Medicaid Enterprise's 2703 Health Home Program
- Technical assistance will be provided by the National Academy of State Health Policy

Policy Briefs

- Committed to complete 4 by end of October
- CMWF most interested in:
  - A comparison of funding sources and impact of ACA, ACO and other delivery system changes
  - How to integrate primary care in the safety into secondary, tertiary and other related services in the area-ties into ACOs
  - A comparison of current HIT capabilities and perceived need for the future

Policy Briefs

Other possibilities:

- Issues for incorporating safety net providers into ACOs
- A comparison of the funding sources and patient characteristics of FQHCs and RHCs
- A comparison of safety net workforce and issues/needs for the future
- Care coordination/care management and the role for the safety net

NASHP Update

NASHP Learning Collaborative Update

- Required partnership between Medicaid agencies and safety net providers
- Seven states with common goals
- 15-month technical assistance period (June 2012 – August 2013)
- Development of work plan to guide the implementation
- In-person meeting
- Bi-monthly calls
- Individualized TA

NASHP Iowa's 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;

NASHP Iowa Goals, cont.

- Understanding that the development of high performing health homes is necessary prior to the creation of larger value-based purchasing agreements, we are also seeking technical assistance to gather information regarding how safety net providers are being included meaningfully in such agreements like Accountable Care Organizations (ACOs).

NASHP Activities In Progress

- Collection and reconciliation of various sources of data for Rural Health Clinics (RHCs) and electronic medical record adoption, including the Iowa Association of Rural Health Clinics (IARHC), Safety Net Network, and Telligen (HIT-REC).
- Review and sorting of Medicaid data to identify RHCs with higher than average Medicaid rates
- Targeting of RHCs to promote the IME 2703 Health Home program. A webinar will be scheduled specifically for RHCs.

NASHP Activities In Progress, cont.

- Compilation of patient-centered medical home resources for RHCs, all of which have been posted on the IARHC website.
- Sought technical assistance from NASHP on patient outreach for IME 2703 Health Home program.
- Schedule an on-site visit to Iowa with the NASHP team during the next six months.
- A future focus on primary care/behavioral health integration will occur based on the updated project work plan.

Community Care Team Models

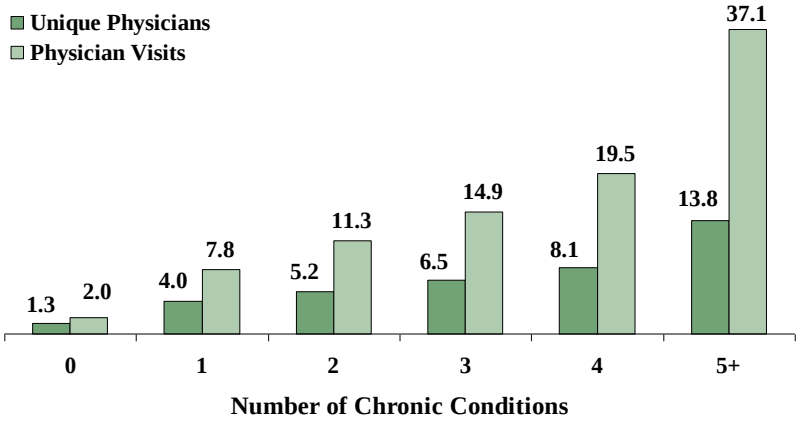
Determinants of Health

- #1 Social/societal characteristics and total ecology
- #2 Health behaviors
- #3 Medical care
- #4 Genes and biology

Centers for Disease Control and Prevention

Challenges in Primary Care Have Increased

- 36% of US primary care physicians are not satisfied (11% in Norway)
- 50% of physicians have symptoms of burnout
- There is a primary care workforce shortage
- Reimbursement is decreasing
- Complexity has increased
  - 24% of Medicare patients have 4+ chronic conditions (66% cost)



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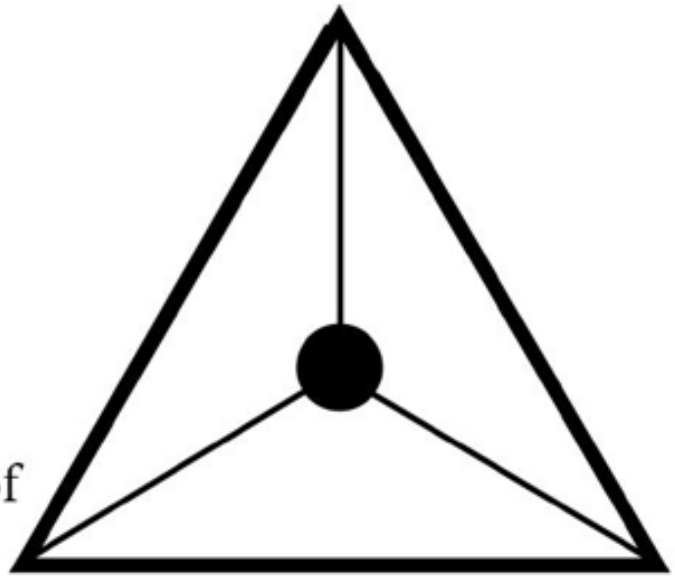
Something Everyone Can Agree On



Experience of Care

- Safe
- Effective
- Patient centered
- Efficient
- Timely
- Equitable

The IHI *Triple* Aim

Better care for individuals, better health for populations, lower per capita costs

Better Health, Better Care, Lower Costs

- Keys to the Triple AIM:
  - Supportive multi-payer environment: enhanced accountable payment
  - Continuous improvement driven by data
  - Optimal use of health IT
  - Comprehensive primary care functions
    - Risk stratified care management
    - Access and continuity
    - Planned care for chronic conditions and preventive care
    - Patient and caregiver engagement
    - Coordination of care across the medical neighborhood

AAFP, Comprehensive Primary Care Initiative

North Carolina's Vision

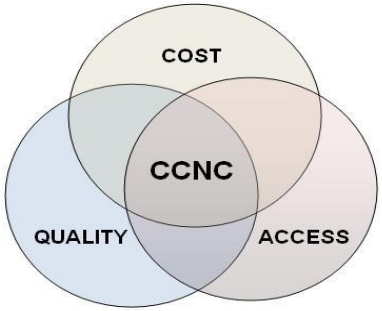
- Building a delivery system where:
  - Primary Care is the foundation
  - Patients with chronic illnesses are the target
  - Physicians and other health care providers are engaged
  - Local collaboration and support is in place
  - Meaningful data is available to enhance care delivery
  - Performance expectations are clear and aligned
  - Performance is tracked and feedback is provided
  - Processes are in place to drive on-going improvement

Community Care Provides North Carolina with:

- Statewide medical home & care management system to address quality, utilization and cost
- 100 percent of all Medicaid savings remain in state
- A private sector Medicaid management solution that improves access and quality of care
- Medicaid savings that are achieved in partnership with – rather than in opposition to – doctors, hospitals and other providers.

Key Tenets of Community Care

- Public-private partnership
- "Managed not regulated"
- Community-based, physician-led medical homes
- Cut costs by delivering greater quality and efficiency
- Providers who are expected to improve care must have ownership of the improvement process



Community Care: "How it works"

- Primary care medical homes available to 1.4 million individuals in all 100 counties.
- Provides 4,600 local primary care physicians (94% of all NC primary care physicians) with resources to better manage Medicaid population
- Links local community providers (health systems, hospitals, health departments and other community providers) to primary care physicians
- Every network provides local care managers (600), pharmacists (26), psychiatrists (14) and medical directors (20) to improve local health care delivery

How it Works, cont.

- The State identifies priorities and provides financial support to community networks
- Networks pilot potential solutions and monitor implementation (physician-led)
- Networks voluntarily share best practice solutions and best practices are spread across all networks
- The State provides the physicians & networks access to data
- Cost savings / effectiveness are evaluated by the State and third-party consultants (Mercer, Milliman, Treo Solutions)

CCNC Structure

- Structure and Financing: Network is non profit 501(c)3 organization
  - Receive $3 pmpm, $5 pmpm for high risk
  - Hire case managers, quality improvement staff
  - Medical director
  - Pharmacist
  - Network Psychiatrist/ Behavioral health care manager
- Governance
  - Network Medical Director and Network Director
  - Steering Committee
  - Medical Management Committee

CCNC Areas of Focus

- 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)

CCNC Areas of Focus, cont.

- 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)

CCNC Informatics Center

- Medicaid claims data
  - Practices can identify patients and at risk populations
  - Utilization (ER, Hospitalizations, DME, Mental Health)
  - Identify providers (prescribers, specialists, mental health)
  - Costs
- Real time data
  - Hospital and ER
- Pharmacy Home
- Provider Portal
- Quality Measurement and Feedback

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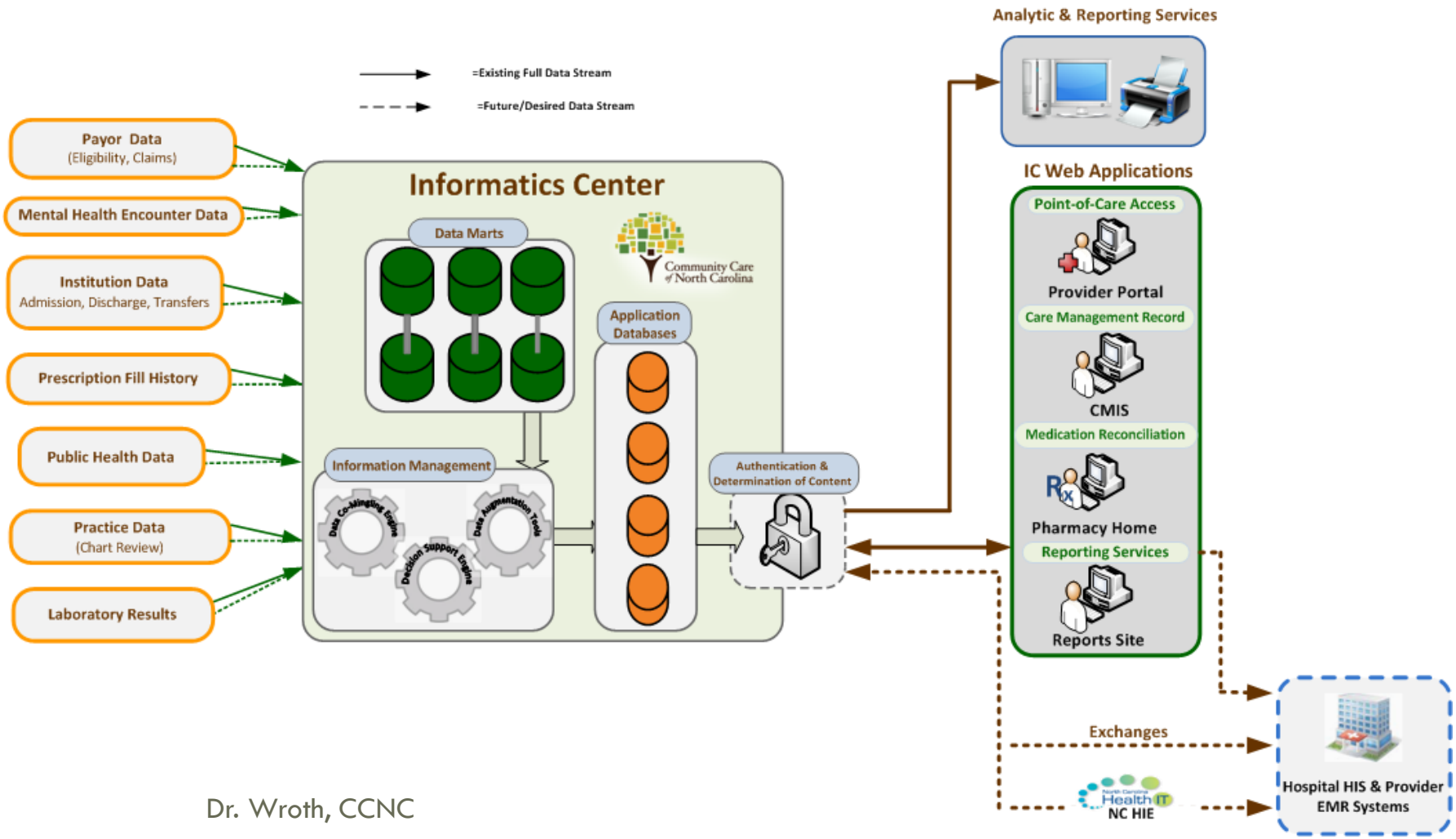
CCNC Informatics Center



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CCNC Results

- CCNC is in the top 10 percent in US in HEDIS for diabetes, asthma, heart disease compared to commercial managed care
- Adjusting for severity, costs are 7 % lower than expected. Costs for non-CCNC patients are higher than expected by 15 percent in 2008 and 16 percent in 2009
- 2010: Savings of $382 million according to the Milliman analysis

What's In It For the Practice?

- Motivation to improve care
  - Many seeking PCMH recognition
  - Align PCMH high risk populations with network priorities
  - Decrease unnecessary ER use ("frequent fliers")
  - Improve care transitions
- Care management support
  - Help with Medicaid policy, billing
  - Difficult patients
  - No-shows
  - Quality improvement coaching
  - Support self management
- Practice level quality data

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Community Care Team Goals

- Improve quality, population health, cost at local level
- Become extension of primary care team
  - Care management of high risk patients
  - Support Diabetes, Heart Failure, Asthma, COPD… self management
- Engage practices in quality improvement initiatives
  - Practice support and coaching
  - Feedback of quality data
- *After initial focus on clinical needs of patients, begin to address social/behavioral needs of patients*

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Lessons Learned

- Primary care is foundational
- Data essential (timely and patient specific)
- Additional community based resources to help manage populations needed (best is located in practice)
- Collaborative local networks builds local accountability and collaboration
- Physician leadership essential
- Must be flexible (healthcare is local) and incremental
- Make wise choices of initiatives (where you can make a difference- success breeds success)

Key Factors for Success

- State level accountability combined with local autonomy
- Clinician leadership and engagement
- Focus on high-risk/high-need patient populations
- Use of informatics to identify areas of focus (i.e. pharmacy management, poorly controlled asthma, improvement to care transitions, etc.)

Return on Investment

Number of patients needing to receive transitional care in order to avert 1 hospital admission in the coming year:

- Complex, chronic patients = 6

  non-mental health discharges = 5.6

  mental health discharges = 7.2

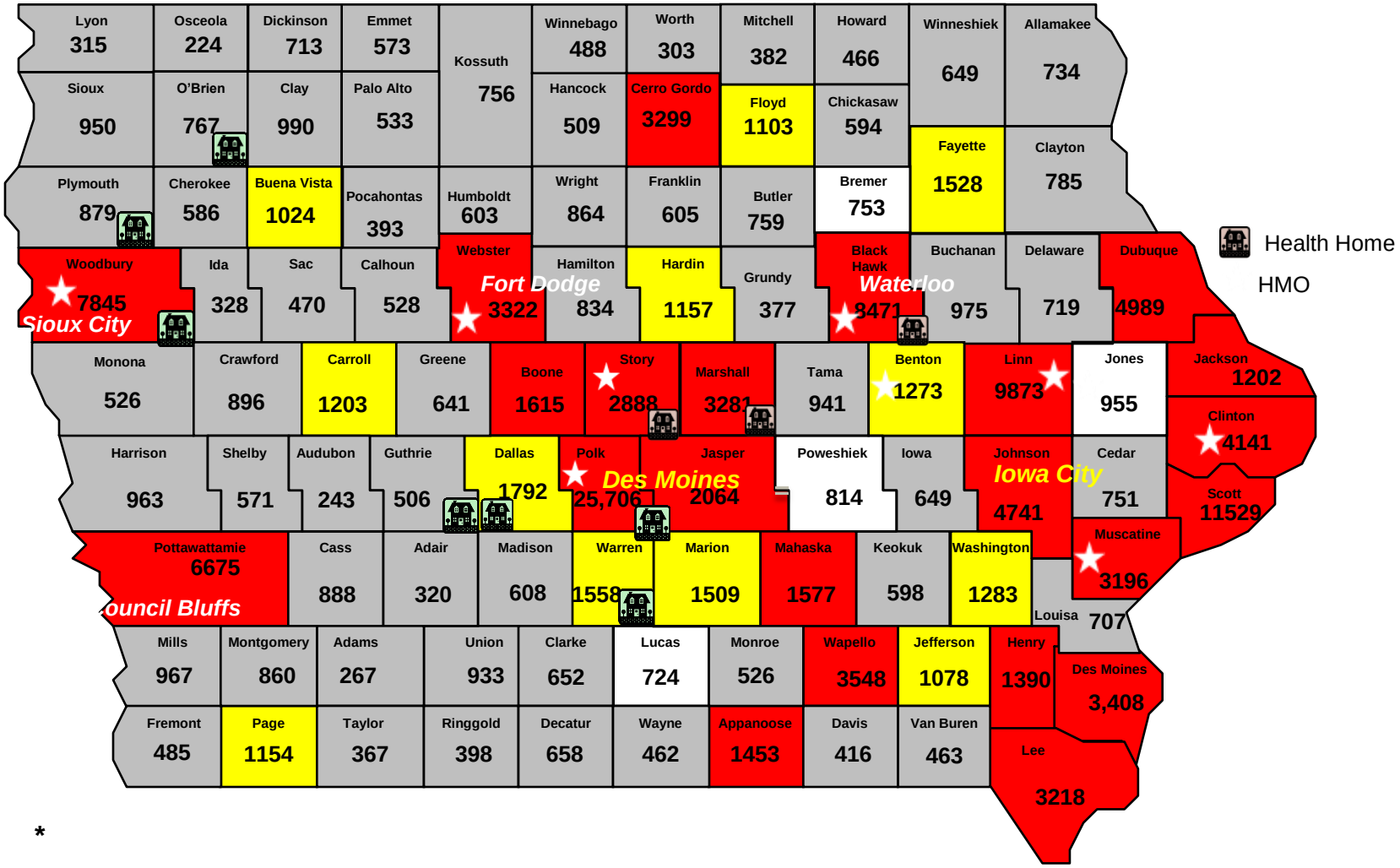
- Healthier patients = 133

Development Opportunities in Iowa

- Iowa's 2703 SPA Health Home Program
- NCQA Recognition
- Medicaid Subcommittee – CMWF Project
- National Academy of State Health Policy Technical Assistance
- PCCM Advisory Council Meeting Discussion
- Community Transformation Grant in Iowa
- ACO Development
  - Innovation model proposal for multi-payer ACO
- Blue Zones Communities

Iowa Department of Human Services

Potential Health Home Candidates



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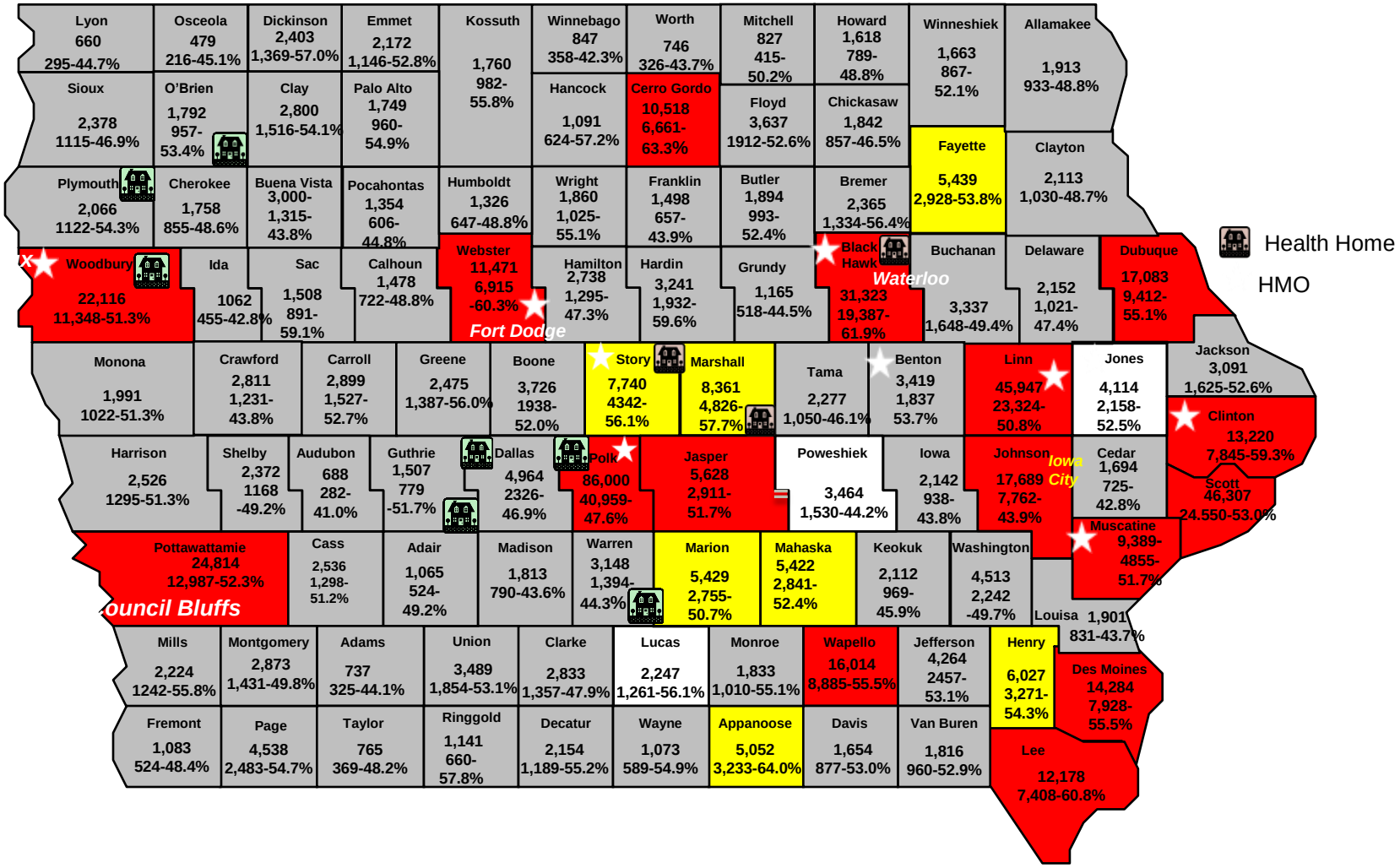
Iowa Department of Human Services

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



Other States with Community Care Team Development

- Alabama
- Maine
- Maryland
- Minnesota
- Montana
- New York
- North Carolina
- Oklahoma
- Oregon
- Vermont

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