State Innovation Model (SIM) Evaluation Report on Award Year 3 (AY3) Activities: Overview of SIM Implementation Activities from November 2017 - October 2018

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Overview of SIM Implementation Activities from November 2017 - October 2018

November 2, 2018
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Executive Summary

This report covers the process and implementation activities of the State Innovation Model (SIM) test grant in Iowa during the last half of SIM award year 3 (November – December 2017 and January – April 2018) and the first half of SIM award year 4 (May – October 2018). The objective of the process and implementation evaluation is to describe the structure of the interventions and actions being utilized in the SIM initiative and identify advances and challenges encountered during implementation.

A variety of methods were used to gather the information provided in this report. The University of Iowa Public Policy Center (PPC) team reviewed documents and collected information from pertinent websites, participated in bi-weekly phone conferences with the state SIM team, participated in monthly phone conferences with the state SIM team, the Center for Medicare and Medicaid Innovation (CMMI) and the national evaluators, and conducted surveys and interviews with several stakeholder groups to understand how the SIM initiative was being implemented during this time period and identify the successes and challenges encountered. The following table provides a list of the stakeholder groups surveyed or interviewed for this reporting period.

Sources of Stakeholder Experiences

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A summary of some of the successes and challenges in the implementation of the SIM activities in this reporting period are below.

Stakeholder Engagement

Successes

- Both MCOs and three of the four ACOs interviewed noted regularly convening healthcare stakeholders through meetings, workgroups, and the Governor’s Healthcare Innovation and Visioning Roundtable (Roundtable) as a positive impact of the SIM.
- One MCO reported actively disseminating SIM updates throughout their organization to ensure employees at all levels are informed about SIM activities and resources.

Challenges and Opportunities

- With the introduction of the Medicaid MCOs, the Medicaid ACOs were one level removed from the SIM organizers, in particular IME, and this was reflected in all four ACOs reporting infrequent and “sporadic” involvement with the SIM staff, with two ACOs noting more involvement when they were contracting directly with the state (prior to Medicaid Modernization).
- Disrupted engagement with the ACOs has impacted relationships, as ACOs report diminished roles in decision-making and uncertainty about the SIM goals and the role of ACOs. ACOs perceived they were not sufficiently involved in decision making and planning of policies and programs that their organizations were impacted by and/or compelled to adopt.
• ACOs described SIM engagement in workgroups and the Roundtable as “surface level,” “conceptual,” and “visionary,” and expressed a need for continuing SIM efforts, such as the Roundtable, to produce concrete contractual commitments toward statewide goals.

Governor’s Healthcare Innovation and Visioning Roundtable

Successes

• The Roundtable convened in December 2017. Six meetings of the Roundtable have been held during this reporting period.

• Two workgroups, one focusing on Healthy Communities and the other focusing on Data Sharing and Use were formed in May 2018 and have met four times.

• In September 2018, the Roundtable shared recommendations with the Iowa Governor’s Office, which included workgroup goals, processes, and strategies.

Opportunities

• Members invited to the Roundtable could be updated to include key stakeholders recommended by the National Governor’s Association (specifically, the state Attorney General’s Office, a Health Information Organization, and a State Health IT Coordinator).

• Other healthcare stakeholder groups could also be considered for membership to the Roundtable.

  ◦ First, to provide a patient-centered perspective, additional patient or consumer advocacy groups could be appointed to membership (i.e., behavioral health groups, child advocacy groups, or healthcare consumers themselves – perhaps from a C3 region).

  ◦ Second, the inclusion of state legislators, particularly from the Health Policy Oversight Committee, could be beneficial to provide an additional policymaker stakeholder perspective.

Community and Clinical Care Initiatives (C3s)

Successes

• The C3s are making progress towards becoming ACHs, improving care and care processes for patients with diabetes, and providing enhanced care coordination to address SDHs.

• There has been evident progress in the C3s development into Accountable Communities of Health. Each of the C3 sites have the components of the ACH model required by the contract.

• The C3s have been particularly successful at building strong relationships and partnerships across sectors, connecting traditional clinical services to community-based services to address patient needs, and promoting understanding of the impact of social determinants of health on the overall patient and population health.

• There has been steady progress in the C3 systems toward integrating new processes for care and care coordination into their delivery system protocols.

• Resource sharing among partners has developed steadily over time; data sharing has developed more slowly.

Challenges and opportunities

• Difficulties were identified with regard to addressing the specific needs of the focal population of individuals with diabetes.

  ◦ Some C3 initiatives reported difficulties accessing their patient/client populations who had diabetes.

  ◦ Providers and community coalitions were less likely to know about the gaps in diabetic services in their community/region and how the C3 initiatives could address those gaps. This finding presents an opportunity to engage local community coalitions more in diabetes activities.
While all seven C3 sites identified using existing diabetes resources such as the NDPP and DSME to address needs, around half of the patients/clients with diabetes surveyed had ever taken a course of class in how to self-manage their diabetes. And, around one-third of those with a chronic condition reported strong confidence in being able to manage and control their health problems. These findings indicate an opportunity to further engage individuals with diabetes in the self-management of their health.

- Limitations in the current workforce were noted by different stakeholders. In particular, they noted limited capacity and skills in the area of data analytics and limited understanding of how to manage and integrate non-traditional providers (i.e., nurse practitioners, care coordinators, health navigators/coaches) into the traditional delivery system model.

- Data collection and data sharing were identified as challenges by most stakeholders and C3s.
  - Use of the AMH as the tool to collect SDH information was seen as duplicative of other HRAs already in use, time consuming to administer, or was not preferred over other HRA tools. Some stakeholders questioned the sustainability of the AMH tool past the funding period.
  - An inadequate HIT infrastructure, inability to access and share needed data and understand it was noted by many stakeholders. Most C3 sites were still in the developmental stage with regard to HIT and utilizing data to improve patient care processes or population health. This presents an opportunity to provide additional resources to bolster the data sharing infrastructure and/or more targeted training about HIT and how best to use data within their communities.

- MCOs and ACOs had somewhat limited direct interaction with the C3 initiatives. Yet, both of these stakeholders were aware of the initiatives and expressed support. And, one of the payers noted providing some project-specific resources to at least one of the C3 communities. These findings could indicate an opportunity for all C3s (i.e., seeking resources from the MCOs for particular projects) as they contemplate ways to sustain and/or fund their initiatives going forward.

Statewide Alert Network (SWAN)

Successes

- UnityPoint Next Gen Medicare ACO began SWAN participation, marking a milestone toward the SWAN goal to expand into payers beyond Medicaid
- The SWAN is transitioning from Informatics Corporation of America (ICA) platform to Collective Medical Technologies (CMT), at which time it will become SWAN+. SWAN+ is intended to feature added functionality, including direct integration with hospital EHR (without additional data entry), and real-time ADT alerts with patient history to be shared with admitting hospital, primary care provider, and health plan.
- Both MCOs reported using the SWAN to help coordinate care after patient discharges.

Challenges and Opportunities

- MCOs and ACOs reported that SWAN would have more value if the alerts were timelier (immediately after an ADT event) and all hospitals in Iowa were connected. Since the last reporting period, the number of hospitals in Iowa connected to the SIM has remained the same (51 out of 118 hospitals.)
- MCOs expressed frustration that use of and participation in the SWAN was required contractually before the platform and infrastructure was fully developed.
- Formalized processes triggered by SWAN alerts could be developed to include larger patient populations and enhance the effectiveness of the SWAN.
- Both MCOs believed the SWAN could be sustained beyond SIM funding, especially if alerts were sent instantaneously after ADT events and if all hospitals in Iowa were connected.
Data Collection, Sharing, and Reporting

Successes

• Continuous quality improvement initiatives through the community scorecards progressed during this time period from developmental to implementation as scorecard design was finalized and reports were generated and distributed to the C3s.

• Progress was also made in the collection and use of social determinants of health data through Medicaid’s health risk assessment (HRA) tool, Assess My Health.

• Stakeholders understood the value of collecting and using SDH data (and credit the SIM with initiating and maintaining conversations about SDHs) and some have incorporated SDH information into their internal processes and patient care plans.

Challenges and Opportunities

• Data systems and infrastructure – Different clinics and sites used different, incompatible, and/or underdeveloped EMRs

• Workforce – Lack of workforce with experience in HIT and data analytics

• HRAs – Many different types of HRAs instruments are in use across clinics and systems and this creates a challenge when trying to integrate data across systems

• AMH – ACOs reported difficulty integrating AMH data received from the state back into their own systems; C3s reported the AMH tool was time consuming to implement and/or it was duplicative of other tools preferred by partners and predicted it would not be used after the SIM C3 funding ended

Value-based Purchasing (VBP), Quality Metrics and the Value Index Score (VIS)

Successes

• State-approved value-based contracts were in place as of September 2017, and both MCOs reported that they were satisfied with the conclusion of negotiations. The Iowa SIM team update in 2018 noted that incentive payments had been received and disseminated to providers in one MCO.
  ◦ Both MCOs were knowledgeable about contract expectations regarding increasing the percentage of members covered in a VBP arrangement to 30% by July 2018 and 40% by December 2018.
  ◦ MCOs reported active engagement in SIM VBP activities and explicitly reported collaborative relationships and participation in negotiations as a success.
  ◦ Three ACOs talked about the inclusion of standardized of quality metrics in VBP contracts across payers and systems as a SIM success.

Challenges and Opportunities

• With regard to progress toward VBP benchmarks, one MCO reported being on track to meet or exceed the targets, and the other MCO endorsed the state’s VBP goals, but also recognized the relatively short time frame to be in compliance as a challenge.

• ACOs reported less engagement in SIM VBP activities, no access to VIS dashboards, infrequent inclusion in discussions, and a lack of inclusion in the VBP contract development process.

• All MCOs and ACOs interviewed noted hesitation to adopt the VIS metrics, with five of these stakeholders noting that the VIS was developed to measure privately insured populations, and was not suited to the Medicaid population. One ACO suggested increased alignment with Medicare methodologies as a potential solution. Neither MCO was able to identify added value from the requirement to incorporate VIS into performance-based measures.
  ◦ Stakeholders have conflicting motivations in regards to standardization. MCOs want less standardization across ACO contracts (referring to the required use of
state-approved contract templates) to promote competition in the MCO contracting process, and ACOs prefer standardization to simplify practice and reporting processes for providers.

**Technical Assistance (TA)**

The Iowa SIM continues to provide technical assistance directly to the C3 sites and Medicaid health systems, along with strategies to reach statewide audiences, such as Learning Community Events and online platforms.

**Opportunities**

- All stakeholders interviewed (MCOs, ACOs, C3s) described various limitations in workforce skills and capacity as challenges which could be an **opportunity** for providing targeted TA.
- Representatives from two ACOs described a lack of applicability of SIM provided training within their unique systems and settings.
- Three C3 site representatives reported a lack of follow-through in regards to the cyclical quality improvement plan process, and six sites reported a need for customized TA.

**Common Themes, Future Considerations, and Potential Opportunities**

- Most stakeholders are aware of the SIM and SIM-related activities or goals and reported participation in workgroups, TA opportunities, and utilization of SIM tools.
- Development of collaborative relationships among different stakeholders and across different types of healthcare, public health, and social service providers have been some of the most noted successes of the SIM.
- The work on social determinants of health (SDH) was seen as important and stakeholders reported understanding its value with regard to patient and overall population health. While understanding and addressing SDH issues with patients at the local level has progressed over the course of the SIM, there is still some work to be done in determining how best to collect, synthesize, and report back on SDHs at the population level.
- ACOs and MCOs are trying to support SIM activities but only as long as they see reasonable approaches to integrating SIM efforts and are able to partake in these activities with benefit to their organizations and very little cost.
- Across many initiatives (SWAN, AMH/HRAs, VIS, C3 care coordination, VBP), the HIT infrastructure needed to fully engage in the data collection, sharing, reporting, and use necessary for delivery and payment system reform is underdeveloped and which presents challenges and frustration to stakeholders.
Introduction

The State Innovation Model (SIM) is a federal grant program administered by the Centers for Medicare and Medicaid Service’s (CMSs) Center for Medicare and Medicaid Innovation (CMMI). The purpose of this grant program is to provide funding for states to develop innovative ways to address the “triple aim” of healthcare reform; namely, to improve the patient experience of care and population health while simultaneously reducing health system costs. To do this, states are encouraged to use SIM funding to transform their public and private healthcare payment and delivery systems.

CMMI has awarded three types of SIM grants – Model Design, Model Pre-Test, and Model Test awards. Design grants were awarded to states/entities to design plans and strategies for how to transform healthcare in their states. Test states received awards to implement their plans for comprehensive statewide healthcare transformation. In 2013, Iowa received a Model Design award and in 2015 received a $43 million Model Test award to implement and test its plan over the course of four years.

Report Focus and Organization

This report covers the process and implementation activities of the SIM initiative test grant in Iowa during the third and fourth quarters of the second implementation year (November-December 2017 and January- April 2018) and the first two quarters of the third implementation year (May – October 2018). The objective of the process and implementation evaluation is to describe the structure of the interventions/actions being utilized in the SIM initiative and the characteristics of the communities and settings which are impacted by the SIM. The key questions addressed in this report include:

1. How are the SIM interventions being implemented around the state of Iowa?
2. What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?
3. How effective has the implementation of SIM been? Level of use by stakeholders?

This report will be organized by providing a summary update about each SIM activity or intervention (to address questions 1 & 2 above) followed by a section on the stakeholder experiences relevant to that activity (to address question 3 above). Reports with more detail on methodology and results of each data collection effort from stakeholders will be provided in the appendices and referenced in each pertinent section.

Methods

The PPC state-level evaluation of Iowa’s SIM includes both qualitative and quantitative methods and incorporates multiple data sources and collection methods to capture information from many areas of the healthcare system (local, regional, and state-level; patient, provider, payer, and other stakeholders). The overall evaluation includes two-parts: 1) assessment of the process and implementation of the key SIM interventions and activities and, 2) assessment of the core SIM goals (primary outcomes used to measure the success of the SIM). As noted previously, this report focuses on part 1, the description of and progress update on the implementation activities in this reporting period.

A variety of methods were used by the PPC evaluation team to gather the information provided in this report. To provide data to inform key questions 1 and 2, the team regularly conducts a systematic environmental scan of SIM-related initiatives. This includes a review of documents and information collected from pertinent websites, review of documents requested from SIM partners, including work group meeting minutes, work plans, and survey and evaluation instruments, and participation in phone conferences with the state SIM team, CMMI, and the national evaluators.

The following specific sources were used to gather information. Sources were reviewed at least quarterly.

Websites

- Iowa Department of Public Health
- Iowa Department of Human Services
- Iowa Healthcare Collaborative
- Iowa Medicaid Enterprise
- Centers for Medicare & Medicaid Services State Innovation Models Initiative
- SIMplify (the Iowa SIM initiative website for the community partners)
- Amerigroup Iowa
- United Healthcare of Iowa
- Iowa Health Information Network (IHIN)
- Centers for Disease Control and Prevention (CDC)

Periodic Publications

- SIMplify newsletter
- Community and Clinical Care (C3) proposals, action plans, and quarterly reports
- Iowa SIM quarterly reports to CMMI
- Quarterly MCO reports

For key question 3, the PPC team conducted a variety of stakeholder surveys and interviews to understand how the SIM initiative was being implemented and perceived by stakeholders during this time period. The PPC evaluation team includes a subcontractor, Rural Health Solutions (RHS), a consulting company with national rural health development, research, and evaluation expertise. RHS focused efforts on evaluation of the Community and Clinical Care (C3) initiatives. Table 1 provides a summary of the stakeholder groups asked to provide input on their experiences with the SIM and/or SIM initiatives during this reporting period as well as a reference to the associated detailed methodologic reports specific to that particular data collection effort. The detailed methodologic reports can be found in the appendices.

2 http://www.rhsnow.com/
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Iowa’s State Innovation Model (SIM)

Vision and Goals

The overall vision of the Iowa SIM Test Award during its first two years was to transform healthcare to improve the health of Iowans. In AY3, the SIM vision was revised to “Iowans experience better health and have access to accountable and affordable healthcare in every community.” An updated driver diagram and subsequent plans were created to outline AY3 activities and forecast the coming grant years. The figure on the following page is the AY3 and AY4 driver diagram.

The SIM focuses efforts around two primary drivers: 1) delivery system reform and 2) payment reform. Delivery system reform centers on providers in the community and healthcare systems to equip them with tools to engage in population health and educate them to focus on value outcomes as a way to support their initiation into payment reform. Payment reform centers on aligning payers and providers in value-based purchasing (VBP). The combination of these two reform efforts is intended to achieve statewide healthcare transformation where providers are paid based on quality and value and communities and health systems work together to produce a healthy population.

The primary implementation strategies used by the SIM to address the aims of the grant cross both primary drivers but focus on a variety of activities. These include:

- Funding community and clinical care coalitions (C3s),
- Deployment of a statewide alert network (SWAN),
- Data collection, sharing, and reporting,
- Instituting value-based purchasing (VBP) as a method of payment reform, and
- Providing technical assistance (TA) at both the community and healthcare system levels.

Governance

With oversight from the Governor’s office, the governance of the Iowa SIM is primarily led by representatives from the Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH). Two representatives from the governor’s cabinet, specifically the Director of DHS and the Director of IDPH, are responsible for working with the state executive and legislative branches. Senate file 505 requires DHS to report on SIM activities annually to a legislative committee; however, both DHS and IDPH interact with legislators more frequently as needed.

The Director of DHS is the recipient of the SIM grant and as such, DHS is accountable for the operation and execution of the SIM activities. IDPH partners with DHS to implement particular functions of the SIM grant. The Iowa Healthcare Collaborative (IHC) provides technical assistance and quality improvement support services to healthcare providers and other stakeholders. These three entities have the primary responsibilities for carrying out the majority of the SIM activities.

During this evaluation period, there were some leadership changes of note. On August 23, 2017 the Iowa Medicaid Director, Mikki Stier, was appointed to serve as Deputy Director of DHS. On November 17, 2017, Michael Randol was appointed director of the Iowa Medicaid Enterprise (IME). Both Ms. Stier and Mr. Randol are involved in the leadership of the SIM.

Iowa SIM Vision:
Iowans Experience Better Health and Have Access to Accountable, Affordable Healthcare in Every Community

Healthcare Innovation & Visioning Roundtable

**GOALS by the end of 2019**

- Healthcare costs are reduced while quality is improved by:
  - Increase Medicaid and Wellmark provider participation in ACOs to 50%
  - Increase the number of lives covered under either a Medicaid or Wellmark VBP to 50%
  - Receiving approval of at least one Other Payer Advanced APM program from CMS
  - Reduce Total Cost of Care by 15% below expected Wellmark and Medicaid

- Patients are empowered and supported to be healthier by:
  - Reduce the rate of potentially preventable readmissions in Iowa by 20%
  - Reduce the rate of potentially preventable ED visits in Iowa by 20%
  - Reduce the rate of the Hospital Acquired Conditions (HAC) to met the national goal (97/1000) by focusing on a 20% reduction to Clostridium Difficile and All Cause Harm measures
  - Increase the number of provider organizations that are financially successful in Alternative Payment Models under Medicaid & Wellmark

**Primary Drivers**

- Payment Reform: Align Payers In VBP
  - Align clinical and claims-based quality measures linked to payment
  - Increase contracts with ACOs that include up and down side risk
  - Educate stakeholders on ACO Models in Iowa
  - Mature infrastructure and use of HIT analytics to support VBP
  - Elevate the use of Social Determinant of Health data within VBP programs

- Delivery System Reform: Equip Providers
  - Develop common language and a shared vision of delivery system reform across payers
  - Implement Accountable Communities of Health pilot to prepare communities for value based delivery models
  - Address patient social needs through linkages to community based resources
  - Utilize the Iowa Health Information Network and the Statewide Alert Notification System to optimize transitions of care
  - Develop a community scorecard for process improvement that emphasizes and raises the standards of care
  - Improve use of HRAs that collect SDH and measure health confidence
  - Provide technical assistance to providers engaged in transformation and value based models

**Secondary Drivers**

- Health IT Enhancement
- Quality Measurement

**ROADMAP TO IMPROVE POPULATION HEALTH**
Stakeholder Engagement Activities

There are many stakeholders who are integral to the implementation of the SIM in Iowa. Partners in the SIM vision and implementation include payers, providers, communities, state governmental entities, and others. Table 2 provides a list of SIM stakeholders organized by sector.

Table 2. SIM Stakeholders

<table>
<thead>
<tr>
<th>State Government</th>
<th>Payers</th>
<th>Providers</th>
<th>Communities</th>
<th>Contracted Entities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Iowa Department of Human Services (DHS)</td>
<td>• MCO: United Healthcare</td>
<td>• Accountable Care Organizations (ACOs)</td>
<td>• C3 community care teams</td>
<td>• Iowa Healthcare Collaborative (IHC)</td>
</tr>
<tr>
<td>• Iowa Department of Public Health (IDPH)</td>
<td>• MCO: Amerigroup</td>
<td>• Independent primary care providers</td>
<td>• Social services agencies</td>
<td>• 3M Analytics</td>
</tr>
<tr>
<td>• Iowa Medicaid Enterprise (IME)</td>
<td>• Wellmark</td>
<td>• Hospitals</td>
<td>• Local government</td>
<td>• Public Policy Center (PPC)</td>
</tr>
<tr>
<td>• Governor’s Office</td>
<td></td>
<td></td>
<td>• Local and county public health</td>
<td>• Iowa Health Information Network (IHIN)</td>
</tr>
<tr>
<td>• Iowa Department on Aging</td>
<td></td>
<td></td>
<td>• Healthcare consumers</td>
<td></td>
</tr>
</tbody>
</table>

During this reporting period, two primary stakeholders in the SIM, namely a Medicaid MCO (AmeriHealth) and a Medicaid ACO (University of Iowa Health Alliance), no longer participated in SIM activities for different reasons. In October 2017, the state announced the withdrawal of AmeriHealth Caritas Iowa from Iowa’s Medicaid management. And, in March 2018, the University of Iowa Health Alliance announced its decision to dissolve its Medicaid ACO.

The following sections describe some of the main stakeholder engagement activities and stakeholder experiences with these activities.

SIM Communication Workgroup

The SIM Communication Workgroup, which began in May 2017, continues to hold bimonthly meetings. The Communication workgroup provides a platform for members of the SIM team to discuss updates, successes, barriers, grant requirements, and progress towards goals.

Standardized Social Determinants of Health (SDH) Workgroup

The SIM team convened a group of stakeholders with the end goal of standardizing social determinants of health data collection across the state. Since its inception in June 2017, members of the SDH workgroup have held monthly meetings. Members of the SDH workgroup include state government entities, public health, payers, health systems, provider groups, health and social service providers. The goal of the SDH workgroup is to “suggest standardized measures and provide guidance for collecting, analyzing, reporting, and utilizing the data to our stakeholders through education and advocacy.” The SDH workgroup progressed towards its goal by completing activities listed below throughout the reporting period.

- Created a cross-walk of items included in four established SDH screening tools
- Selected and added standardized SDH items to the Assess My Health (AMH) screening tool
- Narrowed focal areas from five to three (housing stability, food security, and income capacity)
- Identified existing data sources to establish a baseline of SDH related needs in the state (e.g. Community Health Needs Assessments)
- Collected, analyzed, and reported on the SDH data collected on the AMH tool
- Started the process of conducting an environmental scan to identify existing resources and programs which could be leveraged to address SDH

Value-based Purchasing (VBP) Workgroup

Throughout the SIM grant, the MCOs managing Medicaid were engaged in VBP workgroups, which facilitated the negotiations of quality metrics and contractual expectations for progress. The regularly scheduled VBP workgroups adjourned in late 2017 after finalizing 2018 program requirements and contract language. At that time, Medicaid in Iowa was managed by three MCOs, Amerigroup Iowa Inc. (Amerigroup) and United Healthcare Plan of the River Valley, Inc. (United Healthcare), and AmeriHealth Caritas (AmeriHealth). However, in November 2017, AmeriHealth announced its withdrawal from Iowa’s managed care program, effective December 1, 2017. Engagement with MCOs regarding payment reform continued in December 2017 through the assembly of the Governor’s Healthcare Innovation and Visioning Roundtable, in which both Amerigroup and United Healthcare are members. In addition, both MCOs have representatives actively involved in the two Roundtable workgroups focused on healthy communities and data sharing.

Stakeholder Experiences – SIM Engagement Activities

SIM Engagement and Payers – Medicaid MCOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. More detailed methods and results can be found in the Appendix A.

In regard to interactions with SIM staff, MCO A reported that communication with SIM staff was satisfactory, and that weekly ongoing meetings were being held. MCO B reported actively disseminating SIM updates throughout their organization to ensure employees at all levels are informed about SIM activities and resources.

Each MCO elaborated on their perceptions of the role of payers in the SIM. Along with implementing VBP, both MCOs recognized that participation in SIM workgroups was an expectation. Both MCOs reported participation in the SIM VBP workgroup and reported positive experiences with that group. Both MCOs reported satisfaction with the resolution of VBP workgroup compromises. MCO B noted that ongoing compromise was expected, when working across multiple organizations with unique goals. MCO B also talked about their role as collaborators in SIM-aligned policy development. Each MCO mentioned participation in additional SIM-related initiatives, including State Strategy Plan workgroups, C3 steering committee meetings, SDH workgroup (MCO A), Learning Community events, and ongoing quarterly contact (MCO B). MCO A reported positive experiences in SIM workgroups, saying “We find workgroups valuable in the sense that we interact with people outside of our sphere with different perspectives, so we’re better able to understand and collaborate.”

While both MCOs were actively cooperative in the VBP workgroup and quality measure discussion, MCO B had reservations about the feasibility of the SIM goal to align quality measures across various payers and populations, stating, “The expectation that alignment can be achieved that is complete is unworkable and will continue to prove to be unworkable.”

Both MCOs reported building collaborative relationships as successes associated with SIM involvement, with MCO B stating, “I think collaboration with the other organizations with the other MCOs, and with our external partners. I think the relationships that we’ve built through attending these various meetings has been beneficial.”

SIM Engagement and Providers – Medicaid ACOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. More detailed methods and results can be found in the Appendix A.

In regard to interactions with SIM staff, MCO A reported that communication with SIM staff was satisfactory, and that weekly ongoing meetings were being held. MCO B reported actively disseminating SIM updates throughout their organization to ensure employees at all levels are informed about SIM activities and resources.

Each MCO elaborated on their perceptions of the role of payers in the SIM. Along with implementing VBP, both MCOs recognized that participation in SIM workgroups was an expectation. Both MCOs reported participation in the SIM VBP workgroup and reported positive experiences with that group. Both MCOs reported satisfaction with the resolution of VBP workgroup compromises. MCO B noted that ongoing compromise was expected, when working across multiple organizations with unique goals. MCO B also talked about their role as collaborators in SIM-aligned policy development. Each MCO mentioned participation in additional SIM-related initiatives, including State Strategy Plan workgroups, C3 steering committee meetings, SDH workgroup (MCO A), Learning Community events, and ongoing quarterly contact (MCO B). MCO A reported positive experiences in SIM workgroups, saying “We find workgroups valuable in the sense that we interact with people outside of our sphere with different perspectives, so we’re better able to understand and collaborate.”

While both MCOs were actively cooperative in the VBP workgroup and quality measure discussion, MCO B had reservations about the feasibility of the SIM goal to align quality measures across various payers and populations, stating, “The expectation that alignment can be achieved that is complete is unworkable and will continue to prove to be unworkable.”

Both MCOs reported building collaborative relationships as successes associated with SIM involvement, with MCO B stating, “I think collaboration with the other organizations with the other MCOs, and with our external partners. I think the relationships that we’ve built through attending these various meetings has been beneficial.”

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In regard to interactions with SIM staff, MCO A reported that communication with SIM staff was satisfactory, and that weekly ongoing meetings were being held. MCO B reported actively disseminating SIM updates throughout their organization to ensure employees at all levels are informed about SIM activities and resources.

Each MCO elaborated on their perceptions of the role of payers in the SIM. Along with implementing VBP, both MCOs recognized that participation in SIM workgroups was an expectation. Both MCOs reported participation in the SIM VBP workgroup and reported positive experiences with that group. Both MCOs reported satisfaction with the resolution of VBP workgroup compromises. MCO B noted that ongoing compromise was expected, when working across multiple organizations with unique goals. MCO B also talked about their role as collaborators in SIM-aligned policy development. Each MCO mentioned participation in additional SIM-related initiatives, including State Strategy Plan workgroups, C3 steering committee meetings, SDH workgroup (MCO A), Learning Community events, and ongoing quarterly contact (MCO B). MCO A reported positive experiences in SIM workgroups, saying “We find workgroups valuable in the sense that we interact with people outside of our sphere with different perspectives, so we’re better able to understand and collaborate.”

While both MCOs were actively cooperative in the VBP workgroup and quality measure discussion, MCO B had reservations about the feasibility of the SIM goal to align quality measures across various payers and populations, stating, “The expectation that alignment can be achieved that is complete is unworkable and will continue to prove to be unworkable.”

Both MCOs reported building collaborative relationships as successes associated with SIM involvement, with MCO B stating, “I think collaboration with the other organizations with the other MCOs, and with our external partners. I think the relationships that we’ve built through attending these various meetings has been beneficial.”
stakeholders, the PPC evaluation team invited representatives from the major state-level provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM to participate in telephone interviews. Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Representatives from Broadlawns reported prior involvement with the SIM, but opted out of the being interviewed due to lack of recent engagement. Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018. More detailed methods and results can be found in Appendix A.

Three ACO representatives described their organization’s participation in SIM as fulfilling a need to be aware of potential changes that would impact their organizations and remain a key player in the state, but noted they had limited opportunity to influence the initiative’s strategic direction or decision-making. ACO B described the dynamic for ACO stakeholders, saying, “Our goal is, I guess that I see it, is to keep informed, watch what’s going on, and look for an opportunity to become involved, but other than sit in meetings, I don’t know that there’s much I’ve seen to this point.” Representatives from ACOs C and D commented on the diminished role of ACOs in the SIM, saying, “it’s been dormant in terms of its visibility to us.” and “we’ve basically had virtually no role with SIM… We’re just doing our best to try to implement it [SIM], but you can’t get them [IME] to really listen to you and I think it’s because they just don’t understand, but there’s also an unwillingness to listen.”

These reports of tapering ACO involvement are consistent with activities reported by the SIM team during this evaluation period. While each of the four Medicaid ACOs were knowledgeable about the general goals of the SIM, all four noted a divergence between the original expectations for the SIM and the current state of the SIM. Specifically, all four ACOs noted the vision for the SIM had lost direction. In regards to the unclear direction of the SIM, all four ACOs cited shifting and unclear leadership roles at the SIM and state level, and three ACOs attributed the disruption to the entrance of the MCOs and subsequent contract renegotiations. As a representative from ACO A described, “I think the aspirations were pretty high, and then we have the MCO’s step in and we all know in Iowa that that’s been more than a business disruption, and so I think we’ve lost sight a bit of how to go about making those goals happen.” A representative from ACO B expressed disappointment in the narrowed scope (i.e. Medicaid population and program focus) of the SIM, saying, “that really is one of our big complaints about these programs [SIM], is, we don’t want programs that help one contract out of our 20 contracts… I guess that was the hope that the SIM would do that. I don’t think that’s produced much positive results in that way.”

With the introduction of the Medicaid MCOs, the Medicaid ACOs were one level removed from the SIM organizers, in particular IME, and this was reflected in all four ACOs reporting infrequent and “sporadic” involvement with the SIM staff, with two ACOs noting more involvement when they were contracting directly with the state (prior to Medicaid Modernization). When asked about SIM staff relationships, two ACOs were uncertain, as one replied, “Who is SIM staff?” and another reported, “we’ve had no contact with healthcare collaborative [IHC] or Public Health [IDPH] nor any of those folks that I understand received funding.”

All ACOs perceived the SIM engagement with ACOs as being perfunctory, as one ACO described, “I just don’t think they really understand what it really means from the perspective of the ACOs and why would they, right? I mean, I don’t think it’s fair to expect that they would, but I don’t think that they engage enough in a conversation beyond surface level.”

One ACO reported receiving regular updates and positive experiences interacting with SIM staff, saying, “They keep sending us all the information, and we can get it. We’ve had connections there. If I wanted to talk to someone about some programs… They’re very responsive and helpful. I think their communication, it’s fine.”

Another ACO reported fewer positive experiences, and described meetings in which ACO feedback was solicited, but not acted upon.

Two ACOs expressed desire to be involved in SIM (or any statewide initiatives) planning, saying “we participate as much as we are invited or nose our way into some of the conversations around what those parameters might look like or initiatives might look like, whether it’s contracting or whether it’s support for infrastructure development.” The other ACO representative added an appeal to maintain organizational autonomy in implementation, saying, “We want to have input if they’re going to design anything like new metrics, incentive programs, we’d like to have some input on it so we can hopefully have, once developed, that we can build into our own systems. But we’re not looking for the state to provide systems for us.”
Two ACOs identified the unclear direction and eventual goals of the SIM as a challenge, saying “Well, my challenge is understanding what their goals are. So I think they’re in search of a reason to exist. And so I guess that would be the biggest challenge” and “What that future looks like for all of these entities is an unknown. Like what are we working toward? Are we working toward provider agreements on behalf of our health centers and someday, centralized billing systems? I don’t know. That’s yet to be defined.”

Two ACOs noted value in inclusive statewide conversations about SDH, which raised awareness and broadened the definition of quality care, as one ACO representative described, “The SIM gave a platform. One of its most important functions is that it gave everybody in the state a platform to talk about things like how do we address social determinants? It brought a focus on how our community should convene, and they should talk about these hard issues. Nobody was doing that before, and it set an expectation that the best kind of care was partnering with folks on the ground in the community. A recognition that patients don’t live in a clinic, they live in the community...Honestly, that in itself is of enormous, enormous value.”

Another ACO shared a similar sentiment, describing the value of the SIM in its foundation of ongoing cooperation amongst health stakeholders in the state, saying, “Well, to the extent, I would not say it’s currently very much of a factor but I think, the framework that was set to start with, certainly helped everybody have a vision of what could be possible working together. So, I wouldn’t dismiss it as not having had anything to do with where we’re at. You don’t feel it very much today I would say.”

ACOs and the SIM Workgroups

The ACO representatives also talked about interaction with the SIM through workgroup participation. Specific workgroups mentioned included an SDH workgroup, Care Coordination workgroup, Patient Engagement workgroup, Health Risk Assessment workgroup, and a Quality Metrics workgroup. In regard to workgroup contributions and outcomes, ACO C said, “I think we just actively participated in helping to define those [Social Determinants of Health] and refine the policy papers that came out of it. There’s been some assessments that have come out since that I think have been of frankly minimal value, but kind of developing statewide, philosophical or conceptual documents out of this.”

One ACO described workgroups as “haphazard” saying meetings are “supposedly on a quarterly basis but it often gets pushed off.” In regard to the Quality Metrics workgroup (during the SIM planning year), both ACOs who reported involvement described some workgroup outcomes as predetermined, saying that while everyone agreed on the idea of standardized quality metrics, the decision to align around Wellmark’s Value Index Score (VIS) was a “decision [that] was made before anybody ever stepped in the room.”
Governor’s Healthcare Innovation and Visioning Roundtable

The AY3 & AY4 Operational Plan for the Iowa SIM included plans to convene a Governor’s Healthcare Innovation and Visioning Roundtable (indicated as the Roundtable from this point forward), which would be responsible for gathering stakeholders, planning the remaining years of the SIM, and sustaining the SIM initiatives beyond the granting period. The Roundtable is chaired by Jerry Foxhoven, the Iowa DHS director, and is facilitated by Health Management Associates (HMA). Since the Roundtable’s beginning in December 2017, six Roundtable meetings have been held. In addition, two workgroups (Healthy Communities and Data Sharing and Use) were formed in May 2018, and have met four times.

In September 2018, the Roundtable shared recommendations with the Iowa Governor’s Office, which included workgroup goals, processes, and strategies. See Appendix I.

Governor’s Healthcare Innovation and Visioning Roundtable Vision

Working inside and outside the healthcare system, we will create healthier communities and transform the delivery and financing of care to enable all Iowans to live longer and healthier lives.

Composition

While roundtable meetings are open to the public, members were appointed by Iowa DHS. The initial roundtable meeting featured recommendations from the National Governors Association (NGA) Center for Best Practices, which recommends including the stakeholders outlined in Table 3.6

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### Table 3. Recommended and Actual Composition of the Governor’s Healthcare Innovation and Visioning Roundtable

<table>
<thead>
<tr>
<th>NGA Recommended Stakeholders</th>
<th>Iowa Roundtable and Workgroup Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governor’s Office</td>
<td>Office of the Governor of Iowa</td>
</tr>
<tr>
<td>Attorney General's Office</td>
<td></td>
</tr>
<tr>
<td>State Health IT Coordinator</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>Iowa Department of Public Health</td>
</tr>
<tr>
<td>State Employee Benefits</td>
<td>Iowa Insurance Division</td>
</tr>
</tbody>
</table>
| Medicaid (Privacy Counsel, Policy Director, Chief Information Officer) | Iowa Department of Human Services  
Iowa Medicaid Enterprise (Director)  
Telligen  
UnitedHealthcare  
Amerigroup of Iowa |
| Health Care Practitioners    | Iowa Clinic  
Iowa Medical Society  
University of Iowa Health Care  
McFarland Clinic  
Iowa Hospital Association |
| Health Systems               | Mercy ACO  
UnityPoint Accountable Care |
| Privacy and Consumer Advocates | Iowa Primary Care Association  
Iowa Department on Aging |
| Health Information Organizations (HIOs) | Des Moines University |
| Academic Experts             | National Federation of Independent Business  
Farm Bureau  
Association of Business and Industry  
Iowa Business Council  
Healthiest State Initiative  
Wellmark Blue Cross Blue Shield |
| Not Specifically Recommended by NGA |                                    |

Three of the stakeholder groups recommended by the NGA are not included in the official membership of the Governor’s Healthcare Innovation and Visioning Roundtable or workgroups, namely the Attorney General’s Office, a Health Information Organization, and a State Health IT Coordinator. While representatives from the Iowa Health Information Network (IHIN) have attended 3 of the 5 Roundtable meetings, they are not formally recognized as Roundtable members, and would fulfill the HIO recommendation. Likewise, Carrie Ortega, the State Health IT Coordinator has attended 2 of the 5 Roundtable meetings, but is not formally a Roundtable member.

### Consideration for Membership

In addition to those recommended by the NGA noted in the previous paragraph, other healthcare stakeholder groups could be considered for membership. First, the advocacy groups listed are focused on their respective consumers (e.g. aging and underserved populations), so potentially including other patient or consumer advocacy groups could further fill out Roundtable membership. Second, the inclusion of state legislators, particularly from the Health Policy Oversight Committee, could be beneficial to provide an additional policymaker stakeholder perspective.

### Stakeholder Experiences – Governor’s Healthcare Innovation and Visioning Roundtable

At the time the MCO interviews were conducted, the Governor’s Healthcare Innovation and Visioning Roundtable (Roundtable) was being reinstated, restructured, and reintroduced after a period of inactivity, so MCO experiences with the Roundtable were not collected.

All four ACO representatives confirmed that their organizations are members of the Roundtable, with two ACOs saying the Roundtable is their most substantial connection with the SIM at this time.
Perceptions of the Roundtable and its potential impact varied. Two ACOs acknowledged the value of convening major health care stakeholders in the state, which has opened communication across stakeholders to better understand roles, motives, and opportunities to align. One ACO credited the Roundtable with influencing Wellmark to use the SIM Statewide Alert Network (SWAN) vendor (Iowa Health Information Network (IHIN)), saying, “that was the first time I’ve seen anybody walk the talk. It’s just such a big deal now to have Wellmark playing ball.”

Two ACOs said the impact of the Roundtable was contingent on concrete follow-through, saying, “I thought it was really good dialogue to tell the truth, but it was very visionary” and “I think how useful it is depends a lot on how much attention it will get beyond it being a roundtable. What’s really the commitment? It’s so easy to do things in a work group and a roundtable, it’s what happens in contracts and in the things that you do that matter.”

Two ACOs hoped that the Roundtable would be an avenue to promote population health across sectors and reopen the quality metrics discussion. These two ACOs talked about a need to replace the value index score (VIS) as the statewide quality metric tool, with one suggesting increased alignment with Medicare methodologies as a potential solution.

**Stakeholder Engagement Summary**

- Both MCOs were knowledgeable about the SIM, actively participated in workgroups, reported positive relationship with SIM staff, and explicitly reported collaborative relationships as a success.
- Both MCOs and three of the four ACOs interviewed noted regularly convening healthcare stakeholders through meetings, workgroups, and the Roundtable as a positive impact of the SIM.
- Disrupted engagement with the ACOs has impacted relationships, as ACOs report diminished roles in decision-making and uncertainty about the SIM goals and the role of ACOs.
- ACOs described SIM engagement in workgroups and the Roundtable as “surface level,” “conceptual,” and “visionary,” and expressed a need for continuing SIM efforts, such as the Roundtable, to produce concrete contractual commitments toward statewide goals. ACOs perceived they were not sufficiently involved in decision making and planning of policies and programs that their organizations were impacted by and/or compelled to adopt.
- Members appointed to the Roundtable could be amended to include key stakeholders recommended by the National Governor’s Association (specifically, the state Attorney General’s Office, a Health Information Organization, and a State Health IT Coordinator).
Evaluation of Implementation Activities

The implementation activities at the end of AY3 and into AY4 and were a continuation of previous activities to promote the two primary drivers of the Iowa SIM; namely delivery system reform (equipping providers with tools and technical assistance for how to use the tools and information) and payment reform (establishment of quality measurement and promotion of value-based purchasing contracts). The following outline shows how the activities will be organized and presented in this section.

I. Healthcare Delivery System Reform
   1. Community and Clinical Care Initiatives (C3s)
   2. Statewide Alert Network (SWAN)
   3. Data Sharing, Collection, and Reporting
      a. Continuous Quality Improvement – Community Scorecards
      b. Social Determinants of Health – Health Risk Assessments (HRAs)

II. Payment Reform
   1. Value-Based Purchasing (VBP)
   2. Quality Measures and the Value Index Score (VIS)

III. Technical Assistance (TA)

The rest of this section provides a description of each activity, the status of implementation during this reporting period, and the experiences of stakeholders with each SIM implementation activity.

Community and Clinical Care (C3) Initiatives

SIM-funded Community and Clinical Care (C3) Initiatives were designed to transform healthcare delivery by promoting care coordination across the traditional divide between medical, public health, and social service delivery systems. There are 7 C3 service regions across the state that include 15 counties. The following map (Figure 1) provides the C3 sites and associated service areas for SIM AY3 and AY4.
In the first year (SIM AY2) of the C3 initiatives, the Marion, Des Moines, and Linn county C3 sites were developmental sites and the Sioux, Dallas, and Webster county regional C3 sites were implementation sites. The UnityPoint Health – Trinity Muscatine C3 site began operations in year two (SIM AY3). In year two (SIM AY3) and going forward, all C3 regions are considered implementation sites.

The structure and function of the C3s is based on the Accountable Community of Health (ACH) model of health care delivery. The ACH model was designed to bring stakeholders from a variety of sectors (health care, behavioral health, public health, social services, and community-based supports) together to address not just the medical factors but also the non-clinical factors (social determinants of health) that influence health.

Specific to the SIM, the C3s have two primary functions:

1) Develop and implement population-based, community-applied interventions for their target population, individuals at risk for, or having diabetes

2) Address social determinants of health through care coordination

In this reporting period, the PPC evaluation team assessed the progress and status of the C3 initiatives implemented during their second award year (which ended April 30, 2018) and into the third award year (which began on May 1, 2018). This section describes how C3s are meeting the tenets of the ACH model and their progress with regard to diabetes initiatives and provision of enhanced care coordination.

In addition, this section includes the experiences of several stakeholder groups as they relate to the C3 initiative. The stakeholders interviewed or surveyed for their experiences included various entities from the local C3s (program staff, steering committee and community coalition members, providers, clinic managers, a diabetes educator, and patient/clients who received care coordination.

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services from the C3) and representatives from some of the major state-level payers and providers (Medicaid MCOs and Medicaid ACOs).

**C3s as Accountable Communities of Health (ACH)**

As noted earlier, the structure and function of the C3s is based on the Accountable Community of Health (ACH) model of health care delivery. The C3 RFP included criteria to increase and strengthen clinical partnerships within the C3s. In particular, five components of the ACH model were required of applicants.

1) Integrator Organization – an entity outside of the clinical healthcare delivery system that functions as the lead entity for bringing various stakeholders together.

3) Governance (Steering Committee) – a group that provides leadership and strategic health planning for the C3 community. The steering committee membership had to include representation from the local public health agency/board of health, at least one Accountable Care Organization (ACO), at least one hospital, a primary care provider from each involved health system or hospital, and the integrator organization.

4) Multi-Sector Partnership (Community Care Coalition) – a group of stakeholders from a variety of community sectors including, but not limited to, area agencies on aging, governmental bodies, Federally Qualified Health Centers (FQHCs), community-based nonprofits, educational institutions, law enforcement and correctional agencies, etc. All steering committee members and at least one community member from the target patient population (adults with diabetes) must have membership on the coalition. The role of this coalition is to implement SIM-related activities (tactics) and serve to advise the steering committee.

5) Financial and Administrative Functions – ability to perform basic financial and administrative functions including management of grant budgets and planning.

6) Sustainability – Development of specific ways to ensure the C3 work would be sustainable beyond the SIM award period.

The outline below provides a summary of the ACH components for each of the seven C3 initiatives. The evaluation team defined partnership sectors in the table as follows.

- **Public Health** – Organizations which provide public health services. These could include county, state, or hospital-based public health departments.
- **Primary Care** – Primary care providers associated with the local health system or hospital.
- **Other Healthcare Providers** – Organizations such as behavioral health clinics, diabetes educators, pharmacies, home health providers, dental clinics, and others. These organizations/individuals could be hospital-based.
- **Payers** – Organizations (such as Medicaid Managed Care Organizations or private insurers) which manage the reimbursement of health services.
- **Social Services** – Organizations (such as housing shelters, food pantries, transportation services, etc.) which provide direct service specific to social determinants of health.
- **Community Programs** – Organizations (such as non-profits, local boards/associations/coalitions, community members, advocacy groups, faith-based organizations, etc.) which are locally based and provide services and supports for the community and specific subpopulations (not directly related to social service provision).
- **Governmental Entities** – Organizations (such as police departments, local government, educational institutions, etc.) which are funded through the government (excluding public health).
- **Private Industry** – Organizations not otherwise categorized (such as businesses, employers, for-profit companies, private foundations, etc.) which are privately operated.

Each of the C3 sites have the main components of the ACH model as required. Five sites have distinctly county government based public health departments as their integrator organizations while two have integrator organizations that are more of a health system/county government public health department hybrid. The size and variety of sectors that compose the membership of each steering committee and, more specifically, each community care coalition, is reflective of the
environment, population, and needs of the local communities involved. Sustainability plans are, for the most part, in the developmental phases and should become more defined in their third award year. C3 steering committees are a group that provides leadership and strategic health planning for the C3 community, and coalitions are a group of stakeholders from a variety of community sectors which implement SIM-related activities.

Figure 2. C3 Steering Committee and Coalition Members by Sector
Table 4. Summary of the ACH components of the C3 sites

<table>
<thead>
<tr>
<th>Service Area Population</th>
<th>Map Region 1 Sioux County</th>
<th>Map Region 2 Dallas County</th>
<th>Map Region 3 Des Moines County</th>
<th>Map Region 4 Linn County</th>
<th>Map Region 5 Marion County</th>
<th>Map Region 6 Webster County Area (7 counties)</th>
<th>Map Region 7 Trinity Muscatine (3 counties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>34,937</td>
<td>84,516</td>
<td>40,055</td>
<td>219,916</td>
<td>33,248</td>
<td>105,975</td>
<td>72,559</td>
</tr>
<tr>
<td>Integrator Organization</td>
<td>Community Health Partners of Sioux County</td>
<td>Dallas County Public Health Nursing Services</td>
<td>Great River Medical Center &amp; Des Moines County Public Health</td>
<td>Linn County Board of Health</td>
<td>Marion County Public Health Department</td>
<td>Webster County Health Department</td>
<td>Unity HealthCare &amp; Muscatine County Public Health Department</td>
</tr>
<tr>
<td># Members by Partnership Sector</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
<td>Steer - ing Coali - tion</td>
</tr>
<tr>
<td>Public Health</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hospital</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ACO</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other Health-care Provider</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Payer</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community Programs</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Private Industry</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Government Entities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Total Members</td>
<td>9</td>
<td>17</td>
<td>10</td>
<td>31</td>
<td>6</td>
<td>26</td>
<td>13</td>
</tr>
<tr>
<td>Examples of Sustainability Plans</td>
<td>Identify a sustainability workgroup, host planning discussions, develop communications plan, use IT to integrate org work</td>
<td>Demonstrate cost savings; contract with a marketing and/or healthcare analytics team to help build a business case and messaging to use for finding investors</td>
<td>C3 leadership &amp; partners will discuss a strategy for the coordination of the local coalition to ensure continuity &amp; stakeholder support</td>
<td>Create training guides and videos for TAVConnect and host a “train the trainer”/“super user” training to ensure increased its use and sustainability</td>
<td>Cost of staff dedicated to care coordination as part of C3 will be absorbed by each facility after the grant period has ended</td>
<td>Continue to build partnerships, mobilize the community, &amp; focus on a regional approach. Will work with others to discuss &amp; secure financial opportunities</td>
<td>In development</td>
</tr>
</tbody>
</table>
Target Population – Individuals with Diabetes

In SIM AY3, a major change for the C3 communities was a requirement to focus their activities on improving the health of a particular target population, namely individuals with diabetes. This change was implemented to provide a way for the C3 sites and the SIM project to test initiatives and measure progress within a specified target population with the intent of expanding successful initiatives to other populations over time.

One of the SIM activities involves promoting “population based, community applied” interventions designed to encourage providers to use evidence-based care and support patients in self-managing their health conditions. One of the ways C3 initiatives do this is through leveraging existing community evidence-based programming supporting diabetes self-management such as the Diabetes Self-Management Education and Training (DSME) program, the Stanford Chronic Disease Self-Management Program (CDSMP), and the National Diabetes Prevention Program (NDPP).

In Figure 2, diabetes-related programming in Iowa is highlighted. The map shows the C3 counties highlighted in darker blue. Diabetes education programs/sites are indicated by the colored circles; those with state certification are indicated with a star inside the circle.

Diabetes education programs are widespread across the state and it is important to note those with state certification. All DSME programs included in this map are American Diabetes Association Recognized Education Programs. This accreditation qualifies Medicare program participants for cost reimbursement and, in Iowa, state-certified DSME programs are reimbursed by Medicaid and some private insurers. Thus, efforts to promote state-certification of DSME programs is another strong policy angle for SIM activities. Efforts to implement this part of the population health initiative of the SIM during this reporting period have involved many policy levers for change including establishment of cooperative agreements and relationships, helping build infrastructure, and offering financial incentives through reimbursement for education programs. While the number of DSME sites have remained constant, 25 additional DSME sites in the state have received the designation of state certified since 2014, with 91 total state certified sites in Iowa in 2018. In addition, 9 NDPP sites and 6 CDSME sites have been added to the state’s landscape since 2017.

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Figure 3. Diabetes Programming Map

Note: all program sites may not be visible on the map, due to overlap in dense locations

**DSME:** Diabetes Self-Management Education (DSME) is a ten-hour program for people diagnosed with diabetes which provides education on medical management and self-care behaviors [Source: ADA Recognized Education Programs and American Association of Diabetes Educators accredited programs]

**NDPP:** National Diabetes Prevention Program (NDPP) is a yearlong program (16 sessions + 6 follow-up sessions) that can help prevent or delay type 2 diabetes for people with prediabetes [Source: CDC NDPP Registry]

**CDSMP:** Chronic Disease Self-Management Program/Education (CDSMP) is a six-week workshop (15 hours total) for individuals with chronic conditions to improve health outcomes through managing lifestyle behaviors [Source: Iowa Department of Public Health]

**State Certification:** The IDPH certifies diabetes outpatient education programs – certification is necessary to obtain reimbursement from Medicaid and some private insurers in the state of Iowa [Source: Iowa Department of Public Health]

Based on information obtained from the evaluation team site visits in the Fall of 2017, the C3 initiatives have implemented a variety of actions specific to the diabetes focus including:

- **Completion of needs assessments** – Four C3 sites completed needs/gaps assessments specific to diabetes care in their communities.
- **Development of diabetes-specific referral processes** – Six C3 sites were in the process of developing a referral process specific to their patients with diabetes.
- **Utilization of existing diabetes resources** – All seven C3 sites had identified and were utilizing existing diabetes resources (5 sites specifically mentioned NDPP and 2 mentioned DSME).

**Care Coordination**

The C3 initiative has a variety of goals related to the SIM but one of the original intentions for the C3 communities was to establish coordinated patient care to link clinical and community-based services and address social determinants of health. At the local level, the C3 communities are designed to be on the forefront of providing enhanced care coordination activities as part of their role on the SIM.

At the end of award year 1 and award year 2 for the C3 grants, we asked the lead staff for each C3...
initiative to self-rate their progress with some of the tactics advocated in the Care Coordination statewide strategy plans to get a sense of where the C3 communities were with regard to care coordination activities. For each of the tactics under the care coordination objectives assessed, progress was ranked from 0-5:

0=Not Applicable/Not Intending to Implement
1=No Activity
2=Planning Underway
3=Developing
4=Implementation Initiated/Underway
5=Completed/Fully Operational

Scores were calculated for each site by summing the status rankings and dividing by the number of tactics. The scores presented in Table 5 are aggregated over the original six C3 sites. The newest C3 site was not included because it was in its first year of operation during this reporting period.

Table 5. Year 1 and Year 2 Self-Assessment of Care Coordination Activities

<table>
<thead>
<tr>
<th>Objective (# Tactics)</th>
<th>End of Award Year 1</th>
<th>End of Award Year 2</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Advance patient centered care practices (7)</td>
<td>3.2</td>
<td>3.6</td>
<td>+</td>
</tr>
<tr>
<td>1.2 Facilitate the impactful delivery of healthcare services (5)</td>
<td>3.2</td>
<td>4.2</td>
<td>++</td>
</tr>
<tr>
<td>1.3 Establish coordinated connections to needed community-based services (3)</td>
<td>3.4</td>
<td>4.3</td>
<td>+</td>
</tr>
<tr>
<td>2.1 Develop multi-discipline patient-centered care teams (6)</td>
<td>2.3</td>
<td>2.8</td>
<td>+</td>
</tr>
<tr>
<td>2.2 Use of HIT to facilitate cross-communication and documentation (4)</td>
<td>3.1</td>
<td>3.1</td>
<td>No change</td>
</tr>
<tr>
<td>2.3 Establish standardized processes and protocols for collaborative care delivery (3)</td>
<td>3.2</td>
<td>3.7</td>
<td>+</td>
</tr>
<tr>
<td>2.4 Enhance collaboration among healthcare providers, community-based services, and the payer community (3)</td>
<td>2.4</td>
<td>3.1</td>
<td>+</td>
</tr>
<tr>
<td>3.1 Align community-based services for each patient/service recipient to ensure greatest impact (3)</td>
<td>3.9</td>
<td>4.4</td>
<td>+</td>
</tr>
<tr>
<td>3.2 Connect clinical services with community-based services (4)</td>
<td>3.6</td>
<td>4.4</td>
<td>+</td>
</tr>
<tr>
<td>4.1 Promote and enhance the use of HIT to identify, track, and monitor population health (3)</td>
<td>3.2</td>
<td>3.4</td>
<td>+</td>
</tr>
</tbody>
</table>

[+]= Increase in score from Year 1 to Year 2 of less than 1.0; ++= Increase in score from Year 1 to Year 2 of 1.0 or more.

Overall, for all but one (2.2) of the care coordination objectives, the C3 sites are showing progress toward implementation. Objectives related to facilitating and establishing the connections necessary to link patients’ clinical and community-based service needs (1.2, 1.3, 3.1, 3.2) were most likely to be in the implementation stage during year 2. Those objectives relating to establishing specific practice changes such as advancing patient centered care (1.1) and standardizing processes and protocols for care delivery (2.3) were next closest to being in the implementation stage. Objectives relating to developing multi-disciplinary care teams (2.1), enhancing collaboration among important stakeholders (2.4), and using HIT (2.2, 4.1), were mostly in the developmental stage in Year 2.

C3 sites were required to develop activities for their initiatives for five specific care coordination tactics. Table 6 presents the developmental progress of the C3s in meeting this requirement after one and two years of SIM funding based on C3 site self-assessments. The table shows each required care coordination tactic, the progress levels for tactic implementation, and how many C3 sites rated themselves at each level.
<table>
<thead>
<tr>
<th>Required Care Coordination Tactic</th>
<th>Stage of Implementation</th>
<th>Year 1 end # Sites</th>
<th>Year 2 end # Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1f. Promote the implementation of comprehensive and high quality health risk assessments (HRAs) that identify patient, clinical, social, and community needs.</td>
<td>No Activity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Implementation Started</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Fully Operational</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>1.2c. Designate defined care coordination roles and/or responsibilities with the clinic, practice, or organization.</td>
<td>No Activity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Implementation Started</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully Operational</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1.3a. Increase recognition and capacity to address SDH through education and incorporation within HRAs to identify patient-specific needs.</td>
<td>No Activity</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Implementation Started</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Fully Operational</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1.3b. Identify available assistance within the community and establish points of contact to enable resource sharing and referral.</td>
<td>No Activity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Implementation Started</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Fully Operational</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2.2a. Promote the use of available HIT resources to allow mutual access to patient care information from all appropriate members of the patient care team, i.e., Iowa Health Information Network (IHIN), shared electronic health records (HER) view, and messaging functionalities.</td>
<td>No Activity</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Planning</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Development</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Implementation Started</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Fully Operational</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

By the end of year 2 SIM funding, the majority of C3 sites were in some phase of implementation for four of the five required tactics. And, consistent with results from Table 6 above, the C3 sites experienced the slowest progress with the tactic involving the use of HIT with tactic 2.2a showing the fewest number of sites reporting implementation after year 2. For more information about the care coordination statewide strategy matrix analysis and specific detail on each C3 site’s progress toward implementing the care coordination statewide strategies, see Appendix B.
Relationship Building – Network Analysis

At the local/regional level, the C3s were designed to include a multi-sector group of stakeholders including healthcare providers, community-based providers, public health organizations, and social services to implement care coordination strategies and referral processes to meet both the clinical and social determinant of health (SDH) needs of their population.

A survey was sent to all steering committee and coalition members at each C3 site to gather information about the relationships and networks from the perspectives of the multi-sector partners involved in C3s. Some detail about methodology is included below. For more detailed methodology and results, refer to Appendix C.

Network Trust and Relationships

To better understand the quality of relationships within the C3 networks, survey respondents were asked to rate their relationships with each of the organizations with which they collaborate. Overall, relationships across sites were rated highly, with nearly half of all reported relationships between steering committee and coalition members receiving the highest possible rating in all C3 sites (See Appendix C). In addition, integrator organizations at each C3 site were highly rated by collaborating organizations in their respective networks, with an average rating of 2.7 (out of possible 3).

Network Evolution

To learn more about the C3 role in stimulating and fortifying collaborative relationships, survey respondents were asked to report about four types of networks 1) collaborations that preexisted the C3, 2) networks that were stimulated by C3 activities, 3) connections specific to only C3 activities, and 4) whether collaboration was expected to continue after the funding period (Figure 3).

Figure 4. Network Evolution by C3 site

The percentages above show the proportion of responses for each type of network evolution connection (pre-existing, C3 stimulated, C3 exclusive, expected continuation) reported as a proportion of all responses for each site. The types of connections selected by respondents were not mutually exclusive.

Of the connections reported for each network, the C3 grant had varying degrees of impact. For example, sites which reported collaborative networks before the grant had lower rates of attributing collaboration to the C3, and lower rates of predicting continued collaboration for C3 related activities after the grant funding ends (relative to pre-existing networks). However, most sites reported positive growth in collaborative networks when comparing the pre-existing network to the perceived sustained network. Across sites, an average of 39% of established relationships were expected to continue.

C3 Network Diagrams

The following figures represent the networks of collaborating organizations at each C3 site. Each figure represents all reported connections between organizations from steering committees and coalitions at the C3 sites. Looking across the network figures on the following pages, networks at each C3 site vary by the variety of sectors involved and frequency of connections within and across sectors. Variations in the robustness of network diagrams (e.g. sector representation and connections between sectors) could be due to varying quantities of steering committee and coalition members (i.e. the survey sample) and survey response rates.
In order to clearly display cross-sector connections, all organizations involved with C3s were categorized into sectors, and each organization’s reported connections were aggregated by sector. The integrator organizations in each figure were isolated (not aggregated into corresponding sector), so network connections could be seen independently (since integrator organizations are charged with leading collaboration at each site). See Appendix C for definitions of sector categories.

Multi-Sector Networks

Each C3 site varies in size of the overall network and representation in each sector, so some sites have more concentrated connections between C3 partners, rather than a wide variety of connections. For example, the C3 Site E (shown below) includes organizations in 6 of the 7 sectors, but not all sectors are connected. While the network at Site F only includes representatives from 4 of the 7 sectors (and has the fewest number of C3 partners), each sector shares collaborative ties with all other sectors. As network sizes grow, network density (i.e. connections amongst all partners) is more difficult to achieve. More details about network measures, like density, and results can be found in Appendix C.

![Network diagrams for Site E and Site F]

All 7 C3 Sites have established multi-sector networks. In addition to Site E, Sites A, C, and D all incorporated organizations from 6 of the 7 sector categories. C3 Site B and Site F lacked partners in social services, which could inhibit the site’s capacity to address Social Determinants of Health.

Connections Between Sectors

In addition to noting which sectors are involved at C3 sites, these figures display the frequency of connections between sectors. The thickness of the ties between symbols indicate the frequency of connections, meaning thicker lines represent more numerous connections between the sectors (or in the case of symbols with a “halo”, connections, within sectors).
As examples, the diagrams and corresponding tables below provide details about the distribution of ties among sectors and their visualizations for Site G and Site C. The connections reported in the tables below represented aggregated connections, meaning incoming and outgoing connections from each sector were summed.

### Selected Connections by Sector for Site G

<table>
<thead>
<tr>
<th>Sector(s) Involved</th>
<th>Number of Connections reported</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within Healthcare</strong> (9)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Social Services</strong> (7) and <strong>Community Programs</strong> (9)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Healthcare</strong> (9) and <strong>Community Programs</strong> (9)</td>
<td>13</td>
</tr>
<tr>
<td><strong>Healthcare</strong> (9) and <strong>Social Services</strong> (7)</td>
<td>13</td>
</tr>
<tr>
<td><strong>Public Health Integrator Org.</strong> (1) and <strong>Healthcare</strong> (9)</td>
<td>11</td>
</tr>
<tr>
<td><strong>Social Services</strong> (7) and <strong>Public Health Integrator Org.</strong> (1)</td>
<td>9</td>
</tr>
<tr>
<td><strong>Within Social Services</strong> (7)</td>
<td>6</td>
</tr>
</tbody>
</table>

### Selected Connections by Sector for Site C

<table>
<thead>
<tr>
<th>Sector(s) Involved</th>
<th>Number of Connections reported</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within Healthcare</strong> (17)</td>
<td>51</td>
</tr>
<tr>
<td><strong>Healthcare</strong> (17) <strong>Social Services</strong> (6)</td>
<td>36</td>
</tr>
<tr>
<td><strong>Healthcare</strong> (17) <strong>Public Health Integrator Org.</strong> (1)</td>
<td>22</td>
</tr>
<tr>
<td><strong>Healthcare</strong> (17) and <strong>Community Programs</strong> (8)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Public Health Integrator Org.</strong> (1) and <strong>Community Programs</strong> (8)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Social Services</strong> (6) and <strong>Community Programs</strong> (8)</td>
<td>8</td>
</tr>
<tr>
<td><strong>Within Social Services</strong> (6)</td>
<td>7</td>
</tr>
</tbody>
</table>

In five of the seven C3 site networks, the densest connections are within the healthcare sector (for examples, see Site G and Site C above). Of note, those five sites have government public health – based integrator organizations (green diamond symbols).
In contrast to the government public-health led C3 sites, the densest connections at healthcare-based integrator organizations (Site A and Site D) are between Community Programs and Healthcare Providers and within Community Programs, respectively (pictured right). This pattern suggests that the sector of the integrator organizations may have impacted the selection of C3 partners and/or utilization of partners in collaborative efforts. Meaning, public health-based integrator organizations may have included a wider array of local healthcare providers, while healthcare provider-based integrator organizations may have relied more upon their own facility for healthcare provider representation in the network.

**Opportunities for Network Enhancement**

In addition to noting the connections between sectors and frequency of connections, these figures also display where connections are missing. Notably, the networks at C3 Site B and Site F lacked partners in social services, so cross-sector connections with the social service sector were impossible to establish.

The **red dotted lines** seen in the network figures for Sites A, B, and D (pictured right) indicate connections which ideally would be present, but were not reported. For example, connections between public health, healthcare, and social services would indicate established relationships which could theoretically facilitate care coordination outside the clinical healthcare sector (i.e. the network is better equipped to address SDH). Connections between public health and social services are missing in Sites A and D.

In addition, connections between the integrator organizations and all sectors in the network would best align with the definition of the integrator organization, namely *“an entity outside of the clinical healthcare delivery system that functions as the lead entity for bringing various stakeholders together.”* The network figures for C3 Site D and Site B (pictured right) are missing connections between the integrator organization and all sectors in the network.

**Recommendations**

Going forward, C3 sites could enhance local networks and ACH function by ensuring connections amongst all types of partners (especially for integrator organizations). In addition, partners from public health and social services sectors should be purposefully included and integrated into governance structures for care coordination efforts, particularly for initiatives related to addressing Social Determinants of Health (C3 Site B and Site F lacked partners in social services). Finally, baseline and intermittent collection of network relationships should be considered for future grants involving strengthening local care coordination networks to monitor this foundational aspect of cross-organization collaboration.

**Functional Networks**

To gather more information about the networks involved in carrying out C3 activities, members of C3 steering committees and coalitions were asked to report about involvement in four types of collaborative activities, including 1) Advisory Roles, 2) Care Coordination, 3) Data Sharing, and 4) Resource Sharing. See Appendix C for activity descriptions. On average, survey respondents across sites reported the most connections related to Resource Sharing (33% average), followed by Care Coordination (31%), Data Sharing (20%), and Advisory Roles (16%) (Figure 4).
The percentages above show the proportion of responses for each type of network evolution connection (pre-existing, C3 stimulated, C3 exclusive, expected continuation) reported as a proportion of all responses for each site. The types of connections selected by respondents were not mutually exclusive.

Network development varied across activity types, as measured by the average densities across networks (Figure 5). Network density is an indicator of efficiency (more details in network measures section in Appendix C) and average densities for all sites indicate that the most developed networks are those involved in resource sharing, and the least developed are the data sharing networks. In addition to resource sharing networks being the most developed, all integrator organizations played key roles in their respective resource sharing networks (see Appendix C for more detailed results).

**Key Takeaways**

- Overall, the stakeholders in C3 sites have been successful in developing strong working relationships with the integrator organizations and other partnering organizations.
- Five of the seven C3 networks included stakeholders from the healthcare, public health, and social services sectors, which aligns with the ACH quality of multi-sector partnerships. The remaining two networks can continue to be strengthened by involving diverse sectors in planning and administration of activities.
- The C3 grant had a role in stimulating collaboration, with an average of 21% of respondents across sites attributing current collaborative relationships to the C3. In addition, respondents expected 39% of the current relationships (on average) to be sustained past the funding period.
- Resource sharing networks across sites were the most developed, and integrator organizations play key roles in their respective sites in the facilitation of resource sharing.
- Three of the seven integrator organizations are leading the brokerage of care coordination at their sites. The integrator organizations at these high scoring sites have established and are
responsible for the maintenance of HIT data sharing systems utilized by local organizations for care coordination (See Care Coordination section in Appendix C for more detailed results).

- While data sharing networks were the least developed on average across sites, integrator organizations had key leadership roles in the developing data sharing networks (See Data Sharing section in Appendix C for more detailed results).
- Qualitative feedback from C3 survey respondents were largely positive, and comments represented two general themes: 1) Improved communication and coordination (34 comments) and 2) Strengthened relationships (28 comments). Only four comments were neutral or negative.

Stakeholder Experiences with the C3 Initiatives

To understand progress made by C3 communities toward SIM objectives, the evaluation team surveyed or interviewed a variety of stakeholders in the C3 initiatives. Within this evaluation period, PPC evaluators gathered insights about the C3s from:

- C3 Project Staff
- C3 Steering Committee Members
- C3 Community Coalition Members
- C3 Local Healthcare Providers
- C3 Clinic Managers and Diabetes Educator
- C3 Patients/ Clients
- State-level Payers (specifically, Medicaid MCOs and Wellmark)
- State-level Providers (specifically, Medicaid ACOs)

A more detailed report from each of these data collection efforts can be found in the Appendices referenced within each section. A summary of the findings from each follows.

C3 Project Staff

In the fall of 2017 (the beginning of this evaluation period), PPC team evaluator RHS, made site visits to each of the C3s. C3 project staff were interviewed to get an update on their activities, project strengths and successes, challenges to implementation, and to obtain an idea of their main needs and concerns. The following section provides the highlights from these site visits.

Activities

SIM Tools

- Utilization of Statewide Strategy Plans (SSPs) -- 4 sites reported using Statewide Strategy Plans (SSPs) for planning and implementing interventions
- Utilization of AssessMyHealth (AMH) -- 2 sites have operationalized use of the AMH; home visits, and sometimes follow-up, are needed to complete AMH at one site, the other site was creating a job description specific to administering AMH

Innovative Pilot Projects

- C3 sites have been conducting their own pilot projects relating to SIM goals and objectives which have involved advancing Health Information Technology (HIT), utilization of non-clinic providers (pharmacy), development of health home models, standardization of pre-diabetes programming across C3s (within UnityPoint clinics), diabetes programming, coordinating care across different and highly competitive local health systems, reducing emergency department (ED) utilization, and reducing incarceration.

Strengths and Successes

Relationship Building

- All 7 sites reported initiating, maintaining, and strengthening relationships with local
stakeholders through steering committee participation and/or working together on C3 activities

- Amongst steering committee (4 sites)
- Other local partners (6 sites)
- Includes health navigators, local public health entities, nurse practitioners, pharmacies, hospital CEOs, local clinics, hospitals, competing health systems
- Medicaid Accountable Care Organizations (ACOs) (2 sites)

- Involvement with other local non-C3 entities – One site reported C3 team participating in other local boards/subcommittees

Capacity Building

- Increased knowledge of local resources – 3 sites reported increased understanding of local issues and service delivery systems
- Staff Competence – 2 sites specifically noted having especially qualified, experienced, and capable staff
- Improved service delivery for diabetic population -- 2 sites reported improvements in diabetes services and delivery, 1 other site reported increased and sustained patient participation
- Applied for additional funding – 2 sites credited the C3 initiative with stimulating applications for additional funding with partners
- Financial investment from partners – 1 site reported financial investment from local partners to support infrastructure

Challenges

Workforce

- Need for qualified workforce – 4 sites reported limited capacity (volume and skills) amongst the workforce, particularly in the area of data analytics and the supervision and understanding of the roles of non-traditional healthcare providers such as nurse practitioners, care coordinators, health navigators, and health coaches
- Staff turnover – 4 sites reported setbacks due to staff turnover at SIM and C3 levels

C3 Operations

- Sustained stakeholder engagement – 4 sites reported difficulty maintaining stakeholder engagement (gaining/sustaining trust, catering to various organizational cultures, defining roles, reluctance recognizing C3 site as leaders/experts)
  - 3 sites cited shifts in C3 goals as a cause for disengagement
- Issues with using AMH – 4 sites reported difficulty implementing AMH (duplicative to current operations, time consuming to administer, clinic preference for other HRA tools)

Data Collection and Management

- Difficulty developing data sharing infrastructure – 4 sites reported difficulty building and operationalizing data sharing infrastructure (e.g. missing baseline data, partner resistance to reporting C3 required measures, ensuring patient confidentiality)
- Electronic health record (EHR) compatibility – 3 sites reported variance in EHRs of partner systems as a data collection barrier
- Access to data – 3 sites needed access to data (specifically baseline data for required reporting and National Quality Forum (NQF) data)

Client Population

- Low participation rates -- 4 sites reported low participation in programming (few referrals, patient resistance, big time commitment, sustaining communication)
- Hard to reach focus population -- 3 sites reported difficulty accessing the desired patient population; (addressing perceptions in communities with higher socio-economic status that
people are not in need of care coordination or help with SDHs, maintaining contact with patients in need of and receiving care coordination services, and trying to serve patients who decide they are not interested in care coordination)

**Needs and Concerns**

**Support Needs from SIM team**

- **Legal help** – 2 sites reported needing legal assistance with contracts and HIPAA compliance
- **State policy changes** – 2 sites suggested systemic issues to be addressed at the state level (e.g., NDPP and DSME gaps, reimbursement for care coordination, reliable funding, sustaining data sharing)
- **Quality improvement plan feedback** – 3 sites reported not receiving feedback/analysis on the quality improvement plans they submitted to IDPH/IHC
- **Site-specific technical assistance (TA)** – 6 sites reported needing TA specific to their site’s programming (e.g., integrating TAVHealth and IHIN data, training healthcare staff, population health resources)
- **Goal clarification** – 2 sites reported needing clarification on C3 and SIM goals

**SIM Operations**

- **Requirement to use the AMH** – 6 sites reported the requirement to use AMH as a concern and don’t believe it will be used beyond the SIM
- **Usefulness of the resources and training provided by the SIM** – 2 sites reported that resources and training provided to them had not been useful, and suggested obtaining more input from C3 sites regarding what resources and training should be provided

**Sustainability**

- **Overall C3 operations** – 5 sites reported concerns that overall C3 operations would not be sustainable (progress won’t be measurable, burnout due to lack of direction/ shifting foci throughout grant)
- **Workforce limitations** – 2 sites reported limitations in the workforce as a sustainability concern (healthcare workforce needs ongoing training and data specialists)
- **Data sharing across partners** – 2 sites reported data sharing across partners will likely end when funding does

**Steering Committee Members**

A web-based survey was conducted of the steering committee members from all seven C3 sites during February and March 2018. Forty surveys were completed for an aggregate response rate of 56% with varying response rates by C3. Sioux County and Linn County had the highest survey response rates while Webster County had the lowest response rate. Survey respondents indicated they are public health providers (36%), hospital leaders (23%), healthcare providers (20%), clinic leaders (18%), others (18%), or community members (8%).

In general, C3 steering committee members are aware of and participating in the planning and development of their local C3 initiatives with a higher percentage reporting “strong agreement” with C3 initiatives when compared to the first year of the program. Areas for improvement include encouraging the use of local patient population data to inform their planning and decision-making and helping to identify gaps in regional diabetes services to meet the needs of the key focus population of adults with diabetes.

For more detailed methodologic information and results, see Appendix D.

**Community Coalition Members**

A web-based survey was conducted of the Community Coalition members from all seven C3 sites during February and March 2018. Community coalitions’ inclusion in C3 activities was added to C3 Year-2 requirements. The role of this group varied from C3 to C3; however, all focused more on programmatic activities, such as those related to diabetes and obesity versus C3 planning and
development as a whole.

Forty-five members of C3 community coalitions completed the survey for an aggregate response rate of 28%. Response rates varied by site with the highest response (47%) from coalition members of the Dallas County C3.

Over half, but less than three-quarters of coalition members reported contributing to C3 planning and development or using local patient data to drive C3 decision-making. However, over three-quarters (78%) were either “satisfied” or “very satisfied” with the C3 and the initiatives underway in their communities.

When asked statements on awareness about the primary features of the C3 initiatives, community coalition members were very aware of the role of care coordination and social determinants of health (SDHs) and the impact of each on health outcomes (i.e., 100% reported agreement with these two components). When asked their agreement with how the primary functions of the C3 were being met in their region, the majority (84%, 46% strongly) agreed that community members’ needs related to SDHs were being addressed by the C3 initiative.

There was somewhat less strong agreement with the statements about care coordination and partnerships working better together. While most still agreed, less than 20% “strongly” agreed that the local C3s were implementing care coordination in the region and that care coordination had improved in the region within the past year. In fact, 8% “disagreed” that care coordination efforts had improved. And, less than 20% “strongly” agreed that within the past year, community partners/social services had been working more/better together to meet patient needs.

With regard to the focus area of diabetes, 65% reported agreement that they were aware of the gaps in diabetic services in their community/region (4% strongly agreed). And, just over half (52%) either “agreed” or “strongly agreed” that community members’ diabetic needs were being addressed because of the local C3 initiative with the rest either neutral (44%) or disagreeing (4%) with that statement.

In summary, all community coalition respondents understood the impact of SDHs on health outcomes and the majority reported that community member needs related to SDHs were being addressed by their local C3 initiative. While all members also reported understanding the impact of care coordination on health outcomes and most reported agreement that C3s were implementing care coordination in their region, the level of agreement about care coordination needs being met was not as strong when compared to addressing SDH needs of community members. These findings suggest that there is some work to be done when engaging community coalition members in the focus area of addressing the needs of community members with diabetes.

For more detailed methodologic information and results, see Appendix E.

Local Healthcare Providers

A mailed healthcare provider survey was conducted during March-April 2018 of those healthcare providers participating in the Webster County and Great River C3s to get a sense of how local healthcare providers viewed the work of the C3 initiative. Provider lists were provided to the evaluation team by the project leads from each C3. The survey was mailed to 50 nurse practitioners, physicians, physician assistants, psychiatrists, and two registered nurses. Nine providers (response rate = 18%) returned the survey. Five respondents were physicians, two were nurse practitioners, and two did not state their profession.

The findings from this work derive from the responses of nine healthcare providers from two different C3 regions (Webster County and Great River Health System in Des Moines County). The response rate is low and, because it only includes providers from two of the seven regions, the findings should not be interpreted to be representative of the C3s as a whole. The findings are a snapshot of the experiences of healthcare providers at the local level with regard to the work of the C3 initiatives. In summary,

- The three providers with the strongest reported participation in the C3 initiatives were also the three providers reporting the most knowledge of the SIM and C3 initiatives.
- Yet, in all, almost half of these provider respondents did not report a strong awareness of
the C3’s roles and activities. And, most did not use information collected as part of the C3 initiative to inform patient care plans.

- Although survey respondents reported a lack of awareness of the C3s and their work, it is possible that C3 activities are being imbedded in the care coordination activities and operations of clinics without attributing the work to the C3 and its goals.
- Healthcare providers may also have limited awareness of the C3s and their work due to referrals into the C3 being made from the clinic’s care coordinators, limiting the healthcare provider’s contact and exposure with the C3 as whole.
- In all, these findings suggest that continued engagement of providers at the local level may be the key to more widespread adoption of the principles of the SIM and C3s.

For more detailed methodologic information and results, see Appendix F.

Clinic Managers and Diabetes Educator

Telephone interviews were conducted in April 2018 with two clinic managers and one diabetes educator involved with the Great River, Linn County, and Webster County C3s. The clinic managers and diabetes educator were identified by the C3 program officers. One of the clinics was a federally qualified health center (FQHC) that offers an array of services (e.g., family practice, oral health, OB/GYN, after-hour walk-ins, student health) and who serves primarily Medicaid patients. The second clinic was a designated rural health clinic with a large Medicare population. Both clinics have been participating in C3 activities since program start. The diabetic educator serves as the Diabetic Program Coordinator in a small clinic setting.

Interviews with clinic managers in 2018 were from C3 sites different from those in 2017 (Dallas County and Sioux County). The interview of a diabetes educator was new to 2018 and was conducted as a result of the shift in the requirements of the C3 initiatives to a target a specific health condition, namely diabetes, for which to focus program efforts, data collection, and reporting.

In summary,

- Similar to what was reported in 2017, clinic operations have not changed markedly due to the C3s but are constantly changing due to a variety of factors such as trends or shifts in health policy, new regulatory or insurance-related requirements, or grant funding.
- Many SIM and/or C3 goals were identified as successes including work toward reducing duplication of efforts, hospitalizations, targeting at-risk populations, increased knowledge of local and regional health and social services resources, improved partnerships among agencies/organizations, and increased awareness about the need to address social determinants of health.
- Interviewees identified several needs specific to the care and education of their patients with diabetes.
- Challenges remain with regard to the design, development, and implementation of workflows, project plans, and care coordination data tracking systems.

For more detailed methodologic information and results, see Appendix G.

Patients/Clients of the C3s

The survey of patients/clients of the C3 initiative was conducted over the course of several months, from December 2017 through April 2018. The purpose of this survey was to understand the experiences of adults who received care coordination/referral services from the C3 initiatives. To do this, the PPC evaluation team utilized a convenience sample of adults in C3 communities who received care coordination or referral services from a C3 entity and used a paper survey with a mail back option to collect data on their experiences.

Overall, 115 patients/clients involved in C3 initiatives responded to this survey. The vast majority of respondents came from the Dallas County Public Health, Webster County Public Health, or Marion County Public Health C3 regions. Very few respondents were patients/clients from the other three C3 sites. The majority of C3 clients who responded to this survey were 35 or older, white, female, and had at least a high school degree. Around 1 in 10 were Hispanic/Latino.
Perceptions of Health

- Around one-third (30%) reported ‘Very good’ or ‘Excellent’ physical health while over one-third (37%) reported ‘Fair’ or ‘Poor’ physical health.
- Over one-third (36%) reported ‘Very good’ or ‘Excellent’ mental/emotional health; less than one-third (28%) reported ‘Fair’ or ‘Poor’ mental/emotional health.
- Around one-half (51%) had been diagnosed with a chronic physical or mental health condition. A little over one-third (35%) of those with a chronic condition reported being ‘Very Confident’ they could manage and control their health problems.

Target Population – Diabetes

- 37 of the 115 respondents reported having been diagnosed with diabetes.
- The majority (n=34) had worked with a health professional to develop a diabetes care plan.
- Around half (n=18) had ever taken a course or class in how to self-manage their diabetes.

Experiences of the C3 patients with obtaining needed services (health care, personal care, and social services)

- Most (69%) reported a need for some type of medical service (care, prescriptions, or treatment) within the previous six months.
- Almost half (49%) reported a need for transportation to health care visits.
- Less than half reported a need for help with daily chores (41%) and one-third needed help obtaining food for their household (32%); few (15%) reported a need for stable housing.
- Most received the services they needed.
  - The vast majority (over 85%) received the medical care, help with daily chores, transportation, and food they needed.
  - Around three-quarters received the housing support they needed.
- Most people relied on family and/or friends to help them obtain needed services, regardless of service type (medical, help with daily chores, transportation, food, or housing).
- Almost one-half reported relying on their local health department for help obtaining needed food for their household; a little over one in five relied on their local health department for help with transportation to health care visits.

For more detailed methodologic information and results, see Appendix H.

Payers – Medicaid MCOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. More detailed methods and results can be found in Appendix A.

With regard to payer experiences specific to the C3 initiative, payer involvement with the C3s was limited in scope and the discussion about C3s was brief. Both MCOs were aware of the C3s and reported some involvement with particular C3 sites, namely the Dallas and Linn County sites. MCO A reported participation on a steering committee,

“We have participated on their Steering Committee, primarily during Year 1 by participating on their Steering Committee calls. We have had more limited involvement over Year 2.”
MCO B reported providing some resources to C3 communities and using information from C3 meetings to inform internal case management teams of resources in C3 counties.

“Currently, we are acting as a sounding board and an advocate for our members. So when they are talking about activities that are going to occur within the communities, then we provide various resources to get those activities accomplished. Also, we disseminate a lot of information coming through those meetings to the case management.”

By design, direct interaction of the payers with the C3 initiatives is limited in scope. However, these findings suggest that at least one payer is directly involved with providing some resources to a C3 community which could present an opportunity for all C3s (i.e., seeking resources from the MCOs for particular projects) as they contemplate ways to sustain and/or fund their initiatives going forward.

**Health System Providers – Medicaid ACOs**

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited representatives from the major state-level provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM to participate in telephone interviews. Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Representatives from Broadlawns reported prior involvement with the SIM, but opted out of the being interviewed due to lack of recent engagement. Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018. More detailed methods and results can be found in [Appendix A](#).

Some of the key take-away points from the interviews follow.

**Awareness of the C3s**

All four ACOs described supporting the C3 initiative at a regional level (i.e. ACO affiliated clinics lead involvement in C3 regions). Two ACO representatives reported having an indirect, supporting role for clinics involved in C3s, and specifically mentioned providing guidance, fulfilling data requests, and creating reports at the request of C3 sites.

“From an ACO perspective, we’re not really doing anything with the C3s. We have a couple of health centers, I think five or six of them that are located in those communities and they participate in those initiative. Occasionally, they ask for support or guidance or what not, but, it’s an informal process.”

“I don’t really hear anything about it, anything in the way of results, good or bad, even though we have a couple of sites involved in it. Outside of just them [C3s] asking for us to create reports and give them data, that’s the only requests, any communication that we’ve had. And obviously, we put that on back burner because we’re not directly involved with the C3s...At least from my standpoint I’m aware that they’re out there, but I have no specific information about what they’re doing.”

The remaining two ACO representatives were on opposite ends of the knowledge and involvement spectrum, meaning one reported high involvement with the C3,

“It’s very much a regionally focused, and so depending on, to be quite honest, where the C3’s were awarded, those folks got pretty involved in the SIM overall, but that did not happen in every one of our region’s, and because of that I would say we have the sort of variant approach...I think from a regional perspective almost everybody is working more at a C3 level in the region.”

and the other had little information to offer.

“Yeah, C3’s, and one of our staff I think helped them out with it...She’s left, now... but I think she was fairly involved when they were trying to get that going, but organizationally, I personally wasn’t very involved in that. I know they have it, but that was through their own contract.”

**Successes**

One ACO commented on successes observed in the C3 work, specifically noting strong partnerships, clear role definition, local coalition building, efficient care coordination, and sustainability planning,
Talking about C3s creating platform for community service coordination] “A recognition that patients don’t live in a clinic, they live in the community. Everybody has a role. How do you convene that community and whether the health system did it or the counties did it or the C3 awardees did it, didn’t really matter. They were conversations that needed to happen.”

“We’ve had successes in some of our C3 work, I think that’s all really promising.”

The same ACO noted successes at specific C3 sites:

Webster County “On the other hand, you go up into the Fort Dodge region with Webster County, and I can tell you those clinics would have a really, really hard time not having their public health partner right at hand. So the Berry Hill Center for Mental Health, the care coordinators in the clinic and the care coordinators in public health under the C3 they staff patients together. They are like almost a single unit, and you would have a hard time in the room trying to figure out who’s working for who. They’ve been at it for six years. They just know what each other needs, and so there are school based clinics, for instance. At the middle school, the school nurses are involved and public health comes on site at the schools.”

Linn County “Cedar Rapids seems to be doing some really, really good work. They’re working hard at sharing information back and forth. They’ve got mostly, in that region, more work going on between sort of hospital leaders and the SIM than they do in the [ACO] clinic level, but they have a very strong organized system of care, and they meet together regularly, and they problem solve together regularly.”

Data and Data Systems Issues
Two ACOs talked about limited ACO level involvement with the C3s due to a lack of compatibility with their data systems and variation across C3 sites, along with a reluctance to modify their systems or adopt the C3 data systems in order to participate more fully in a short-term project.

The two representatives elaborated, saying

“That C3 uses data systems that are different than the ones we use. And we don’t want to set up our teams on a new data system for one program… the C3 program is using a different system than the one we use. So it doesn’t integrate with what we’re doing. But, it’s there on the side and it’s just sitting there on the side” and “So for us to build something just for [a particular C3 site], we can’t do that. To build something just for [a different C3 site], we can’t do that. So not having some kind of synergy or similar operational approach clinic to clinic is really what makes it difficult because then what we have to do is revert to a paper process within the clinic to customize that for a single county.”

One ACO noted that having the public health department lead the regional initiative was not conducive to sharing clinical data, saying

“The organizations that are leading these efforts in the counties in which our ACO overlaps, are not part of our ACO. So it’s driven through the, I believe it’s through the public health organization in both [named two C3 sites] in which they wouldn’t even have access to our data system because they’re not part of our ACO.”

Diabetes Focus
One ACO commented on the shift in focus from social determinants of health [SDH] to diabetes for the C3s, saying, “I mean they built [on SDH focus] for a year-and-a-half and so I thought that was really disruptive to solidifying the role of C3s and addressing the social determinants that our patients had.” This representative perceived the redirection as a missed opportunity to address underlying causes behind disease states, and noted added difficulty completing referrals because of the narrowed scope, saying “While we see diabetics in the hospital, it’s rarely that it’s the diabetes itself that brought the patients there. It’s [diabetes] usually a secondary [condition], and yet when I see now what’s happening with the C3s, and all this work around diabetes, and what are we going to do about diabetes?, I understand why they did that, but yet that’s not why patients are necessarily going to the emergency department or having an avoidable admission to a hospital… it’s been very, very hard to get specific diabetic referrals for the C3 out of the clinic into the SIM.”

Sustainability
Three ACO representatives shared their perceptions of the sustainability of the C3s. All three ACOs acknowledged the need for continued funding. They noted,
“It all depends on how much money they get to be able to sustain it,” and “As soon as the funding’s gone, I can’t imagine it’s going to continue.”

One ACO suggested systematic changes to payment reform are needed to truly sustain the work of the C3s, as opposed to continually applying for short-term funding, saying

“That’s what I think part of the whole C3 and SIM and everything is there has to be a payment method that supports these activities or people can’t afford to do it.”

One representative did note the variation in maturity and diverse funding streams of the C3s as a major sustaining factor, saying of one well-established site, “They [C3 site] combined staffing. They built a consortium, leveraged their Title V block grants. They did all kinds of things that sort of weaved and braided the services together, so that not any single county was solely dependent on [having to finance things].”

One ACO commented on the difficulty of building partnerships across clinical and public health sectors, saying “They’re doing some really good work, but it has been really difficult to get the value proposition to the clinic for the county [public health] agency... It’s just been rough going.”

One ACO representative commented on the intent to duplicate the C3 model and need for standardization across sites, saying, “Really varying levels of sophistication and experience, and very, very different from region to region as to how they awarded those C3s and what the C3s decided to emphasize. So, again, in my mind way too much variation...How do you duplicate something with that much variation? And I don’t believe you do that around a disease state like diabetes. You do it around building a health IT infrastructure that really works, and works well so people want to use.”

Summary of Stakeholder Experiences of the C3 Initiative

- The C3s are making progress towards becoming ACHs, improving care and care processes for patients with diabetes, and providing enhanced care coordination to address SDHs.
- Common themes across stakeholders:
  - The C3s have been particularly successful at building strong relationships and partnerships across sectors, connecting traditional clinical services to community-based services to address patient needs, and promoting understanding of the impact of social determinants of health on the overall patient and population health.
  - There has been steady progress in the C3 systems toward integrating new processes for care and care coordination into their delivery system protocols.
  - Resource sharing among partners has developed steadily over time; Data sharing has developed more slowly.
- Challenges and opportunities:
  - Difficulties were identified with regard to addressing the specific needs of the focal population of individuals with diabetes.
    - Some C3 initiatives reported difficulties accessing their patient/client populations who had diabetes.
    - Providers and community coalitions were less likely to know about the gaps in diabetic services in their community/region and how the C3 initiatives could address those gaps. This finding presents an opportunity to engage local community coalitions more in diabetes activities.
    - While all seven C3 sites identified using existing diabetes resources such as the NDPP and DSME to address needs, around half of the patients/clients with diabetes surveyed had ever taken a course of class in how to self-manage their diabetes. And, around one-third of those with a chronic condition reported strong confidence in being able to manage and control their health problems. These findings indicate an opportunity to further engage individuals with diabetes in the self-management of their health.
Limitations in the current workforce were noted by different stakeholders. In particular, they noted limited capacity and skills in the area of data analytics and limited understanding of how to manage and integrate non-traditional providers (i.e., nurse practitioners, care coordinators, health navigators/coaches) into the traditional delivery system model.

Data collection and data sharing were identified as challenges by most stakeholders and C3s.

- Implementation of the AMH as the tool to collect SDH information presented challenges and was seen as duplicative of other HRAs in use, time consuming to administer, or was not preferred over other HRA tools. Some stakeholders questioned the sustainability of the AMH tool past the funding period.

- An inadequate HIT infrastructure, inability to access and share needed data and understand it was noted by many stakeholders. Most C3 sites were still in the developmental stage with regard to HIT and utilizing data to improve patient care processes or population health. This presents an opportunity to provide additional resources to bolster the data sharing infrastructure and/or more targeted training about HIT and how best to use data within their communities.

Perhaps by design, MCOs and ACOs had somewhat limited direct interaction with the C3 initiatives. Yet, both of these stakeholders were aware of the initiatives and expressed support. And, at one of the payers noted providing some resources to at least one of the C3 communities. These findings could indicate an opportunity for all C3s (i.e., seeking resources from the MCOs for particular projects) as they contemplate ways to sustain and/or fund their initiatives going forward.

Statewide Alert Notification System (SWAN)

The SWAN is a part of an HIT infrastructure investment through the SIM to promote better care coordination within the healthcare delivery system. The SWAN is a software technology hub that uses ADT (Admission, Discharge, and Transfer) files from participating hospitals to formulate alerts to providers and care teams when one of their patients has a hospital admission or an emergency department (ED) visit. The SWAN tool is intended to help transform the healthcare delivery system by improving the quality of care coordination activities and, as a result, reduce the rates of preventable readmissions and preventable ED visits.

SWAN Developments in 2018

- Expansion to Medicare – UnityPoint Next Gen Medicare ACO began SWAN participation, marking a milestone toward the SWAN goal to expand into payers beyond Medicaid

- Platform Transition – The SWAN will transition from Informatics Corporation of America (ICA) platform to Collective Medical Technologies (CMT), at which time it will become SWAN+.

- During this transition period, monthly updates to member eligibility lists have not been solicited, and will resume when the CMT platform is fully functional. At this time, both platforms (ICA and CMT) are running simultaneously, and SWAN users will continue to use the ICA platform until the transition is completed (no later than April 2019, at which time the ICA contract is finished).

- SWAN+ will feature added functionality, including direct integration with hospital EHR (additional data entry is not required), and real-time ADT alerts with patient history to be shared with admitting hospital, primary care provider, and health plan.

C3 pilot – the planned SWAN+ pilot in C3 communities was delayed due to leadership transitions at IHIN.

Per the fifth amendment to MCO contracts effective in October 2017, participation in the SWAN is required for Medicaid members in VBP arrangements with the
intention of improving reporting requirement and meeting readmission goals.

“Any members that are part of a VBP must be assigned by the Contractor to a designated primary care provider (PCP). This PCP information shall be immediately reported by the Contractor for use in system-wide coordination enhancements as specified by the Agency, such as provider alerts through the Iowa Health Information Network (IHIN); the Contractor shall also require that all contracted hospitals report admission and discharge information to support this exchange and coordination. Contractors shall use the State-wide Alert Notification (SWAN) system, or other processes as approved by the Agency, to satisfy hospital inpatient reporting requirements for Medicaid members. The Contractor shall use the SWAN system, or other Agency approved tool, to provide a consistent, real-time notification platform for hospitals to uniformly report inpatient and ED events for Medicaid members to the Contractor and care teams participating in VBP agreement.”

IHIN conducted several presentations during this reporting period, including training for C3 leaders in January 2018 and training for healthcare providers across ten locations in February and March 2018. The presentations provided information about SWAN system operation, guidance for integrating alerts into care coordination processes to improve care transitions, and information about IHIN services and plans for expansions.

The following table (Table 7) provides the current status (during this reporting period) and future goals of the SWAN/SWAN+.

Table 7. Current Status of SWAN/SWAN+ and Future Goals

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Providers and Payers sending eligibility files to SWAN</th>
<th># Hospitals sending ADTs to SWAN engine</th>
<th>Providers and Payers receiving daily SWAN alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid MCOs: • UnitedHealthcare • Amerigroup</td>
<td>• Broadlawns • UnityPoint Medicaid ACO • Iowa Health+ • Mercy ACO • UnityPoint Next Gen Medicaid ACO</td>
<td>51</td>
<td>Medicaid MCOs: • United Healthcare • Amerigroup</td>
</tr>
</tbody>
</table>

| Ultimate Goal | Additional Payers: Wellmark (private insurer) Other Providers in Iowa | All Hospitals in Iowa: 118 | Other Providers in Iowa such as: Medicaid Health Homes Rural Hospitals |

The following map provides the geographical distribution of the 118 targeted hospitals in Iowa, which ones are participating in the SWAN by sending ADTs, and an indication of which of those hospitals might fall within the C3 regions. All 118 hospitals are indicated by a circle. The C3 counties are indicated in blue. Hospitals with representation on C3 steering committees are indicated by a circle with a star in the center. If the hospital is sending alerts to the SWAN, the circle and/or star is filled in. Changes to SWAN participation since 2017 are noted, with two hospitals beginning SWAN participation and two discontinuing participation in the last year.

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Stakeholder Experiences – SWAN

Establishing the main technical infrastructure of the SWAN is foundational, however, encouraging its use by providers is critical to its ability to affect the delivery system and ultimately affect outcomes. In this year of the evaluation, the PPC team interviewed stakeholders (Medicaid MCOs and Medicaid ACOs) and asked if and how they use the SWAN system.

SWAN and the Medicaid MCOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. More detailed methods and results can be found in Appendix A.

MCO Participation in the SWAN

Both MCOs reported using the SWAN to coordinate care after patient discharges. However, both MCOs reported that SWAN would have more value if the alerts were timelier (immediately after an ADT event) and all hospitals in Iowa were connected.
One MCO reported using the SWAN in a limited capacity, and only sent monthly attribution files of their highest risk members, noting that there weren’t response systems in place for the entire patient population, and expanding attribution files shared with SWAN could become unmanageable.

**MCO Likes and Dislikes about the SWAN**

Both MCOs reported that the SWAN was useful for specific populations; MCO A reported that SWAN alerts are helpful to identify members attributed to providers in ACOs, and MCO B reported using SWAN reports for members identified as the highest utilizers. MCO B expressed a need for standardized reporting from providers, noting inconsistencies in information included in Admission, Discharge, and Transfer (ADT) alerts sent to the SWAN.

Both MCOs stated that daily SWAN reports are used by providers and care teams to encourage outreach to recently discharged patients, inform case management, and ensure accountability for follow-ups. MCO B noted that SWAN reports were particularly useful for programs with care coordination infrastructure in place, namely Integrated Health Homes (IHH), which are especially equipped to execute timely discharge follow-ups with patients. Outside of programs like IHH, MCO B reports uncertainty on how to use SWAN data, saying “Once we have that data, what do we do with it? I think that we’re still kind of playing around or trialing lots of different strategies and interventions on what we do with that file when we receive it.”

While both MCOs reported that the SWAN is duplicative of current internal systems, MCO B noted that discharge information from the SWAN is timelier than claims-based reports, which triggers the follow-up process earlier, which leads to more meaningful outreach.

**MCO and Sustainability of SWAN**

Both MCOs believed the SWAN could be sustained beyond SIM funding, especially if alerts were sent instantaneously after ADT events and if all hospitals in Iowa were connected.

**SWAN and the Medicaid ACOs**

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited representatives from the major state-level provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM to participate in telephone interviews. Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Representatives from Broadlawns reported prior involvement with the SIM, but opted out of the being interviewed due to lack of recent engagement. Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018. More detailed methods and results can be found in Appendix A.

**ACO Participation in the SWAN**

In regards to the role of ACOs in the SIM, all four ACOs described active roles in SWAN (Statewide Alert Network) implementation and development, with ACO C reporting, “We’ve been involved with Iowa Health Information Network in the development of the SWAN capabilities. We utilize those tools and just providing feedback as we move along that journey.”

Three ACOs talked about their systems’ participation in the SWAN, with two reporting full participation of ACO-affiliated hospitals (uploading patient lists monthly and receiving daily reports). One ACO noted that participation was determined at the facility level, so some hospitals had opted-out, and described the experience of those hospitals declining SWAN participation, saying, “they had to develop their own communications with hospitals and I think it’s been not ideal and pretty labor intensive.”

Two ACOs talked about ties to contracts with payers to use the SWAN, with one saying, “we’re participating more along the lines in terms because we’re required to, under the MCO value-based arrangements.”

One ACO noted that the nominal cost of engagement in the SWAN was an incentive for participation.
What ACOs liked about the SWAN

Three ACOs agreed that the SWAN was a promising SIM initiative, with two ACOs noting meaningful participation from statewide stakeholders (specifically, Wellmark through its agreement to use the same vendor for ADTs used by the SIM and the Iowa Hospital Association, and United Healthcare through its use of the SWAN alerts). Three ACO representatives talked about the potential value of the SWAN, including:

- improving access to patient information and data about health care interactions outside of their systems,
- more timely patient event notifications than claims-based notifications,
- improving transitions of care, and
- eventual lessening of administrative and IT burden.

ACO D stated,

“it’s [SWAN] a good idea because it has information that we otherwise don’t have about where people are going other than via claims which is way too late to do anything about it.”

Another ACO representative mentioned particular value of ADT alerts assisting performance in the VBP realm, noting SWAN data overlap with the VBP quality metrics included in contracts with MCOs, saying,

“For us, our [VBP] measures with United, two of them were transitions to care, inpatient and ER, and you were just shooting blind without that data.”

One ACO noted the value of laying the groundwork to share ADT notification across the state through the SWAN as a success, saying, “If there’s one thing that came out of the SIM, I think it has recognized the value of doing that [SWAN] and created the momentum for that to continue. I think for sure it’s going to continue.”

What ACOs did not like about the SWAN

All four ACOs noted the lengthy process to sustain the ADT data sharing system, which was delayed by interruptions in functionality, with one ACO capturing this sentiment, saying,

“the state set goals, but didn’t have the infrastructure.”

One ACO commented,

“In terms of our experiences, there’s not a tremendous amount of value in terms of the data and information that’s been provided, or is being provided by both the SWAN as well as the IHIN.”

One ACO did note that while the execution was complicated, it was collaborative, saying,

“Even though it was rocky, I will say they were generally responsive. We had feedback on the fields that we were getting and all of that kind of stuff, and they did try to accommodate it to make it work in our systems.”

ACOs noted that the strengths of the SWAN came with caveats, meaning interviewees acknowledged that experiences with the implementation of SWAN had not yet met their full potential, mainly due to unwieldy integration of SWAN data into their internal systems and incomplete participation from all hospitals in the state. With regard to data integration, three ACOs described issues operationalizing SWAN alerts into their workflows, because the data received required manual adjustments, due to incomplete data (filling in missing fields) and integrating it into internal EHR systems and workflow.

Two ACOs described the issues encountered, saying,

“It was taking us a tremendous amount of work to kind of manually parse it and load it into our systems” and

“Almost all of the fields are empty, so I can’t look at a SWAN report today that tells me why they [the patients] went, and so I have to backtrack through any kind of record that we might have with in our system to try to figure out why the patient was sent.”
Two ACOs reported that SWAN reports are received at the ACO level, then distributed to each facility, and in one case, to the level of care teams. One ACO described intentions to distribute the SWAN reports to affected facilities, but encountered barriers in execution, saying,

“Every day, somebody had to go in and pull down this report and then we had to segment it into each health system or we were going to try to put it into [their health care IT system], but we had a lot of implementation issues with using it...I heard a lot from our data folks of there being a lot of challenges with trying to use it, and a lot of it was pretty manual.”

Another ACO described provider issues with using the SWAN, saying,

“Healthcare providers just really don’t have the time or bandwidth to have a bunch of other systems in front of them, and so in order to be most effective, we really need to get all this data implemented inside the EHR workflow, where all their other work is, where all of the other clinical documentation is, where the whole record is. That’s currently still fairly challenging to get this inside the EHR in a way that the data can be manipulated, inside the EHR so that it can be moved around the EHR in a way that can then be acted on within people’s customary work.”

All four ACOs talked about limitations with the SWAN regarding complete participation, noting the value of the system was diminished without the inclusion of data from all of the hospitals and all patient populations. Three ACOs noted that without full hospital participation, SWAN reports were duplicative of information in internal systems. As ACO A explained,

“where the value of SWAN is that you can see everywhere that the patient went as long as that hospital is uploading.”

ACO A addressed the lack of levers used to expand SWAN participation within the state, saying,

“Voluntary doesn’t work in this day and age. We’ve got way too much administrative burden as it is, and so to have something that potentially like SWAN could be really effective, but when you have a community where not everybody is uploading you really can’t use it.”

ACO B noted inconsistencies between the volume of SWAN alerts and Medicaid MCO reports based on claims, saying,

“There’s pretty sizeable gaps of notifications when it comes to reports that we receive from the Managed Care Organizations, versus the number of alerts that we’re receiving via the SWAN.”

ACO B attributed some of these discrepancies to the SWAN’s current inclusion criteria of statewide hospitals (missing out-of-state claims) and narrow scope of patients (Medicaid members only).

**ACO Suggestions for Improvements**

Along with suggestions for improvements noted earlier (i.e., standardize data reporting, improve compatibility with IT systems, and expand hospital participation and eligible patient populations), three ACOs wished to see improved timeliness of reports. The ACOs talked about usefulness in shortening the day-delay of receiving reports, and one ACO also commented on operationalizing the reports faster internally. Also, ACO A elaborated on the need to include analysis in SWAN reports which could prioritize high risk patients, saying,

“I’d want to see somehow in that SWAN report who was a really high-impact patient. I’d like to see a risk score on that patient right in the SWAN, and so what I would know then is instead of getting a list of 300 patients every single day, and sorting through it might be able to pick out the 30 patients that are the most impactful patients.”

**ACOs and SWAN Sustainability**

Three ACOs shared perceptions of the sustainability of the SWAN, with two ACOs predicting that it will continue beyond the SIM, and the other saying that their organization’s continued participation would be evaluated at that time. One ACO based their expectation for the continuation of the SWAN on Wellmark’s influence in the state, saying,

“the SWAN stuff is definitely a SIM initiated thing that I think is going to continue. If Wellmark gets behind it, there is no question [the SWAN will continue].”
Stakeholder summary of the SWAN

- Both MCOs reported using the SWAN to coordinate care after patient discharges. However, both also reported that SWAN would have more value if the alerts were timelier (immediately after an ADT event) and all hospitals in Iowa were connected.

- There was consensus across MCOs and ACOs – To be effective and useful, SWAN needs the participation of all hospitals.

- MCOs expressed frustration that use of and participation in the SWAN was required contractually before the platform and infrastructure was fully developed.

- Infrastructure limitations regarding interoperability and timing of alerts were mentioned by stakeholders; may be addressed by the SWAN+ enhancements.
Data Collection, Sharing, and Reporting

There was a continued emphasis during this reporting period on developing and refining data collection, sharing, and reporting mechanisms for payers, providers, health systems, and other stakeholders to use to improve patient health at the individual level and plan for policy and/or organizational changes and resource investments at the system level. Two of those data initiatives were community scorecards provided to C3s as a way to promote continuous quality improvement and health risk assessments (HRAs) to aid in understanding and addressing patients’ social determinants of health (SDHs).

Community Scorecards – Continuous Quality Improvement

Community scorecards are feedback reports created from the data reported by the C3 communities through the SIM Portal database. The purpose of the scorecards is for stakeholders to use them to drive quality improvement and healthcare transformation at the community-level.

Each C3 site is required to submit particular data elements to the SIM data portal. The SIM data portal is managed by IHC and acts as a data repository for the C3s and associated health systems. Metrics submitted to the portal include:

- Clinical quality measures (Diabetes, Tobacco, Body Mass Index, Hypertension, Weight Management) based on National Quality Forum (NQF) metrics
- Potentially preventable readmissions, admissions, and emergency department visits from the Hospital Improvement Innovation Network (HIIN) and Medicaid claims
- Screening and referral data on social determinants of health and population health – process measures
- Referrals to care providers and prevention programs – process measures
- Other process measures specific to the C3s

Data collected in the portal is analyzed by the IHC and the resulting information is assimilated into the community scorecard. An example of a community scorecard from one of the C3 sites is here in Appendix J.

The first scorecard was distributed to the C3s in November 2017. Scorecards were intended to be distributed quarterly to each C3 and health system engaged in the SIM. In addition, C3s were to be able to access a live, point-in-time dashboard to access scorecard information. Quality Improvement Advisors (QIAs) from the IHC then work with recipients of the scorecard to help them understand and process the information and develop ways to use the information to drive local process and quality improvement initiatives. With the November 2017 community scorecard distribution, QIAs and a data analyst worked directly with each C3 to discuss the community scorecard results, point out data trends, and identify potential areas for intervention. In addition, IHC held webinars specific to scorecard interpretation and provided other guidance and help upon request.

Health Risk Assessments (HRAs) – Social Determinants of Health

An emphasis on social determinants of health (SDHs) continues to be a fundamental component of the SIM population health improvement framework. The SDH focus is embedded within several SIM activities including: 1) the referral and care coordination networks developed by and implemented in the C3 communities, 2) incorporation of measures of SDH into health risk assessments (HRAs), in particular the Assess My Health (AMH) tool, and 3) aggregating and analyzing SDH data to help inform policy and patient care decisions.

Health risk assessments (HRAs) are screening tools (typically questionnaires) completed by patients that are used to provide both the patient and provider with an evaluation of the person’s health status, health risks, and quality of life. The intention of HRAs is to identify risks, provide feedback, and introduce interventions that could promote health and/or prevent disease. Based on the use of health risk assessments within the Iowa Wellness Plan (IWP)\(^\text{13}\), the Iowa SIM decided to invest effort in using an HRA tool as a way to not only identify SDH issues for individual patient interventions but, in aggregate, to identify SDH issues for community intervention and promote SIM goals.

In SIM AY3, the SIM project embarked on a plan to use HRAs to address SDHs by encouraging the use of a standardized HRA, namely the AssessMyHealth (AMH) tool that is used in the Healthy Behaviors Program of the IWP. The first step in this process was to come up with a set of SDH questions that could be added to the HRAs. One of the goals of the SDH Workgroup was to come up with an additional set of SDH questions to include on the AMH HRA. Several health and some SDH questions were already being used in the AMH HRA including questions on:

- Health confidence
- Education
- Social activities and social support
- Physical and emotional health and activities
- Health and healthcare

During the fall of 2017, the SDH workgroup chose questions to add to the AMH HRA from the following additional SDH categories:

- Housing
- Health Literacy
- Employment
- Food and Material Goods
- Personal and Community Safety
- Stress
- Oral Health

The questions were added to the AMH HRA in February 2018. A pilot test of the SDH measures in the AMH HRA was conducted from July 1, 2017 through June 30, 2018. Data was collected from two sources: 1) from members of the Medicaid Expansion (IWP) who completed the AMH HRA as one of the required activities of the IWP Healthy Behaviors Program, and 2) from members of the C3 target population of Medicaid members at risk of or having been diagnosed with diabetes. The C3s were required to submit at least 100 completions of the AMH HRA from their target population by the end of April 2018. 3M Analytics, the vendor for the AMH HRA tool, compiled and analyzed the data and the results have been shared with other stakeholders, including the C3 sites and Iowa Medicaid leadership.

Stakeholder Experiences – Data Collection, Sharing, and Reporting

Data and Medicaid MCOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. More detailed methods and results can be found in Appendix A.

Both MCOs reported HIT (health information technology) and data sharing infrastructure as challenges encountered during SIM work. Specifically, MCO A cited working across various electronic medical records (EMR) systems as a challenge, and MCO B reported underdeveloped EMR systems, coupled with a workforce that is comparatively behind in HIT experience as challenges.

In regard to addressing SDHs, MCO B reported that providers have access to specific codes for identifying SDH needs, but documentation depends on provider coding savvy. Beyond administrative SDH shortcomings, MCO B also noted that steps needed to make the data meaningful, including analytics and interventions, are not developed for application to populations outside of care.
coordination programs like the Integrated Health Homes and Chronic Condition Health Homes.

Data and Medicaid ACOs

To gather information about the status of the SIM and its initiatives from the perspectives of its key stakeholders, the PPC evaluation team invited representatives from the major state-level provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM to participate in telephone interviews. Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Representatives from Broadlawns reported prior involvement with the SIM, but opted out of the being interviewed due to lack of recent engagement. Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018. More detailed methods and results can be found in Appendix A.

ACO Data Sharing through the SIM portal

One ACO talked about the ACO’s role in contributing to and automating the data collection required by C3s, saying, “I was able, by getting in on that conversation, able to get a single upload going in. We didn’t use the portal doing a direct upload, and that saved us a ton of work, and it took care of all six of the C3s. So any of our clinics that are on a border or in a county that has a C3 are now uploading all of the NQF measures all at once.”

ACOs and Health Risk Assessments (HRAs)

Three ACOs talked about utilizing Health Risk Assessments (HRA) to assess population and patient needs, with one ACO reporting using a mapping tool instead. Of the three ACOs using an HRA to some extent within their organizations, one reported regular administration, documentation of results, and use in care management (both individually and aggregate) saying,

“We have assessments that we do, including the social determinants of health assessments at some of our health centers, that does integrate with our [Electronic Medical Record] EMR and that we utilize for a variety of purposes, both at the point of care and in the way that we partner with community organizations… we’re going to use that for re-stratification and care plan purposes.”

The remaining two ACOs using an HRA reported little consistency or formality in instruments or application of tools across clinics. One ACO reported the lack of data system integration as a barrier to operationalization, saying,

“We don’t have a formal Health Risk Assessment. I suppose we have them scattered here and there. We don’t have any organized Health Risk Assessments that automatically feeds into our data systems.”

Another ACO cited more urgent demands as interfering with a commitment to HRA development, saying,

“What we were trying to do is trying to really focus on the things that were going to lower total cost of care and the downstream impact of a health risk assessment is very long-term, we only had so many resources to focus on implementation.”

Three ACO representatives were familiar with the HRA tool promoted in the SIM, Assess My Health (AMH). All three ACOs reported difficulties in using the data collected in the AMH to inform care management, mainly due to receiving the data in an incompatible format. ACO C described the process, saying

“Assess My Health is not a helpful tool for us. Some of our patients do complete those assessments but that information gets sent into IME, I think, or some centralized entity and then it comes back as a [Portable Document Format] PDF, which means it doesn’t integrate into our electronic medical records. So, we’re not a big fan of that system. In fact, I think it’s pretty useless from a provider perspective…it doesn’t help in the providing of care because, there’s no way that data gets back to help the care team at all.”

ACOs A and B reported similar experiences with AMH, saying, “we wanted to use it [AMH], we tried, we just couldn’t get it integrated into what we did,” and “If you did a health risk assessment, that data was being aggregated for the use of the payer or the use of the state, but we weren’t getting that information back in a meaningful way.”
ACOs and Social Determinants of Health (SDH)

All four ACOs acknowledged the impact of social determinants of health (SDH) on healthcare access and health outcomes. Three ACOs were actively assessing and using SDH factors to inform care management on various scales and intensities, with the fourth ACO reporting little tangible progress in the area due to limitations in resources and infrastructure support, saying,

“the fundamental issue is that until there is a change in the payment methodology and there is some way to financially support the people it would take to do that, I do not see it happening.”

One ACO reported a grant-funded three-year pilot project in two clinics which supported community health workers to administer universal SDH screenings and connect patients with community resources, but noted compiling a “directory of social determinant type resources” prior to the grant. One ACO reported routinized collection of SDH data through health risk assessments, which subsequently informed population health and individual care strategies. The third ACO active in SDH data collection used geographic data to better understand patient population SDH needs, including identification of food deserts, transportation inadequacy, and low-income areas. The two ACOs employing SDH screening tools noted data compatibility (SDH data integrated with their data systems) as a facilitator for workflow integration, and one noted the concise nature (8 items) of their tool as an important factor for easing implementation.

One ACO noted underutilization of SDH data sharing from public health departments, and expressed a desire to identify patients with SDH needs based on eligibility for state assistance, saying, “The state knows every patient that’s in a [assistance] program. So how do we get that back out to a provider so that we don’t have to go out there and find it separately? [Iowa Department of Public Health] IDPH already knows it.”

Two ACOs mentioned advocating for the inclusion of SDH metrics in VBP performance measures, and one ACO reported involvement in the SIM-led SDH workgroup. One ACO perceived little progress during the SIM in adequately addressing SDH, saying, “Yeah, I still think the challenge is really understanding how to measure and report social determinants. I just don’t see it.”

One ACO noted the value in inclusive statewide conversations about SDH, which raised awareness and broadened the definition of quality care, as one ACO representative described, “The SIM gave a platform. One of its most important functions is that it gave everybody in the state a platform to talk about things like how do we address social determinants? It brought a focus on how our community should convene, and they should talk about these hard issues. Nobody was doing that before, and it set an expectation that the best kind of care was partnering with folks on the ground in the community. A recognition that patients don’t live in a clinic, they live in the community. Everybody has a role. How do you convene that community and whether the health system did it or the counties did it or the C3 awardees did it, didn’t really matter. They were conversations that needed to happen. Honestly, that in itself is of enormous, enormous value.”

Data and the C3 Regions

The C3 project staff interviews occur during the fall of each reporting year. The experiences of C3 project staff included in this report are from interviews conducted in the fall of 2017; those interviews did not include discussions about the community scorecards as those tools were mostly in the development phase prior to that time. The fall 2018 project staff interviews include discussions about the community scorecards and that information will be presented in the next evaluation report.

C3 project staff interviews did include some discussion of SDH and AMH in particular. Two of the seven C3 sites had incorporated the completion of the AMH into their operations. At one, home visits are used to conduct the AMH assessment, identify home barriers, and create patient plans based on the information received. At the other, administration of the HRA is included in the job description for the diabetes care coordinator position.

Six of seven sites reported difficulty with the AMH, specifically noting that because it was time consuming to implement and/or it was duplicative of other preferred tools, the AMH would not be used after the SIM C3 funding ended. One site noted little buy-in from their partners to use the AMH tool; although one partner agreed to use it, the other program partners decided that the AMH tool was not sustainable. Another site reported that after an AMH training session, the majority of the feedback received from their partners was negative.
Some challenges were identified by the C3 projects that reflect on the ability to effectively use data for population health and SDH activities. Some sites noted particular workforce issues; in particular the lack of data analysts on staff with the expertise to work with and appropriately report the data so that it would be useful for population health improvement. Two sites thought that data sharing across partners would end with the SIM C3 funding with one noting that a state-level plan for data sharing across health systems and providers would be beneficial for the sustainability of population health efforts.

Summary of Data Collection, Sharing, and Reporting

- Continuous quality improvement initiatives through the community scorecards progressed during this time period from developmental to implementation as scorecard design was finalized and reports were generated and distributed to the C3s.
- Progress was also made in the collection and use of social determinants of health data through the HRA AMH tool.
- Implementation challenges included:
  - Data systems and infrastructure – Different clinics and sites used different, incompatible, and/or underdeveloped EMRs
  - Workforce – Lack of workforce with experience in HIT and data analytics
  - HRAs – Many different types of HRAs instruments are in use across clinics and systems and this creates a challenge when trying to integrate data across systems
  - AMH – ACOs reported difficulty integrating AMH data received from the state back into their own systems; C3s reported the AMH tool was time consuming to implement and/or it was duplicative of other preferred tools and predicted it would not be used after the SIM C3 funding ended
- Stakeholders understood the value of collecting and using SDH data (and credit the SIM with initiating and maintaining conversations about SDHs) and some have incorporated SDH information into their internal processes and patient care plans
Value-Based Purchasing

Value-Based Purchasing (VBP) is broadly defined as linking healthcare provider payment and incentives to improved quality of care and performance. This payment methodology is intended to hold healthcare providers accountable for both the cost and quality of care they provide. VBP programs can take on many forms but all attempt to encourage reductions in inappropriate care and identify and reward the best-performing providers. A primary driver of change in Iowa’s SIM is to encourage an increase in the use of VBP within the three major payers for healthcare in the state, namely Medicaid, Medicare, and Wellmark. Partnerships between the IME, Medicaid ACOs, and Medicaid MCOs are critical to improving healthcare delivery, lowering the cost of care, and advancing population health. While the ultimate goal is to encourage VBP participation by all payers in Iowa, at this time, the focus of the VBP initiative continues to be Medicaid, specifically, VBP contracting between the MCOs and the five Medicaid ACOs. As a SIM goal, establishment of VBP is measured by an increase in the number of provider contracts in a VBP arrangement and number of lives covered under VBP contracts. Ultimately, the SIM aims to develop draft contract language that advances requirements to achieve level 3B AAPM (APMs with Shared Savings and Downside Risk) models by 2019 across all MCOs.

The Iowa SIM progressed in its goal to increase the prevalence of VBP arrangements across Medicaid membership. Throughout the SIM grant, the MCOs managing Medicaid were engaged in MCO workgroups, which facilitated the negotiations of quality metrics and contractual expectations for progress. The regularly scheduled MCO workgroups adjourned in late 2017 after finalizing 2018 program requirements and contract language. At that time, Medicaid in Iowa was managed by three MCOs, namely Amerigroup Iowa Inc. (Amerigroup) and United Healthcare Plan of the River Valley, Inc. (United Healthcare), and AmeriHealth Caritas (AmeriHealth). However, in November 2017, AmeriHealth announced its withdrawal from Iowa’s managed care program, effective December 1, 2017. From MCO stakeholder interviews conducted during this period, the two active MCOs reported positive experiences with the MCO workgroup and satisfaction with the conclusion of contract negotiations. Engagement with MCOs regarding payment reform continued in December 2017 through the assembly of the Roundtable, in which both Amerigroup and United Healthcare are members. In addition, both MCOs have representatives actively involved in the two Roundtable workgroups focused on healthy communities and data sharing.

The SIM goal of aligning payers in quality measurement and contractually requiring thresholds for membership enrolled in VBP was realized during this reporting period. In addition, SIM staff reported in September 2018 that incentive payments to providers participating in SIM approved VBP programs were paid, according to one MCO (United Healthcare). The SIM goal regarding payment reform was described in the SIM Award Year 3 Operational Plan:

“In award year 3, the MCOs have been given parameters and timeframes for establishing aligned VBP contracts, including quality targets maintained through the Medicaid Agency. In addition for year 3, the MCO’s also have capitation-withhold-based performance incentives tied to the same measure of quality required of the delivery system (the Value Index Score) along with total cost of care targets that are necessary to qualify for the incentive payout.”
In September 2017, the third amendments to contracts with Amerigroup and United Healthcare were approved and included withhold risk tied to Value-based Purchasing performance, specifically 40% membership coverage (see Figure 8)\textsuperscript{14,15}.

According to the most recent Managed Care Organization Report (State Fiscal Year 2018, Quarter 4) the preliminary 30% membership coverage benchmark set for June 2018 was met, with Amerigroup reporting 32% membership coverage, and United Healthcare already exceeding the December 2018 goal, reporting 48% coverage. Iowa Medicaid Enterprise (IME) planned to formally validate the progress towards the 40% requirement in December 2018, at which time the 2% withhold would be applied. Contracts to continue Medicaid management for State Fiscal Year 2019 were signed by Amerigroup and United Healthcare in September 2018.\textsuperscript{14,15}

\textit{Stakeholder Experiences – Value-Based Purchasing}

The following sections are a summary of interviews with payers and providers involved in SIM payment reform efforts. The PPC evaluation team invited the major state payers (Medicaid Managed Care Organizations (MCOs) and Wellmark) to participate in telephone interviews. Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to participate and were interviewed. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017. In order to protect the confidentiality of interviewees, payer-specific responses will be designated as from MCO A or MCO B. In addition, the PPC evaluation team invited representatives from the major state-level provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM to participate in telephone interviews. Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018.

More detailed accounts of these interviews can be found in Appendix A.

\textit{VBP and Payers – Medicaid MCOs}

\textbf{VBP contracts}

Based on the stakeholder interviews, both MCOs were knowledgeable about contract expectations regarding increasing the percentage of members covered in a VBP arrangement to 30% by June 2018.


\textsuperscript{15} https://dhs.iowa.gov/sites/default/files/PR_Amendment_7_Aug2018.pdf
and 40% by December 2018. With regard to progress towards these benchmarks, one MCO reported being on track to meet or exceed the targets, and the other MCO endorsed the state’s VBP goals, but also recognized the relatively short time frame to be in compliance as a challenge. Neither MCO mentioned any withhold of quality payments.

Both MCOs reported having state-approved VBP contracts in place with providers and Medicaid ACOs, with MCO B reporting performance-based reimbursements expected to begin in 2018. MCO B described a discrepancy in their expectations of relationships with ACOs, and the current, more uniform contracting arrangement. MCO B explained that they expected more flexibility to offer competitive incentives, in order to gain preference from ACOs over other MCOs, and instead all ACOs are contracting with both MCOs, using a state-approved template. They did state that the competitive environment they expected when they began managing Medicaid in the state might be realized in 2018. Iowa SIM staff provided an update in September 2018, reporting that incentives for MCO A providers participating in SIM approved VBP programs have been paid.

MCOs and VBP Payment Models

The Iowa SIM Award Year 3 Operational Plan articulated plans to achieve a level 3B advanced alternative payment model (APM) (APMs with Shared Savings and Downside Risk) by 2019 across MCOs.16 Both MCOs mentioned the lack of downside risk in current agreements, and MCO B suggested that providers would need adequate time to adjust to payments for performance in shared savings arrangements before incorporating downside risk, saying, “This evolves over a number of years as providers figure out what they need to do to change their scores, and they need to be given time to do that…I hesitate to put a prediction on it, but it won’t be this year or next year that we’re getting into these downside risk relationships.”

Both MCOs reported having operational state-approved shared savings models that incorporate Value Index Score (VIS) and other quality measures in payment calculations, as required by state contracts.

SIM Impact and VBP Sustainment

Both MCOs noted limitations in workforce capacity as a challenge regarding VBP progress, specifically provider familiarity and abilities to use HIT and dashboards in practice and decision-making. Both MCOs provided training to improve competencies in these areas. The provision of training led to the identification of another challenge concerning the wide range of provider abilities across the state. In addition to skill-based deficits, one MCO also reported needing a cultural shift among providers, citing provider pushback to reforms.

Both MCOs reported a spectrum of provider interest in and readiness to be successful in VBP arrangements. MCO A reported preparing providers for VBP arrangements by offering an incremental payment model which used quality metrics, but lacked a shared savings component. MCO B reported provider reluctance (due to Medicaid management transitions in state) and limitations in provider skills (training needed) as challenges in VBP tool use and VBP payment model implementation.

“You’re just not going to see these providers moving forward in their contract relationships until they see some of the dust settle around the change being made.”

When asked, “Does your organization perceive the SIM to impact outcomes for MCOs?” both MCOs were undecided about the potential impact of the SIM. MCO A reported independently working towards SIM objectives prior to the SIM grant, stating, “[MCO A] is already at forefront of general health innovation trends, so SIM impact on processes / payment reform is minimal.” MCO B withheld judgment, citing a need for adequate claims data to examine trends (the 18-20 months of data they had at the time of the interview was not sufficient).

VBP and Providers – Medicaid ACOs

The four ACO representatives all knew about the requirements for SIM-related contracts, and all four ACOs reported they had established VBP shared savings contracts with at least one MCO. All four ACOs demonstrated interest in the idea of VBP contracts based on standardized metrics, with one ACO saying, “If successful, it’s exactly what we need to have happen so that we do as a smaller system of care,

16 https://dhs.iowa.gov/sites/default/files/SIM_AY3FinalOPSPlan.pdf
have access to the information and are aware of all the processes that are going to make our ability to deliver value-based care, our ability to do that is enhanced or capacity as a result of not having to navigate differently for every payer.”

While all ACOs have VBP arrangements in place for their Medicaid populations, one ACO representative described the VBP contracts as secondary to fee-for-service arrangements, saying, “Everybody keeps getting paid fee-for-service, and then the value-based contract sort of sits to the side of it.” However, all ACOs had plans to encourage participation in VBP arrangements through both incremental and blanket strategies, with one ACO predicting more reliance on VBP arrangements for funding in the future, saying, “Their [MCO] desire to keep paying us $3 per member per month indefinitely isn’t going to continue.”

ACOs and Implementation of VBP

Medicaid ACO experiences with and investment in implementing VBP in Medicaid varied, depending on the proportion of their organization’s Medicaid patient population and longevity of the ACO. Meaning, more established, larger ACOs had more experience implementing VBP prior to the SIM, and more financial security. Three ACOs (two with relatively higher proportions of Medicaid members in their patient populations) were wary of entering shared savings agreements with MCOs, as ACO D elaborated, “I think they forget about that, too, is for all of us, Medicaid is a huge part of our business and we’re having to go to tremendous efforts just to get paid…the idea of doing this value-based thing on top, which is another thing we’re going to spend resources on and not get paid… I just don’t think that’s probably a recipe for success.” Along with fundamental uncertainty about the actual accumulation of shared savings for distribution, another ACO shared doubts that value-based reimbursements would be dispersed as planned, citing past experiences with MCOs in the Medicaid Chronic Condition Heath Home program, saying, “for their Chronic Care Health Home, they’ve [MCOs] made it more difficult to get paid for that than it was when it was under the Medicaid program.”

Two ACOs were concerned that the value-based payments earned would not offset the costs of infrastructure investments needed to earn the shared shavings, as one ACO described, “One thing that gets missed in this whole ACO discussion is how much it’s costing health systems to up-front finance and make the investments in the ACO infrastructure. That’s generally not borne by any of the physicians in a health system, it’s generally borne by the hospital or the health system, and that includes costs for hiring and employing care managers that don’t have any funding stream to support them other than these value-based revenues that I mentioned that come very, very late, if you get them at all, and generally don’t cover your costs.”

VBP Contracts and the ACOs

Representatives from the four ACOs were fairly knowledgeable about the VBP expectations outlined in the SIM-aligned contracts. While interviewees were not prompted for details about the content of the VBP contracts, several components were specifically mentioned extemporaneously.

- 40% lives covered target [ACO B & D]
- Shared savings (upside only risk) [ACO A & D]
- State-approved templates [ACO B & C]
- VIS metric requirement [ACO C & D]
- Quality metrics linked to reimbursement [ACO B & D]

Stakeholder Dynamics Regarding ACOs and VBP

The four Medicaid ACO representatives described their experiences entering the VBP contracts in January 2018, and only ACO C talked about discussing template parameters with IME before the negotiation with MCOs. Three ACOs noted a lack of ACO inclusion in the VBP contract development process, as ACO D summarizes, saying, “they run it like a program and I don’t think they think of it as a two-way relationship.” One ACO proposed a more transparent process, saying, “Their [IME] requirements of what MCOs must have in their value-based contracts, is public policy. That should be a known set of information to the public. It should also be open to vetting by the public.”

Three ACO representatives discussed the exclusive nature of VBP contract development, saying
that input from ACOs was not elicited as IME worked with MCOs on the template requirements. A representative from ACO C captured this sentiment, saying, “the Medicaid agency has been pretty closed to a lot of influence in what their contract and templates look like, but we have attempted to communicate our priorities in that.”

In negotiations with MCOs, three ACOs (A, B, and D) were uncertain of commitment from the MCOs, particularly Amerigroup, saying, “We really haven’t seen much engagement by the MCO’s in terms of wanting to value-based arrangement, at least where Medicaid is concerned” and “we don’t feel any confidence Amerigroup’s going to stick with the program” and “when we didn’t just immediately adopt whatever program they [Amerigroup] were offering, then we didn’t hear anything from them for a solid year.”

In regard to the SIM’s role in VBP contracts between ACOs and MCOs, one ACO noted, “SIM really guides some of the path it takes but I don’t think it has a lot of impact on our negotiations with the MCOs … They’re [IME] very sensitive about getting in the middle of a contracting relationship between us and the plan, the provider and the plan.” Another ACO said, of the SIM goals for payment reform and IME’s role in VBP, “I just don’t think they have the bandwidth to really dig in and understand all this stuff… I also don’t think that they’re having a deep enough conversation with the ACOs about what it would look like to get there” This perception is consistent with the Award Year 2 PPC evaluation report, which notes, “The SIM team has primarily worked with the Medicaid MCOs regarding VBP. Effort will need to be made to re-engage the Medicaid ACO providers in VBP discussions and activities.”

ACO Provider Participation and Payment Distribution Practices

Each ACO representative described provider participation in VBP, and related internal policies. All ACOs were proactive in encouraging provider participation in VBP contracts, either through organizational norms, employee requirements, or auto-enrolling and opt-out policies for certain provider types. The representative from ACO A described the expectations for VBP participation at their ACO, saying, “We intend to be in value-based with every payer. There won’t be a payer that we just stick with a fee for service kind of arrangement. If we can get into a value-based arrangement we’re getting in. That’s just kind of our philosophy.”

SIM Impact and VBP Sustainability from the ACO Perspective

The ACO representatives shared their perceptions of SIM influence on VBP contracting, with three ACOs doubting the direct impact of the SIM on payment reform, noting that VBP is part of the market driven evolution of care, and efforts in this direction predated the SIM. One ACO captured this, saying, “Well just strategically, we have to do this anyhow. Moving towards a value-based world is just part of what we recognize is happening on the landscape. That’s why we formed the ACO to start with,” but acknowledged that SIM may have been influential in the state’s contract template development and standardized use of the VIS.

Another ACO suggested that SIM impact was not tangibly evident, saying “I think it’s more of those [VBP] arrangements are taking components of the SIM, and not necessarily mandating all of the different components, but rather picking and choosing to align to the existing contracts in play.” One ACO did perceive SIM influence in the incorporation of VBP into MCO contracts, saying, “I do not think that the managed-care contracts would’ve included anything like this [VBP] or targets had it not been for the fact SIM existed.”

One ACO representative commented on the likelihood of sustaining VBP, saying “I have concerns about its sustainability, but I guess I have a concern in general, given our experience, about the sustainability about value-based contracting.”

VBP and Accountable Communities of Health – C3s

In AY3, C3 sites were to be introduced to the concept of VBP through the use of performance incentives and disincentives (i.e., upside/downside risk). C3 integrator organizations were required to track two process measures and one outcome measure and for improvement were to receive a bonus payment and for any decreases would be subject to a disincentive (applied to contract payments).

The VBP payments (incentives/disincentives) based on performance were removed from C3 contracts. Due to the change in scope and slow start many of the C3s had in developing actual processes to impact the identified measures, the performance measure was not perceived to be an accurate indicator of success of the C3s and did not have the effect of risk sharing that was intended,
particularly because the clinics the C3s were working with did not have any risk associated with those measures and therefore did not understand the implications. Due to this change, the evaluation team did not ask the C3s about this part of the VBP initiative.

**Quality Measures and the Value Index Score**

The Value Index Score (VIS) is a quality metric comprised from claims and encounter data that is generated at the ACO/Provider level based on their attributed population. It was designed to be a tool for measuring health system change and the components that make up that change. Based on six primary care specific domains (derived from sixteen key process and outcome measures), the VIS is a single, composite score that is supposed to drive quality improvement by quantifying how well a provider is caring for their entire patient population. At this time, the VIS score is made available to MCOs through an online dashboard that is periodically updated (latest refresh in October 2017, which determined payments for claims through June 2017). The main purpose of the VIS within the SIM is to support VBP efforts by providing a quantifiable basis for quality-based payments. While the VIS and VIS dashboard was intended for use by ACOs as well, as of September 2018, the SIM team reported continued processing issues as a barrier to producing usable VIS scores for Medicaid ACOs.

Discussions around quality measures and statewide standardization reached a conclusion in late 2017, and requirements were delineated in MCO VBP contracts. While the original SIM goal was to require the MCOs to adopt the Value Index Score (VIS) used in the pre-MCO Medicaid program and Wellmark, negotiations between the state and MCOs ended in agreement to only use VIS partially in payment calculations. Both MCOs use national quality measures (HEDIS and NCQA) along with VIS to calculate reimbursement in shared savings models. One MCO mentioned utilizing a payment model in which quality measures are computed into a Medical Loss Ratio (MLR), a methodology which was preferred over the Total Cost of Care (TCOC) calculation informed by the VIS. In the September 2017 MCO contract amendments, the MLR or the TCOC were both acceptable calculations to determine the success in VBP arrangements.

The Roundtable’s Data Sharing Workgroup briefly discussed the VIS in a May 2018 meeting, and noted a need for transparency at the service delivery level for both the VIS and TCOC.

**Stakeholder Experiences – Quality Measures and VIS**

**VIS and Payers – Medicaid MCOs**

Both MCOs reported reluctance to using VIS, based on concerns that the tool was developed for a commercial population, and does not suit the Medicaid population. In addition, neither MCO was able to identify added value from the requirement to incorporate VIS into performance-based payments. Both MCOs stated it was too early to make a judgment on the value of VIS, and MCO B cited “a proliferation of dashboards” without adequate understanding among providers of how to use the data as detracting value from the VIS and VIS dashboard.

At the time of the interviews, both MCOs reported that the VIS dashboard was in a cooperative test and review phase between the two MCOs, 3M Analytics, and Iowa Medicaid Enterprise (IME). MCO A reported that claims data from the MCOs has been uploaded, and the next step is sharing results with the Medicaid ACOs. In September 2018, Iowa SIM staff reported the last VIS dashboard refresh was in October 2017. While both MCOs were actively cooperative in the VBP workgroup and quality measure discussion, MCO B had reservations about the feasibility of the SIM goal to align quality measures across various payers and populations, stating, “The expectation that alignment can be achieved that is complete is unworkable and will continue to prove to be unworkable.”

Indeed, both MCOs described a lengthy process of negotiating quality metrics to include in state approved performance-based payment calculations before a compromise to only require partial use of VIS in calculations was reached. Subsequently, both MCOs use national quality measures (HEDIS and NCQA) along with VIS to calculate reimbursement in shared savings models.

**VIS and Providers – Medicaid ACOs**

**Quality Metrics, VIS, and the ACOs**

In discussions about VBP methodology, three ACOs agreed that a standardized set of measures
crosses providers would be ideal, but all ACOs critiqued the current standard tool, the VIS. Three ACOs brought up the prevailing influence of Wellmark on the decision to use the VIS in SIM-affiliated VBP contracts, with one ACO attributing the decision to “Wellmark muscle” and the other two ACO representatives saying, “When you see the Treo guy, the 3M guy, the VP that led the Wellmark work come in and sit as one of the conveners, in one of the [SIM quality metric] sessions, you know it’s done,” and “they were there in force, and they won.”

The four Medicaid ACO representatives were unanimous in their frustrations that the VIS methodology was not transparent due to the proprietary nature of the tool, describing it as a “black box.” All four ACOs found challenges operationalizing the VIS scores to inform practices, saying, “the VIS score does not relate to a meaningful number to physicians,” and “[the VIS is] challenging to understand… to know what levers to push to really move things along,” and “If you’re trying to use [the VIS] to actually impact your own performance, it’s worthless, because it’s very retrospective… No providers think that VIS is the right methodology.” and “Functionally, I would say that I don’t think… that they are having very specific operational direction toward some of those metrics.”

ACOs B and C talked about efforts to gather more information about the scoring methodology and even reverse engineering the scores internally to better understand and utilize the VIS to guide practices (in addition to determining reimbursement), saying, “We keep telling Wellmark, we’d like to have the Ns and the percentages and not just the VIS scores. But they haven’t been producing those reports to this point. So we go in and we produce them through the back end on our own,” and, “We did a lot of pushing to try to get at what are the concrete specifics that drive the VIS score. That was a frustrating effort… So, one of our top priorities is developing our own data infrastructure so we can track our performance on some of those things.”

ACO A compared the VIS to other quality metrics, saying “It’s based on their own formulas, and that really doesn’t make any sense. There needs to be a uniform way that you determine if somebody is a high-risk versus something a company came up with because you just get so much variation, and it’s not how the MCO’s do it. Medicare doesn’t do it that way. Medicare Advantage doesn’t do it that way, and so that feels really off to me.” ACO D suggested that expectations for the VIS to inform individual practice change may be unrealistic, saying, “I think we get kind of stuck in this conversation that there’s a perfect measurement system, but that perfect measurement system for measuring your outcomes after the fact is not going to be the same measures that can help a physician impact their performance right now.”

Three ACOs talked about how the quality metrics included in the VBP contracts have influenced priorities for care management and process examination. One ACO talked about prioritizing VIS metrics which overlapped with other contracts, saying “[So] we’re not asking physicians to manage patients differently depending on who pays for it.” Specifically, ACO B and D mentioned increased attention to transitions of care metrics (post-hospital admission and emergency department use follow-up), reaching out to newly attributed members, and identifying and coordinating care for patients with chronic conditions (i.e. high-risk). ACO D elaborated, saying “I think when this all started, I think they were very tangible and very actual useful things to focus on… Hospitals have been focused on, to some degree on transitions of care and trying to reduce readmissions for five years or so, so none of that was really foreign. I think what it was helping us do was really dig into the workflows of who’s doing what and how can we report it and how can we routinize it.”

Two ACOs described pursuing practices that would impact their VIS score, regardless of clarity, saying “It really wasn’t a big driver. Even though we tried to understand it, it wasn’t a big driver of our strategy. Instead, we said we know what would work well and it did appear to show up in the measurement” and “We were planning to focus on nuts and bolts, sort of more upstream things, like access and transitions, which contribute to your performance on VIS.”

Two ACOs hoped that that Roundtable would be an avenue to reopen the quality metrics discussion. These two ACOs talked about a need to replace the VIS as the statewide quality metric tool, with one ACO suggesting increased alignment with Medicare methodologies as a potential solution. During the interviews, the ACO representatives discussed the pros, cons, and evolution of quality metric negotiations in the SIM context. ACO perspectives on the VIS are summarized in Table 8, and a more detailed account can be found in Appendix A.

**VIS Dashboard**

In discussions about the VIS dashboard, representatives from two ACOs noted that they hadn’t had access to the dashboard recently, saying, “Well, it’s not really been operating since May of 2016. So, there’s
not been anything to interact with for quite a while” and “Prior to the MCOs coming on board, IME would facilitate regular conversations around VIS performance. But since the MCOs have taken over, there’s been next to no exposure of the VIS dashboard for purposes of the Medicaid population.” This is consistent with reports from the SIM team, as noted in the PPC’s SIM AY2 evaluation report, “During this reporting period, access to the VIS dashboard was suspended for Medicaid ACOs, and the SIM team anticipated that ACO user access would be reinstated in late 2017, after MCO users have validated encounter data in the VIS dashboard.” One ACO described the curtailment of ACO involvement in the VIS dashboard refreshes, saying, “We keep getting told things are going to be updated and we’ll be a part of it and then every month, it’s been moved on. So, we don’t ask anymore.” As of September 2018, the SIM team reported continued processing issues as a barrier to producing usable VIS scores for Medicaid ACOs.

Each ACO representative talked about how their ACO used the VIS dashboard when they had access to it. All four representatives noted they used the VIS as tool for aggregate level analysis. Specific employee types who used the VIS dashboard included health system management, health coaches, ACO program managers, and health system staff. Each ACO reported using a separate internal data system to support and track the work of care teams and practitioners.
Table 8. Summary of Perceived Strengths and Challenges of the VIS

<table>
<thead>
<tr>
<th>Concept</th>
<th>Number of ACOs (of 4)</th>
<th>Example(s) from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VIS Strengths</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardization</td>
<td>3</td>
<td>&quot;The idea of having a standardized set of measures ... So we don’t have complete measure fatigue in terms of things to pay attention to and generate data for and all that kind of stuff, there is significant value in there being a state utility for that.”</td>
</tr>
<tr>
<td>Retrospective Insight into System Practices</td>
<td>2</td>
<td>&quot;If you’re using it to measure aggregate outcomes on a looking-backward basis, I think VIS has some good qualities about that.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;At the network level, we just decided that we know what good care looks like and we know what our clinical and operational transformation priorities are. If this tool [VIS] is worthwhile, it will catch, it will show up in its measurement. That seemed to work very well.”</td>
</tr>
<tr>
<td>Risk adjusted</td>
<td>2</td>
<td>&quot;We want to be measured on a risk adjusted basis, and that has been helpful... we find value in it because it’s a risk adjusted measurement tool”</td>
</tr>
<tr>
<td><strong>VIS Challenges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclear implications</td>
<td>4</td>
<td>&quot;How do you know how far off you are from getting from a 3.5 to a 3.6 in a VIS score? Because generally you don’t know what that necessarily means. How many patients do we have to touch to make a difference, to raise our score?... from a VIS score you have no concept of specifically what the work is.”</td>
</tr>
<tr>
<td>Medicaid ACO input not seriously solicited</td>
<td>3</td>
<td>&quot;I think they decided what metrics to use before they brought the community together to sign the metrics”</td>
</tr>
<tr>
<td>No practitioner use</td>
<td>3</td>
<td>&quot;Physicians don’t use it in any way at all. At least in [ACO], physicians are hardly aware of their scores. Or understand the system.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Our providers are scientists and they just want to be able to reproduce it ourselves and see whether they’re counting right and all that kind of stuff and it stops way short of being able to do that.”</td>
</tr>
<tr>
<td>Not suited to the population</td>
<td>3</td>
<td>&quot;I really felt the state was very myopic, and those that were doing the work were very myopic when they went to Treo. I just don’t feel that’s the right tool as it stands for Medicaid population.”</td>
</tr>
<tr>
<td>No SDH measures</td>
<td>2</td>
<td>We talked a lot about why aren’t there any social determinants in here [VIS metrics], and [they] basically said, &quot;Well, it’s just too hard. We can’t figure out how to do it. We have to use claims.</td>
</tr>
<tr>
<td>Relative measure</td>
<td>1</td>
<td>&quot;You can grade yourself in relationship to others. But you don’t know your absolute performance. You know your relative performance.”</td>
</tr>
<tr>
<td>Network level data</td>
<td>1</td>
<td>&quot;We were only getting network level data. So, it was hard to even assign an incentive payment down to the health centers or a specific provider, because we couldn’t drill down the data that far.”</td>
</tr>
</tbody>
</table>

Key Takeaways – ACO and MCO experiences with the SIM payment reform efforts

State-approved value-based contracts were in place as of September 2017, and both MCOs reported that they were satisfied with the conclusion of negotiations. The Iowa SIM team update in 2018 noted that incentive payments had been received and disseminated to providers in one MCO.

- Very different experiences for MCOs and ACOs with regard to engagement with SIM VBP implementation. MCOs reported active engagement in SIM VBP activities and explicitly reported collaborative relationships and participation in negotiations as a success. ACOs reported less engagement, no access to VIS dashboards, or inclusion in discussions.
• All six stakeholders interviewed (two MCOs and four ACOs) independently noted hesitation to adopt the VIS metrics, with five stakeholders noting that the VIS was developed to measure privately-insured populations, and was not suited to the Medicaid population.

• Neither MCO was able to identify the value added of using VIS measurements. Both MCOs reported using national quality measures (HEDIS and NCQA) along with VIS in their shared savings payment models.

• Despite criticisms about the contracting process and metric selection, three ACOs talked about the inclusion of standardized quality metrics in VBP contracts across payers and systems as a SIM success.

• Stakeholders have conflicting motivations in regards to standardization. MCOs want less standardization across ACO contracts (referring to the required use of state-approved contract templates) to promote competition in the MCO contracting process, and ACOs prefer standardization to simplify practice and reporting processes for providers.
Technical Assistance Initiatives

Providing technical assistance (TA) to the various stakeholders involved in both primary drivers (payment and delivery system reform) is one of the main activities supported by the SIM. Technical assistance activities are intended to educate stakeholders on the many facets of payment reform and delivery system change and provide information and data for health systems to use to enact change.

The IHC and subcontractors’ (IPCA, IPA, IMS, IHA, and AIMM) TA activities included a wide variety of opportunities, strategies, and venues to provide education and training to, along with information sharing among, C3 communities and other interested stakeholders. Table 9 provides a summary of the main TA activities implemented over this reporting period.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Intent/Description</th>
<th>Timeline Implemented</th>
<th>Venue/ Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIM Unplugged</td>
<td>Monthly webinar series posted on YouTube and SIMplify website</td>
<td>Began series in November 2017, with monthly editions through May 2018</td>
<td>Online – SIMplify portal</td>
</tr>
<tr>
<td>Learning Community Events</td>
<td>Day-long conferences designed to provide SIM-specific education and training to stakeholders</td>
<td>Held 3 times/year November 2017 March 2018 July 2018</td>
<td>In person – C3 and others</td>
</tr>
<tr>
<td>Targeted TA to C3 Communities – Site Visits</td>
<td>Site visits to C3 communities were conducted to introduce the SIM, provide education and training, and incorporate feedback from C3s into planning for future events.</td>
<td>Quarterly</td>
<td>In person – C3 specific</td>
</tr>
<tr>
<td>Targeted TA to C3 Communities – SIMplify Website</td>
<td>A web-based communication platform which facilitates communication between SIM staff and C3 members</td>
<td>Ongoing</td>
<td>C3 specific</td>
</tr>
</tbody>
</table>

* The SIM newsletter, public forums, and feedback email account are ongoing, but not shown above.

SIM Unplugged series

The SIM Unplugged series is a monthly webinar series organized by the IHC. The series produces videos which cover a variety of topics, outlined in Table 10, and each video is available on the IHC website, posted to the SIMplify forum and YouTube channel, and disseminated through a SIM Unplugged newsletter.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Presenting Organization</th>
<th>Views*</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2017</td>
<td>Finding and using SDH data</td>
<td>Iowa Primary Care Association</td>
<td>86</td>
</tr>
<tr>
<td>December 2017</td>
<td>SIM and Healthcare Transformation</td>
<td>Iowa Healthcare Collaborative</td>
<td>108</td>
</tr>
<tr>
<td>January 2018</td>
<td>Risk in Healthcare</td>
<td>Iowa Healthcare Collaborative</td>
<td>54</td>
</tr>
<tr>
<td>February 2018</td>
<td>Heart Health</td>
<td>Iowa Healthcare Collaborative</td>
<td>24</td>
</tr>
<tr>
<td>March 2018</td>
<td>Patient Centered Care</td>
<td>Marshalltown Primary Healthcare</td>
<td>70</td>
</tr>
<tr>
<td>April 2018</td>
<td>Advanced Care Planning</td>
<td>HCI Care Services</td>
<td>47</td>
</tr>
<tr>
<td>May 2018</td>
<td>Building a Business Case for Quality Improvement</td>
<td>Iowa Healthcare Collaborative</td>
<td>18</td>
</tr>
<tr>
<td>July 2018</td>
<td>Community Partnerships</td>
<td>Iowa Healthcare Collaborative</td>
<td>10</td>
</tr>
</tbody>
</table>

* View data collected 10/15/18
Statewide Learning Events

SIM Learning Community events were designed to be day-long in-person conferences to provide education and training for healthcare providers, payers, care coordination teams, hospitals, ACOs, MCOs, and C3s in their respective roles in the SIM Initiative. The conferences featured speakers, panels, and networking breaks. During this evaluation period, IHC held three Statewide Learning Communities.

Table 11. Topics covered in SIM Statewide Learning Events

<table>
<thead>
<tr>
<th>November 9, 2017</th>
<th>March 7, 2018</th>
<th>July 17, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Use and Integration</td>
<td>Health Information Exchange</td>
<td>Community Engagement and Complex Patients</td>
</tr>
<tr>
<td>SWAN Capabilities and application</td>
<td>Community Health Transformation</td>
<td>Rural Health Model</td>
</tr>
<tr>
<td>Data Management and Application</td>
<td>Patients Perspectives in Care Partnerships</td>
<td>Understanding and Serving Communities</td>
</tr>
<tr>
<td>ACO Shared Savings models</td>
<td>Patient and Family Centered Care</td>
<td>Community Partner Collaboration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategic Communication</td>
</tr>
</tbody>
</table>

Attendance at Learning Community Events declined during this reporting period. To gain more understanding of the composition of attendees, registration rosters were examined to assess which stakeholders were still continuing engagement with the SIM Learning Communities. It should be noted that registration does not necessarily reflect the full attendance at Learning Community events.

Table 12. Learning Community (LC) Registrants – Position Type Definitions

<table>
<thead>
<tr>
<th>LC Stakeholders</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Leadership</td>
<td>Positions which are responsible for an organization’s strategic direction and overall management</td>
<td>Executive Director, President, CEO, COO, CFO, Director</td>
</tr>
<tr>
<td>Mid-level</td>
<td>Varied positions which are not in the top tiers of organizational leadership, and are not involved in care delivery</td>
<td>Department leadership, management, administration, coordinators, specialists, analysts, consultants, academics</td>
</tr>
<tr>
<td>Direct care providers</td>
<td>Positions which work directly with patients</td>
<td>Nurses, care coordinators, health coaches, clinic managers, pharmacists</td>
</tr>
</tbody>
</table>

Figure 9. Learning Community Registration by Position Type

* Virtual learning community
**Table 13. Learning Community Registrants – Stakeholder Type Definitions**

<table>
<thead>
<tr>
<th>Stakeholder Type</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3 site leadership</td>
<td>All registrants from C3 integrator organizations</td>
<td>Linn County Public Health, Trinity Muscatine Public Health, Great River Medical Center</td>
</tr>
<tr>
<td>SIM team</td>
<td>Formally contracted and sub-contracted organizations responsible</td>
<td>Iowa Department of Human Services, Iowa Medicaid Enterprise, Iowa Department of Public Health, Iowa Healthcare Collaborative, IHIN, IPCA, CMMI, CHCS, PPC, CDC</td>
</tr>
<tr>
<td>Medicaid ACOs</td>
<td>Registrants representing one of the five Medicaid ACOs in the state</td>
<td>UnityPoint ACO, Broadlawns Medical Center, Mercy Health Network, IowaHealth+, University of Iowa Health Alliance</td>
</tr>
<tr>
<td>Payers</td>
<td>Medicaid MCOs and private payers</td>
<td>AmeriHealth, Amerigroup, United Healthcare, Wellmark, Delta Dental</td>
</tr>
<tr>
<td>C3 Providers</td>
<td>Medical, behavioral, social service providers affiliated with a C3 as a</td>
<td>Dallas County Hospital, Eastern Iowa Health Center, Knoxville Hospital &amp; Clinics, Hawarden Regional Healthcare</td>
</tr>
<tr>
<td></td>
<td>steering committee member or coalition member</td>
<td></td>
</tr>
<tr>
<td>Non- SIM Care providers</td>
<td>Medical, behavioral, social service providers unaffiliated with a C3</td>
<td>Plains Area Mental Health, Guthrie County Hospital providers, social service agencies, community programs</td>
</tr>
<tr>
<td>Other</td>
<td>Consumer advocacy groups, provider groups, community and statewide programs</td>
<td>TAV Health, Drake University, Heritage Area Agency on Aging, Legislative Services Agency, Matura Action Corporation</td>
</tr>
<tr>
<td></td>
<td>and boards, private industry, academic institutions, governmental</td>
<td></td>
</tr>
<tr>
<td></td>
<td>departments not affiliated with SIM, healthcare IT agencies</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 10. Learning Community Registration by Stakeholder Type**

* Virtual learning community
The disaggregation of registrants at the Learning Community events showed that no particular stakeholder groups or position types discontinued participation in Learning Community events. Rather, the volume of each stakeholder group decreased, so proportionately, representation was maintained. Participation by C3 site leadership declined the least of all groups.

**Targeted TA to C3 Communities**

The IHC is primarily responsible for providing TA and building capacity within C3 sites to ensure that C3 communities are equipped to accomplish SIM goals. Each C3 site has an assigned TA/Quality Improvement (QI) advisor from IHC who conducts site visits and can provide small group and individual level TA at each site.

During this reporting period, IHC oriented the newest C3 site, and continued regular visits with the six established sites. TA topics included SDH assessment, SWAN, medication management, physician engagement, workplace wellness, data management, population health resource mapping, community EHR engagement, pharmacy partnerships, referral flow, diabetes patient resources, calculating cost savings, SWAN+ pilot preparation, partnership engagement related to the administration of the AMH tool, and data portal entry.

**SIMplify Website**

The SIMplify website, a web-based communication platform which facilitates communication between SIM staff and C3 members. The SIMplify website was developed to “share information, resources, and tools and promote interaction and networking.” To evaluate the usage of the discussion forum on the SIMplify website, an interaction rating scale was developed. The rating scale was designed to measure how C3 representatives were interacting with TA partners and other C3 sites (Table 14).

<table>
<thead>
<tr>
<th>Table 14. SIMplify website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Classification of Discussion Posts</strong></td>
</tr>
<tr>
<td>SIM TA discussion post</td>
</tr>
<tr>
<td>Discussion entry posted by SIM TA personnel or subcontractor (IDPH, IHC, IPCA, IHIN, IPA), with no replies from a C3 representative</td>
</tr>
<tr>
<td>Standalone discussion post (C3)</td>
</tr>
<tr>
<td>Discussion entry posted by a C3 representative with no replies</td>
</tr>
<tr>
<td>SIM TA initiated discussion</td>
</tr>
<tr>
<td>Discussion entry posted by SIM TA personnel with at least 1 reply from a C3 representative</td>
</tr>
<tr>
<td>C3 initiated discussion</td>
</tr>
<tr>
<td>Discussion entry posted by a C3 representative with a response from SIM TA personnel</td>
</tr>
<tr>
<td>Discussion across C3 sites</td>
</tr>
<tr>
<td>Discussion entry posted by a C3 representative with a response from another C3 site</td>
</tr>
<tr>
<td>Total posts</td>
</tr>
</tbody>
</table>

**TA to Healthcare Systems**

During this reporting period, IHC provided technical assistance to partnering Medicaid ACOs, Mercy Health Network, UnityPoint Health, and the University of Iowa Health. Of note, two of the five Medicaid ACOs in the state (Broadlawns and IowaHealth+) were not included in IHC’s healthcare system TA partnerships. The assistance provided was wide-ranging, and included the development of resource guides for practitioners on the topics of Advanced Payment Models,
Accountable Communities of Health, and risk sharing. Other technical assistance included establishing population management incentives, standardizing administrative processes, exploring global budgets for rural providers, and resolving data management and sharing issues.

**Stakeholder Experiences – Technical Assistance**

**Medicaid MCOs**

Preparing the workforce to execute SIM initiatives was mentioned by SIM stakeholders. Both MCOs noted limitations in workforce capacity as a challenge, specifically provider familiarity and abilities to use HIT and dashboards in practice and decision-making. Both MCOs provided training to improve competencies in these areas. The provision of training led to the identification of another challenge concerning the wide range of provider abilities across the state. In addition to skill-based deficits, MCO B also reported needing a cultural shift among providers, citing provider pushback to reforms. Each MCO mentioned participation in Learning Community events.

**Medicaid ACOs**

Two ACO representatives said their organizations participated in SIM Learning Community Events. Both ACO representatives who talked about Learning Communities were in agreement that the content lacked applicability (particularly because each ACO has unique processes and systems), and said of the meetings, “we didn’t find them useful” and “those learning collaboratives and other things they’re developing, they don’t have much impact.”

One ACO representative talked about efforts to coordinate across systems and sectors, saying, “I think there has been an attempt to do some standardization of language, terminology, how we talk about things, social determinants of health, care coordination, that kind of stuff. I’m not sure to what extent that’s really stuck.”

Two ACOs mentioned the role of the IHC in the SIM. One ACO reported IHC preferred to work with larger systems, so relatively smaller systems were overlooked for collaboration. Another ACO perceived that IHC’s involvement in the SIM sidetracked the SDH focus, saying, “for about a year there we got off track and we were thinking more about hospital safety measures than really the social determinants that we needed to address.”

**Accountable Communities of Health – C3s**

Six C3 sites reported needing TA specific to their site’s programming (e.g. integrating TAVHealth and IHIN data, training healthcare staff, population health resources). Three C3 sites reported not receiving feedback/analysis on the quality improvement plans they submitted. Two sites reported that resources and training provided to them had not been useful, and suggested obtaining more input from C3 sites regarding what resources and training should be provided.

C3s provided some insight about some additional assistance needs. Four C3 sites reported limited capacity (volume and skills) amongst the workforce as a challenge, particularly in the area of data analytics and the supervision and understanding of the roles of non-traditional healthcare providers such as nurse practitioners, care coordinators, health navigators, and health coaches. And, two sites reported needing legal assistance with contracts and HIPAA compliance.

**Key Takeaways- Technical Assistance**

The Iowa SIM continues to provide technical assistance directly to the C3 sites and Medicaid health systems, along with strategies to reach statewide audiences, such as Learning Community Events and online platforms.

- All stakeholders interviewed (MCOs, ACOs, C3s) described various limitations in workforce skills and capacity as challenges. Both MCOs reported facilitating supplementary training for their providers, and ACOs and C3s both reported limitations in SIM-sponsored technical assistance. Specifically, representatives from both stakeholder groups (two ACOs, and six C3s) described a lack of applicability of SIM provided training within their unique systems and settings.

- Currently, SIM technical assistance to healthcare systems works with the three largest Medicaid ACOs, and one ACO representative perceived less opportunity for impact, since
similar initiatives are implemented internally in large systems.

- Three C3 site representatives reported a lack of follow-through in regards to the cyclical quality improvement plan process, and six sites reported a need for customized technical assistance.
- Attendance at SIM Learning Communities has been less robust during this reporting period, and two ACOs reported the content presented was not useful.

**Evaluation Next Steps**

The PPC state-level evaluation team will continue to monitor the progress and implementation of the SIM initiative in Iowa. In the coming year, the implementation evaluation will particularly include a focus on sustainability efforts, exit interviews of C3 staff and partners, and the results of a statewide survey of healthcare consumers for comparison to the 2016 statewide survey.
Appendices

Appendix A: Medicaid MCO & ACO Stakeholder Interview Report
Appendix B: C3 Care Coordination Statewide Strategy Analysis Report
Appendix C: Network Analysis Report
Appendix D: C3 Steering Committee Member Survey Report
Appendix E: C3 Community Coalition Survey Report
Appendix F: C3 Healthcare Provider Survey Report
Appendix G: C3 Clinic Manager and Diabetes Educator Interviews Report
Appendix H: C3 Patient/Client Survey Report
Appendix I: Governor’s Roundtable Recommendations
Appendix J: Sample C3 Scorecard
Appendix A: Medicaid MCO & ACO Stakeholder Interview Report

Iowa SIM Stakeholder Interviews – Payers and Providers

To gather information about the status of the State Innovation Model (SIM) from the perspectives of its key stakeholders, the Public Policy Center (PPC) evaluation team interviewed SIM staff, major payers (Medicaid Managed Care Organizations (MCOs) and Wellmark), and the major provider organizations (the Medicaid Accountable Care Organizations (ACOs)) involved in the SIM. First, the team interviewed members of the SIM Implementation Team housed in IME (Iowa Medicaid Enterprise) to collect general perceptions of SIM stakeholder relationships and receive a status update of relevant implementation activities. The results of the SIM implementation team interview were used to inform the payer interview scripts and the results of the payer interviews were used to inform health system interviews.

Methods

Recruitment

The PPC evaluation team contacted members of the Iowa SIM team and requested contact information for representatives from SIM-affiliated payers (three Medicaid Managed Care Organizations (MCOs) and Wellmark) and health systems (five Medicaid Accountable Care Organizations (ACOs). The Iowa SIM team provided phone numbers and e-mail addresses of contacts engaged in SIM activities from these organizations. The PPC contacted potential interviewees via e-mail and invited them to participate in a one-hour phone interview about their organization’s involvement with the SIM. The e-mail invitation can be found in Addendum. Interviewee Invitation.

Payers

Representatives from two of the three state MCOs (Amerigroup and United Healthcare) agreed to be interviewed. Although an interview with AmeriHealth representatives was scheduled, it was canceled due to the AmeriHealth’s withdrawal from, and subsequent transition out of the state’s Medicaid program. A representative from Wellmark was contacted for an interview and declined, citing limited interaction with the SIM, but noted greater involvement was expected in the future. Interviews with representatives from Amerigroup and United Healthcare were conducted in November and December 2017.

Health Systems

Representatives from four of the five Medicaid ACOs in the state agreed to be interviewed (Mercy Health Network, UnityPoint Health, University of Iowa Health Alliance, and IowaHealth+). Representatives from Broadlawns reported prior involvement with the SIM, but opted out of the being interviewed due to lack of recent engagement. Interviews with representatives from the four Medicaid ACOs were conducted in February and March 2018.

Interview Scripts

The development of the SIM implementation team, payer, and health systems interview scripts were guided by the Iowa SIM Award Year 3 Operational Plan, workgroup meeting minutes, and prior SIM state-led evaluations. After reviewing these resources, the PPC evaluation team developed a semi-structured interview script with questions that fit into four general categories of SIM-related activities 1) SIM in general, 2) Value Based Purchasing, 3) Delivery System Transformation, and 4)
Communication. The interviews lasted between 60 and 90 minutes in length and began with broad questions about general knowledge and experiences, became more specific for each SIM component, and concluded with questions about interactions and communication with SIM partners at the state. The full interview scripts are in Addendum. Payer Interview Script and Addendum. ACO Interview Script. The interviews had four primary aims:

1) Assess the level of awareness and knowledge regarding SIM goals and operations
2) Gather information about the status and operationalization of SIM activities within the organization
3) Assess the perceived value of SIM activities and perceptions of sustainability
4) Document challenges and successes experienced during the Iowa SIM

While the interview scripts provided some structure, elaboration was encouraged to allow additional themes to emerge. As a result, not all topics were covered in all interviews because of time constraints.

Analysis

Documents used for analysis included notes taken by the PPC team during interviews, e-mail exchanges with interviewees, and transcripts from audio recorded interviews (five of the six interviews for this analysis were recorded with permission and transcribed). These documents were reviewed and categorized within the main themes of the interview structure. Along with themes that were predetermined by the interview questions, themes across stakeholders emerged throughout the interviews, and were included as categories in the content analysis.
Payers

Insurers in Iowa are essential stakeholders in the implementation of Iowa’s State Innovation Model vision for payment reform. Ultimately, the Iowa SIM aims to increase participation in value based purchasing (VBP) arrangements with both public payers (Medicaid) and commercial payers (Wellmark) in the state. In order to gather information from the perspective of payers and evaluate the status of payment reform, the Public Policy Center (PPC) evaluation team planned to interview all payers involved in SIM activities. The Iowa SIM team has focused VBP and payment reform activities most intensely within the Medicaid population. Three private managed care organizations (MCOs) began the management of Iowa’s Medicaid population in April 2016. During this evaluation period, the three MCOs that manage the majority of Iowa’s Medicaid population were engaged with the state in negotiating VBP agreements during regular workgroup meetings. In addition, representatives from three MCOs and Wellmark have regularly attended SIM Statewide Learning Collaborative events and are members of the Roundtable.

At the time the PPC was requesting interviews (October 2017), Medicaid in Iowa was managed by three MCOs, namely Amerigroup Iowa Inc. (Amerigroup) and United Healthcare Plan of the River Valley, Inc. (United Healthcare), and AmeriHealth Caritas (AmeriHealth). In November 2017, AmeriHealth announced its withdrawal from Iowa’s managed care program, effective December 1, 2017.1

Interviewees

With one of the Medicaid MCOs leaving the state in December 2017, the PPC team interviewed representatives from each of the two remaining organizations. Both MCOs have a national presence with regard to the management of Medicaid populations and have contracts with multiple states (in addition to Iowa). Representatives from Wellmark were contacted for an interview and declined, citing limited interaction with the SIM at the time of the intended interviews.

The Medicaid MCO representatives who participated in the interviews were from various departments within their organization and included a Quality Director, Health Plan Chief Financial Officer (CFO), Chief Medical Officer, Program Director, Business Change Manager, and Manager in Quality Management.

Before the interview began, participants were asked to consent to audio recording. One MCO agreed to an audio recording, and the audio file was sent to a vendor for transcription. The other MCO did not consent to audio recording of the interview so the PPC team took notes during this interview. Text documents from the two interviews were reviewed. During analysis of the interview texts, responses to questions were organized by topic area, and reported experiences with the SIM were examined for similarities and differences.

In this report, the MCOs will be referred to as MCO A and MCO B to maintain the confidentiality of the respondents.

Results

General SIM

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The first set of interview questions were focused on general SIM knowledge, contractual obligations, and experiences as a stakeholder in SIM workgroups. In response to the question, “What is your organization’s understanding of the goals of the State Innovation Model (SIM) in Iowa?” Responses from both MCOs were consistent with the language and vision articulated in the SIM Operational Plans, with both payers acknowledging their role in implementing Value Based Purchasing and improving care coordination. Each MCO acknowledged additional SIM goals, which included supporting and empowering patients, reducing Hospital Acquired Conditions (HAC), preventable emergency department (ED) use, unnecessary hospital admissions and readmissions (MCO A), promoting data exchange, and improving continuity of care (MCO B).

Each MCO elaborated on their perceptions of the role of payers in the SIM. Along with implementing VBP, both MCOs recognized that participation in SIM workgroups was an expectation. MCO B also talked about their role as collaborators in SIM-aligned policy development. Both MCOs reported participation in the SIM VBP workgroup, which is consistent with the Iowa SIM team reports. Each MCO mentioned participation in additional SIM-related initiatives, including State Strategy Plan workgroups, C3 steering committee meetings, Social Determinants of Health workgroup (MCO A), Learning Collaborative events, and ongoing quarterly contact (MCO B). MCO A reported positive experiences in SIM workgroups, saying “We find workgroups valuable in the sense that we interact with people outside of our sphere with different perspectives, so we’re better able to understand and collaborate.”

When asked, “Does your organization perceive the SIM to impact outcomes for MCOs?” both MCOs were undecided about the potential impact of the SIM. MCO A reported independently working towards SIM objectives prior to the SIM grant, stating, “[MCO A] is already at forefront of general health innovation trends, so SIM impact on processes / payment reform is minimal.” MCO B withheld judgment, citing a need for adequate claims data to examine trends (the 18-20 months of data they had at the time of the interview was not sufficient).

**Value Based Purchasing**

The Value Based Purchasing section of the interview script included questions about contracts, payment models, quality measures, and related tools (e.g. the VIS (Value Index score) dashboard).

**Contractual Obligations**

As delineated in the SIM AY3 Operational Plan, “Each of Iowa’s three Medicaid MCO’s have contractually committed to supporting the activities of the SIM grant, both in a general way as well as with specific requirements relating to patient assignment, value based purchasing (VBP) thresholds and aligned quality measurement. In award year 3, the MCOs have been given parameters and timeframes for establishing aligned VBP contracts, including quality targets maintained through the Medicaid Agency. In addition for year 3, the MCO’s also have capitation-withhold-based performance incentives tied to the same measure of quality required of the delivery system (the Value Index Score) along with total cost of care targets that are necessary to qualify for the incentive payout.”

Both MCOs were knowledgeable about contract expectations regarding increasing the percentage of members covered in a VBP arrangement to 30% by July 2018 and 40% by December 2018. In regards to progress towards these benchmarks, one MCO reported being on track to meet or exceed the targets, and the other MCO endorsed the state’s VBP goals, but also recognized the relatively short time frame to be in compliance as a challenge. Neither MCO mentioned any withhold of quality payments.

**Payment Models**
The Iowa SIM Award Year 3 Operational Plan articulated plans to achieve a level 3B advanced alternative payment model (APM) (APMs with Shared Savings and Downside Risk) models by 2019 across MCOs.² Both MCOs mentioned the lack of downside risk in current agreements, and MCO B suggested that providers would need adequate time to adjust to payments for performance in shared savings arrangements before incorporating downside risk, saying, “This evolves over a number of years as providers figure out what they need to do to change their scores, and they need to be given time to do that…I hesitate to put a prediction on it, but it won’t be this year or next year that we’re getting into these downside risk relationships.”

Both MCOs reported having operational state-approved shared savings models that incorporate Value Index Score (VIS) and other quality measures in payment calculations, as required by state contracts. MCO B talked about other payment models they utilize besides the state-approved shared savings agreement, which incentivizes providers based on reduction to their medical loss ratio (MLR). The other payment models MCO B employs are part of an internal program, which uses HEDIS quality metrics to determine performance-based payments. MCO B noted strengths of their internal payment model, which included long term (7-8 years) use in several states, and flexibility to customize metrics to the provider’s patient population.

When describing various payment models, both MCOs reported a spectrum of provider interest in and readiness to be successful in VBP arrangements. MCO A reported preparing providers for VBP arrangements by offering an incremental payment model which used quality metrics, but lacked a shared savings component. MCO B reported provider reluctance (due to Medicaid management transitions in state) and limitations in provider skills (training needed) as challenges in VBP tool use and VBP payment model implementation.

“You’re just not going to see these providers moving forward in their contract relationships until they see some of the dust settle around the change being made.”

Quality Measures
Both MCOs reported reluctance to using VIS, based on concerns that tool was developed for a commercial population, and does not suit the Medicaid population. In addition, neither MCO was able to identify added value from the requirement to incorporate VIS into performance based payments. Both MCOs stated it was too early to make a judgment on the value of VIS, and MCO B cited “a proliferation of dashboards” without adequate understanding among providers of how to use the data as detracting value from the VIS and VIS dashboard.

At the time of the interviews, both MCOs reported that the VIS dashboard was in a cooperative test and review phase between the two MCOs, 3M Analytics, and Iowa Medicaid Enterprise (IME). MCO A reported that claims data from the MCOs has been uploaded, and the next step is sharing results with the Medicaid Accountable Care Organizations (ACOs). In September 2018, Iowa SIM staff reported the last VIS dashboard refresh was in October 2017. While both MCOs were actively cooperative in the VBP workgroup and quality measure discussion, MCO B had reservations about the feasibility of the SIM goal to align quality measures across various payers and populations, stating, “The expectation that alignment can be achieved that is complete is unworkable and will continue to prove to be unworkable.”

Indeed, both MCOs described a lengthy process of negotiating quality metrics to include in state approved performance based payment calculations before a compromise to only require partial use of

VIS in calculations was reached. Subsequently, both MCOs use national quality measures (HEDIS and NCQA) along with VIS to calculate reimbursement in shared savings models.

**Delivery System Transformation**

The two MCOs were asked a series of questions about delivery system transformation, which included items about stakeholders, contracting with ACOs and providers, the use and value of the Statewide Alert Network (SWAN), and interaction with Community and Clinical Care Initiatives (C3s).

When asked, “What stakeholders in the state context are responsible for encouraging delivery system transformation?” both MCOs identified MCOs, the state government (specifically, IME and Iowa Department of Public Health), and providers as primary stakeholders in delivery system reform. MCO A also listed legislators, Centers for Medicare & Medicaid Services (CMS), provider organizations, Iowa Healthcare Collaborative (IHC), Iowa Primary Care Association (IPCA), Iowa Hospital Association (IHA), and Medicaid members as stakeholders.

Both MCOs reported having state-approved VBP contracts in place with providers and Medicaid ACOs, with MCO B reporting performance-based reimbursements expected to begin in 2018. In regards to the dissemination of performance based payments, MCO A reported each Medicaid ACO contract determined whether payments reached individual providers. MCO B described a discrepancy in their expectations of relationships with ACOs, and the current, more uniform contracting arrangement. MCO B explained that they expected more flexibility to offer competitive incentives, in order to gain preference from ACOs over other MCOs, and instead all ACOs are contracting with both MCOs, using a state-approved template. They did state that the competitive environment they expected when they began managing Medicaid in the state might be realized in 2018. Iowa SIM staff provided an update in September 2018, reporting that incentives for MCO A providers participating in SIM approved VBP programs have been paid.

MCO A reported monthly meetings with ACOs, to discuss topics including Medicaid best practices, clinical outcomes, transitions of care, and care coordination. Both MCOs reported facilitating training for providers in areas including best practices in VBP arrangements (MCO A), practice transformation consulting, and technical assistance to use data and implement strategies (MCO B).

In regards to addressing social determinants of health (SDH), MCO B reported that providers have access to specific codes for identifying SDH needs, but documentation depends on provider coding savvy. Beyond administrative SDH shortcomings, MCO B also noted that steps needed to make the data meaningful, including analytics and interventions, are not developed for application to populations outside of care coordination programs like the Integrated Health Homes and Chronic Condition Health Homes.

**Statewide Alert Network (SWAN)**

The SWAN is a part of an HIT infrastructure investment through the SIM to promote better care coordination within the healthcare delivery system. The SWAN is a software technology hub that uses ADT (Admission, Discharge, and Transfer) files from participating hospitals to formulate alerts to providers and care teams when one of their patients has a hospital admission or an emergency department (ED) visit. The SWAN tool is intended to help transform the healthcare delivery system by improving the quality of care coordination activities and, as a result, reduce the rates of preventable readmissions and preventable ED visits.
Both MCOs report that the SWAN is useful for specific populations; MCO A reports that SWAN alerts are helpful to identify members attributed to providers in ACOs, and MCO B reports using SWAN reports for members who have been identified as the highest utilizers. At this time, MCO B reports using the SWAN in limited capacity, and only sends monthly attribution files of their highest risk members, noting that there aren’t response systems in place for the entire patient population, and expanding attribution files shared with SWAN could become unmanageable. MCO B expressed a need for standardized reporting from providers, noting inconsistencies in information included in Admission, Discharge, and Transfer (ADT) alerts sent to the SWAN.

Both MCOs stated that daily SWAN reports are used by providers and care teams to encourage outreach to recently discharged patients, inform case management, and ensure accountability for follow-ups. MCO B reports that SWAN reports are particularly useful for programs with care coordination infrastructure in place, namely Integrated Health Homes (IHH), which are especially equipped to execute timely discharge follow-ups with patients. Outside of programs like IHH, MCO B reports uncertainty on how to use SWAN data, saying “Once we have that data, what do we do with it? I think that we’re still kind of playing around or trialing lots of different strategies and interventions on what we do with that file when we receive it.”

While both MCOs reported that the SWAN is duplicative of current internal systems, MCO B noted that discharge information from the SWAN is timelier than claims-based reports, which triggers the follow-up process earlier, which leads to more meaningful outreach. Both MCOs believed the SWAN could be sustained beyond SIM funding, especially if alerts were sent instantaneously after ADT events, and if all hospitals in Iowa were connected.

C3 involvement

Both MCOs report some involvement with C3 sites, namely Dallas and Linn County sites. MCO A reported participation on a steering committee, and MCO B reported disseminating updates on C3 activities to inform internal case management teams of resources in C3 counties.

Communication

In regards to interactions with SIM staff, MCO A reported that communication with SIM staff was satisfactory, and that weekly ongoing meetings were being held. MCO B reported actively disseminating SIM updates throughout their organization to ensure employees at all levels are informed about SIM activities and resources. In addition, both MCOs reported satisfaction with resolution of VBP workgroup compromises. MCO B noted that ongoing compromise was expected, when working across multiple organizations with unique goals.

Successes

Both MCOs reported building collaborative relationships as successes associated with SIM involvement, with MCO B stating, “I think collaboration with the other organizations with the other MCOs, and with our external partners. I think the relationships that we’ve built through attending these various meetings has been beneficial.”

In addition, MCO B credited SIM activities with influencing attitudes of Medicaid providers to regard the value of data and real-time information more positively.

Both MCOs reported using daily reports from the SWAN to improve care coordination processes, specifically, follow-up after hospital discharges.
Although areas for improvement have been identified, both MCOs are participating in and utilizing functioning SIM components, including SIM workgroups, VBP contracts, the SWAN, and VIS dashboard.

**Challenges**

Both MCOs report HIT (health information technology) and data sharing infrastructure as challenges encountered during SIM work. Specifically, MCO A cites working across various electronic medical records (EMR) systems as a challenge, and MCO B reports that underdeveloped EMR systems, coupled a workforce that is comparatively behind in HIT experience as challenges.

MCO B reported that transitions in networks, including the exit of an MCO in 2017, have delayed VBP progress and made providers wary to commit to initiatives. In addition, MCO B reported that meeting SIM goals is a challenge due to their relatively short tenure in the state.

As detailed in the *Value Based Purchasing* section, a challenge for both MCOs was renegotiating the SIM goal of alignment across payers and incorporating VIS metrics into their established VBP payment models.

Both MCOs noted limitations in workforce capacity as a challenge, specifically provider familiarity and abilities to use HIT and dashboards in practice and decision-making. As described in the *Delivery System Transformation* section, both MCOs are providing training to improve competencies in these areas. The provision of training led to the identification of another challenge concerning the wide range of provider abilities across the state. In addition to skill-based deficits, MCO B also reported needing a cultural shift among providers, citing provider pushback to reforms.

MCO B suggested that SWAN data validity could be improved with more consistent requirements for provider data submissions (as described in the *Delivery System Transformation* section). Also, formalized processes triggered by SWAN alerts could be developed to include larger patient populations and enhance the effectiveness of the SWAN.

**Key Takeaways - MCOs**

**Positive Engagement**

Both MCOs were knowledgeable about the SIM, actively participated in workgroups, came to agreements in the quality metrics negotiations, reported positive relationship with SIM staff, and explicitly reported collaborative relationships as a success.

Of note, at the time of these interviews, the Roundtable was being reinstated, restructured, and reintroduced after a period of inactivity, so MCO experiences with the Roundtable were not collected.

**Quality Measures**

Neither MCO was able to identify the value added of using VIS measurements, and both MCOs stated that the VIS was not suited to the Medicaid population. Both MCOs reported using national quality measures (HEDIS and NCQA) along with VIS in their shared savings payment models.

**SWAN**

Both MCOs reported using the SWAN to coordinate care after patient discharges. However, both MCOs reported that SWAN would have more value if the alerts were timelier (immediately after an ADT event) and all hospitals in Iowa were connected.

**Workforce Limitations**
Both MCOs reported that the current workforce capacity was limited, specifically provider familiarity and abilities to use HIT and dashboards in practice and decision-making. Both MCOs reported facilitating training for providers to improve competencies around VBP.

**Value-Based Contract Realization**

Both MCOs reported implementation of state-approved VBP contracts. The Iowa SIM team updated in 2018 that incentive payments had been received and disseminated to providers in one MCO.
Medicaid ACOs

Medicaid Accountable Care Organizations (ACOs) in Iowa are essential stakeholders in the implementation of the Iowa SIM’s vision for delivery system reform. The Iowa SIM aims to improve the state’s delivery system and provider practices with infrastructure development (e.g. Statewide Alert Network (SWAN)) and value based payment contracting. In order to gather information from the perspective of provider health systems and evaluate the status of delivery system reform, the PPC evaluation team planned to interview all Medicaid ACOs in the state, since the Iowa SIM team has focused delivery system reform activities most intensely within the Medicaid population. Within the last year, representatives affiliated with the five Medicaid ACOs have attended SIM Statewide Learning Collaborative events (generally care team staff (health coaches, case managers) and various management and specialist positions). Additionally, four of the five ACOs (the exception is Broadlawns) have representatives on the Roundtable.

Interviewees

Five entities in the State of Iowa are Medicaid ACOs, namely Mercy Health Network, University of Iowa Health Alliance, UnityPoint Health Partners, Broadlawns Medical Center, and Iowa Health Plus. The Medicaid ACOs in the state vary in size, patient population, strategic direction, and capacity. See table below for details about each ACO.

<table>
<thead>
<tr>
<th>Medicaid ACO</th>
<th>Size</th>
<th>Established</th>
<th>Service Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broadlawns Medical Center</td>
<td>1 acute care hospital 4 clinics</td>
<td>June 2014&lt;sup&gt;4&lt;/sup&gt;</td>
<td>Centralized campus in the Des Moines area</td>
</tr>
<tr>
<td>Iowa Health Plus</td>
<td>13 health centers 13 clinics</td>
<td>Unknown</td>
<td>Network of statewide Community Health Centers (CHCs)</td>
</tr>
<tr>
<td>Mercy Health Network</td>
<td>11 hospitals 146 clinics</td>
<td>Unknown</td>
<td>Statewide network</td>
</tr>
<tr>
<td>UnityPoint Health Partners</td>
<td>17 hospitals 280 clinics</td>
<td>April 2014&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Statewide network</td>
</tr>
<tr>
<td>University of Iowa Health Alliance*</td>
<td>Includes three health systems and a public academic medical center and affiliated clinics</td>
<td>April 2014&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Network primarily focused in Eastern Iowa</td>
</tr>
</tbody>
</table>

<sup>*During the interviewing period (March 2018), the University of Iowa Health Alliance ACO announced its decision to dissolve, citing reduced and uncertain funding streams.</sup><sup>6</sup>

Four of the five Medicaid ACOs consented to an interview. The key contact at Broadlawns was unable to identify a SIM-involved staff member at the ACO, so participation was declined.

<sup>5</sup> http://dhs.iowa.gov/sites/default/files/PR_4.4.14_Provider_ACO_Agreements.pdf
The Medicaid ACO representatives who participated in the interviews were from various leadership positions within their organizations and included a Chief Strategy Officer, Chief Executive Officer (CEO), Vice President of Operations, President of the ACO, Lead Executive of ACO Operations, Assistant Vice President for Health Policy and Strategy, and Vice President for Medical Affairs.

In this report, the ACOs will be referred to as ACO A, B, C, and D to maintain the confidentiality of the respondents.

Results

General SIM

All four of the ACO representatives interviewed were conversant in the purpose and goals of the SIM. Specifically, all four described the SIM goal of aligning quality measures across private and public payers and increasing participation in VBP. Three ACOs also mentioned the expectation of standardizing infrastructure across providers to support service delivery unification across the state. Representatives from ACOs A and B captured these concepts, saying, “Well, my original understanding was that they were to develop a unified plan for financing and providing care across the state of Iowa. By unified, I meant they’re going to unify commercial insurers and the Medicaid plan to have similar metrics and incentives” and “Initially I think the thought was that if the state innovation models worked we would have a more centralized structure that would allow us as medical providers to use a more mature infrastructure, use more health IT analytics that are bringing in more robust information about our patients.”

While each of the four Medicaid ACOs were knowledgeable about the general goals of the SIM, all four noted a divergence between the original expectations for the SIM and the current state of the SIM. Specifically, all four ACOs noted the vision for the SIM had lost direction. In regards to the unclear direction of the SIM, all four ACOs cited shifting and unclear leadership roles at the SIM and state level, and three ACOs attributed the disruption to the entrance of the MCOs and subsequent contract renegotiations. As a representative from ACO A described, “I think the aspirations were pretty high, and then we have the MCO’s step in and we all know in Iowa that that’s been more than a business disruption, and so I think we’ve lost sight a bit of how to go about making those goals happen.” A representative from ACO B expressed disappointment in the narrowed scope (i.e. Medicaid population and program focus) of the SIM, saying, “that really is one of our big complaints about these programs [SIM], is, we don’t want programs that help one contract out of our 20 contracts…I guess that was the hope that the SIM would do that. I don’t think that’s produced much positive results in that way.”

Contractual Obligations

The four ACO representatives all knew about components included and requirements for SIM-related contracts, and all four ACOs reported they had established VBP shared savings contracts with at least one MCO. Besides VBP, no other contractual obligations related to the SIM were identified, as ACO B described, “There is related language specific to SIM regarding the encouragement of participating in the initiative, but no hard line contractual obligation.” Two ACOs mentioned administering the Medicaid Integrated (IHH) and Chronic Condition Health Homes (CCHH) as contractual requirements, but the SIM has not actively incorporated those programs into its implementation activities at this time.

Three ACO representatives discussed the exclusive nature of VBP contract development, saying that input from ACOs was not elicited as IME worked with MCOs on the template requirements. A representative from ACO C captured this sentiment, saying, “the Medicaid agency has been pretty closed to
a lot of influence in what their contract and templates look like, but we have attempted to communicate our priorities in that.” More details on contracts can be found in the Value Based Purchasing section.

ACO Role in SIM

In regards to the role of ACOs in the SIM, all four ACOs described active roles in SWAN (Statewide Alert Network) implementation and development, with ACO C reporting, “We’ve been involved with Iowa Health Information Network in the development of the SWAN capabilities. We utilize those tools and just providing feedback as we move along that journey.” All four ACOs described supporting the C3 initiative at a regional level (i.e. ACO affiliated clinics lead involvement in C3 regions). More details about ACO participation in the SWAN and C3s can be found in the Delivery System Transformation section. Two ACOs described their organization’s efforts to promote the inclusion of social determinants of health during the SIM planning year.

Three ACO representatives described their organization’s participation in SIM as fulfilling a need to be aware of potential changes that would impact their organizations and remain a key player in the state, but noted they had limited opportunity to influence the initiative’s strategic direction or decision-making. ACO B described the dynamic for ACO stakeholders, saying, “Our goal is, I guess that I see it, is to keep informed, watch what’s going on, and look for an opportunity to become involved, but other than sit in meetings, I don’t know that there’s much I’ve seen to this point.” Representatives from ACOs C and D commented on the diminished role of ACOs in the SIM, saying, “it’s been dormant in terms of its visibility to us.” and “we’ve basically had virtually no role with SIM… We’re just doing our best to try to implement it [SIM], but you can’t get them [IME] to really listen to you and I think it’s because they just don’t understand, but there’s also an unwillingness to listen.”

These reports of tapering ACO involvement are consistent with activities reported by the SIM team during this evaluation period. As noted in the PPC evaluation report, regular meetings between the state SIM team and ACOs were suspended during the Award Year 2 period.7

SIM Learning Collaboratives and Workgroups

Two ACO representatives said their organizations participated in SIM Learning Collaborative Events and three ACOs were aware of involvement in workgroups. Both ACO representatives who talked about Learning Collaboratives were in agreement that the content lacked applicability (particularly because each ACO has unique processes and systems), and said of the meetings, “we didn’t find them useful” and “those learning collaboratives and other things they’re developing, they don’t have much impact.”

Specific workgroups that were mentioned included a Social Determinants of Health workgroup, Care Coordination workgroup, Patient Engagement workgroup, Health Risk Assessment workgroup, and a Quality Metrics workgroup. In regards to workgroup contributions and outcomes, ACO C said, “I think we just actively participated in helping to define those [Social Determinants of Health] and refine the policy papers that came out of it. There’s been some assessments that have come out since that I think have been of frankly minimal value, but kind of developing statewide, philosophical or conceptual documents out of this.”

One ACO described workgroups as “haphazard” saying meetings are “supposedly on a quarterly basis but it often gets pushed off.” In regards to the Quality Metrics workgroup (during the SIM planning year), both ACOs who reported involvement described some workgroup outcomes as predetermined, saying

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that while everyone agreed on the idea of standardized quality metrics, the decision to align around Wellmark’s Value Index Score (VIS) was a “decision [that] was made before anybody ever stepped in the room.”

**Roundtable**

All four ACO representatives confirmed that their organizations are members of the Roundtable, with two ACOs saying the Roundtable is their most substantial connection with the SIM at this time. Perceptions of the Roundtable and its potential impact varied. Two ACOs acknowledged the value of convening major health care stakeholders in the state, which has opened communication across stakeholders to better understand roles, motives, and opportunities to align. One ACO credited the Roundtable with influencing Wellmark to use the SIM Statewide Alert Network (SWAN) vendor (Iowa Health Information Network (IHIN)), saying, “that was the first time I’ve seen anybody walk the talk. It’s just such a big deal now to have Wellmark playing ball.”

Two ACOs said the impact of the Roundtable was contingent on concrete follow-through, saying, “I thought it was really good dialogue to tell the truth, but it was very visionary” and “I think how useful it is depends a lot on how much attention it will get beyond it being a roundtable. What’s really the commitment? It’s so easy to do things in a work group and a roundtable, it’s what happens in contracts and in the things that you do that matter.”

Two ACOs hoped that that Roundtable would be an avenue to promote population health across sectors and reopen the quality metrics discussion. These two ACOs talked about a need to replace the VIS as the statewide quality metric tool, with ACO D suggesting increased alignment with Medicare methodologies as a potential solution.

**Value Based Purchasing**

The Medicaid ACO representatives talked about various aspects of Value Based Purchasing (VBP), including contracts with MCOs, quality measures, the VIS dashboard, logistics (financing infrastructure and payment distribution), dynamics among stakeholders, perceptions of SIM influence, and sustainability.

All four ACOs reported they had established VBP shared savings contracts with at least one MCO, and demonstrated interest in the idea of VBP contracts based on standardized metrics, with one ACO saying, “If successful, it’s exactly what we need to have happen so that we do as a smaller system of care, have access to the information and are aware of all the processes that are going to make our ability to deliver value based care, our ability to do that is enhanced or capacity as a result of not having to navigate differently for every payer.”

All four ACOs mentioned contractual engagement in a separate $3.00 Per Member Per Month care coordination funding stream (i.e. Clinical Integration Payment) that was more certain and timely (monthly basis, as opposed to 18 month delay in shared savings payments) than the VBP shared savings arrangements. One ACO elaborated, saying, “that was the other thing that was attractive, honestly, about the United program was that there was a plan to actually earn some dollars right at the get-go through these monthly payments, when based on our experience in Medicare, you should not plan on earning shared savings because it’s pretty tough.” While all ACOs have VBP arrangements in place for their Medicaid populations, one ACO representative described the VBP contracts as secondary to fee-for-service arrangements, saying, “Everybody keeps getting paid fee-for-service, and then the value-based contract sort of sits to the side of it.” However, all ACOs had plans to encourage participation in VBP arrangements.
through both incremental and blanket strategies, with one ACO predicting more reliance on VBP arrangements for funding in the future, saying, “Their [MCO] desire to keep paying us $3 per member per month indefinitely isn’t going to continue.”

Implementation of VBP

Medicaid ACO experiences with and investment in implementing VBP in Medicaid varied, depending on the proportion of their organization’s Medicaid patient population and longevity of the ACO. Meaning, more established, larger ACOs had more experience implementing VBP prior to the SIM, and more financial security. Three ACOs (two with relatively higher proportions of Medicaid members in their patient populations) were wary of entering shared savings agreements with MCOs, as ACO D elaborated, “I think they forget about that, too, is for all of us, Medicaid is a huge part of our business and we’re having to go to tremendous efforts just to get paid…the idea of doing this value-based thing on top, which is another thing we’re going to spend resources on and not get paid… I just don’t think that’s probably a recipe for success.” Along with fundamental uncertainty about the actual accumulation of shared savings for distribution, another ACO also shared doubts that value-based reimbursements would be dispersed as planned, citing past experiences with MCOs in the Medicaid Chronic Condition Heath Home program, saying, “for their Chronic Care Health Home, they’ve [MCOs] made it more difficult to get paid for that than it was when it was under the Medicaid program.”

Two ACOs were concerned that the value based payments earned would not offset the costs of infrastructure investments needed to earn the shared shavings, as one ACO described, “One thing that gets missed in this whole ACO discussion is how much it’s costing health systems to up-front finance and make the investments in the ACO infrastructure. That’s generally not borne by any of the physicians in a health system, it’s generally borne by the hospital or the health system, and that includes costs for hiring and employing care managers that don’t have any funding stream to support them other than these value-based revenues that I mentioned that come very, very late, if you get them at all, and generally don’t cover your costs.”

VBP Contracts

Representatives from the four ACOs were fairly knowledgeable about the VBP expectations outlined in the SIM-aligned contracts. While interviewees were not prompted for details about the content of the VBP contracts, several components were specifically mentioned extemporaneously (see Table 2).

- 40% lives covered target [ACO B & D]
- Shared savings (upside only risk) [ACO A & D]
- State-approved templates [ACO B & C]
- VIS metric requirement [ACO C & D]
- Quality metrics linked to reimbursement [ACO B & D]

An ACO representative experienced in VBP arrangements said that the incorporation of risk into the contracts would boost the application and, eventually, advance health system capabilities involved in practice change around payment reform, saying, “Risk makes it real. So what we saw I think is the general attitude that folks thought care coordination itself would be enough, and it is not enough. There are just core competencies that are different in value based arrangement than are in care coordination” The two ACOs who self-reported substantial experience with VBP arrangements described the SIM VBP contracts as lacking definition and structure, describing the contracts as “rudimentary” and “bare bones.”
Three ACO representatives talked about patient attribution methodologies for primary care, noting the complexities, which included providing care to unattributed patients, attributed patients receiving care routinely outside of their ACO network, and fluctuating populations due to various attribution methodology across payers.

**Stakeholder Dynamics**

The four Medicaid ACO representatives described their experiences entering the VBP contracts in January 2018, and only ACO C talked about discussing template parameters with IME before the negotiation with MCOs. Three ACOs noted a lack of ACO inclusion in the VBP contract development process, as ACO D summarizes, saying, “they run it like a program and I don’t think they think of it as a two-way relationship.” One ACO proposed a more transparent process, saying, “Their [IME] requirements of what MCOs must have in their value based contracts, is public policy. That should be a known set of information to the public. It should also be open to vetting by the public.”

In negotiations with MCOs, three ACOs (A, B, and D) were uncertain of commitment from the MCOs, particularly Amerigroup, saying, “We really haven’t seen much engagement by the MCO’s in terms of wanting to value based arrangement, at least where Medicaid is concerned” and “we don’t feel any confidence Amerigroup’s going to stick with the program” and “when we didn’t just immediately adopt whatever program they [Amerigroup] were offering, then we didn’t hear anything from them for a solid year.”

In regards to the SIM’s role in VBP contracts between ACOs and MCOs, one ACO noted, “SIM really guides some of the path it takes but I don’t think it has a lot of impact on our negotiations with the MCOs …They’re [IME] very sensitive about getting in the middle of a contracting relationship between us and the plan, the provider and the plan.” Another ACO said, of the SIM goals for payment reform and IME’s role in VBP, “I just don’t think they have the bandwidth to really dig in and understand all this stuff… I also don’t think that they’re having a deep enough conversation with the ACOs about what it would look like to get there” This perception is consistent with the Award Year 2 PPC evaluation report, which notes, “The SIM team has primarily worked with the Medicaid MCOs regarding VBP. Effort will need to be made to re-engage the Medicaid ACO providers in VBP discussions and activities.”

**Quality Metrics**

The Quality Metrics section of the report text is summarized in Table 2.

In discussions about VBP methodology, three ACOs agreed that a standardized set of measures across providers would be ideal, but all ACOs critiqued the current standard tool, the Value Index Score (VIS). Three ACOs brought up the prevailing influence of Wellmark on the decision to use the Value Index Score in SIM-affiliated VBP contracts, with one ACO attributing the decision to “Wellmark muscle” and the other two ACO representatives saying, “When you see the Treo guy, the 3M guy, the VP that led the Wellmark work come in and sit as one of the conveners, in one of the [SIM quality metric] sessions, you know it’s done,” and “they were there in force, and they won.”

The four Medicaid ACO representatives were unanimous in their frustrations that the VIS methodology was not transparent due to the proprietary nature of the tool, describing it as a “black box.” All four ACOs found challenges operationalizing the VIS scores to inform practices, saying, “the VIS score does not relate to a meaningful number to physicians,” and “[the VIS is] challenging to understand…to know what levers to push to really move things along,” and “If you’re trying to use [the VIS] to actually impact your own performance, it’s worthless, because it’s very retrospective… No providers think that VIS is the right methodology.” and “Functionally, I would say that I don’t think… that they are having very specific operational direction toward some of those metrics.”
ACOs B and C talked about efforts to gather more information about the scoring methodology and even reverse engineering the scores internally to better understand and utilize the VIS to guide practices (in addition to determining reimbursement), saying, “We keep telling Wellmark, we’d like to have the Ns and the percentages and not just the VIS scores. But they haven’t been producing those reports to this point. So we go in and we produce them through the back end on our own,” and, “We did a lot of pushing to try to get at what are the concrete specifics that drive the VIS score. That was a frustrating effort…So, one of our top priorities is developing our own data infrastructure so we can track our performance on some of those things.”

ACO A compared the VIS to other quality metrics, saying “It’s based on their own formulas, and that really doesn’t make any sense. There needs to be a uniform way that you determine if somebody is a high-risk versus something a company came up with because you just get so much variation, and it’s not how the MCO’s do it. Medicare doesn’t do it that way. Medicare Advantage doesn’t do it that way, and so that feels really off to me.”

ACO D suggested that expectations for the VIS to inform individual practice change may be unrealistic, saying, “I think we get kind of stuck in this conversation that there’s a perfect measurement system, but that perfect measurement system for measuring your outcomes after the fact is not going to be the same measures that can help a physician impact their performance right now.”

Three ACOs talked about how the quality metrics included in the VBP contracts have influenced priorities for care management and process examination. One ACO talked about prioritizing VIS metrics which overlapped with other contracts, saying “[So] we’re not asking physicians to manage patients differently depending on who pays for it.” Specifically, ACO B and D mentioned increased attention to transitions of care metrics (post-hospital admission and emergency department use follow-up), reaching out to newly attributed members, and identifying and coordinating care for patients with chronic conditions (i.e. high-risk). ACO D elaborated, saying “I think when this all started, I think they were very tangible and very actual useful things to focus on…Hospitals have been focused on, to some degree on transitions of care and trying to reduce readmissions for five years or so, so none of that was really foreign. I think what it was helping us do was really dig into the workflows of who’s doing what and how can we report it and how we can routinize it.” Two ACOs described pursuing practices that would impact their VIS score, regardless of clarity, saying “It really wasn’t a big driver. Even though we tried to understand it, it wasn’t a big driver of our strategy. Instead, we said we know what would work well and it did appear to show up in the measurement” and “We were planning to focus on nuts and bolts, sort of more upstream things, like access and transitions, which contribute to your performance on VIS.”
Table 2. Summary of Perceived Strengths and Challenges of the VIS

<table>
<thead>
<tr>
<th>Concept</th>
<th>Number of ACOs (of 4)</th>
<th>Example(s) from Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VIS Strengths</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardization</td>
<td>3</td>
<td>“The idea of having a standardized set of measures ... So we don’t have complete measure fatigue in terms of things to pay attention to and generate data for and all that kind of stuff, there is significant value in there being a state utility for that.”</td>
</tr>
<tr>
<td>Retrospective Insight into System Practices</td>
<td>2</td>
<td>“If you’re using it to measure aggregate outcomes on a looking-backward basis, I think VIS has some good qualities about that.”</td>
</tr>
<tr>
<td>Risk adjusted</td>
<td>2</td>
<td>“We want to be measured on a risk adjusted basis, and that has been helpful... we find value in it because it’s a risk adjusted measurement tool”</td>
</tr>
<tr>
<td><strong>VIS Challenges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclear implications</td>
<td>4</td>
<td>“How do you know how far off you are from getting from a 3.5 to a 3.6 in a VIS score? Because generally you don’t know what that necessarily means. How many patients do we have to touch to make a difference, to raise our score?... from a VIS score you have no concept of specifically what the work is.”</td>
</tr>
<tr>
<td>Medicaid ACO input not seriously solicited</td>
<td>3</td>
<td>“I think they decided what metrics to use before they brought the community together to sign the metrics”</td>
</tr>
<tr>
<td>No practitioner use</td>
<td>3</td>
<td>“Physicians don’t use it in any way at all. At least in [ACO], physicians are hardly aware of their scores. Or understand the system.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Our providers are scientists and they just want to be able to reproduce it ourselves and see whether they’re counting right and all that kind of stuff and it stops way short of being able to do that.”</td>
</tr>
<tr>
<td>Not suited to the population</td>
<td>3</td>
<td>“I really felt the state was very myopic, and those that were doing the work were very myopic when they went to Treo. I just don’t feel that’s the right tool as it stands for Medicaid population.”</td>
</tr>
<tr>
<td>No SDH measures</td>
<td>2</td>
<td>We talked a lot about why aren’t there any social determinants in here [VIS metrics], and [they] basically said, “Well, it’s just too hard. We can’t figure out how to do it. We have to use claims.”</td>
</tr>
<tr>
<td>Relative measure</td>
<td>1</td>
<td>“You can grade yourself in relationship to others. But you don’t know your absolute performance. You know your relative performance.”</td>
</tr>
<tr>
<td>Network level data</td>
<td>1</td>
<td>“We were only getting network level data. So, it was hard to even assign an incentive payment down to the health centers or a specific provider, because we couldn’t drill down the data that far.”</td>
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**VIS Dashboard**

In discussions about the VIS dashboard, representatives from two ACOs noted that they hadn’t had access to the dashboard recently, saying, “Well, it’s not really been operating since May of 2016. So, there’s not been anything to interact with for quite a while” and “Prior to the MCOs coming on board, IME would facilitate regular conversations around VIS performance. But since the MCOs have taken over, there’s been next
to no exposure of the VIS dashboard for purposes of the Medicaid population.” This is consistent with reports from the SIM team, as noted in the PPC’s SIM AY2 evaluation report, “During this reporting period, access to the VIS dashboard was suspended for Medicaid ACOs, and the SIM team anticipates that ACO user access will be reinstated in late 2017, after MCO users have validated encounter data in the VIS dashboard.” One ACO described the curtailment of ACO involvement in the VIS dashboard refreshes, saying, “We keep getting told things are going to be updated and we’ll be a part of it and then every month, it’s been moved on. So, we don’t ask anymore.” As of September 2018, the SIM team reported continued processing issues as a barrier to producing usable VIS scores for Medicaid ACOs.

Each ACO representative talked about how their ACO used the VIS dashboard when they had access to it. All four representatives noted they use the VIS as a tool for aggregate level analysis. Specific employee types who used the VIS dashboard included health system management, health coaches, ACO program managers, and health system staff. Each ACO reported using a separate internal data system to support and track the work of care teams and practitioners. The representative from ACO B elaborated on the unique value of each system, saying, “The core competencies to manage population are not the same core competencies that you need in the office, and as a physician.” One ACO described how they use the VIS dashboard for their Wellmark patient population, saying, “We use it [VIS dashboard] all the time for Wellmark patients. And I use them regularly for Wellmark. I’ve never used the Medicaid one. So the primary users are leadership from a direction-setting perspective of where the opportunities are. Data staff [are also users], in order to pull data and information out of the Treo system so that then the front line care managers can act somewhat on that data.”

Provider Participation and Payment Distribution Practices

Each ACO representative described provider participation in VBP, and related internal policies. All ACOs were proactive in encouraging provider participation in VBP contracts, either through organizational norms, employee requirements, or auto-enrolling and opt-out polices for certain provider types. The representative from ACO A described the expectations for VBP participation at their ACO, saying, “We intend to be in value based with every payer. There won’t be a payer that we just stick with a fee for service kind of arrangement. If we can get into a value based arrangement we’re getting in. That’s just kind of our philosophy.”

All four ACO representatives talked about how payments are distributed internally, with varying methods and priorities. Three ACOs did not directly release incentive payments to providers, but deferred payment distribution decisions to local entities (i.e. individual health centers/facilities). One ACO talked about being in the process of adjusting their current system to enable provider-level incentive payments, as opposed to tracking outcomes at a facility level, but noted internal and external data system limitations, “We traditionally have PCP assignments at the facility level and all of those things. So, moving into that provider realm is new territory for us, and we’ve just been adjusting our systems to operate and to report out in those ways…it was hard to even assign an incentive payment down to the health centers or a specific provider, because we couldn’t drill down the data that far. The systems were not and still really aren’t set up well to do that at even the health plans.” One ACO described their payment process, in which a health center could retain funds for system level use, or distribute to individual providers, saying, “it [payments] went to that entity, that corporate entity, and they would then decide how they were going to spend it, whether they were going to give money back to physicians in the form of incentives, or whether they were going to retain the shared savings to offset their cost.” Another ACO described an internal tier system which determined payments to physicians based on categorical ranking (i.e. gold, silver, bronze) of performance on prioritized claims-based metrics.
SIM Impact and VBP Sustainment

The ACO representatives shared their perceptions of SIM influence on VBP contracting, with three ACOs doubting the direct impact of the SIM on payment reform, noting that VBP is part of the market driven evolution of care, and efforts in this direction predated the SIM. One ACO captured this, saying, “Well just strategically, we have to do this anyhow. Moving towards a value based world is just part of what we recognize is happening on the landscape. That’s why we formed the ACO to start with,” but acknowledged that SIM may have been influential in the state’s contract template development and standardized use of the VIS. In fact, Iowa Medicaid adopted the VIS as a quality measurement tool in 2015, the same year as the Iowa SIM’s development phase. Another ACO suggested that SIM impact was not tangibly evident, saying “I think it’s more of those [VBP] arrangements are taking components of the SIM, and not necessarily mandating all of the different components, but rather picking and choosing to align to the existing contracts in play.”

One ACO did perceive SIM influence in the incorporation of VBP into MCO contracts, saying, “I do not think that the managed-care contracts would’ve included anything like this [VBP] or targets had it not been for the fact SIM existed.”

One ACO representative commented on the likelihood of sustaining VBP, saying “I have concerns about its sustainability, but I guess I have a concern in general, given our experience, about the sustainability about value-based contracting.”

Delivery System Transformation

The next section of interview topics concerned delivery system transformation. The ACO representatives were asked about various SIM-related constructs, including the Statewide Alert Network (SWAN), the Community and Clinical Care Initiatives (C3s), Social Determinants of Health (SDH), Health Risk Assessments (HRAs), Statewide Strategy Plans (SSPs), and population health.

A representative from ACO C perceived a relatively more pronounced SIM presence in the delivery system aspects of the model, compared to payment reform efforts, saying, “Medicaid really set that [payment reform] aside as they were trying to make managed care work. What you saw instead was a greater emphasis like on the C3 things, the C3 communities that the Healthcare Collaborative was working on, and to the social determinants of health component. It seemed a lot more active over in those spaces and the ADT space than it did in driving managed care stuff.”

SWAN

Three ACOs agreed that the SWAN was a promising SIM initiative, with two ACOs noting meaningful participation from statewide stakeholders (specifically, Wellmark through its agreement to use the same vendor for ADTs used by the SIM and the Iowa Hospital Association, and United Healthcare through its use of the SWAN alerts). Three ACOs shared their perceptions of the SWAN’s potential value, with one ACO commenting only on current experiences with SWAN, which have not yet been useful, saying, “In terms of our experiences, there’s not a tremendous amount of value in terms of the data and information that’s been provided, or is being provided by both the SWAN as well as the IHIN.” All four ACOs noted the lengthy process to sustain the ADT data sharing system, which was delayed by interruptions in functionality, with one ACO capturing this sentiment, saying, “the state set goals, but didn’t have the infrastructure.” One ACO did note that while the execution was complicated, it was collaborative, saying, “Even though it was rocky, I will say they were generally responsive. We had feedback on the fields that we were getting and all of that kind of stuff, and they did try to accommodate it to make it work in our systems.”

The three ACO representatives talked about the potential value of the SWAN, including:
• improving access to patient information and data about health care interactions outside of their systems,
• more timely patient event notifications than claims-based notifications,
• improving transitions of care, and
• eventual lessening of administrative and IT burden.

As ACO D stated, “it’s [SWAN] a good idea because it has information that we otherwise don’t have about where people are going other than via claims which is way too late to do anything about it.” One ACO representative mentioned particular value of ADT alerts assisting performance in the VBP realm, noting SWAN data overlap with the VBP quality metrics included in contracts with MCOs, saying, “For us, our [VBP] measures with United, two of them were transitions to care, inpatient and ER, and you were just shooting blind without that data.”

However, these strengths of the SWAN came with caveats, meaning interviewees acknowledged that experiences with the implementation of SWAN have not yet met their full potential, mainly due to unwieldy integration of SWAN data into their internal systems and incomplete participation from all hospitals in the state. With regard to data integration, three ACOs described issues operationalizing SWAN alerts into their workflows, because the data received requires manual adjustments, due to incomplete data (filling in missing fields) and integrating it into internal EHR systems and workflow. Two ACOs described the issues encountered with SWAN data, saying, “It was taking us a tremendous amount of work to kind of manually parse it and load it into our systems” and “Almost all of the fields are empty, so I can’t look at a SWAN report today that tells me why they [the patients] went, and so I have to backtrack through any kind of record that we might have with in our system to try to figure out why the patient was sent.”

ACO D described the needs of providers in order to operationalize the SWAN data, saying, “Healthcare providers just really don’t have the time or bandwidth to have a bunch of other systems in front of them, and so in order to be most effective, we really need to get all this data implemented inside the EHR workflow, where all their other work is, where all of the other clinical documentation is, where the whole record is. That’s currently still fairly challenging to get this inside the EHR in a way that the data can be manipulated, inside the EHR so that it can be moved around the EHR in a way that can then be acted on within people’s customary work.”

All four ACOs talked about limitations with the SWAN regarding participation, noting the value of the system was diminished without the inclusion of data from all of the hospitals and all patient populations. As ACO A explains, “where the value of SWAN is that you can see everywhere that the patient went as long as that hospital is uploading.” ACO B noted inconsistencies between the volume of SWAN alerts and Medicaid MCO reports based on claims, saying “There’s pretty sizeable gaps of notifications when it comes to reports that we receive from the Managed Care Organizations, versus the number of alerts that we’re receiving via the SWAN.” ACO B attributed some of these discrepancies to the SWAN’s current inclusion criteria of statewide hospitals (missing out-of-state claims) and narrow scope of patients (Medicaid members only). ACO A addressed the lack of levers used to expand SWAN participation within the state, saying “Voluntary doesn’t work in this day and age. We’ve got way too much administrative burden as it is, and so to have something that potentially like SWAN could be really effective, but when you have a community where not everybody is uploading you really can’t use it.” Three ACOs noted that without full hospital participation, SWAN reports were duplicative of information in internal systems.

Three ACOs talked about their systems’ participation in the SWAN, with two reporting full participation of affiliated hospitals (uploading patient lists monthly and receiving daily reports). One
ACO noted that participation was determined at the facility level, so some hospitals had opted-out, and described their experience forgoing SWAN participation, saying “they had to develop their own communications with hospitals and I think it’s been not ideal and pretty labor intensive.” Two ACOs talked about ties to contracts with payers to use the SWAN, with one saying, “we’re participating more along the lines in terms because we’re required to, under the MCO value-based arrangements.” One ACO noted that the nominal cost of engagement in the SWAN was an incentive for participation.

Three ACOs talked about how the SWAN data was used or intended to be used within their systems. Two ACOs reported that SWAN reports are received at the ACO level, then distributed to each facility, and in one case, to the level of care teams. One ACO described intentions to distribute the SWAN reports to affected facilities, but encountered barriers in execution, saying, “Every day, somebody had to go in and pull down this report and then we had to segment it into each health system or we were going to try to put it into [their health care IT system], but we had a lot of implementation issues with using it...I heard a lot from our data folks of there being a lot of challenges with trying to use it, and a lot of it was pretty manual.”

Along with suggestions for improvements described earlier (standardize data reporting, improve compatibility with IT systems, and expand hospital participation and eligible patient populations), three ACOs wished to see improved timeliness of reports. The ACOs talked about usefulness in shortening the day-delay of receiving reports, and one ACO also commented on operationalizing the reports faster internally. Also, ACO A elaborated on the need to include analysis in SWAN reports which could prioritize high risk patients, saying, “I’d want to see somehow in that SWAN report that was a really high-impact patient. I’d like to see a risk score on that patient right in the SWAN, and so what I would know then is instead of getting a list of 300 patients every single day, and sorting through it I might be able to pick out the 30 patients that are the most impactful patients.”

Three ACOs shared perceptions of the sustainability of the SWAN, with two ACOs predicting that it will continue beyond the SIM, and the other saying that their organization’s continued participation would be evaluated at that time. One ACO based their expectation for the continuation of the SWAN on Wellmark’s influence in the state, saying “the SWAN stuff is definitely a SIM initiated thing that I think is going to continue. If Wellmark gets behind it, there ain’t no question [the SWAN will continue].”

Community and Clinical Care Initiatives (C3s)

As noted in the ACO Role section, all four ACOs described supporting the C3 initiative at a regional level (i.e. ACO affiliated clinics lead involvement in C3 regions). Two ACO representatives reported the ACO had an indirect, supporting role for clinics involved in C3s, and specifically mentioned providing guidance, fulfilling data requests, and creating reports at the request of C3 sites. The remaining two ACO representatives were on opposite ends of the knowledge and involvement spectrum, meaning one reported high involvement with the C3, and the other had little information to offer.

Two ACOs talked about limited ACO level involvement with the C3s due to a lack of compatibility with their data systems and variation across C3 sites, along with a reluctance to modify their systems or adopt the C3 data systems in order to participate more fully in a short-term project. The two representatives elaborated, saying “the C3 program is using a different system than the one we use. So it doesn’t integrate with what we’re doing...we don’t want to set up our teams on a new data system for one program” and “So for us to build something just for Dallas [Dallas County Public Health], we can’t do that. To build something just for Cedar Rapids [Linn County Public Health], we can’t do that. So not having some kind of
synergy or similar operational approach clinic to clinic is really what makes it difficult because then what we have
to do is revert to a paper process within the clinic to customize that for a single county.”

Three ACO representatives shared their perceptions of the sustainability of the C3s. All three ACOs
acknowledged the need for continued funding, saying, “As soon as the funding’s gone, I can’t imagine it’s
going to continue,” and “It all depends on how much money they get to be able to sustain it.” The third ACO
suggested systematic changes to payment reform are needed to truly sustain the work of the C3s, as
opposed to continually applying for short-term funding, saying “That’s what I think part of the whole C3
and SIM and everything is there has to be a payment method that supports these activities or people can’t afford
to do it.” One representative did note the variation in maturity and diverse funding streams of the C3s
as a major sustaining factor, saying of a well-established site, “They [C3 site] combined staffing. They built
a consortium, leveraged their Title V block grants. They did all kinds of things that sort of weaved and braided
the services together, so that not any single county was solely dependent on [having to finance things.]” One ACO
commented on the difficulty of building partnerships across clinical and public health sectors, saying
“They’re doing some really good work, but it has been really difficult to get the value proposition to the clinic for
the county [public health] agency... It’s just been rough going.”

Disclaimer: The next four paragraphs are data from one source and therefore the sentiments expressed
are not necessarily representative of the group’s [all four ACOs] knowledge or involvement in the C3s.

One ACO talked about the ACO’s role in contributing to and automating the data collection required
by C3s, saying, “I was able, by getting in on that conversation, able to get a single upload going in. We didn’t
use the portal doing a direct upload, and that saved us a ton of work, and it took care of all six of the C3s. So any
of our clinics that are on a border or in a county that has a C3 are now uploading all of the NQF measures all at
once.”

One ACO representative commented on the intent to duplicate the C3 model and need for
standardization across sites, saying, “Really varying levels of sophistication and experience, and very, very
different from region to region as to how they awarded those C3s and what the C3s decided to emphasize. So,
again, in my mind way too much variation...How do you duplicate something with that much variation? And I
don’t believe you do that around a disease state like diabetes. You do it around building a health IT infrastructure
that really works, and works well so people want to use.”

One ACO commented on the shift in focus from social determinants of health [SDH] to diabetes for the
C3s, saying, “I mean they built [on SDH focus] for a year-and-a-half and so I thought that was really disruptive
to solidifying the role of C3s and addressing the social determinants that our patients had.” This representative
perceived the redirection as a missed opportunity to address underlying causes behind disease states,
and noted added difficulty completing referrals because of the narrowed scope, saying “While we see
diabetics in the hospital, it’s rarely that it’s the diabetes itself that brought the patients there. It’s [diabetes]
usually a secondary [condition], and yet when I see now what’s happening with the C3s, and all this work around
diabetes, and what are we going to do about diabetes?, I understand why they did that, but yet that’s not why
patients are necessarily going to the emergency department or having an avoidable admission to a hospital... it’s
been very, very hard to get specific diabetic referrals for the C3 out of the clinic into the SIM.” Prior to the shift
to focusing on diabetes, one representative suggested the MCOs may have disrupted C3 care
coordination development, saying “Then having the MCOs structure, which said, “No, we’re going to
arrange for transportation. We’re going to address social determinants. We are going to do this,” when in fact
they didn’t have the maturity to do it. Didn’t have the network.”
One ACO commented on successes observed in the C3 work, specifically noting strong partnerships, clear role definition, local coalition building, efficient care coordination, and sustainability planning.

**Health Risk Assessments (HRAs)**

Three ACOs talked about utilizing Health Risk Assessments (HRA) to assess population and patient needs, with one ACO reporting using a mapping tool instead. Of the three ACOs using an HRA to some extent within their organizations, one reported regular administration, documentation of results, and use in care management (both individually and aggregate) saying, “We have assessments that we do, including the social determinants of health assessments at some of our health centers, that does integrate with our [Electronic Medical Record] EMR and that we utilize for a variety of purposes, both at the point of care and in the way that we partner with community organizations… we’re going to use that for re-stratification and care plan purposes.” The remaining two ACOs using an HRA reported little consistency or formality in instruments or application of tools across clinics. One ACO reported the lack of data system integration as a barrier to operationalization, saying, “We don’t have a formal Health Risk Assessment. I suppose we have them scattered here and there. We don’t have any organized Health Risk Assessments that automatically feeds into our data systems.” Another ACO cited more urgent demands as interfering with a commitment to HRA development, saying, “What we were trying to do is trying to really focus on the things that were going to lower total cost of care and the downstream impact of a health risk assessment is very long-term, we only had so many resources to focus on implementation.”

Three ACO representatives were familiar with the HRA tool promoted in the SIM, Assess My Health (AMH). All three ACOs reported difficulties in using the data collected in the AMH to inform care management, mainly due to receiving the data in an incompatible format. ACO C described the process, saying “Assess My Health is not a helpful tool for us. Some of our patients do complete those assessments but that information gets sent into IME, I think, or some centralized entity and then it comes back as a [Portable Document Format] PDF, which means it doesn’t integrate into our electronic medical records. So, we’re not a big fan of that system. In fact, I think it’s pretty useless from a provider perspective…it doesn’t help in the providing of care because, there’s no way that data gets back to help the care team at all.” ACOs A and B reported similar experiences with AMH, saying, “we wanted to use it [AMH], we tried, we just couldn’t get it integrated into what we did,” and “If you did a health risk assessment, that data was being aggregated for the use of the payer or the use of the state, but we weren’t getting that information back in a meaningful way.”

**Social Determinants of Health (SDH)**

All four ACOs acknowledged the impact of social determinants of health (SDH) on healthcare access and health outcomes. Three ACOs were actively assessing and using SDH factors to inform care management on various scales and intensities, with the fourth ACO reporting little tangible progress in the area due to limitations in resources and infrastructure support, saying “the fundamental issue is that until there is a change in the payment methodology and there is some way to financially support the people it would take to do that, I do not see it happening.” One ACO reported a grant-funded three year pilot project in two clinics which supported community health workers to administer universal SDH screenings and connect patients with community resources, but noted compiling a “directory of social determinant type resources” prior to the grant. One ACO reported routinized collection of SDH data through health risk assessments, which subsequently informed population health and individual care strategies. The third ACO active in SDH data collection used geographic data to better understand patient population SDH needs, including identification of food deserts, transportation inadequacy, and low income areas. The two ACOs employing SDH screening tools noted data compatibility (SDH data integrated with their
data systems) as a facilitator for workflow integration, and one noted the concise nature (8 items) of their tool as an important factor for easing implementation.

One ACO noted underutilization of SDH data sharing from public health departments, and expressed a desire to identify patients with SDH needs based on eligibility for state assistance, saying, “The state knows every patient that’s in [an assistance] program. So how do we get that back out to a provider so that we don’t have to go out there and find it separately? [Iowa Department of Public Health] IDPH already knows it.”

As mentioned in the Quality Metrics and SIM Learning Collaboratives and Workgroups sections, two ACOs mentioned advocating for the inclusion of SDH metrics in VBP performance measures, and one ACO reported involvement in the SIM-led SDH workgroup. One ACO perceived little progress during the SIM in adequately addressing SDH, saying, “Yeah, I still think the challenge is really understanding how to measure and report social determinants. I just don’t see it.”

**Population Health**

All four ACOs were knowledgeable about population health related concepts, and ACO C was actively engaged in enhancing capacity in clinics to analyze population health needs and outcomes, and promoting preventive care practices. A representative from ACO C described their approach to population health and how its realization would be contingent on a cultural shift, saying “We’re on the horizon to figure out how eHealth figures into that [population health] and what kind of capacity we have to build to be able to do stuff more population health and to have the analytics and capabilities to look at more than what just happened in your clinic...So, some of that population health view, we can have it at the network, but until it starts getting ingrained in the cultures, the perspectives and landscapes, you’re not going to get there.” The other three ACOs spoke to the gap in competencies between the medical and public health sectors, and the differences in resources, motivations, and priorities, with two ACOs saying, “that’s one thing I would look at, is really understanding how do you risk and categorize the populations versus risk and categorize them against disease states.” And “we don’t look at populations from a public health type viewpoint. We look at it from the viewpoint of medical categories and conditions.”

ACO D talked about workforce capacity for tackling population health, including defining roles and recalibrating workflows, saying there is a need to “focus around current workforce, who’s doing what, routinizing and standardizing that and then tying that to an agreed-upon risk profile of who we were trying to impact.”

Only one ACO mentioned IDPH’s Statewide Strategy Plans, which the SIM encourages the use of, saying “Honestly, we don’t take out the state wide care coordination strategy and make sure it aligns with what we’re doing. We do what we think we need to do.”

**Technical Assistance (TA)**

Two ACOs mentioned the role of Iowa Healthcare Collaborative (IHC) in the SIM. One ACO reported IHC preferred to work with larger systems, so relatively smaller systems were overlooked for collaboration. Another ACO perceived that IHC’s involvement in the SIM sidetracked the SDH focus, saying, “for about a year there we got off track and we were thinking more about hospital safety measures than really the social determinants that we needed to address.”

One ACO was familiar with the Iowa Primary Care Association’s SDH technical assistance tied to the SIM.
SIM Impact regarding delivery system transformation

Like VBP, the experiences with SIM’s delivery system transformation efforts varied by the size and capacity of the ACO, as one ACO described, “I can’t speak to the other large systems, but I would suspect there that the work that the SIM is doing, and I get all the emails, I see all their programs. And it’s all duplicative of stuff we already have done or are doing. And the other large systems I imagine are in the same boat. So the value might be some small, independent groups, or critical access hospitals not affiliated with a large system.”

Another ACO representative commented on the SIM’s role, specific to delivery systems in ACOs, saying, “My gut is that it [SIM] doesn’t influence. It has just provided us with a resource and a focus to react to the changing environment.”

One ACO representative talked about efforts to coordinate across systems and sectors, saying, “I think there has been an attempt to do some standardization of language, terminology, how we talk about things, social determinants of health, care coordination, that kind of stuff. I’m not sure to what extent that’s really stuck.”

Communication and Engagement

SIM Staff Relationships

As mentioned in the Stakeholder Dynamics section, all four ACOs reported infrequent and “sporadic” involvement with the SIM staff, with two ACOs noting more involvement when they were contracting directly with the state (prior to Medicaid Modernization). When asked about SIM staff relationships, two ACOs were uncertain, as one replied, “Who is SIM staff?” and another reported, “we’ve had no contact with healthcare collaborative [IHC] or Public Health [IDPH] nor any of those folks that I understand received funding.”

One ACO reported receiving regular updates and positive experiences interacting with SIM staff, saying, “they keep sending us all the information, and we can get it. We’ve had connections there. If I wanted to talk to someone about some programs…They’re very responsive and helpful. I think their communication, it’s fine.”

Another ACO reported less positive experiences, and described meetings in which ACO feedback was solicited, but not acted upon.

Two ACOs expressed desire to be involved in SIM (or any statewide initiatives) planning, saying “we participate as much as we are invited or nose our way into some of the conversations around what those parameters might look like or initiatives might look like, whether it’s contracting or whether it’s support for infrastructure development.” The other ACO representative added an appeal to maintain organizational autonomy in implementation, saying, “we want to have input if they’re going to design anything like new metrics, incentive programs, we’d like to have some input on it so we can hopefully have, once developed, that we can build into our own systems. But we’re not looking for the state to provide systems for us.”

Successes

Despite criticisms about the contracting process and metric selection, three ACOs talked about the inclusion of standardized of quality metrics in VBP contracts across payers and systems as a SIM success.

Two ACOs noted the value in inclusive statewide conversations about SDH, which raised awareness and broadened the definition of quality care, as one ACO representative described, “The SIM gave a platform. One of its most important functions is that it gave everybody in the state a platform to talk about things like how do we address social determinants? It brought a focus on how our community should convene, and they
should talk about these hard issues. Nobody was doing that before, and it set an expectation that the best kind of
care was partnering with folks on the ground in the community. A recognition that patients don’t live in a clinic,
they live in the community. Everybody has a role. How do you convene that community and whether the health
system did it or the counties did it or the C3 awardees did it, didn’t really matter. They were conversations that
needed to happen. Honestly, that in itself is of enormous, enormous value.” Another ACO shared a similar
sentiment, describing the value of the SIM in its foundation of ongoing cooperation amongst health
stakeholders in the state, saying, “Well, to the extent, I would not say it’s currently very much of a factor but I
think, the framework that was set to start with, certainly helped everybody have a vision of what could be possible
working together. So, I wouldn’t dismiss it as not having had anything to do with where we’re at. You don’t feel
it very much today I would say.”

One ACO noted the value of laying the groundwork to share ADT notification across the state through
the SWAN as a success, saying, “If there’s one thing that came out of the SIM, I think it has recognized the
value of doing that [SWAN] and created the momentum for that to continue. I think for sure it’s going to
continue.”

One ACO was satisfied with receiving payments, saying, “We’ve gotten some Medicaid payments. That’s a
success for us.”

Challenges

All ACOs perceived the SIM engagement with ACOs as being perfunctory, as one ACO described, “I
just don’t think they really understand what it really means from the perspective of the ACOs and why would
they, right? I mean, I don’t think it’s fair to expect that they would, but I don’t think that they engage enough in
a conversation beyond surface level”

Three ACOs talked about shortcomings in the state’s health IT infrastructure as a functionality
challenge for sharing data, as one ACO captured, saying, “there’s a lot of just data, technology,
infrastructure, workflow, standardization opportunities that are incredibly difficult.” One ACO acknowledged
the challenge of standardizing across established and varied IT systems in the state, saying, “it’s very
difficult for us to integrate the statewide things designed by committees into our system. We need things designed
for our system, our IT systems, our care management systems.”

Two ACOs identified the unclear direction and eventual goals of the SIM as a challenge, saying “Well,
my challenge is understanding what their goals are. So I think they’re in search of a reason to exist. And so I
guess that would be the biggest challenge” and “What that future looks like for all of these entities is an
unknown. Like what are we working toward? Are we working toward provider agreements on behalf of our health
centers and someday, centralized billing systems? I don’t know. That’s yet to be defined.”

One ACO described issues applying underdeveloped SIM initiatives, saying, “I’ve just found that the
things that the SIM has wanted to do have either been immature or inadequate for what you really need to have to
actually do an intervention.”

One ACO perceived unnecessary complication in SIM planning, saying, “I think sometimes perfection
becomes the enemy of the good and there’s a lot of basics we need to work on and if Medicaid would decide what
are those basics we need to work on, and then tie a little bit of dollars to those, I think you could get a lot more
success than you might think.”

One ACO described SIM activities as shortsighted, with little demonstration of progress towards
overarching goals saying, “They’ve done nothing about what MACRA actually requires in order to be an
advanced alternative payment model three years from now.”
Key Takeaways – Medicaid ACOs

Differing Experiences/Impact of SIM depending on circumstances

The utility of SIM activities and tools differed across ACOs, depending on organizational characteristics like size, internal infrastructure capabilities, and patient population.

Areas of consensus

- SWAN needs full participation to be effective
- ACOs are not sufficiently involved in decision making and planning of policies and programs that their organizations are impacted by and/or compelled to adopt
- Wellmark has gratuitous influence on SIM direction
- Challenging to operationalize the VIS and HRAs
- SDHs have a great effect on patient and population outcomes, and should be a priority for integration into care delivery and quality measurement
- The SIM vision is unclear

Roundtable Impact

The Roundtable was being ramped up and reintroduced during the time period of the MCO interviews and because no Roundtable meetings had occurred by the time of the MCO interviews, the evaluation team did not ask the MCOs about the Roundtable. However, there had been at least one meeting of the Roundtable by the time of the first ACO interview. In summary, the Roundtable is an opportunity to engage ACOs; but meaningful, collaboratively conceived deliverables are needed to have an impact.

General Fragmentation / Initiative Fatigue

Numerous contracts, tools, practices, priorities, data systems, and initiatives complicated ACO participation in the SIM and standardization efforts.

Lacking infrastructure to achieve payment reform and delivery system goals

Infrastructure issues, like incompatibility across electronic systems and underdevelopment, limited the capacity to implement SIM initiatives and utilize SIM tools. Infrastructure limitations were mentioned as barriers in efforts to advance VBP, SWAN, HRA, SDH, C3, and population health. High quality, statewide infrastructure investment and development was a potential missed opportunity in the SIM.

Expectations to work across sectors and with competitors are difficult to meet

It may not be a realistic expectation for health systems to provide comprehensive medical and public health care, because integrating population health metrics requires specialized tools and competencies which are not developed in the current workforce and infrastructure.

Value Based Purchasing has buy-in

ACOs believe payment reform is an effective method to incentivize performance improvements and lower costs of care provision.
Addendum. Interviewee Invitation

I am writing as a member of the Iowa State Innovation Model (SIM) state-led evaluation team from the University of Iowa Public Policy Center. You were identified by the SIM staff from Department of Human Services [DHS] as a key contact who would have the most knowledge about the SIM activities as they relate to the [MCO/ACO].

As part of our evaluation, we would like to interview people in your organization who have insight about interactions between the [MCO/ACO] and the SIM. See the attachment for an outline of topics we would like to cover in the interview.

The focus of the evaluation is the State Innovation Model. We will not use your name or personal information in the report. The interview data will be used to inform how organizations interact with the state of Iowa on SIM-related activities and implementation of SIM goals.

I would like to schedule an interview (about 1 hour in length) as soon as possible with you and anyone you wish to include at a time that is convenient for you. The SIM team provided us with your contact information, but if there are other people from your organization who should be included in the interviews, please forward this e-mail to them and copy me.
Addendum. Payer Interview Script

I. The State Innovation Model (SIM) goals
   • What is your organization’s understanding of the goals of the State Innovation Model (SIM) in Iowa?
   • What are your organization’s contractual obligations (if any) with IME or DHS, specific to the State Innovation Model?

II. Value-Based Purchasing (VBP)
   • Does your organization have specific value-based purchasing activities related to the SIM?
   • Can you tell us about any other payment models or methods for payment reform your organization uses?
   • How does your organization work with Medicaid ACOs to support SIM goals?

III. Quality Measurement – Value Index Score (VIS) and more
   • Does your organization use the VIS Dashboard? If so, how is VIS dashboard information used?
   • Does your organization use any other types of performance metrics to incentivize providers?

IV. HIT and the Statewide Alert Network (SWAN)
   • Does your organization participate in the SWAN? If so, how?
   • How does your organization use the data gathered and reports provided by the SWAN?

V. Community and Clinical Care Initiatives (C3 Communities)
   • Does your organization work with the C3 communities with their activities related to the SIM? If so, what role does your organization have in that community context?

VI. Interactions with the SIM
   • Has anyone from your organization been asked to or is involved in any SIM workgroups? If so, which one(s)? What is your organization’s role in these workgroup(s)?
   • How often does your organization interact with the SIM staff? How satisfied is your organization with the amount of interaction with SIM staff and SIM workgroups?
   • What are the biggest challenges/barriers your organization experiences with being able to achieve the goals of the SIM?
   • Are there any particular goals or successes that your organization has been able to realize because of its involvement with the SIM?
   • Is there anything else I should know about your organization’s involvement with SIM activities?
   • Can we e-mail with follow-up questions if we have any after we review our notes?
Addendum. ACO Interview Script

I. General SIM
   • What is your understanding of the goals of the State Innovation Model (SIM) in Iowa?
   • What role does your organization have in working with the SIM to achieve those goals?
   • Do you have contractual obligations with IME, DHS, or one or more of the Medicaid MCOs that relate to the goals of the SIM? If so, can you tell us with which entities and how you see the SIM goals reflected in those contracts?
   • Has anyone from your organization been asked to or is involved in any SIM workgroups? If so, which one(s)?

II. Value-Based Purchasing (VBP) and Quality Measurement (including VIS)
   • [If they haven’t already identified VBP earlier]. Can you tell us your understanding of value-based purchasing?
   • Does your organization have specific value-based purchasing activities related to the SIM?
   • How does your involvement with the SIM influence your VBP activities? In other words, as a result of your involvement with the SIM, would you characterize your VBP activities as a) about the same as before the SIM, b) more intensive than before the SIM, or c) less intensive than before the SIM?
   • How does your organization work with Medicaid MCOs to support SIM goals with regard to payment system reform?
   • Is your organization familiar with the VIS Dashboard?

III. Delivery System Reform (includes HIT and SDH)
   • What is your understanding of how the SIM is influencing Delivery System Transformation in the state of Iowa?
   • How is your organization involved in delivery system transformation efforts in Iowa?
   • What type of HIT does your health system use?
   • Does your organization have strategies in place to reduce potentially preventable hospital readmissions and/or ED visits? If so, what are they?
   • Does your organization participate in the Statewide Alert Network (SWAN)?
   • Is your organization familiar with Community and Clinical Care Initiative (C3s)?

IV. Population Health
   • Does your organization collect data from your members using a Health Risk Assessment? If so, what HRA do you use? How does your organization use the HRA data it collects?
   • What kinds of policies does your organization implement to promote population health?

V. Communication
   • How often does your organization interact with the SIM staff? Is the communication between your organization and the SIM satisfactory?
• How does your organization perceive the SIM to impact outcomes for ACOs? Payers? Providers? State of Iowa? Members?

• Is there anything else we should know about your organization’s involvement with SIM activities?
C3 Care Coordination Statewide Strategy Analysis

In June of 2016, the Iowa Department of Public Health published its “Care Coordination Statewide Strategy” (Source: https://idph.iowa.gov/SIM ). The mission of this statewide strategy was to, “Establish coordinated patient care as the standard in Iowa” while the vision was, “By 2019, improve patient outcomes and experiences through coordinated delivery of healthcare and community services in the right order, at the right time, and in the right setting.” The strategy included four goals, each with objectives (13 total) and related tactics (51 total) to reach the objectives. Using this strategy document, a strategy matrix was developed to document and track each of the C3’s work on each of the tactics. The statewide strategy and the matrix is in the Addendum. The matrix included each of the tactics by objective and goal along with columns to report the status for each of the tactics: 1) no activity, 2) planning underway, 3) developing, 4) implementation initiated/underway, 5) complete and/or fully operational or 6) not applicable and/or not intending to implement.

In September 2016, April 2017, and April 2018, C3 project staff from each C3 completed a matrix except for Muscatine C3 who completed their first matrix in April 2017. This part of the evaluation work was conducted and compiled by Rural Health Solutions in coordination with the UI PPC.

Comparing baseline matrix reports (September 2016) from all C3s with year-end (April 2018) reports, there were two tactics with little to no change in status of the strategy with three to seven of the C3s having no change or a decline in status. This is a decline from 18 tactics when compared to 2017 findings. In 2018, there was an increase in the number of tactics and C3s reporting a tactic as “not applicable and/or not intending to implement”. Linn County, Sioux County, and Muscatine C3s all reported tactics that are not applicable and/or not intending to implement. Dallas County C3 identified two tactics in 2016 as not applicable and/or not intending to implement but reported them as planning or developing in 2018.

Tactics that C3s continue to report as “planning underway” include:

- 1.1a Establish person and family engagement (PFE) as a standard of care through inclusion practices at the direct level of care through leadership/administration (Muscatine);
- 1.1b Establish patient-centered care planning inclusive of patient and provider shared-decisions around care, treatment, and self-management (Great River);
- 1.2c Designate defined care coordination roles and/or responsibilities with the clinic, practice, or organization (Muscatine)
- 1.2d Promote collaborative provider relationships and team-based care practices, both within and among care settings (Great River);
- 1.3b Identify available assistance within the community and establish points of contact to enable resource sharing and referral (Muscatine);
• 2.1b Develop and maintain protocols and processes to facilitate reciprocal care communication among care teams members, setting expectations for reciprocal communication and closer of referral (Muscatine);

• 2.1f Incorporate involvement from non-clinical support systems as part of a whole-person-centered care model, including community-based services (Muscatine);

• 2.2b Use available EHR and data systems, such as registries, to identify and target high risk or at-risk patients for targeted care coordination and support (Muscatine);

• 2.2c Encourage use of EHR patient access or patient portals to facilitate direct availability and inclusion of information by patients and caregivers (Muscatine);

• 2.2d Promote transparency of relevant and necessary patient care information across appropriate healthcare settings to facilitate optimal care planning and delivery (Great River);

• 2.3a Create and maintain policies for patient-centered care practices across team settings, emphasizing inclusive team-based care, shared-decision making, and patient activation strategies (Great River and Dallas County);

• 2.4b Explore mutual support and sustainability strategies with the payer community to optimize care coordination efforts and resource utilization (Linn County, Great River, Sioux County, and Muscatine);

• 2.4c Champion streamlined processes for closed-loop referrals with clinical site, payers, and community-based services (Great River and Muscatine);

• 3.1c Establish referral and reciprocal communication for closed-loop referral processes between and among clinical providers and community-based services (Great River and Muscatine);

• 3.2a, 3.2b, 3.2c, 3.2d – Advance patient centered care practices (Muscatine);

• 4.1a Encourage full use and optimization of EHR capacities to facilitate collection and capture of patient population health status and care coordination processes (Dallas County and Muscatine);

• 4.1b Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes (Great River and Dallas County); and

• 4.1c Promote cross-systems access and communication among team members and service providers to encourage comprehensive person-centered coordination of care (Great River and Muscatine).

Considering changes in the status of the 41 tactics from baseline to year-end 2018 for each of the C3s, advances/changes were made by all C3s and are summarized as follows:

- **Webster County C3** reported the most tactics “complete and/or fully operational”. Nineteen tactics were reported as “implementation initiated/underway” and 22 were
reported as “complete and/or fully operational”. This is a significant change when compared to 2017 when no tactic was reported as “complete and/or fully operational”. Considering all tactics, from baseline to 2018, Webster County C3 reported advancements in all but 12 tactics. These tactics continue to be reported as “implementation initiated/underway”.

- **Linn County C3** reported movement in all tactics except for five, a significant change when compared to 2017 when all remained the same except for three tactics. Three tactics continue to be “complete and/or fully operational”, including: 1) disseminate and promote evidenced-based best practices for provision of best quality care, including diagnosis, treatment, and management, 2) increase awareness and addressing of health literacy, including the use of patient conversation resources, such as Teach Back and Ask Me 3, and 3) identify available assistance within the community and establish points of contact to enable resource sharing and referral. One tactic: “Establish person and family engagement as a standard of care through inclusion practices at the direct level of care through leadership/administration”, moved from “complete and/or fully operational” to “implementation initiated/underway”. Three tactics moved from “planning” in 2016 and 2017 to “no activity” in 2018: 1) Encourage involvement of team member participation in care services in alignment with highest scope of practice; 2) Promote the use of evidence-based team development and improvement practices, such as TeamSTEPPS, to ensure team execution and efficiency in patient care and safety; and 3) Align payer-supported educational strategies with prioritized evidence-based practices for patient-centered care and coordination of services. Of all the C3s, Linn County is second in its number of tactics (5) it reports as “Not applicable and/or not intending to implement” and all of these moved to this designation in 2018.

- **Marion County C3** reported the largest number of tactics progressing with 33 advancing from baseline to year-end 2018. They also reported a decline in the number of tactics completed (10 in 2018 vs. 14 in 2017), including: 1) Promote the use of available HIT resources to allow mutual access to patient care information from all appropriate members of the patient care team, i.e., Iowa Health Information Network (IHIN), shared electronic health records (EHR) view and messaging functionalities; 2) Use available EHR and data systems, such as registries, to identify and target high risk or at-risk patients for targeted care coordination and support; 3) Identify and engage available and existing clinical and community-based service stakeholders; 4) Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes; and 5) Promote cross-systems access and communication among team members and service providers to encourage comprehensive person-centered coordination of care. In all instances these tactics moved to “implementation initiated/underway”. Marion County
C3 did not report any tactics with “no activity” or “not applicable/not intending to implement”. They have no tactics with “planning underway” a change of three when compared to baseline.

- **Sioux County C3** reported 23 tactics advancing from baseline to 2018, an increase from 15 in 2017. At year-end, Sioux County C3 reported seven tactics as “not applicable and/or not intending to implement.” Twelve tactics had no change in status from baseline to 2018, 11 of these are reported as “implementation initiated/underway”. Sioux County C3 reported five tactics moving from “implementation initiated/underway” at baseline and 2017 to “complete and/or fully operational” in 2018.

- **Dallas County C3** again reported the greatest number of tactics declining from baseline; however, much of this continues to be attributed to the significant statewide C3 requirement changes made in 2017. Three tactics continue to be in the planning stage: 1) Create and maintain policies for patient-centered care practices across team settings, emphasizing inclusive team-based care, shared-decision making, and patient activation strategies; 2) Encourage full use and optimization of EHR capacities to facilitate collection and capture of patient population health status and care coordination processes; and 3) Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes. Dallas County C3 also had the second largest number of tactics “complete and/or fully operational” when compared to all seven C3s – 12 tactics - this includes nine tactics that advanced from 2017 to 2018.

- **Great River C3** reported no change in 18 of the tactics from baseline to 2018, the most of all C3s. Nine tactics continue to be in the planning stage: 1) Establish patient-centered care planning inclusive of patient and provider shared-decisions around care, treatment, and self-management; 2) Promote collaborative provider relationships and team-based care practices, both within and among care settings; 3) Promote transparency of relevant and necessary patient care information across appropriate healthcare settings to facilitate optimal care planning and delivery; 4) Create and maintain policies for patient-centered care practices across team settings, emphasizing inclusive team-based care, shared-decision making, and patient activation strategies; 5) Explore mutual support and sustainability strategies with the payer community to optimize care coordination efforts and resource utilization; 6) Champion streamlined processes for closed-loop referrals with clinical site, payers, and community-based services; 7) Establish referral and reciprocal communication for closed-loop referral processes between and among clinical providers and community-based services; 8) Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes; and 9) Promote cross-systems access and communication among team members and service providers to encourage
comprehensive person-centered coordination of care. Great River C3 continues to have no tactics reported as “not applicable and/or not intending to implement”, they no longer have any tactics with “no activity”, and they have no tactics reported as “complete and/or fully operational”.

- **Muscatine C3** reported its baseline data for all tactics in 2018 because this was its first year of Iowa SIM C3 funding. Baseline data indicates two tactics with “no activity”, 16 tactics in the “planning” phase, 12 tactics “developing”, three tactics with “implementation initiated and/or underway”, and seven tactics “complete and/or fully operational”. Muscatine also reported one tactic as “not applicable and/or not intending to implement”: 1) Promote the use of evidence-based team development and improvement practices, such as TeamSTEPPS, to ensure team execution and efficiency in patient care and safety.
Addendum. Care Coordination Statewide Strategy and Matrix Instrument

The care coordination statewide strategy can be found here https://idph.iowa.gov/SIM but is also included as an attachment to this document entitled "Care Coord State Strategy, Final_06_01_16"

The matrix instrument used to collect the data from C3 staff is on the following pages.
# Care Coordination Statewide Strategy - Annual Status Report

**DATE:**

**C3 Site**

Check the box that applies to your C3's CURRENT Status

<p>| Goal 1. Ensure coordination of services at the primary point of care | Status of Strategy |
| --- | --- | --- | --- | --- | --- |
| <strong>1.1</strong> Advance patient centered care practices | No Activity | Planning Underway | Developing | Implementation Initiated/Underway | Complete &amp;/or Fully Operational | Not Applicable &amp;/or Not Intending to Implement |
| <strong>1.1a</strong> Establish person and family engagement (PFE) as a standard of care through inclusion practices at the direct level of care through leadership/administration. |  |  |  |  |  |  |
| <strong>1.1b</strong> Establish patient-centered care planning inclusive of patient and provider shared-decisions around care, treatment, and self-management. |  |  |  |  |  |  |
| <strong>1.1c</strong> Increase access to needed medical services in locations and at times that meet patients where they are. |  |  |  |  |  |  |
| <strong>1.1d</strong> Disseminate and promote evidence-based best practices for provision of best quality care, including diagnosis, treatment, and management |  |  |  |  |  |  |
| <strong>1.1e</strong> Increase the awareness and addressing of health literacy, including the use of patient conversation resources, such as Teach Back and Ask Me 3. |  |  |  |  |  |  |
| <strong>1.1f</strong> Promote the implementation of comprehensive and high quality health risk assessments that identify patient, clinical, social, and community needs. |  |  |  |  |  |  |
| <strong>1.1g</strong> Create processes for clinical and community care communication encompassing closed-loop referrals for community services. |  |  |  |  |  |  |</p>
<table>
<thead>
<tr>
<th>1.2</th>
<th>Facilitate the impactful delivery of healthcare services.</th>
<th>No Activity</th>
<th>Planning Underway</th>
<th>Developing</th>
<th>Implementation Initiated/Underway</th>
<th>Complete &amp;/or Fully Operational</th>
<th>Not Applicable &amp;/or Not Intending to Implement</th>
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<tbody>
<tr>
<td>1.2a</td>
<td>Educate patients and healthcare providers on evidence-based principles and best practices of care coordination.</td>
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<td>1.2b</td>
<td>Establish high quality referral processes for other needed clinical, specialty, and community-based services.</td>
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<td>1.2c</td>
<td>Designate defined care coordination roles and/or responsibilities with the clinic, practice, or organization.</td>
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<td>1.2d</td>
<td>Promote collaborative provider relationships and team-based care practices, both within and among care settings.</td>
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<td>1.2e</td>
<td>Increase awareness and capacity to address social determinants of health (SDH), promoting inclusion of SDH as a component of implemented health risk assessments (HRAs).</td>
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<td>1.3</td>
<td>Establish coordinated connections to needed community-based services</td>
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<td>1.3a</td>
<td>Increase recognition and capacity to address SDH through education and incorporation within RHAs to identify patient-specific needs.</td>
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<td>1.3b</td>
<td>Identify available assistance within the community and establish points of contact to enable resource sharing and referral.</td>
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<td>1.3c</td>
<td>Create processes for clinical and community care communication encompassing closed-loop referrals for community services.</td>
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<td>2.1</td>
<td>Develop multi-discipline patient-centered care teams.</td>
<td>Status of Strategy</td>
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<td>2.1a</td>
<td>Establish designated roles for involvement of pharmacy, behavioral health, and other specialty providers as members of the patient care teams.</td>
<td>No Activity, Planning Underway, Developing, Implementation Initiated/Underway, Complete &amp;/or Fully Operational, Not Applicable &amp;/or Not Intending to Implement</td>
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<td>2.1b</td>
<td>Develop and maintain protocols and processes to facilitate reciprocal care communication among care team members, setting expectations for reciprocal communication and closer of referral.</td>
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<td>2.1c</td>
<td>Encourage involvement of team member participation in care services in alignment with highest scope of practice.</td>
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<td>2.1d</td>
<td>Instill incorporation of multi-discipline/stakeholder approaches in care transition planning.</td>
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<td>2.1e</td>
<td>Promote the use of evidence-based team development and improvement practices, such as TeamSTEPPS, to ensure team execution and efficiency in patient care and safety.</td>
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<td>2.1f</td>
<td>Incorporate involvement from non-clinical support systems as part of a whole-person-centered care model, including community-based services.</td>
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<td>2.2</td>
<td>Use of health information technology (HIT) to facilitate cross-communication and documentation.</td>
<td>No Activity</td>
<td>Planning Underway</td>
<td>Developing</td>
<td>Implementation Initiated/Underway</td>
<td>Complete &amp;/or Fully Operational</td>
<td>Not Applicable &amp;/or Not Intending to Implement</td>
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<td>2.2a</td>
<td>Promote the use of available HIT resources to allow mutual access to patient care information from all appropriate members of the patient care team, i.e., Iowa Health Information Network (IHIN), shared electronic health records (EHR) view and messaging functionalities.</td>
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<td>2.2b</td>
<td>Use available HER and data systems, such as registries, to identify and target high risk or at-risk patients for targeted care coordination and support.</td>
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<td>2.2c</td>
<td>Encourage use of HER patient access or patient portals to facilitate direct availability and inclusion of information by patients and caregivers.</td>
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<td>2.2d</td>
<td>Promote transparency of relevant and necessary patient care information across appropriate healthcare settings to facilitate optimal care planning and delivery.</td>
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<td>2.3</td>
<td>Establish standardized processes and protocols for collaborative care delivery.</td>
<td>No Activity</td>
<td>Planning Underway</td>
<td>Developing</td>
<td>Implementation Initiated/Underway</td>
<td>Complete &amp;/or Fully Operational</td>
<td>Not Applicable &amp;/or Not Intending to Implement</td>
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<td>2.3a</td>
<td>Create and maintain policies for patient-centered care practices across team settings, emphasizing inclusive team-based care, shared-decision making, and patient activation strategies.</td>
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<td>2.3b</td>
<td>Create and maintain active referral processes across services and settings establishing plans for proactive communication and closed loop referrals.</td>
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<td>2.3c</td>
<td>Identify and incorporate non-clinical services that can be used in care coordination practice processes and protocols to support comprehensive patient-centered care.</td>
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<td>2.4</td>
<td><strong>Enhance collaboration among healthcare providers, community-based services, and the payer community to ensure effective and efficient provision of care and support services.</strong></td>
<td>No Activity</td>
<td>Planning Underway</td>
<td>Developing</td>
<td>Implementation Initiated/Underway</td>
<td>Complete &amp;/or Fully Operational</td>
<td>Not Applicable &amp;/or Not Intending to Implement</td>
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<tr>
<td>2.4a</td>
<td>Align payer-supported educational strategies with prioritized evidence-based practices for patient-centered care and coordination of services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4b</td>
<td>Explore mutual support and sustainability strategies with the payer community to optimize care coordination efforts and resource utilization.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4c</td>
<td>Champion streamlined processes for closed-loop referrals with clinical site, payers, and community-based services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal 3. Execute community-based strategies that proactively link and support clinical and community-based services.**

| 3.1 | **Align community-based services for each patient/service recipient to ensure greatest impact.** | No Activity | Planning Underway | Developing | Implementation Initiated/Underway | Complete &/or Fully Operational | Not Applicable &/or Not Intending to Implement |
| 3.1a | Identify and engage available and existing clinical and community-based service stakeholders. |  |
### 3.1 Establish points of contact and relationships among clinical providers and community-based services.

<table>
<thead>
<tr>
<th></th>
<th>Establish referral and reciprocal communication for closed-loop referral processes between and among clinical providers and community-based services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1b</td>
<td>Establish points of contact and relationships among clinical providers and community-based services.</td>
</tr>
<tr>
<td>3.1c</td>
<td>Establish referral and reciprocal communication for closed-loop referral processes between and among clinical providers and community-based services.</td>
</tr>
</tbody>
</table>

### 3.2 Connect clinical services with community-based services.

<table>
<thead>
<tr>
<th></th>
<th>Connect clinical services with community-based services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2</td>
<td>Connect clinical services with community-based services.</td>
</tr>
<tr>
<td>3.2a</td>
<td>Build, enhance and maintain collaborative relationships and functional referral mechanisms between health care systems and community-based services.</td>
</tr>
<tr>
<td>3.2b</td>
<td>Establish processes for reciprocal communication and information sharing.</td>
</tr>
<tr>
<td>3.2c</td>
<td>Establish processes for referral follow-up between and among community-based services and clinical providers.</td>
</tr>
<tr>
<td>3.2d</td>
<td>Establish community partners and service providers as integral members of the care team, focusing on connection of SDH service and approaches.</td>
</tr>
</tbody>
</table>

### 4. Use data strategies to drive improvement and demonstrate value-based care.

<table>
<thead>
<tr>
<th></th>
<th>Promote and enhance the use of HIT to identify, track, and monitor population health.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Promote and enhance the use of HIT to identify, track, and monitor population health.</td>
</tr>
<tr>
<td>4.1a</td>
<td>Encourage full use and optimization of EHR capacities to facilitate collection and capture of patient population health status and care coordination processes.</td>
</tr>
<tr>
<td>4.1b</td>
<td>Promote use of community-based service data systems to track community-based service provision including referrals, participation and person-based and community outcomes.</td>
</tr>
<tr>
<td>4.1c</td>
<td>Promote cross-systems access and communication among team members and service providers to encourage comprehensive person-centered coordination of care.</td>
</tr>
</tbody>
</table>
The Community and Clinical Care (C3) Initiative is one component of the State of Iowa’s State Innovation Model (SIM) grant. In 2016, six communities (single and multi-county) across the state were funded and charged with coordinating care across medical, public health, and social service delivery systems. Sites were designated as either developmental or implementation sites, based on prior demonstration of local care coordination experience. The C3 sites are led by an integrator organization, which serves as a “neutral partner outside of the clinical healthcare delivery system,” and is responsible for convening and coordinating partnerships, and “building trust among collaborative partners” to carry out C3 activities. Since the C3s were established in March 2016, each site’s integrator organization led local initiatives to address diabetes, tobacco, obesity and social determinants of health. In May 2017, requirements for the C3 site were amended, and the target population for care coordination was narrowed to individuals diagnosed with, or at risk for diabetes and prediabetes. Along with changes to the target population, the requirements for C3 objectives and structure were adjusted to be more aligned with the Accountable Communities of Health model (ACH).

### Table 1. Summary of ACH Elements Required of Applicants in 2017 C3 RFP

<table>
<thead>
<tr>
<th>ACH Element</th>
<th>Evaluation Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multi-sector partnerships</strong></td>
<td>Steering Committee and Coalition members were categorized into seven sectors (Healthcare Providers, Community Programs, Public Health, Social Services, Government Entities, Private Industry, Payers) defined in Table 8.</td>
</tr>
<tr>
<td>&quot;A multi-sector group, separate from the Steering Committee, to serve as a source of communication and collaboration to drive project implementation.”</td>
<td></td>
</tr>
<tr>
<td><strong>Shared Vision and Goals among partners</strong></td>
<td>Members of steering committees and collations reported the levels of trust/strength of relationships across partner organizations.</td>
</tr>
<tr>
<td><strong>Established governance structure or leadership</strong></td>
<td>Connections across steering committee and coalition members were collected (including specific advisory role (i.e. governance) networks). Integrator organizations were isolated from corresponding sector to examine leadership roles in the C3 network.</td>
</tr>
<tr>
<td><strong>Priority focus areas</strong></td>
<td>Strategies and activities across the seven C3 sites involved four main types of collaborative activities (advisory roles, care coordination, data sharing, and resource sharing). Each type of activity was examined individually for participation and efficiency.</td>
</tr>
<tr>
<td>&quot;The Steering Committee is responsible for identifying the health strategies for the C3 initiative”</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainability planning</strong></td>
<td>Perceptions of expected continuation of collaboration were collected.</td>
</tr>
<tr>
<td>&quot;Development of durable local ownership and capability to sustain the C3 work beyond the grant period, including resource sharing”</td>
<td></td>
</tr>
</tbody>
</table>

* This ACH element was not explicitly required in the 2017 Iowa C3 RFP, but is recognized as a core element of ACHs²,³

---

Network Analysis

Network analysis is a methodology used to gather concrete information about the existence and nature of relationships within a group of connected people or entities. In the context of the Iowa State Innovation Model (SIM), this methodology was applied to gather perspectives from stakeholders involved in the seven regional Community and Clinical Care (C3s) Initiatives. Based on prior SIM reports and evaluations throughout the SIM grant period, relationship-building was a common success reported across C3 sites, so network analysis is a tool to measure inter-organizational relationships which facilitate C3 activities. Along with gathering information about the functional nature of collaborative relationships, respondents were also asked about the strength and perceived sustainability of relationships (see Addendum A for Network Survey).

From the information gathered, the relational impact of the C3 initiatives can be described and analyzed quantitatively. The development of collaborative interorganizational relationships is integral to sustaining current activities (i.e. local care coordination), or repurposing relationships (i.e., identifying informal leaders or target underutilized organizations) for future collaborations beyond the grant-funded period.

Throughout this analysis, four main types of networks will be examined 1) Full networks, 2) Functional networks, 3) Trust networks, and 4) Network evolution. The Functional Networks and Network Evolution both include sub networks, described further in Table 2.

<table>
<thead>
<tr>
<th>Type of Network</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full Networks</strong></td>
<td>Any type of collaboration or relationship reported between organizations (includes all connections reported in subnetworks)</td>
</tr>
<tr>
<td><strong>Functional Networks</strong></td>
<td></td>
</tr>
<tr>
<td>Advisory Networks</td>
<td>Work together to guide the strategic direction of the C3</td>
</tr>
<tr>
<td>Care Coordination Networks</td>
<td>Sends and/or receives client care coordination referrals across organizations</td>
</tr>
<tr>
<td>Data Sharing Networks</td>
<td>Contribute to or have access to a shared database, share client data across organizations, share other data (surveys, focus groups, etc.) across organizations.</td>
</tr>
<tr>
<td>Resource Sharing Networks</td>
<td>Contribute or receive resources through C3 collaboration (e.g. monetary, training/educational materials, space, staff time).</td>
</tr>
<tr>
<td>Trust Network</td>
<td>An assessment of strength of relationship, whether the relationships are New, Developing, or Strong.</td>
</tr>
<tr>
<td><strong>Network Evolution</strong></td>
<td></td>
</tr>
<tr>
<td>Pre-Existing Networks</td>
<td>Connections reported as established prior to C3 funding</td>
</tr>
<tr>
<td>C3 stimulated Networks</td>
<td>Connections reported as stimulated by C3 activities</td>
</tr>
<tr>
<td>Sustainment Networks</td>
<td>Connections and collaborations which are perceived to continue after C3 funding period ends</td>
</tr>
</tbody>
</table>

Table 2. Overview of Network Types
Methods

The network analysis surveys were distributed to gather perspectives from organizations which have a role in C3s about connections utilized to carry out C3 activities. An online survey was used to ask representatives from C3-affiliated organizations (including the integrator organization, steering and subcommittee members, and collation members) about inter-organizational relationships which facilitate C3 activities.

The network analysis surveys were sent by e-mail using the Qualtrics platform to all steering committee and coalition members at each C3 site between June and October 2018. The contact lists which comprised survey samples were reviewed for accuracy by staff from each C3 site. The C3 staff-approved contact lists informed the roster of organizations listed in the surveys.

Survey Instrument

Integrator organizations were consulted for guidance during survey development. Each survey included roles and language specific to the site (See Addendum A for generic survey script). The survey contained an introduction, four roster-based (i.e. close-ended format) network collection questions, and concluded with an open-ended question. By providing a list (i.e. roster) of possible collaborators, responses are less subject to recall error (alternatively, network data could be collected by generating open-ended lists from each respondent). This method also strengthens equity of reporting, as each respondent is prompted to consider ties with each eligible organization in the network.

The initial survey item asked respondents to select any organization with which their organization collaborated with in any way. These initial selections informed subsequent rosters, meaning the roster for the following questions was limited to only personally relevant organizations, not the full list. The second survey item asked respondents about the function of collaborative relationships. Respondents were able to report multiple types of collaboration with each organization (i.e. select all that apply). The third survey item asked respondents to rate their relationships with collaborators, and was a single answer item. The responses to this item are ranked, meaning scores are between 1 and 3, with 1 representing the least developed relationship. The third survey items asked respondents about perceptions of prior relationships, C3 influence, and perceptions of sustaining relationships. Respondents were able to select multiple categories for each response. The survey ended with a text write-in question.

<table>
<thead>
<tr>
<th>Site</th>
<th>Invited</th>
<th>Responded</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site E</td>
<td>34</td>
<td>21</td>
<td>62%</td>
</tr>
<tr>
<td>Site G</td>
<td>39</td>
<td>21</td>
<td>54%</td>
</tr>
<tr>
<td>Site B</td>
<td>25</td>
<td>12</td>
<td>48%</td>
</tr>
<tr>
<td>Site D</td>
<td>41</td>
<td>19</td>
<td>46%</td>
</tr>
<tr>
<td>Site C</td>
<td>40</td>
<td>17</td>
<td>43%</td>
</tr>
<tr>
<td>Site F</td>
<td>19</td>
<td>8</td>
<td>42%</td>
</tr>
<tr>
<td>Site A</td>
<td>25</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>223</td>
<td>107</td>
<td>48%</td>
</tr>
</tbody>
</table>
Network Analysis Measures

Network analyses and diagrams consist of two main features: nodes and ties. Nodes (circles) represent an actor in the network. In the context of this report, nodes are organizations affiliated with the C3 sites which were either self-identified as a network member or identified by another organization in the network. Ties (lines) are the connections reported between organizations. To examine the occurrence of cross-sector collaboration within the C3 sites, nodes were collapsed (combined) based on sector assignment (see Table 8).

**Network level measures**

**Density**

Density measures the efficiency of the network by providing information about the channels available to transmit information or resources among the nodes.

Density has a range between 0 and 1: 1 being the most dense (all actors connected, i.e. highly efficient). High network density is more difficult to achieve in large networks.

\[
\text{Density} = \frac{\text{Number of edges in the graph}}{\text{Number of all possible edges}}
\]

**Centralization**

Centralization is a network-level measure which assesses the distribution of centrality (essentially, leadership) amongst nodes. A high level of centralization in a network would indicate a few players are highly active in the network (have a majority of all network connections), while a low level of centralization indicates more evenly distributed influence.

**Table 4. Basic Network Descriptors for Full C3 Networks**

<table>
<thead>
<tr>
<th>Site</th>
<th>Nodes</th>
<th>Ties</th>
<th>Density</th>
<th>Centralization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site B</td>
<td>16</td>
<td>62</td>
<td>0.258</td>
<td>0.848</td>
</tr>
<tr>
<td>Site A</td>
<td>23</td>
<td>127</td>
<td>0.251</td>
<td>0.771</td>
</tr>
<tr>
<td>Site E</td>
<td>26</td>
<td>129</td>
<td>0.198</td>
<td>0.825</td>
</tr>
<tr>
<td>Site F</td>
<td>11</td>
<td>20</td>
<td>0.182</td>
<td>0.756</td>
</tr>
<tr>
<td>Site G</td>
<td>28</td>
<td>118</td>
<td>0.156</td>
<td>0.55</td>
</tr>
<tr>
<td>Site C</td>
<td>36</td>
<td>164</td>
<td>0.133</td>
<td>0.888</td>
</tr>
<tr>
<td>Site D</td>
<td>26</td>
<td>83</td>
<td>0.102</td>
<td>0.427</td>
</tr>
</tbody>
</table>

The table above provides basic network level information about the full networks reported at each site. The density measures across the C3 site networks range from .1 to .26. This range is adequate for the C3 network context, since all organizations in each network are not expected to collaborate with all other organizations. Except for Sites D and G, the measures of centralization across C3 sites are relatively high, meaning that a single or small group of organizations retain a large share of the network activity.
**Node level**

Node level measures characterize the role of an individual node in the network. In most of this report, nodes have been collapsed by their sectors, meaning each node represents all connections by organizations within the defined sector (e.g. connection reported from hospitals and clinics involved with the C3 have been aggregated into a single “Healthcare Providers” node). Two measures (betweenness and centrality) provide insight into the roles of each organization in the network and indicate the level of participation and investment in network collaboration. All measures of nodes are relative to the network being analyzed, and node values of betweenness and centrality are affected by several variables, like network size, and robustness of data (i.e. survey responses). While high betweenness and centrality values are positive, differences between C3 sites aren’t comparable.

**Broker Roles (Betweenness)**

Measuring the betweenness value of a node means assigning each node a ratio based on how often their organization connects otherwise unconnected organizations (see node X, pictured right). Nodes which have high betweenness play a “bridge” or “broker” role, which is important to the network function because they have the ability to conduct and coordinate exchanges, like transmitting information across organizations. Each node in the network is assigned a percentage to represent the occurrences of performing a bridge function in the network (betweenness) (See Addendum B for technical details)

\[
\text{betweenness} = \frac{\text{number of times a node lies between two otherwise unconnected nodes}}{\text{total times any node lies between two otherwise unconnected nodes in the network, excluding the numerator node}}
\]

**Hub Roles (Centrality)**

Measuring the centrality value of a node means assigning each node a ratio which represents how entrenched in the network a node is, based on connections to other nodes (see node X, pictured right). Nodes with high centrality are influential within the network, and have a “hub” role, meaning it has greater access to information. Along with being equipped to communicate with other nodes in the network efficiently, nodes with high centrality are more likely to utilize connections with others in the network (high efficacy in activating influence). Each node in the network is assigned a percentage to represent its level of influence based on reports from other nodes in the network.

\[
\text{centrality} = \frac{\text{number of direct connections each node has to other nodes within the network}}{\text{total possible direct connections of each node}}
\]

---

Table 5 displays the highest betweenness and centrality scores for each integrator organization across all four types of functional networks within each C3 site. Each integrator organization has unique strengths of the roles it plays in its local C3 network. The most common broker roles for integrator organizations are demonstrated in the Resource Sharing networks, and the most common hub roles for integrator organizations are demonstrated in the Advisory and Data Sharing networks. The C3 RFP explicitly includes the establishment of resource sharing as a key to sustaining C3 activities, and brokering the sharing of resources is a key strength of three of the seven sites (see more information about resource sharing in the Resource Sharing section).

<table>
<thead>
<tr>
<th>Site</th>
<th>Broker Roles</th>
<th>Hub Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network (betweenness value)</td>
<td>Network (centrality value)</td>
</tr>
<tr>
<td>Site C</td>
<td>Data Sharing (19%)</td>
<td>Advisory (11%)</td>
</tr>
<tr>
<td>Site A</td>
<td>Care Coordination (21%)</td>
<td>Advisory (28%)</td>
</tr>
<tr>
<td>Site B</td>
<td>NA*</td>
<td>Advisory (33%)</td>
</tr>
<tr>
<td>Site D</td>
<td>Resource Sharing (20%)</td>
<td>Care Coordination (42%)</td>
</tr>
<tr>
<td>Site F</td>
<td>Resource Sharing (39%)</td>
<td>Data Sharing (33%)</td>
</tr>
<tr>
<td>Site G</td>
<td>Resource Sharing (52%)</td>
<td>Data Sharing (47%)</td>
</tr>
<tr>
<td>Site E</td>
<td>Advisory Role (33%)</td>
<td>Data Sharing (20%)</td>
</tr>
</tbody>
</table>

*Calculation not feasible due to limited size of network
Functional Networks

To gather more information about what types of activities C3s are implementing and which sectors are involved, survey respondents were asked to report about involvement in four types of collaborative activities, including 1) Advisory Roles, 2) Care Coordination, 3) Data Sharing, and 4) Resource Sharing. See Table 2 for activity descriptions.

Figure 1. Collaborative Functions by C3 site

The percentages above are each type of activity reported (advisory, care coordination, data sharing, resource sharing) as a proportion of all reported activities summed. The types of connections selected by respondents were not mutually exclusive.

On average, survey respondents across sites reported the most connections related to Resource Sharing (33% average), followed by Care Coordination (31%), Data Sharing (20%), and Advisory Roles (16%).

Network development varies across activity types, as measured by the average densities across networks seen in Figure 2. Network density is an indicator of efficiency and average densities for all sites indicate that the most developed networks are those involved in resource sharing, and the least developed are the data sharing networks.

Figure 2. Networks Densities by Type of Activity
Advisory Role Networks

In order to assess the networks active in the governance structure of the C3 sites, survey respondents were asked to identify organizations which work together to guide the strategic direction of the C3.

Figure 3. Primary Organizations Which Serve as Hubs in Advisory Networks

Figure 3 shows that the integrator organization in six of the seven sites was identified by other organizations in the network as serving a hub role. These findings suggest that integrator organizations are recognized as leaders and informative resources in the governance of the C3. Other prominent organizations involved in C3 governance included government entities, healthcare providers, and community programs.

Figure 4. Primary Organizations Which Serve as Brokers in Advisory Networks*

Figure 4 shows that five of six C3 sites also have roles as brokers within their advisory networks, meaning they are demonstrating the ability to connect partners and convene meetings. The Site E integrator organization had a relatively high broker rating (24%), which means the integrator organization facilitates a connection amongst 24% of organizations which would not otherwise be connected.
Care Coordination Networks

In order to assess the networks active in care coordination activities across the C3 sites, survey respondents were asked to identify organizations which participate in sending and/or receiving client care coordination referrals across organizations.

Figure 5 shows that while integrator organizations still have hub roles in care coordination activities, the role of healthcare providers as hubs in care coordination is prominent. These findings are consistent with expectations, since care coordination relies on healthcare providers for client information and referrals.

Figure 6 shows that three of the seven integrator organizations are leading the brokerage of care coordination at their sites. The integrator organizations at these high scoring sites have established and are responsible for the maintenance of HIT data sharing systems utilized by local organizations for care coordination.
Data Sharing Networks

In order to assess the networks active in data sharing activities across the C3 sites, survey respondents were asked to identify organizations which contribute to or have access to a shared database, share client data across organizations, or share other data (surveys, focus groups, etc.) across organizations.

Figure 7. Primary Organizations Which Serve as Hubs in Data Sharing Networks

As seen in Figure 7, integrator organizations at all C3 sites play a hub role in data sharing networks, with six sites receiving the highest rating in their respective networks.

Figure 8. Primary Organizations Which Serve as Brokers in Data Sharing Networks

Figure 8 shows that integrator organizations at four sites play a broker role in the data sharing networks. While broker ratings are relatively low across sites, the presence of brokers in these networks is needed, as the data sharing networks are the least developed (average network density score is .07) of the four types of functional networks.
Resource Sharing Networks

In order to assess the networks active in resource sharing activities across the C3 sites, survey respondents were asked to identify organizations which contribute or receive resources through C3 collaboration (e.g. monetary, training/educational materials, space, staff time).

As seen in Figure 9, all integrator organizations have a central role in their respective resource sharing networks, as all integrator organizations were the highest rated as hubs in the networks. Also, a variety of sectors are represented in the resource sharing networks, including the RFP suggested partners for sharing resources (local public health and hospitals and clinics).

Figure 10 shows the broker roles of resource sharing at C3 sites, and five of seven integrator organizations are leaders in brokering resource sharing, along with serving as hubs. These results are promising, as the C3 RFP indicates resource sharing as a lever for sustainability.

---

8 “Applicants shall demonstrate this relationship through resource sharing with LPH and hospitals and/or clinics.”
9 “Development of durable local ownership and capability to sustain the C3 work beyond the grant period, including resource sharing”
Network Evolution

To learn more about the C3 role in stimulating and fortifying collaboration, survey respondents were asked to report about four types of networks 1) collaborations that preexisted the C3, 2) networks that were stimulated by C3 activities, 3) connections specific to only C3 activities, and 4) whether collaboration was expected to continue after the funding period.

**Figure 11. Network Evolution by C3 site**

The percentages above are each type of network evolution connection reported (pre-existing, C3 stimulated, C3 exclusive, expected continuation) as a proportion of all reported types of connections summed. The types of connections selected by respondents were not mutually exclusive.

Of the connections reported for each network, the C3 grant had varying degrees of impact. For example, sites which reported collaborative networks before the grant had lower rates of attributing collaboration to the C3, and lower rates of predicting continued collaboration for C3 related activities after the grant funding ends. However, most sites reported positive growth in collaborative networks when comparing the pre-existing network to the perceived sustained network.

**Table 6. Comparison of Connections reported Retroactively and Predicted**

<table>
<thead>
<tr>
<th>Site</th>
<th>Pre-existing ties</th>
<th>Expectations to continue</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site B</td>
<td>50%</td>
<td>37%</td>
<td>-13%</td>
</tr>
<tr>
<td>Site D</td>
<td>51%</td>
<td>40%</td>
<td>-11%</td>
</tr>
<tr>
<td>Site A</td>
<td>37%</td>
<td>31%</td>
<td>-6%</td>
</tr>
<tr>
<td>Site C</td>
<td>34%</td>
<td>37%</td>
<td>3%</td>
</tr>
<tr>
<td>Site E</td>
<td>32%</td>
<td>45%</td>
<td>13%</td>
</tr>
<tr>
<td>Site F</td>
<td>23%</td>
<td>38%</td>
<td>15%</td>
</tr>
<tr>
<td>Site G</td>
<td>30%</td>
<td>47%</td>
<td>16%</td>
</tr>
</tbody>
</table>

The percentages reported are each type of network evolution connection (pre-existing, expected continuation) as a proportion of all connections reported in the network.
Figure 12 shows changes in networks from survey respondent reports of connections between organizations before the C3 grant (preexisting network), the current network reported, and predicted future connections (expectations to continue collaborations). All C3 sites have the densest (i.e. most efficient networks) during the C3 grant period (currently).
Network Trust and Relationships

To better understand the quality of relationships within the C3 networks, respondents were asked to rate their relationships with each of the organizations with which they collaborate. Overall, relationships across sites were rated highly, with nearly half of relationships receiving the highest possible rating in six of the seven C3 sites (Figure 13).

Figure 13. Relationship Ratings of Organizations in C3 Networks

Integrator organizations at each C3 site were highly rated by collaborating organization in their respective networks, with an average rating of 2.7 (out of possible 3).

Table 7. Relationship Ratings of Integrator Organization by Partnering Organizations

<table>
<thead>
<tr>
<th>Site</th>
<th>Percent of survey respondents who rated relationship with integrator organization</th>
<th>Average rating of relationship with integrator organization (1-3 range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site C</td>
<td>65%</td>
<td>2.91</td>
</tr>
<tr>
<td>Site B</td>
<td>92%</td>
<td>2.82</td>
</tr>
<tr>
<td>Site A</td>
<td>89%</td>
<td>2.75</td>
</tr>
<tr>
<td>Site E</td>
<td>48%</td>
<td>2.7</td>
</tr>
<tr>
<td>Site F</td>
<td>75%</td>
<td>2.67</td>
</tr>
<tr>
<td>Site G</td>
<td>76%</td>
<td>2.63</td>
</tr>
<tr>
<td>Site D</td>
<td>58%</td>
<td>2.36</td>
</tr>
</tbody>
</table>
Open-Ended Reponses

Of the 107 total survey respondents, 57 respondents answered the final open-ended question, “Describe how, if at all, relationships between organizations participating in the [C3 site] have changed over the grant period (March 2016-present).” All comments can be found in Addendum C.

Responses were largely positive, and comments represented two general themes: 1) Improved communication and coordination (34 comments) and 2) Strengthened relationships (28 comments). Only four comments were neutral or negative.

Improved communication and coordination

Thirty-four respondents commented on the C3 role in facilitating and encouraging communication and coordination across local agencies and healthcare providers. Respondents elaborated, saying that the C3 has decreased fragmentation and has successfully organized collaborations. Fourteen comments mentioned the positive impact of gaining awareness and understanding of local programs, resources, and agencies. For example, respondents wrote, “I think we have a much better understanding of what roles each member holds in the community and also who is good at doing what’” and “This has been an opportunity to learn about the participating organization’s strategic goals and how the C3 framework can help meet those goals through community collaboration” and “Clinics more aware of what Public Health can do to help connect people with services and coordination that is needed.”

Ten respondents provided examples of how improved coordination enabled improvements to current processes and the creation of additional services in alignment with SIM goals. For example, respondents wrote, “Initiated diabetes prevention program with encouragement from the SIM group. Have received referrals for this program from partners” and “More aware of resources and agencies in the area and are better equipped to provide referrals, collaborate, and meet community needs.” Other C3 stimulated advancements in local collaboration included identifying and sharing resources (specifically, databases, staff, and space), improved referral processes for mental health and social determinants of health services, development of culturally specific diabetes programming, and increased patient outreach.

Respondents noted that increased coordination has built capacity for collaboration amongst local organizations and shifted the culture and expectations to be more team-oriented and patient-centered. For example, respondents wrote, “We have all become good resources amongst ourselves, good team leaders and collaborate between each provider” and “This has been a huge community project where multiple organizations had to be on board with decisions made and think of not only their agency’s goals/wants but also that of the greater good.”

Strengthened relationships

Twenty-eight respondents commented on the formation or continuation of relationships across organizations and representatives involved in the C3, noting that leadership from the integrator organization (5 comments), consistent interactions with organizational contacts (8 comments), and regular meetings (6 comments) were key factors in relationship development. Respondents described the relational impact, saying, “Organizations, who were aware of local programs but did not have personal contacts, have been able to meet, communicate, and create unique partnerships after the meetings that the SIM C3 grant has helped to coordinate,” and “When the C3 formed and work began, some of the partners were not yet at the table but those present needed to work through siloing and some mistrust. Sometimes partnerships simply had not been thought of in the way proposed by the C3” and “[C3 integrator organization] has been absolutely great to work with. Amazing team players.”
Neutral or Negative experiences

Four respondents reported little involvement in the C3, no demonstrable impact of the C3, and some tension in relationships. For example, “The relationship seems to be very one-sided with [C3 integrator organization] not building strong relationships with other community organizations. [C3 integrator organization] tends to take advantage of others hard work and accomplishments for their benefit to access grant funding and reap the accolades.”

Limitations

The following factors could impact the outcomes reported and should be considered when interpreting results:

- Incomplete Participation – Survey responses were not collected from all stakeholders at each site, so reported connections may not reflect all existing connections
- Recall bias – Reports from survey respondents in the retroactive recollection of “pre-existing ties” are subject to inaccuracies due to limitations in recalling circumstances during a specific time period (i.e. prior to the C3 grant)
- Desirability bias – Survey respondents may have over-reported connections to fulfill expectations that they should have established connections

Conclusions

- Overall, the stakeholders in C3 sites have been successful in developing strong working relationships with the integrator organizations and other partnering organizations.
- Five of the seven C3 networks included stakeholders from the healthcare, public health, and social services sectors, which aligns with the goals of establishing an ACH. The remaining two networks can continue to be strengthened by involving diverse sectors in planning and administration of activities.
- The C3 grant had a role in stimulating collaboration, with an average of 21% of respondents across sites attributing current collaborative relationships to the C3. In addition, respondents expected 39% of the current relationships on average to be sustained past the funding period.
- Resource sharing networks across sites were the most developed, and integrator organizations play key roles in their respective sites in the facilitation of resource sharing.
- Three of the seven integrator organizations are leading the brokerage of care coordination at their sites. The integrator organizations at these high scoring sites have established and are responsible for the maintenance of HIT data sharing systems utilized by local organizations for care coordination.
- While data sharing networks were the least developed on average across sites, integrator organizations had key leadership roles in the developing data sharing networks.
Addendum A: Network Survey

While each site administered a slightly different survey to accommodate site-specific language and activities, each survey followed the generic format outlined below.

Hello,

Thank you for taking the time to complete this survey. You are receiving this survey because your organization has been identified as a stakeholder in the State Innovation Model (SIM) Community and Clinical Care (C3) Initiative in [C3 site].

The primary goal of the C3 initiative is to encourage care coordination across medical, public health, and social service delivery systems.

The purpose of this survey is to collect information about the network of organizations involved in C3 related activities at the [C3 site], and you were identified as a representative of a participating organization.

The information collected in this survey will only be publicly available in aggregate form to make general observations about networks related to the C3 activities, implementation activities, and outcomes across all 7 C3 sites in the state. No information will be released publicly or among funders that identifies you as an individual, your organization, or C3 site.

The results of this survey and subsequent analysis will be disseminated to the [C3 site] for internal review and use.

Participation in this survey is voluntary.

Q1

This survey will ask about various collaborative activities your organization may contribute to as a participant in [C3 site] activities.

Examples of collaborative activities:

**Advisory Role:** work together to guide the strategic direction of the C3

**Care Coordination:** Sends and/or receives client care coordination referrals across organizations

**Data Sharing:** Contribute to or have access to a shared database, share client data across organizations, share other data (surveys, focus groups, etc.) across organizations.

**Resource Sharing:** Contribute or receive resources through DMC C3 collaboration (e.g. monetary, training/educational materials, space, staff time)
Please select all (if any) organizations from the list below your organization works with for [C3 site] activities. Do not select your own organization.

- Organization 1
- Organization 2
- Organization 3

**Q2**

Please select the ways your organization collaborates with the organizations listed below. Please review the definitions of types of collaboration below and select all (if any) that apply.

**Advisory Role:** *work together to guide the strategic direction of the C3*

**Care Coordination:** *Sends and/or receives client care coordination referrals across organizations*

**Data Sharing:** *Contribute to or have access to a shared database, share client data across organizations, share other data (surveys, focus groups, etc.) across organizations.*

**Resource Sharing:** *Contribute or receive resources through DMC C3 collaboration (e.g. monetary, training/educational materials, space, staff time).*

<table>
<thead>
<tr>
<th></th>
<th>Advisory Role</th>
<th>Care Coordination</th>
<th>Data Sharing</th>
<th>Resource Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization 1</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Organization 2</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Organization 3</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>

**Q3**

Please indicate the status of relationships/level of trust between your organization and its collaborative partners in the [C3 site].

<table>
<thead>
<tr>
<th></th>
<th>New Relationship / Little Trust</th>
<th>Developing Relationship / Some Trust</th>
<th>Excellent relationship/ High Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization 1</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Organization 2</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Organization 3</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>
Q4

Please select the option(s) that best describe collaborative relationships between your organization and other collaborating organizations involved in the [C3 site].

Please select all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Collaboration preexisted SIM grant</th>
<th>Collaboration was stimulated by SIM participation</th>
<th>Collaboration is specific to only SIM project activities</th>
<th>Collaboration is expected to continue beyond SIM funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization 1</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
</tr>
<tr>
<td>Organization 2</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
</tr>
<tr>
<td>Organization 3</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
<td>⬤</td>
</tr>
</tbody>
</table>

Q5

Describe how, if at all, relationships between organizations participating in the [C3 site] have changed over the grant period (March 2016-present).

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
Sectors and roles within the C3 were defined initially by C3 integrator organizations, and were then collapsed into seven distinct categories, outlined below. The aggregation of organizations into these main seven categories was guided by the initial C3 categorization. For instance, one site categorized a local church as a food system, so that organization was categorized in the social services category instead of community programs, in which a faith-based institution would otherwise be categorized.

Table 8. Sector Categorizations Used for Analysis

<table>
<thead>
<tr>
<th>Sector</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare Providers</td>
<td>Organizations which directly contribute to the provision of healthcare to patients</td>
<td>Primary care clinics, hospitals, Accountable Care Organizations, behavioral health clinics, diabetes education, pharmacies, home health providers, dental clinics, FQHCs</td>
</tr>
<tr>
<td>Public Health</td>
<td>Organizations which provide public health services</td>
<td>Government public health departments (county and state level), hospital-based public health departments</td>
</tr>
<tr>
<td>Social Services</td>
<td>Organizations which provide direct service specific to social determinants of health (food, housing, transportation)</td>
<td>Housing shelters, food pantries, transportations services, crisis intervention</td>
</tr>
<tr>
<td>Payers</td>
<td>Organizations which manage the reimbursement of health services</td>
<td>Medicaid Managed Care Organizations, private insurers</td>
</tr>
<tr>
<td>Government Entities</td>
<td>Organizations which are funded through the government (excluding public health)</td>
<td>Police departments, local government (city/county), educational institutions (school districts, community colleges, universities)</td>
</tr>
<tr>
<td>Community Programs</td>
<td>Organizations and programs which are locally based and provide services and support for the community and specific subpopulations (not directly related to social service provision)</td>
<td>Non-profits, local boards/associations/coalitions, community members, advocacy groups, faith-based institutions</td>
</tr>
<tr>
<td>Private Industry</td>
<td>Organizations which are privately operated</td>
<td>Businesses, employers, for-profit companies, private foundations</td>
</tr>
</tbody>
</table>

Matrix Construction

Survey responses were placed into a matrix which included the entire survey sample for each network. Since the full network did not respond, the matrices were asymmetrical, meaning some connections were only reported by one organization (not mutually reciprocated). For organizations which had more than one representative, the multiple responses were combined. For functional networks, full networks, and network evolution, any connections from any representative were counted, and duplicate connections were only counted once (not summed) (Figure 14). For the network
relationships, connections were valued (i.e. weighted 1, 2, or 3), and multiple reports from one organization were averaged for matrix construction and reporting.

**Measures**

**Centrality:** All values reported as centrality are the indegree centrality measures, meaning centrality for each node is reflective of connections received, as opposed to outdegree centrality, which reflects the connections reported for each node. Indegree centrality was selected to minimize skewedness based on incomplete network participation in the survey.

**Betweenness:** Betweenness values reported vary depending on the network. Freeman betweenness values were used for non-valued networks (all functional networks, all network evolution networks). Because Freeman betweenness binarizes valued data (was used in collapsed networks and relationship network), Flow betweenness was reported for those networks.

**Functional Networks:** In the analyses and graphs presented for each type of the four functional subnetworks, organizations were examined individually (not collapsed), and only the three highest rated organizations (identified by sector) are reported for each network. In the event of equivalent ratings, all organizations with equal ratings are reported (resulting in more than three organizations reported for a site in some instances).
<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understanding of each partner’s role in health care. More open communication.</td>
</tr>
<tr>
<td>Collaboration was strengthened as a result of the meetings. Was very helpful to reconnect with some of the organizations and to find opportunities to continue and strengthen collaboration.</td>
</tr>
<tr>
<td>For the organizations that have consistently sent a representative, especially if it has been the same individual repeatedly in attendance, the level of trust between myself and that organization has increased.</td>
</tr>
<tr>
<td>Have developed broader range of network through the SIM. Working together better for what is best for our community and the patients.</td>
</tr>
<tr>
<td>I don’t have the opportunity to attend the coalition meetings all that often, but the organizations I listed are all ones with whom I have strong or developing partnerships that have been further fostered by the SIM.</td>
</tr>
<tr>
<td>I have been able to help patients connect to more resources within [C3 service area] thanks to SIM as I get more information at quarterly meetings about the services available. I also think participating in SIM allows for the building of more lasting relationships with the organizations participating as we learn about their services and are able to put a consistent face with that organization!</td>
</tr>
<tr>
<td>I would say that many of the relationships have either been maintained or have grown throughout the grant period. All relationships have maintained a high level of trust.</td>
</tr>
<tr>
<td>Initiated diabetes prevention program with encouragement from the SIM group. Have received referrals for this program from partners.</td>
</tr>
<tr>
<td>More aware of resources and agencies in the area and are better equipped to provide referrals, collaborate, and meet community needs.</td>
</tr>
<tr>
<td>Organizations have become more knowledgeable about the other organizations in [C3 service area] and about what services they provide and how we can all work together.</td>
</tr>
<tr>
<td>Relationships have become stronger by collaborating through the [C3 site] SIM project. Future collaborations are welcome and encouraged.</td>
</tr>
<tr>
<td>The more organizations interact the more trust develops between staff. Also, whether it was intentional or a byproduct SIM has helped [C3 service area] as a whole become more organized and connected.</td>
</tr>
<tr>
<td>We’ve come to know what each of us provides to our communities, and have the phone numbers and contacts to reach out as our client and organization needs dictate. I’ve enjoyed the meetings and have successfully followed up as appropriate. The leadership from [C3 staff] has been great.</td>
</tr>
<tr>
<td>New relationships and communication have been opened through the networking and knowledge building at coalition meetings and events.</td>
</tr>
<tr>
<td>Organizations, who were aware of local programs but did not have personal contacts, have been able to meet, communicate, and create unique partnerships after the meetings that the SIM C3 grant has helped to coordinate. Since the beginning of the grant, organizations with different missions have been able to work together in a unique and collaborative fashion.</td>
</tr>
<tr>
<td>Participation in the [C3 site] has improved communication and collaboration between us and other participating organizations in the [C3 site]. There is better awareness of what other groups are doing and how we can help each other.</td>
</tr>
<tr>
<td>They have remained solid throughout.</td>
</tr>
<tr>
<td>We learned things about our community - like the library having a data base we can all use and other resources we could borrow from one another. Relationships with community leaders were formed or deepened. We learned of major issues facing our community and have been working together more and more to tackle these challenges.</td>
</tr>
<tr>
<td>Although slowly, bridges are being built.</td>
</tr>
<tr>
<td>During our meetings related to the grant, we have been able to share and learn about other collaboration opportunities and express ideas or interest in joining. The collaboration has formed relationships that did not previously exist. It has also helped to foster working together in the community - finding common ground and forming some common processes.</td>
</tr>
<tr>
<td>Seems like people are getting more comfortable and will reach out as needed.</td>
</tr>
</tbody>
</table>
There are a few key relationships that have flourished as a result of this project. Due to work with the Steering Committee Exec Team we have been able to build very strong relationships that change how agencies collaborate on a larger scale that as a result, offers collaboration beyond just C3 activities. The level of trust that has been built allows us as a community to be more reactive to the needs of the population and look beyond C3 to additional opportunities.

This has been a huge community project where multiple organizations had to be on board with decisions made and think of not only their agency’s goals/wants but also that of the greater good.

This has been an opportunity to learn about the participating organization’s strategic goals and how the C3 strategic framework can help meet those goals through community collaboration.

When the C3 formed and work began, some of the partners were not yet at the table but those present needed to work through siloing and some mistrust. Sometimes partnerships simply had not been thought of in the way proposed by the C3. The work conducted by this group has forever changed the landscape of collaboration and will continue to do so as long as there is support financially and through staff to maintain the collaborative structure and environment.

I think we have a much better understanding of what roles each member holds in the community and also "who is good at doing what" Our mental health process has improved quite a bit, we have the [community program] and also [community program] that is really providing comprehensive services for certain mental health populations and that has been highly encouraging. We have work to do on how to make referral process more streamlined for the consumer. I feel we are gaining ground on truly understanding and assessing the social determinants of health. This is key to success in the population we serve.

Improved knowledge of each organizations functions, purpose and goals. Relationships continue to improve as success is measured and experienced.

Relationships have strengthened overall. Communication lines are open and increasingly healthy.

The relationships between organizations have strongly developed into great, leading partnerships. These organizations work very close to successfully implement a strategic plan, act upon that plan, and change/learn from anything that could be done better for future. All organizations put in valued time, effort, and care into each patient(s). The [C3 site] program has been very successful with great learning opportunities along the way. Personally, I am very excited so watch this program grow.

Collaboration on Diabetes topics have increased.

Coordinated outreach by service providers throughout the County has improved.

I do not believe that they have changed at all.

I think there has been a greater cooperation to coordinate care and utilize community resources that there previously was.

more aware of each others strengths and how to partnership for the best leverage.

not able to speak to this question

The relationship seems to be very one-sided with [C3 integrator organization] not building strong relationships with other community organizations. [C3 integrator organization] tends to take advantage of others hard work and accomplishments for their benefit to access grant funding and reap the accolades.

We have developed relationships that have grown into trusting partnerships. Trust takes time and having the right people on the team to lead this initiative has been key to its success. [C3 staff member] is a perfect fit!

I am more than happy to express my appreciation to [C3 integrator organization] for granting us the opportunity to hold our diabetes reversal seminar in your boardroom. We found the facilities very adequate for our needs. A group of six participated in the six-week seminar, and one is successfully reversing her diabetes. This degree of success is consistent with that what we see nationally. For this person, renewed health is well worth the effort she has made to improve her lifestyle, and [community program] showed her how to do it.

Got to know contacts at each facility.
<table>
<thead>
<tr>
<th>Improved information sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networking across the organizations is great.</td>
</tr>
<tr>
<td>The Diabetes Educators from the four hospitals in [C3 service area] and [C3 integrator organization] have had a strong working relationship prior to C3 and I anticipate we will continue to collaborate on improving the health of our citizens.</td>
</tr>
<tr>
<td>The Diabetes Educators at [healthcare facility] have had an excellent working relationship with the administration, providers and nursing staff at [healthcare facility]. We have collaborated on several projects, including a joint diabetes support group for Spanish speakers, a bilingual health fair, health care coordination for a complex patient who is a patient at both healthcare facilities, etc. We look forward to partnering with them in other areas, like diabetes prevention in our Spanish speaking community since being Latino is a major risk factor for diabetes and pre-diabetes.</td>
</tr>
<tr>
<td>They have strengthen partly due to this grant but I will have to say that they have strengthen due to the hard work that the specific organization has done as well as our organization.</td>
</tr>
<tr>
<td>We have all become good resources amongst ourselves, good team leaders and collaborate between each Provider City and County work together to find solutions for residents in need.</td>
</tr>
<tr>
<td>Clinics more aware of what Public Health can do to help connect people with services and coordination that is needed.</td>
</tr>
<tr>
<td>Closer relationships have been formed by working together to address needs of C-3 participants.</td>
</tr>
<tr>
<td>collaboration on multiple patients. support of individuals that need services/support not available through other more traditional channels</td>
</tr>
<tr>
<td>I have not been in communication with C3 very much through this grant period. If I have an article to write for [organization] I will reach out to C3 for collaborative opportunities. There isn't a lot of communication between our organization at the county level. [organization] works closely at the IDPH state level with screenings and prevention.</td>
</tr>
<tr>
<td>I think all of the relationships have gained more trust and become stronger. There is definitely comradery between employees that was not present prior to the grant. I see all these relationships continuing to grow.</td>
</tr>
<tr>
<td>Relationships are stronger and the network is broader.</td>
</tr>
<tr>
<td>The structure of the C3 region mirrors the structure of the Service Area 7 Emergency Preparedness region. Which standardizes and streamlines the delivery of a public health system with the hospital system.</td>
</tr>
<tr>
<td>Relationships have strengthened over the project, while some new relationships have been developed.</td>
</tr>
<tr>
<td>[C3 integrator organization] had received a continuation grant in March of 2016, yet the C3 relationships have become part of the ongoing structure of the health care community which was more fragmented prior the C3 program.</td>
</tr>
<tr>
<td>We have worked more collaboratively to meet the needs in our community. We have utilized other providers as a resource to answer questions.</td>
</tr>
<tr>
<td>We work together as one functioning unit.</td>
</tr>
<tr>
<td>[C3 integrator organization] has been absolutely great to work with. I work in both the ER at [healthcare facility] and [healthcare facility]. Amazing team players.</td>
</tr>
</tbody>
</table>
A web-based survey was conducted of the steering committee members from all seven C3 sites during February and March 2018. Each C3 steering committee member received a survey for their own C3 region resulting in seven slightly different C3 steering committee surveys. This approach allowed the survey instruments to be consistent while including introductions that reflected the names and geographic areas of each C3. The survey asked questions about the survey respondent’s role in the C3 and representation on the steering committee, as well as questions about awareness and knowledge of the local C3, participation in C3 activities, and satisfaction with C3 initiatives. The introduction and survey instrument are in the Addendum. Most questions in the survey used a Likert scale; survey respondents were asked to rate their agreement with various statements, using the ratings: “strongly disagree”, “disagree”, “neither agree nor disagree”, “agree”, and “strongly agree”.

In 2018, forty surveys were completed for an aggregate response rate of 56% with varying response rates by C3 (as shown in Table 1 below). Sioux County and Linn County had the highest survey response rates while Webster County had the lowest response rate. The steering committee survey included a brief overview of why the survey was being conducted and for those that needed additional information about the Iowa SIM and C3s, additional information was made available electronically. Two survey respondents, both from the Muscatine C3 – new C3 site in Year 2 - requested additional information.

<table>
<thead>
<tr>
<th>C3</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of Steering Committee Members</td>
<td>Survey Response Rate</td>
</tr>
<tr>
<td>Webster County</td>
<td>12</td>
<td>50%</td>
</tr>
<tr>
<td>Great River</td>
<td>37</td>
<td>32%</td>
</tr>
<tr>
<td>Linn County</td>
<td>18</td>
<td>61%</td>
</tr>
<tr>
<td>Marion County</td>
<td>27</td>
<td>56%</td>
</tr>
<tr>
<td>Dallas County</td>
<td>18</td>
<td>78%</td>
</tr>
<tr>
<td>Sioux County</td>
<td>15</td>
<td>80%</td>
</tr>
<tr>
<td>Muscatine¹</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

¹The Muscatine C3 site was not in operation in Year 1.

Respondent Role

When asked to report their role on the C3 steering committee, survey respondents indicated they are public health providers (35.5%), hospital leaders (22.5%), healthcare providers (20%), clinic leaders (17.5%), others (17.5%) or community members (7.5%). Comparing Year-1 survey respondents to those in Year-2 (Table 2), survey respondents in Year-2 were more likely to be a public health provider or a healthcare provider and much less likely to be a community member.
### Table 2. Respondent Role on the Steering Committee

<table>
<thead>
<tr>
<th>Role on the Steering Committee</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Provider</td>
<td>29%</td>
<td>36%</td>
</tr>
<tr>
<td>Community Member</td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>Healthcare Provider</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital Leader</td>
<td>21%</td>
<td>23%</td>
</tr>
<tr>
<td>Clinic Leader</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Other</td>
<td>25%</td>
<td>18%</td>
</tr>
</tbody>
</table>

### Awareness of and Participation in the C3 Initiative

Several questions were asked to assess how well the steering committee members interacted with the C3 initiative. (Table 3) When asked, “I am aware of the C3’s role in my community”, survey respondents reported they “strongly agree” (60%), “agree” (34%), or “neither agree nor disagree” which is an increase in those who strongly agree from year 1. When asked, “I am aware of the C3 initiatives underway in my community”, survey respondents reported they “strongly agree” (66%), “agree” (26%), “neither agree nor disagree” (6%) or “disagree” (3%), again indicating similar overall awareness but an increase in those who strongly agree when compared to Year-1. When C3 steering committee members were asked, “It’s important that I participate in the C3 steering committee”, 61 percent “strongly agree”, 35 percent “agree”, and 3 percent “neither agree nor disagree”. This question was not asked in year 1.

When the survey stated, “I participate in local C3 initiative planning and development”, 63 percent “strongly agree”, 34 percent “agree”, and 3 percent “neither agree nor disagree.” These data suggest a greater percentage of steering committee members are participating in C3 planning and development when compared to Year-1. All steering committee members from Linn County C3 and Marion County C3 “strongly agree” they participate in C3 planning and development. Complementing this, C3 steering committee members were asked in year 2 if they participate in local C3 decision-making. Sixty-three percent “strongly agree”, 28 percent “agree”, and 9 percent “neither agree nor disagree” they participate. Also new in year 2, C3 steering committee members were asked to rate their agreement that the steering committee uses local patient data to drive C3 decision-making. They were most likely to “strongly agree” (44%) or “agree” (44%) with 14% “neither agree nor disagree”. At least one survey respondent in Linn, Webster and Sioux County C3s indicated they neither agree nor disagree.

Finally, C3 steering committee members were asked about their satisfaction with the C3 and the initiatives underway in their communities, they reported: 21 percent are “very satisfied”, 73 percent are “satisfied”, and 6 percent are “neither satisfied nor dissatisfied”. Comparing this to Year-1, a lower percentage of survey respondents were “very satisfied” in Year-2; however, no survey respondents were dissatisfied in Year-2. Linn County C3 steering committee members were most likely to be “very satisfied” (62.5%) with the local C3 and its initiatives.
### Table 3. Awareness of and Participation in the C3 Initiative

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who Strongly Agree</td>
<td>% who Agree</td>
<td>% who Strongly Agree</td>
</tr>
<tr>
<td>Aware of local C3’s role in the community</td>
<td>55%</td>
<td>42%</td>
</tr>
<tr>
<td>Aware of the local C3’s activities underway in the community</td>
<td>50%</td>
<td>45%</td>
</tr>
<tr>
<td>It is important to participate in the C3 Steering Committee</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
<tr>
<td>Participate in local C3 initiative planning and development</td>
<td>35%</td>
<td>45%</td>
</tr>
<tr>
<td>Participate in local C3 initiative decision-making</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
<tr>
<td>Steering committee uses local patient data to drive C3 decision-making</td>
<td>Not asked</td>
<td>Not asked</td>
</tr>
</tbody>
</table>

**Awareness of primary features of C3 work**

As stated in the Iowa SIM operational plan, the C3s have two primary intentions: 1) enhance care coordination by identifying population risks and addressing barriers to health such as social determinants of health and 2) develop and implement tactics from the statewide strategies to address diabetes and risk factors relating to diabetes. In year 2, steering committee members were asked about their knowledge of care coordination, social determinants of health, and gaps in diabetes services in their region. Table 4 provides a summary of their responses.

In general, steering committee members were knowledgeable about the concepts of care coordination and social determinants of health. Steering committee members (84%) were most strongly in agreement with, “I am aware of social determinants of health and their impact on health outcomes”. Yet, 50% expressed strong agreement with the statement “I am aware of the gaps in diabetic services in my community/region.”
Table 4. Awareness and Knowledge of Primary Intentions of C3 Initiative

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of the role of care coordination and its intended impact on health outcomes.</td>
<td>69%</td>
<td>28%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of social determinants of health and their impact on health outcomes.</td>
<td>84%</td>
<td>13%</td>
<td>3%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of the gaps in diabetic services in community/region.</td>
<td>50%</td>
<td>41%</td>
<td>9%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

C3 ability to meet community member needs

Steering committee members were asked their agreement with how the primary functions of the C3 initiatives were being met in their communities. In Table 5 below, we see a shift from year 1 towards care coordination services being implemented in year 2 and more steering committee members in year 2 who strongly agree that community members’ needs related to social determinants of health are being addressed. However, there was a decline in the percentage who strongly agreed their community members’ diabetic needs were being addressed because of the local C3 (39% in year 1, 27% in year 2) even though the overall agreement (strongly agree and agree) was slightly higher in year 2 (88%) than year 1 (82%). Results were comparable between year 1 (89%) and year 2 (88%) on those who agree that “In the past year, community partners/social services have been working more/better together to meet patient needs”.
Table 5. Agreement regarding C3 initiatives ability to meet community member needs

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>% who Strongly Agree % who Agree % who Strongly Agree % who Agree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care coordination needs in my community will be or are being</td>
<td>40%</td>
<td>Not asked</td>
</tr>
<tr>
<td>addressed through the local C3 initiative.</td>
<td>49%</td>
<td>Not asked</td>
</tr>
<tr>
<td>The local C3 is initiative is implementing care coordination</td>
<td>Not asked</td>
<td>52%</td>
</tr>
<tr>
<td>for patients in my community/region.</td>
<td>Not asked</td>
<td>42%</td>
</tr>
<tr>
<td>Community members’ needs related to social determinants of</td>
<td>42%</td>
<td>48%</td>
</tr>
<tr>
<td>health are being addressed because of the local C3 initiative.</td>
<td>45%</td>
<td>36%</td>
</tr>
<tr>
<td>Community members’ diabetic needs are being addressed because</td>
<td>39%</td>
<td>27%</td>
</tr>
<tr>
<td>of the local C3 initiative.</td>
<td>43%</td>
<td>61%</td>
</tr>
<tr>
<td>In the past year, community partners/social services have been</td>
<td>46%</td>
<td>44%</td>
</tr>
<tr>
<td>working more/better together to</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>meet patient needs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key Take-Away Points**

In general, C3 steering committee members are aware of and participating in the planning and development of their local C3 initiatives with a higher percentage reporting “strong agreement” with C3 initiatives when compared to the first year of the program. Areas for improvement include encouraging the use of local patient population data to inform decision-making and identification of gaps in regional diabetes services to meet the needs of the key focus population of adults with diabetes.
Addendum. Steering Committee Survey Instrument 2018

Introduction:

Below is a survey that is part of a State Innovation Model (SIM) evaluation being conducted in all Community Care Coalition (C3) communities by the University of Iowa Public Policy Center, under contract with Rural Health Solutions. You were identified as a steering committee member that is part of a C3 initiative. Therefore, we would like to learn about your experience and any health system changes that may be underway. The survey will take approximately 3 minutes to complete. Survey analysis will be based on aggregate responses by C3 and statewide.

If you have questions about the survey or need additional information or assistance, please contact Rochelle Schultz Spinarski at rspinarski@rhsnow.com or telephone at 651/731-5211.

Thank you for participating.

For More Information about C3s and SIM click here:

The SIM is a federal grant program administered by the Centers for Medicare and Medicaid Services (CMS). The purpose of the grant is to provide three years of funding for states to develop innovative ways to address the “Triple Aim” of healthcare reform: improve population health and patient experiences and decrease per capita costs. To do this, states are encouraged to use SIM funds to transform their public and private healthcare payment and delivery systems. In Iowa, the SIM includes several overarching methods of action, including: to promote a plan to improve population health, encourage care coordination among providers and across the spectrum of health and social services, enact community-based performance improvement strategies, and encourage the implementation of value-based purchasing into payer and provider contracts.

C3 grants were made to seven organizations in Iowa to transform healthcare delivery by promoting care coordination across the traditional divide between medical, public health, and social service delivery. C3s are community-based coalitions of health and social services stakeholders who collaborate to promote the coordination of the population’s care across a variety of care settings and systems of care. The main intent of the grant program is to provide funding for care coordination teams (whether through public health departments or hospital-based programs) to help primary care providers connect vulnerable populations to resources in the community that could be used to address their particular barriers to health improvement, which include both biomedical and social determinants of health. Six of the C3s are in their second year of funding and are implementing care coordination across a variety of care settings and systems of care. One C3 is in year-one of its initiative.
# C3 Steering Committee Member Questionnaire, February 2018

Survey responses should reflect your experiences and views directly related to the work of the C3 in your community/region.

## Role in C3

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am a member of the local C3 steering committee.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>My role/representation on the steering committee.</td>
<td>Cmty Member</td>
<td>HC Provider</td>
</tr>
</tbody>
</table>

## Awareness and Knowledge of C3

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>I am aware of the local C3’s role in my community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>I am aware of the local C3’s activities underway in my community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Participation in C3 Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>I participate in local C3 initiative planning and development.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>I participate in local C3 initiative decision-making.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>The steering committee uses local patient data to drive C3 decision-making.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>It is important that I participate in the C3 Steering Committee.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I am aware of the social determinants of health and their impact on health outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Community members’ needs related to social determinants of health are being addressed because of the local C3 initiative.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>I am aware of the role of care coordination and its intended impact on health outcomes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>The local C3 initiative is implementing care coordination for patients in my community/region.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>In the past year, care coordination in my community/region has improved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. I am aware of the gaps in diabetic services in my community/region.

15. Community members’ diabetic needs are being addressed because of the local C3 initiative.

16. In the past year, community partners/social services have been working more/better together to meet patient needs.

Satisfaction Overall

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied Nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
</table>

17. How satisfied are you with the local C3 initiative?

18. Comments or Feedback Regarding the Local C3 Initiative:

Thank you for participating in the survey.
A web-based survey was conducted of the Community Coalition members from all seven C3 sites during February and March 2018. Community coalitions’ inclusion in C3 activities was added to C3 Year-2 requirements. The role of this group varied from C3 to C3; however, all focused more on programmatic activities, such as those related to diabetes and obesity versus C3 planning and development as a whole.

The aggregate response rate for this survey was 28 percent. Table 1 provides the number of community coalition members and response rates by C3 site. Response rates varied by site with the highest response (47%) from coalition members of the Dallas County C3.

The Community Coalition survey included a brief overview of why the survey was being conducted, and for those that needed additional information about the Iowa SIM and C3s, additional information was made available electronically (see Addendum). Twenty-three percent of survey respondents indicated a need for additional information about the SIM and/or C3s, including at least one person from each C3 community coalition except for Linn County C3. Two survey respondents, one from Muscatine C3 and one from Webster County C3, indicated they are not members of their C3 Community Coalition.

<table>
<thead>
<tr>
<th>C3</th>
<th># of Community Coalition Members</th>
<th>Survey Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webster County</td>
<td>22</td>
<td>23%</td>
</tr>
<tr>
<td>Great River</td>
<td>21</td>
<td>24%</td>
</tr>
<tr>
<td>Linn County</td>
<td>42</td>
<td>19%</td>
</tr>
<tr>
<td>Marion County</td>
<td>7</td>
<td>29%</td>
</tr>
<tr>
<td>Dallas County</td>
<td>32</td>
<td>47%</td>
</tr>
<tr>
<td>Sioux County</td>
<td>16</td>
<td>31%</td>
</tr>
<tr>
<td>Muscatine</td>
<td>21</td>
<td>24%</td>
</tr>
</tbody>
</table>

The Community Coalition member survey asked questions about the survey respondent’s role in the C3 and representation on the community coalition, as well as questions about awareness and knowledge of the local C3, participation in C3 activities, and satisfaction with C3 initiatives (Survey instrument in Addendum). Similar to the steering committee survey, each C3 had a survey that reflected the names and geographic areas of each C3 and most questions on the survey used a Likert scale; survey respondents were asked to rate their agreement with various statements, using the ratings: “strongly disagree”, “disagree”, “neither agree nor disagree”, “agree”, and “strongly agree”.

**Respondent Role**

When asked to report their role on the C3 community coalition, survey respondents indicated they are ‘Other’ (38%), social services provider (22.5%), community member (20%), healthcare provider (12.5%), hospital leader (7.5%), clinic leader (5%), public health provider (5%), or
behavioral health provider (2.5%). The community coalitions was designed to be a multi-sector partnership and therefore, had a broad member make-up. Thus, the category of ‘other’ could have included individuals from local government, community-based nonprofits, faith-based organizations, area agencies on aging, educational institutions, and other organizations.

**Awareness of and Participation in the C3 Initiative**

Table 2 provides a summary of how well community coalition members were aware of and participated in C3 initiatives. When asked if the member or organization “provides services that are part of the C3 implementation activities, most (73%) survey respondents either “agreed” or “strongly agreed” while 15% “neither agreed nor disagreed” and 12% “disagreed.” When the survey asked, “I am aware of the C3’s role in my community”, again, most (85%) of survey respondents reported they “agree” or “strongly agree.” Similarly, when the survey stated, “I am aware of the C3 initiatives underway in my community”, 85% of survey respondents reported they “agree” or “strongly agree.” Only Community Coalition members from Dallas County C3 reported they “disagree”.

With regard to participation, C3 Community Coalition members were asked if they contribute to C3 planning and development. While most (60%) reported they “agree” or “strongly agree,” several (22%) were either neutral (i.e., “neither agree nor disagree”) or “disagreed” (18%). C3 community coalition members were asked to rate their agreement that the Community Coalition uses local patient data to drive C3 decision-making. Almost three-quarters (71%) either “agreed” or “disagreed” with the rest choosing “neither agree nor disagree” (29%). And, when C3 Community Coalitions were asked, “It’s important that I participate in the C3 Community Coalition”, more respondents “agreed” (63%) than “strongly agreed” (26%).

Finally, C3 Community Coalition members were asked about their satisfaction with the C3 and the initiatives underway in their communities and they reported: “very satisfied” (26%), “satisfied” (52%), and “neither satisfied nor dissatisfied” (22%).
Table 2. Awareness of and Participation in the C3 Initiative

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides services that are part of C3 implementation activities</td>
<td>31%</td>
<td>42%</td>
<td>15%</td>
<td>12%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of the local C3s role in the community/region</td>
<td>44%</td>
<td>41%</td>
<td>9%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of the local C3s activities underway in the community/region</td>
<td>44%</td>
<td>41%</td>
<td>9%</td>
<td>6%</td>
<td>0%</td>
</tr>
<tr>
<td>Contribute to local C3 initiative planning and development</td>
<td>30%</td>
<td>30%</td>
<td>22%</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>C3 Community Coalition uses local/regional patient data to drive decision-making</td>
<td>21%</td>
<td>50%</td>
<td>29%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>It is important to participate in the C3 Community Coalition</td>
<td>26%</td>
<td>63%</td>
<td>11%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Awareness of primary features of C3 work**

As stated in the Iowa SIM operational plan, the C3s have two primary intentions: 1) enhance *care coordination* by identifying population risks and addressing barriers to health such as *social determinants of health* and 2) develop and implement tactics from the statewide strategies to address *diabetes* and risk factors relating to diabetes. Community coalition members were asked about their knowledge of care coordination, social determinants of health, and gaps in diabetes services in their region. Table 3 provides a summary of their responses.

As indicated, community coalition members were most in agreement with, “I am aware of the social determinants of health and their impact on health outcomes” as 100% reportedly “agree” or “strongly agree”. And, there was also strong agreement in “I am aware of the role of care coordination and its intended impact on health outcomes” as 96% either “agree” or “strongly agree” with that statement. While the majority (61%) “agreed” to being aware of the gaps in diabetic services in their community, few (4%) reported strong agreement and 7% disagreed.
Table 3. Community Coalition Awareness of C3 Activities

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aware of the role of care coordination and its intended impact on health outcomes.</td>
<td>44%</td>
<td>52%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of social determinants of health and their impact on health outcomes.</td>
<td>46%</td>
<td>54%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Aware of the gaps in diabetic services in community/region.</td>
<td>4%</td>
<td>61%</td>
<td>29%</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

C3 ability to meet community member needs

Community coalition members were asked their agreement with how the primary functions of the C3 initiatives were being met in their communities. Table 4 summarizes the responses. The statement with the most agreement from the members was about C3s addressing needs relating to social determinants of health with the majority (84%) agreeing with that needs were being met (nearly half (46%) reported “strong” agreement). There was somewhat less strong agreement with the statements about care coordination and partnerships working better together. While most still agreed, less than 20% “strongly” agreed that the local C3s were implementing care coordination in the region and that care coordination had improved in the region within the past year. In fact, 8% “disagreed” that care coordination efforts had improved. And, less than 20% “strongly” agreed that within the past year, community partners/social services had been working more/better together to meet patient needs.

Regarding diabetic needs being met, just over half (52%) either “agreed” or “strongly agreed” that community members’ diabetic needs were being addressed because of the local C3 initiative with the rest either neutral (44%) or disagreeing (4%) with that statement.
Table 4. Community Coalition Agreement with Activities and Outcomes of All C3 Initiatives Meeting Community Member Needs

<table>
<thead>
<tr>
<th>Activities and Outcomes of the C3 Initiatives</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree nor Disagree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local C3 is implementing care coordination for patients in my community/region</td>
<td>19%</td>
<td>52%</td>
<td>26%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>In the past year, care coordination in my community/region has improved</td>
<td>15%</td>
<td>46%</td>
<td>31%</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Community members’ needs related to social determinants of health will be or are being addressed by the local C3 initiative</td>
<td>48%</td>
<td>36%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Community members’ diabetic needs are being addressed because of the local C3 initiatives</td>
<td>11%</td>
<td>41%</td>
<td>44%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>In the past year, community partners/social services have been working more/better together to meet patient needs</td>
<td>19%</td>
<td>54%</td>
<td>27%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Key Take-Away Points**

New to this evaluation period was an assessment of the experiences of the members of the C3 community coalition. Surveys were returned by 45 members of community coalitions across all seven C3 sites. In summary, all community coalition members understood the impact of social determinants of health (SDHs) on health outcomes and the majority reported that community member needs related to SDHs were being addressed by their local C3 initiative. While all members also reported understanding the impact of care coordination on health outcomes and most reported agreement that C3s were implementing care coordination in their region, the level of agreement about care coordination needs being met was not as strong when compared to SDH needs being met. Finally, these findings suggest that there is some work to be done when engaging community coalition members in the focus area of addressing the needs of community members with diabetes.
Addendum. Coalition Member Survey Instrument 2018

Introduction:

Below is a survey that is part of a State Innovation Model (SIM) evaluation being conducted in all Community Care Coalition (C3) communities by the University of Iowa Public Policy Center, under contract with Rural Health Solutions. You were identified as a C3 Coalition member. Therefore, we would like to learn about your experience and any health system changes that may be underway. The survey will take approximately 3 minutes to complete. Survey analysis will be based on aggregate responses by C3 and statewide.

If you have questions about the survey or need additional information or assistance, please contact Rochelle Schultz Spinarski at rspinarski@rhsnow.com or telephone at 651/731-5211.

Thank you for participating.

For More Information about C3s and SIM click here:

The SIM is a federal grant program administered by the Centers for Medicare and Medicaid Services (CMS). The purpose of the grant is to provide three years of funding for states to develop innovative ways to address the “Triple Aim” of healthcare reform: improve population health and patient experiences and decrease per capita costs. To do this, states are encouraged to use SIM funds to transform their public and private healthcare payment and delivery systems. In Iowa, the SIM includes several overarching methods of action, including: to promote a plan to improve population health, encourage care coordination among providers and across the spectrum of health and social services, enact community-based performance improvement strategies, and encourage the implementation of value-based purchasing into payer and provider contracts.

C3 grants were made to seven organizations in Iowa to transform healthcare delivery by promoting care coordination across the traditional divide between medical, public health, and social service delivery. C3s are community-based coalitions of health and social services stakeholders who collaborate to promote the coordination of the population’s care across a variety of care settings and systems of care. The main intent of the grant program is to provide funding for care coordination teams (whether through public health departments or hospital-based programs) to help primary care providers connect vulnerable populations to resources in the community that could be used to address their particular barriers to health improvement, which include both biomedical and social determinants of health. Six of the C3s are in their second year of funding and are implementing care coordination across a variety of care settings and systems of care. One C3 is in year-one of its initiative.
C3 Coalition Member Survey, February 2018

Survey responses should reflect your experiences and views directly related to the work of the C3 in your community/region.

### Role in C3

1. I am a member of the local C3 Coalition.
   - Yes
   - No

2. My role/representation as part of the C3 Coalition.
   - Cmty Member
   - HC Provider
   - Hospital Leader
   - Clinic Leader
   - Other

### Awareness and Knowledge of C3

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>3. I am aware of the local C3’s role in my community/region.</td>
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<td>4. I am aware of the local C3’s activities underway in my community/region.</td>
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### Participation in C3 Initiatives

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<tr>
<th>Initiative</th>
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<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>5. I contribute to local C3 initiative planning and development.</td>
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<td>6. Me or my organization provides services that are part of C3 implementation activities.</td>
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<td>7. It is important that I participate in the C3 Community Coalition.</td>
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<tr>
<td>8. The C3 Community Coalition uses local/regional patient data to drive decision-making.</td>
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<td>9. I am aware of the social determinants of health and their impact on health outcomes.</td>
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<tr>
<td>10. Community members’ needs related to social determinants of health are being addressed because of the local/regional C3 initiative.</td>
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<tr>
<td>11. I am aware of the role of care coordination and its intended impact on health outcomes.</td>
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<tr>
<td>12. The local C3 initiative is implementing care coordination for patients in my community/region.</td>
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<tr>
<td>13. I/my organization participate(s) in the C3 patient referral process.</td>
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</table>
14. In the past year, care coordination in my community/region has improved.

15. I am aware of the gaps in diabetic services in my community/region.

16. Community members’ diabetic needs are being addressed because of the local C3 initiative.

17. In the past year, community partners/social services have been working more/better together to meet patient needs.

<table>
<thead>
<tr>
<th>Satisfaction Overall</th>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied Nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
</tr>
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<tbody>
<tr>
<td>18. How satisfied are you with the local C3 initiative?</td>
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19. Comments or Feedback Regarding the Local C3 Initiative:

*Thank you for participating in the survey.*
A mailed healthcare provider survey was conducted during March-April 2018 of those healthcare providers participating in the Webster County and Great River C3s. Provider lists were provided to the evaluation team by the project leads from each C3. The survey was mailed to 50 nurse practitioners, physicians, physician assistants, psychiatrists, and two registered nurses. Nine providers (response rate = 18%) returned the survey. Five respondents were physicians, two were nurse practitioners, and two did not state their profession.

The survey asked questions about C3 awareness, knowledge, and participation in C3 initiatives; C3 satisfaction overall; and background information on the survey respondent. For the awareness, knowledge, and participation questions, the respondents were asked to use a Likert scale ranging from “strongly disagree” to “strongly agree” (the same used in the steering committee and community coalition surveys) to rate the 17 statements provided. The introductory script and survey instrument are in the Addendum.

**Awareness and Knowledge of the C3 Initiative**

When asked about awareness of the SIM initiative, 44% of survey respondents reported they “strongly agree” or “agree” they are aware while 22% “neither agree nor disagree”. When asked about awareness of the local C3’s role in the community, and 2) activities underway in the community, healthcare providers were more likely to “disagree” (44% and 33% respectively) or “strongly disagree” (11%).

Although survey respondents didn’t report a strong awareness of the C3’s roles and activities, 44% “strongly agree” or “agree” and 56% “neither agree nor disagree” that they support their clinic’s collaboration with C3 initiatives and activities. Additionally, 33% “strongly agree” or “agree” and 66% “neither agree nor disagree” that they actively encourage the clinic’s collaboration with C3 initiatives and activities. These findings suggest some support as well as some indifference to collaboration with the C3 initiative.

Providers did seemed to be aware of community services available to their patients. When asked about whether they are aware of the local and regional health and social services available to patients, the majority “agree” (67%). This awareness is similar to findings from the 2017 survey (of Webster C3 providers only) when 71% “strongly agreed” or “agreed”.

Healthcare providers who “strongly agree” they are aware of the SIM also “strongly agree” or “agree” they are aware of the local C3, its activities, regional health and social services, and actively support and encourage the clinic’s collaboration in C3 activities and initiatives.

**Participation in and Implementation of C3 Initiatives**

Two healthcare providers (22%) reported they “agree” that they use information from the C3’s care coordination database to learn more about their patients. Two providers also “agree” that collecting and sharing patient data for C3 activities helps to inform patient care plans. Yet, at the same time, five providers (44%) “neither agreed nor disagreed” and two other providers (22%) “disagreed” that it helps to inform their patient care plans.
Three out of nine healthcare providers (33%) reported they “strongly agree” or “agree” they are better able to support patients’ needs related to their social determinants of health because of the local C3 initiatives. These same three providers reported they “agree” that they are able to support patients’ diabetic needs because of the local C3 initiative. Considering all survey responses, healthcare providers reporting awareness of the SIM and C3 initiatives were the only healthcare providers reporting they “strongly agree” or “agree” they are using the C3 as a means to support patients’ social determinants of health and/or diabetic needs; however, all survey respondents indicated an interest in learning more. Of these three healthcare providers, two report they “agree” that through the local C3 initiative, the clinical care coordination needs of their patients are met and the social determinants of health-related needs are being addressed. Overall, three out of nine healthcare provider respondents (33%) reported they “agree” that in the past year, the C3 initiative has contributed to the improvement of care coordination for their patients and the C3 has contributed to their ability to work more/better with community partners/social services to meet patient needs.

**Key Take-Away Points**

The findings from this work derive from the responses of nine healthcare providers from two different C3 regions (Webster County and Great River Health System in Des Moines County). The response rate is low and, because it only includes providers from two of the seven regions, the findings should not be interpreted to be representative of the C3s as a whole. The findings are a snapshot of the experiences of healthcare providers at the local level with regard to the work of the C3 initiatives. In summary,

- Providers with the strongest awareness of and knowledge of the SIM and C3 initiatives also have the strongest participation in the C3 initiatives and belief that the C3s have contributed to better patient care through enhanced care coordination and addressing social determinants of health.

- Yet, almost half of these provider respondents did not report a strong awareness of the C3’s roles and activities. And, most did not use information collected as part of the C3 initiative to inform patient care plans.

- Although survey respondents reported a lack of awareness of the C3s and their work, it is possible that C3 activities are being imbedded in the care coordination activities and operations of clinics without attributing the work to the C3 and its goals.

- Healthcare providers may also have limited awareness of the C3s and their work due to referrals into the C3 being made from the clinic’s care coordinators, limiting the healthcare provider’s contact and exposure with the C3 as whole.

- In all, these findings suggest that continued engagement of providers at the local level may be the key to more widespread adoption of the principles of the SIM and C3s.
Addendum. 2018 Healthcare Provider Survey Instrument

Date: April 5, 2018

Dear Healthcare Provider,

The attached questionnaire is part of a State Innovation Model (SIM) evaluation being conducted in all Community Care Coalitions (C3) communities by the University of Iowa Public Policy Center, under contract with Rural Health Solutions. You were identified as a healthcare provider that is part of a Year-2 C3 initiative. Therefore, we would like to learn about your experience and health system changes that may be underway. The questionnaire will take approximately 3 minutes to complete and should be returned in the envelope provided by April 20, 2018. Questionnaire analysis will be based on aggregate responses by C3 and statewide.

The SIM is a federal grant program administered by the Centers for Medicare and Medicaid Services (CMS). The purpose of the grant is to provide funding for states to develop innovative ways to address the “Triple Aim” of healthcare reform: improve population health and patient experiences and decrease per capita costs. To do this, states are encouraged to use SIM funds to transform their public and private healthcare payment and delivery systems. In Iowa, the SIM includes several overarching methods of action, including: to promote a plan to improve population health, encourage care coordination among providers and across the spectrum of health and social services, enact community-based performance improvement strategies, and encourage the implementation of value-based purchasing into payer and provider contracts.

Year-2 C3 grants were made to seven communities in Iowa to transform healthcare delivery by promoting care coordination across the traditional divide between medical, public health, and social service delivery. C3s are community-based coalitions of health and social services stakeholders who collaborate to promote the coordination of the population’s care across a variety of care settings and systems of care. The main intent of the grant program is to provide funding for care coordination teams (whether through public health departments of hospital-based programs) to help primary care providers connect vulnerable populations to resources in the community that could be used to address their particular barriers to health improvement, which include both biomedical and social determinants of health. The C3 that you are participating is implementing care coordination and is in Year-2 of its 3-year funding.

As noted above, please return the questionnaire in the envelope provided by April 20, 2018. If you have questions about the questionnaire or need additional information or assistance, please contact Rochelle Schultz Spinarski at rspinarski@rhsnow.com or telephone at 651/731-5211.

Thank you for participating.

Sincerely, the Iowa SIM Evaluation Team

University of Iowa Public Policy Center

Rural Health Solutions
C3 Year-2 Healthcare Provider Questionnaire, April 2018

Survey responses should reflect your experiences and views directly related to the Year-2 work of the C3 in your community/region.

### C3 Awareness and Knowledge

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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
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<tbody>
<tr>
<td>1. I am aware of the State Innovation Model (SIM) initiative.</td>
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<td>2. I am aware of the local C3’s role in my community.</td>
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<td>3. I am aware of the local C3’s activities underway in my community.</td>
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<td>4. I am aware of the local and regional health and social services available to patients.</td>
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<td>5. I support our clinic’s collaboration with the C3 initiative and activities.</td>
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<td>6. I actively encourage our clinic’s collaboration with the C3 initiative and activities.</td>
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### Participation in and Implementation of C3 Initiatives

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<th>Strongly Disagree</th>
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<th>Neither Agree nor Disagree</th>
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<tr>
<td>7. My clinic participates in the local C3 initiative.</td>
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<td>8. I participate in local C3 Initiative planning and development.</td>
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<td>9. I use information from the C3’s care coordination database to learn more about my patients.</td>
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<td>10. I am better able to support patients’ needs related to their social determinants of health because of the local C3 initiative.</td>
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<tr>
<td>11. I am better able to support patients’ diabetic needs because of the local C3 initiative.</td>
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<td>12. C3 related care coordination processes are integrated into routine workflow.</td>
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<td>13. Through the local C3 initiative, the clinical care coordination needs of my patients are being met.</td>
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<td>14. Through the local C3 initiative, the social determinants of health-related needs of my patients are being addressed.</td>
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<td></td>
<td>Strongly Disagree</td>
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<td>15. In the past year, the C3 initiative has contributed to the improvement of care coordination for my patients.</td>
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<td>16. In the past year, the C3 initiative has contributed to my ability to work more/better with community partners/social services to meet patient needs.</td>
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<tr>
<td>17. Collecting and sharing patient data for C3 activities helps to inform patient care plans.</td>
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**Satisfaction Overall**

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<tr>
<th></th>
<th>Very Dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither Satisfied Nor Dissatisfied</th>
<th>Satisfied</th>
<th>Very Satisfied</th>
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<tbody>
<tr>
<td>How satisfied are you with the local C3 initiative?</td>
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<tr>
<td>How satisfied are you with your role in the local C3 initiative?</td>
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Comments or Feedback Regarding the Local C3 Initiative:

**Background Information**

Are you a physician, nurse practitioner or physician assistant? (check one) __M.D. __NP __PA

How many years have you been practicing at this clinic? ___ Yrs.

How many years have you been in practice since completing your training? ___ Yrs.

What was your age on your last birthday? ___ Yrs.

Are you male or female? __Male __Female

What hospital and/or health system(s) are you/your clinic affiliated? Specify. __________________________________________

*Thank you for participating. Please return the survey by *April 20, 2018* in the attached envelope.*
Telephone interviews were conducted in April 2018 with two clinic managers and one diabetes educator involved with the Great River, Linn County, and Webster County C3s. The clinic managers and diabetes educator were identified by the C3 program officers. One of the clinics was a federally qualified health center (FQHC) that offers an array of services (e.g., family practice, oral health, OB/GYN, after-hour walk-ins, student health) and who serves primarily Medicaid patients. The second clinic was a designated rural health clinic with a large Medicare population. Both clinics have been participating in C3 activities since program start. The diabetic educator serves as the Diabetic Program Coordinator in a small clinic setting.

The interview was based on a semi-structured script (see Addendum) and was conducted over the telephone. Each interview was about an hour in duration.

**Effect of C3 Initiative on Organizational Operations**

Clinic managers and the diabetes educator agreed their operations had not changed solely because of the C3s. Instead, roles, degree of coordination and integration, patient engagement, and operations have been constantly changing due to Accountable Care Organizations (ACOs), managed care, other insurers, grant funded initiatives (e.g., SIM and National Association of Community Health Centers - NACC), and health policy changes in general.

**Successes**

All interviewees reported working to improve access and patient outcomes as well as decrease duplication of services. One example of this was FQHCs around the state who met once a week to develop a risk stratification plan to identify patients to target for care management and additional resources. The aim of that work was to decrease hospitalizations and ultimately costs. This work aligns well with the goals of the SIM and the C3 initiative.

Clinic managers and the diabetes educator agreed their participation in the C3 has:

- improved transparency,
- increased their knowledge of local and regional health and social services resources,
- improved local and regional partnerships, and
- increased awareness of the need and process to uncover and address patients’ social needs.

**Challenges and Needs**

Interviewees agreed their organizations are committed to long-term implementation of C3 goals; however, for some organizations, it is still early in the process, so work-flows are not fully determined, care coordination data tracking systems are just getting rolled out, and in some instances, project plans are still being developed.
Several questions on the survey were specific to the C3 focal health area of diabetes. When asked about diabetes needs and next steps, the clinic managers and diabetes educator reported the following needs:

- Better pre-diabetes resources and insurance to cover costs.
- Standardized diabetes education.
- Standardized blood glucose logs that are easily and consistently understood by both patients and healthcare providers.
- Increased focus on and resources to address behavioral health.
- Engagement and involvement by the staff and healthcare providers who are working directly with patients.
- Knowledge of and access to technology that can support patients and the care process.

**Key Take-Away Points**

Interviews with clinic managers in 2018 were from C3 sites different from those in 2017 (Dallas County and Sioux County). The interview of a diabetes educator was new to 2018 and was conducted as a result of the shift in the requirements of the C3 initiatives to focus program efforts, data collection, and reporting.

In summary,

- Similar to what was reported in 2017, clinic operations have not changed markedly due to the C3s but are constantly changing due to a variety of factors such as trends or shifts in health policy, new regulatory or insurance-related requirements, or grant funding.
- Many SIM and/or C3 goals were identified as successes including work toward reducing duplication of efforts, hospitalizations, targeting at-risk populations, increased knowledge of local and regional health and social services resources, improved partnerships among agencies/organizations, and increased awareness about the need to address social determinants of health.
- Interviewees identified several needs specific to the care and education of their patients with diabetes.
- Challenges remain with regard to the design, development, and implementation of work-flows, project plans, and care coordination data tracking systems.
Addendum. Clinic Manager and Diabetes Educator Interview Scripts

IA SIM, C3 Initiative, Clinic Team Interviews

| Introduction | I want to thank you for taking the time to meet with me today. My name is Rochelle Spinarski and I am working with the team at the University of Iowa Public Policy Center that is responsible for the Iowa SIM Evaluation. More specifically, I am conducting interviews and surveys with community partners involved with the C3s (community care coalitions). Our aim is to learn about and document various health system changes that are occurring because of the C3s. To do this, I would like to talk to you about your experiences participating as a partner in your local C3 initiative that is underway. I won’t be asking any patient-specific questions but as we go through the questions, feel free to share any examples of patient experiences that may highlight or describe some of the work underway and the impact it is/is not having. |
| Purpose of Interview | The interview should take about an hour. We may find that as we walk through the questions you respond to other questions at the same time and the questions end up out of order during the conversation. This is fine as we will just make sure we have covered all of the topics as we move through the interview. Also, I will only be taking notes during the interview and it will not be recorded. |
| Confidentiality/How Interview Information Will Be Used/Shared | Please note that all responses will be kept confidential; however, anonymous quotes may be used. This means that your interview responses may be shared with research team members at the University of Iowa but we will ensure that any information we include in our reporting does not identify you as the respondent. You don’t have to talk about anything you don’t want to. |
| Name and Title: | Are there any questions about what I have just explained? Are you willing to participate in this interview? |
| Duration | |
| How Interview Will Be Conducted | |
| Clinic Name: | |
| Clinic Location: | |
| Date: | |
| C3 Initiative: | |

<p>| Interview | 1. Briefly describe your organization including any affiliations or special populations that it serves. |
| | 2. What is your role within the organization? Has your role changed because of participation in the C3? Describe. |
| | 3. When and how did you get involved in the C3? If appropriate, describe any program planning or development support that you are involved. |
| | 4. How receptive has your organization been to being a part of the C3 initiative (from leadership to staff)? |
| | 5. Are you sharing and/or accessing patient related data as part of the C3? Describe, including any data sharing with/from providers, care coordinators, and community partners and how this data is being used. |
| | 6. Has data sharing changed or evolved since partnering with the C3? Please elaborate. |
| | 7. To what extent has your participation in the C3 advanced or hindered the work you do, care provided, services, care |</p>
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<tr>
<th>Closing</th>
<th>I’ll be summarizing the information from your interview and others’ and submitting a draft report to the University of Iowa. This information is then added to the broader IA SIM evaluation that is being developed. Evaluation findings are then reported to the Iowa Department of Public Health and CMS. Thank you again for participating. We really appreciate the ability to include your insight into this work. If you have any questions or have other things that you wished you would have said/included in the interview, don’t hesitate to email or call. Thanks again.</th>
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<tr>
<td>Additional Comments</td>
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<td>Next Steps</td>
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<td>Thank You</td>
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IA SIM, C3 Initiative, Diabetes Education Interviews

I want to thank you for taking the time to meet with me today. My name is Rochelle Spinarski and I am working with the team at the University of Iowa, Public Policy Center that is responsible for the Iowa SIM Evaluation. More specifically, I am conducting interviews and surveys with community partners involved with the C3s (community care coalitions). Our aim is to learn about and document various health system changes that are occurring because of the C3s. To do this, I would like to talk to you about your experiences participating as a partner in your local C3 initiative that is underway. I won’t be asking any patient-specific questions but as we go through the questions, feel free to share any examples of patient experiences that may highlight or describe some of the work underway and the impact it is/is not having.

The interview should take about an hour. We may find that as we walk through the questions you respond to other questions at the same time and the questions end up out of order during the conversation. This is fine as we will just make sure we have covered all of the topics as we move through the interview. Also, I will only be taking notes during the interview and it will not be recorded.

Please note that all responses will be kept confidential; however, anonymous quotes may be used. This means that your interview responses may be shared with research team members at the University of Iowa but we will ensure that any information we include in our reporting does not identify you as the respondent. You don’t have to talk about anything you don’t want to.

Are there any questions about what I have just explained?
Are you willing to participate in this interview?

<table>
<thead>
<tr>
<th>Interview</th>
<th>1. Briefly describe your organization including any affiliations or special populations that it serves.</th>
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<tr>
<td></td>
<td>2. What is your role within the organization? Has your role changed because of participation in the C3? Describe.</td>
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<td>3. When and how did you get involved in the C3? If appropriate, describe any program planning or development support that you are involved.</td>
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<td>4. How receptive has your organization been to being a part of the C3 initiative (from leadership to staff)?</td>
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<td></td>
<td>5. Are you sharing and/or accessing patient related data as part of the C3? Describe, including any data sharing with/from providers, care coordinators, and community partners and how this data is being used.</td>
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<tr>
<td></td>
<td>6. Has data sharing changed or evolved since partnering with the C3? Please elaborate.</td>
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<tr>
<td></td>
<td>7. To what extent has your participation in the C3 advanced or hindered the work you do, care provided, services, care</td>
</tr>
<tr>
<td>Closing Additional Comments Next Steps Thank You</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>I’ll be summarizing the information from your interview and others’ and submitting a draft report to the University of Iowa. This information is then added to the broader IA SIM evaluation that is being developed. Evaluation findings are then reported to the Iowa Department of Public Health and CMS. Thank you again for participating. We really appreciate the ability to include your insight into this work. If you have any questions or have other things that you wished you would have said/included in the interview, don’t hesitate to email or call. Thanks again.</td>
<td></td>
</tr>
</tbody>
</table>
Background

The State of Iowa Department of Human Services State Innovation Model (SIM) project has the broad goal of transforming the health care delivery and payment system in order to improve population health, improve patient care, and bend health care cost trends. One of the main SIM initiatives to promote this goal is the Community and Clinical Care (C3) initiative. For the C3 initiative, the SIM project chose six sites in Iowa to receive funding to provide enhanced care coordination and referral systems to people in their communities who may experience unmet healthcare and/or social service needs.

The purpose of this study is to understand the experiences of adults who received care coordination/referral services from the C3 initiatives. To do this, the PPC evaluation team utilized a convenience sample of adults in C3 communities who received care coordination or referral services from a C3 entity and used a paper survey with a mail back option to collect data on their experiences. At the time of these surveys, all six of the C3 initiatives included in this study had been receiving SIM funding for over two years. It is of note that three of the six regions started the SIM award period as implementation sites, meaning that they were ready to implement initiatives at the start of the grant period. The other three C3 organizations were developmental sites, meaning that the first year of the grant would be spent assessing and developing the initiatives for their region. [see Table 1] By the third year of the SIM grant and at the time of this survey, all six sites were implementing SIM-related initiatives.

Methods

The survey of patients/clients of the C3 initiative was conducted over the course of several months during the winter of 2017/2018 and early spring of 2018. The six C3 organizations from which patients/clients were surveyed were:

- Webster County Health Department (WCHD)
- Community Health Partners of Sioux County (CHPSC)
- Dallas County Public Health Nursing Services (DCPH)
- Great River Medical Center in Des Moines County (GRMC-DMC)
- Linn County Public Health (LCPH)
- Marion County Public Health Department (MCPH)

The inclusion/exclusion criteria were the same for each site. The subject population included adults (people over the age of 18) who interacted with a care coordinator from one of the C3 organizations. The PPC team communicated with the program officer from each C3 organization to identify appropriate times to conduct the study. Potential study participants were identified by the care coordinators at each site. The PPC team provided the care coordinators from each site with a packet of information to give to the potential participants. The packet included a cover letter from the UI team, the survey, a pen, and a postage-paid reply
envelope. Spanish versions of the materials were also available to each site. Care coordinators were to identify potential participants and give them the packet which was in an unsealed outer envelope. The potential participant then had two options to return the survey to the UI team: 1) mail the completed survey directly back to the UI PPC in the postage-paid reply envelope, or 2) fill out the survey, put it in the outer envelope of the packet, seal it, and give it back to the care coordinator. For the second option, the C3 organization would collect these sealed envelopes and mail them back to the UI PPC at the end of the time in field. Participants did not have to provide any identifying information to participate in the survey, but could provide identification (name and address) on a form separate from the survey to receive a $10 thank-you gift card.

The survey instrument is in the Addendum. The survey included the following topic areas:

- Demographics (age, gender, race/ethnicity, education)
- Health status (general physical and mental health, self-reported chronic health condition)
- Assessment of self-confidence managing health
- Diabetes diagnosis, and for those with diabetes, questions related to diabetes self-management and potential consequences of diabetes (emergency room visit or hospitalization)
- Care Coordination: Need, Receipt of, and Source of Help Receiving each of the following: a) Medical care, tests, prescriptions, or treatment, b) Someone to help with daily chores, c) Transportation to healthcare visits, d) Food for the household, and e) Stable housing.

Surveys were in the field for at least one month at each C3 site. Table 1 provides the dates in field, number of surveys requested by the C3 site, and number of surveys completed and returned by participants for each C3 site.

<table>
<thead>
<tr>
<th>Site</th>
<th>Original SIM Designation</th>
<th>Field Dates</th>
<th>Number of Surveys Provided to the Site</th>
<th>Number of Completed Surveys Returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCHD</td>
<td>Implementation</td>
<td>11.29.17 – 1.18.18</td>
<td>75</td>
<td>17</td>
</tr>
<tr>
<td>CHPSC</td>
<td>Implementation</td>
<td>11.30.17 – 2.22.18</td>
<td>75</td>
<td>2</td>
</tr>
<tr>
<td>DCPH</td>
<td>Implementation</td>
<td>12.8.17 – 2.2.18</td>
<td>75</td>
<td>43</td>
</tr>
<tr>
<td>GRMC-DMC</td>
<td>Developmental</td>
<td>2.20.18 – 4.16.18</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>LCPH</td>
<td>Developmental</td>
<td>2.27.18 – 4.16.18</td>
<td>50</td>
<td>4</td>
</tr>
<tr>
<td>MCPH</td>
<td>Developmental</td>
<td>3.2.18 – 4.9.18</td>
<td>55</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>355</td>
<td>115</td>
</tr>
</tbody>
</table>
There was a great deal of variation in completions by site. The majority of completed surveys came from three of the six sites. Reasons given by the other three sites for the low numbers of returned surveys included a) it was flu season and they were too busy to hand out surveys, b) there were not as many referrals during the period as they thought they would have, and c) at one site, one of the care coordinators forgot to hand out packets when she met with clients. The intention was for each site to hand out packets for a one-month time period but some sites requested additional time in the field because of start delays, competing priorities over the holiday and flu season, or to account for care coordinator vacation times.

Results are aggregated over all sites. Due to the nature of the convenience sampling method, the small overall sample size, and the variation in survey completions across sites, the results should be interpreted with caution and should be viewed as a snapshot of the experiences of individuals who have received the type of enhanced care coordination that the C3 initiative is intended to provide.
Results

Characteristics of the Survey Respondents

Table 2 provides some of the demographic characteristics of the survey respondents. Due to the nature of the convenience sampling method and the small sample sizes, this information should not be taken to be representative of the demographics of the C3 regions.

In general, around one-third of respondents were in the youngest age group (between 18-34), a little over one-fifth (22%) were between 35 and 54, and 42% were 55 years of age or older. Almost three-quarters of respondents were female, 80% were white, and 13% were Hispanic/Latino. The majority of respondents had at least a high school education but over one-fifth (22%) reported not having graduated from high school.

Table 2. Demographics of the Survey Respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>% of 115 respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>18 – 34</td>
<td>36%</td>
</tr>
<tr>
<td>35 – 54</td>
<td>22%</td>
</tr>
<tr>
<td>55 or older</td>
<td>42%</td>
</tr>
<tr>
<td>Female</td>
<td>74%</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>80%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>13%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>4%</td>
</tr>
<tr>
<td>Other*</td>
<td>3%</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Did not graduate high school</td>
<td>22%</td>
</tr>
<tr>
<td>High school graduate/GED</td>
<td>56%</td>
</tr>
<tr>
<td>College degree or higher</td>
<td>22%</td>
</tr>
</tbody>
</table>

* Other races reported included ‘Arab’ (n=2) and ‘Spanish/Dutch/Irish/Welsh’ (n=1).

Health Status

Several questions were asked to assess the self-reported health status and self-rated health management confidence level of the respondents. Respondents were asked:

- In general, how would you rate your overall physical health right now?
- In general, how would you rate your overall mental or emotional health right now?
- Have you been diagnosed with a chronic physical or mental health condition that has lasted or is expected to last for at least 6 months?
- How confident are you that you can manage and control most of your health problems?

Clients of C3 regions reported varying levels of physical and emotional health. Around one-third (30%) reported ‘very good’ to ‘excellent’ physical health while a little over one-third (37%) reported being in ‘fair’ or ‘poor’ physical health. Conversely, over one-third (36%) reported
‘very good’ to ‘excellent’ mental/emotional health while a little under one-third (28%) reported being in ‘fair’ or ‘poor’ mental/emotional health. (Figure 1)

Figure 1. Self-reported Health Status of Survey Respondents

Figure 2. Confidence Managing and Controlling Health Problems by Health Status

Around half (51%) reported having been diagnosed with a chronic physical or mental health condition. Whether or not someone felt confident managing their health depended on their chronic health status, as noted in Figure 2. Only around one-third (35%) of those with a chronic health condition reported being ‘very confident’ that they can manage and control their health problems; 60% were ‘somewhat confident.’ Conversely, 69% of those without a chronic health condition felt ‘very confident’ they could manage and control their health problems while 26% were ‘somewhat confident.’
Diabetes

Because the C3s had a particular focus of effort on their diabetic population, we asked several questions related to diabetes, including:

- Since you have been an adult, has a doctor, nurse, or other health professional EVER told you that you have diabetes? For those who said “Yes”:
  - During the last 6 months, have you had to visit an emergency room or stay overnight in a hospital because of your diabetes?
  - Have any healthcare professionals worked with you to develop a plan so that you know how to take care of your diabetes?
  - Have you ever taken a course or class in how to manage your diabetes yourself?

One-third (n=37) of respondents had been told by a doctor, nurse, or other health professional that they had diabetes. Of those,

- 22% (n=8) reported visiting an ED or staying overnight in a hospital during the previous six months because of their diabetes
- Most (92%; n=34) had worked with a health professional to develop a diabetes care plan
- Around half (49%; n=18) had ever taken a course or class in how to self-manage their diabetes

Care Coordination

The survey included a series of questions to understand the need for, receipt of, and source of help for receiving a variety of health care, home care, and social services. Specifically, the following five service areas were assessed:

1) Medical care – Any kind of care, tests, prescriptions, or treatment for a physical or mental health condition.
2) Help with daily chores – Someone to help with daily chores because respondent was sick or otherwise unable to do them by themselves.
3) Transportation to health care visits - Provided by someone other than respondent.
4) Food security – Household need for food because there was not enough money to buy food.
5) Housing - Housing that respondent owns, rents, or stays in as part of a household.

Need for and Receipt of Services

For each of the service areas, respondents were asked “Within the past 6 months, did you need any…?” For those who reported a need for each service, respondents were asked “Were you able to get the [service] you needed? Table 3 provides the need for and receipt of services.
Table 3. C3 Clients – Need For and Receipt of Services

<table>
<thead>
<tr>
<th>Service</th>
<th>% of Respondents with Need for Service</th>
<th>% of those in Need who Received the Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>69% (79/115)</td>
<td>94% (74/79)</td>
</tr>
<tr>
<td>Help with daily chores</td>
<td>41% (47/115)</td>
<td>89% (42/47)</td>
</tr>
<tr>
<td>Assistance with transportation to health care visits</td>
<td>49% (56/115)</td>
<td>96% (54/56)</td>
</tr>
<tr>
<td>Food</td>
<td>32% (37/115)</td>
<td>89% (33/37)</td>
</tr>
<tr>
<td>Housing</td>
<td>15% (17/115)</td>
<td>77% (13/17)</td>
</tr>
</tbody>
</table>

Source of help getting needed service

The following question was asked of those who needed and received a given service. Did you get help from any of the following to get the needed service?

- Friends and/or family
- Doctor’s office
- Home health nurse
- Local health department
- Other

Respondents were allowed to choose more than one response. Table 4 provides a snapshot of the resources C3 clients used to obtain help getting needed services.
Table 4. Resources Utilized by C3 clients to get needed services.

<table>
<thead>
<tr>
<th>Service</th>
<th>Source of Help</th>
<th>% of Received Help from the Source (# who received help/# who needed and received help)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>Friends/family</td>
<td>39% (29/74)</td>
</tr>
<tr>
<td></td>
<td>Doctor’s Office</td>
<td>39% (29/74)</td>
</tr>
<tr>
<td></td>
<td>Home health nurse</td>
<td>20% (15/74)</td>
</tr>
<tr>
<td></td>
<td>Local health department</td>
<td>28% (21/74)</td>
</tr>
<tr>
<td></td>
<td>Other^1</td>
<td>16% (12/74)</td>
</tr>
<tr>
<td>Help with daily chores</td>
<td>Friends/family</td>
<td>79% (33/42)</td>
</tr>
<tr>
<td></td>
<td>Doctor’s Office</td>
<td>5% (2/42)</td>
</tr>
<tr>
<td></td>
<td>Home health nurse</td>
<td>24% (10/42)</td>
</tr>
<tr>
<td></td>
<td>Local health department</td>
<td>14% (6/42)</td>
</tr>
<tr>
<td></td>
<td>Other^2</td>
<td>7% (3/42)</td>
</tr>
<tr>
<td>Transportation to health care visits</td>
<td>Friends/family</td>
<td>57% (31/54)</td>
</tr>
<tr>
<td></td>
<td>Doctor’s Office</td>
<td>2% (1/54)</td>
</tr>
<tr>
<td></td>
<td>Home health nurse</td>
<td>9% (5/54)</td>
</tr>
<tr>
<td></td>
<td>Local health department</td>
<td>22% (12/54)</td>
</tr>
<tr>
<td></td>
<td>Other^3</td>
<td>15% (8/54)</td>
</tr>
<tr>
<td>Food</td>
<td>Friends/family</td>
<td>42% (14/33)</td>
</tr>
<tr>
<td></td>
<td>Doctor’s Office</td>
<td>3% (1/33)</td>
</tr>
<tr>
<td></td>
<td>Home health nurse</td>
<td>9% (3/33)</td>
</tr>
<tr>
<td></td>
<td>Local health department</td>
<td>49% (16/33)</td>
</tr>
<tr>
<td></td>
<td>Other^4</td>
<td>39% (13/33)</td>
</tr>
<tr>
<td>Housing</td>
<td>Friends/family</td>
<td>47% (7/15)</td>
</tr>
<tr>
<td></td>
<td>Doctor’s Office</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>Home health nurse</td>
<td>7% (1/15)</td>
</tr>
<tr>
<td></td>
<td>Local health department</td>
<td>13% (2/15)</td>
</tr>
<tr>
<td></td>
<td>Other (not specified)</td>
<td>13% (2/15)</td>
</tr>
</tbody>
</table>

^1 Chiropractor, emergency room, health navigator, mental health provider, pharmacy, Medicaid.

^2 Cdac worker.

^3 Case manager, Dart bus, home care, insurance, Medicaid, navigators.

^4 Church, food pantry, health navigator, food stamps, and WIC food stamps.

**Key Take-Away Points**

Overall, 115 patients/clients involved in C3 initiatives responded to this survey.

Who participated in the survey?

- The vast majority of respondents came from the Dallas County Public Health, Webster County Public Health, or Marion County Public Health C3 regions. Very few respondents were patients/clients from the other three C3 sites.
- The majority of C3 clients who responded to this survey were 35 or older, white, female, and had at least a high school degree. Around 1 in 10 were Hispanic/Latino.
How did they perceive their health?

- Around one-third (30%) reported ‘Very good’ or ‘Excellent’ physical health while over one-third (37%) reported ‘Fair’ or ‘Poor’ physical health.
- Over one-third (36%) reported ‘Very good’ or ‘Excellent’ mental/emotional health; less than one-third (28%) reported ‘Fair’ or ‘Poor’ mental/emotional health.
- Around one-half (51%) had been diagnosed with a chronic physical or mental health condition. A little over one-third (35%) of those with a chronic condition reported being ‘Very Confident’ they could manage and control their health problems.

What were the experiences of C3 patients with diabetes?

- 37 of the 115 respondents reported having being diagnosed with diabetes.
- The majority (n=34) had worked with a health professional to develop a diabetes care plan.
- Around half (n=18) had ever taken a course or class in how to self-manage their diabetes. Diabetes education is a promoted initiative of the SIM so this is an area for continued work in C3 regions.

What were the experiences of the C3 patients with regard to obtaining needed health care, personal care, and social services?

- Most (69%) reported a need for some type of medical service (care, prescriptions, or treatment) within the previous six months.
- Almost half (49%) reported a need for transportation to health care visits.
- Less than half reported a need for help with daily chores (41%) and one-third needed help obtaining food for their household (32%); few (15%) reported a need for stable housing.
- Most received the services they needed.
- The vast majority (over 85%) received the medical care, help with daily chores, transportation, and food they needed.
- Around three-quarters received the housing support they needed.
- Most people relied on family and/or friends to help them obtain needed services, regardless of service type (medical, help with daily chores, transportation, food, or housing).
- Almost one-half reported relying on their local health department for help obtaining needed food for their household; a little over one in five relied on their local health department for help with transportation to health care visits.
Addendum. Survey Instrument

Q1. Within the past 6 months, did you need any kind of care, tests, prescriptions, or treatment for a physical or mental health condition?
1 □ Yes
2 □ No – If no, Go to Q5

Q2. Were you able to get the care, tests, prescriptions, or treatment you needed?
1 □ Yes
2 □ No – If no, Go to Q5

Q3. Did you get help from any of the following to get the care, tests, prescriptions, or treatment you needed? Check all that apply.
1 □ I did not need help
2 □ My friends and/or family
3 □ Someone from my doctor’s office
4 □ Your home health nurse
5 □ Someone from the local health dept.
6 □ Other (Describe):

Q4. How helpful was the person(s) from Q3 in getting you the care, tests, prescriptions, or treatment you needed?
1 □ Very helpful
2 □ Somewhat helpful
3 □ Not at all helpful

Q5. Within the past 6 months, did you need someone to help you with daily chores because you were sick or otherwise unable to do them yourself?
1 □ Yes
2 □ No – If no, Go to Q9

Q6. Were you able to find someone to help you with daily chores?
1 □ Yes
2 □ No – If no, Go to Q9

Q7. Did you get help from any of the following to find someone to help you with daily chores? Check all that apply.
1 □ I did not need help
2 □ My friends and/or family
3 □ Someone from my doctor’s office
4 □ Your home health nurse
5 □ Someone from the local health dept.
6 □ Other (Describe):

Q8. How helpful was the person(s) from Q7 in finding someone to assist you with daily chores?
1 □ Very helpful
2 □ Somewhat helpful
3 □ Not at all helpful

Q9. Within the past 6 months, did you need transportation provided by someone other than yourself to get to a healthcare visit?
1 □ Yes
2 □ No – If no, Go to Q13

Q10. Were you able to get the transportation you needed to get to your visit?
1 □ Yes
2 □ No – If no, Go to Q13

Q11. Did you get help from any of the following to get the transportation you needed? Check all that apply.
1 □ I did not need help
2 □ My friends and/or family
3 □ Someone from my doctor’s office
4 □ Your home health nurse
5 □ Someone from the local health dept.
6 □ Other (Describe):

Q12. How helpful was the person(s) from Q11 in getting you the transportation you needed?
1 □ Very helpful
2 □ Somewhat helpful
3 □ Not at all helpful

Q13. Within the past 6 months, did your household need food because there wasn’t enough money to buy food?
1 □ Yes
2 □ No – If no, Go to Q17

Q14. Were you able to get the food your household needed?
1 □ Yes
2 □ No – If no, Go to Q17

Q15. Did you get help from any of the following to get the food you needed? Check all that apply.
1 □ I did not need help
2 □ My friends and/or family
3 □ Someone from my doctor’s office
4 □ Your home health nurse
5 □ Someone from the local health dept.
6 □ Other (Describe):

+Please turn over the page and continue.
Q16. How helpful was the person(s) from Q15 in getting you food for your household?
   1 □ Very helpful
   2 □ Somewhat helpful
   3 □ Not at all helpful

Q17. Within the past 6 months, did you need help finding housing that you own, rent, or stay in as part of a household?
   1 □ Yes
   2 □ No – If no, Go to Q21

Q18. Were you able to get the housing you needed?
   1 □ Yes
   2 □ No – If no, Go to Q21

Q19. Did you get help from any of the following to get stable housing? Check all that apply.
   1 □ I did not need help
   2 □ My friends and/or family
   3 □ Someone from my doctor’s office
   4 □ Your home health nurse
   5 □ Someone from the local health dept.
   6 □ Other (Describe):

Q20. How helpful was the person(s) from Q19 in getting you the housing you needed?
   1 □ Very helpful
   2 □ Somewhat helpful
   3 □ Not at all helpful

Q21. In general, how would you rate your overall physical health right now?
   1 □ Excellent
   2 □ Very good
   3 □ Good
   4 □ Fair
   5 □ Poor

Q22. In general, how would you rate your overall mental or emotional health right now?
   1 □ Excellent
   2 □ Very good
   3 □ Good
   4 □ Fair
   5 □ Poor

Q23. Have you been diagnosed with a chronic physical or mental health condition that has lasted or is expected to last for at least 6 months?
   1 □ Yes
   2 □ No

Q24. How confident are you that you can manage and control most of your health problems?
   1 □ Very confident
   2 □ Somewhat confident
   3 □ Not at all confident

Q25. Since you have been an adult, has a doctor, nurse, or other health professional EVER told you that you have diabetes?
   1 □ Yes
   2 □ No – If no, Go to Q29

Q26. During the last 6 months, have you had to visit an emergency room or stay overnight in a hospital because of your diabetes?
   1 □ Yes
   2 □ No

Q27. Have any healthcare professionals worked with you to develop a plan so that you know how to take care of your diabetes?
   1 □ Yes
   2 □ No

Q28. Have you ever taken a course or class in how to manage your diabetes yourself?
   1 □ Yes
   2 □ No

Q29. What is your age?
   1 □ 18 - 34
   2 □ 35 - 54
   3 □ 55 or older

Q30. What is your gender?
   1 □ Female
   2 □ Male
Q31. What is your race or ethnicity? Check all that apply.

1. American Indian
2. Asian
3. Black/African American
4. Hispanic/Latino
5. White
6. Other (Describe):

Q32. What is the highest level of school that you have completed?

1. Did not graduate high school
2. High school graduate/GED
3. College degree or higher

Thank you for completing this survey
Appendix I: Governor’s Roundtable Recommendations

SEPTEMBER 2018

Recommendations to
GOVERNOR REYNOLDS
—on—
IMPROVING THE HEALTH OF IOWANS

from the
Healthcare Innovation and
Visioning Roundtable
Socio-economic challenges in providing access to high quality healthcare in Iowa’s communities threaten the sustainability of the healthcare system and the health of Iowans. To address these challenges, Governor Reynolds established the Healthcare Innovation and Visioning Roundtable (Roundtable) engaging a diverse group of business leaders, payers, providers and public agency leaders from rural and urban communities across the state to recommend strategies to improve the health and well-being of all Iowans.

The Roundtable, launched in December 2017 and convened through August 2018, developed a three-year transformation vision, guiding principles, and recommendations through a robust public-private partnership and multi-stakeholder engagement process. The recommendations were developed with consensus-driven support and focus on elements deemed most critical to improving outcomes while controlling costs across the health care sector. The Roundtable has established concrete recommendations that could be phased in over the next three years with an incremental approach to maximize the likelihood of success. The recommendations focus on two key and interconnected areas: creating healthy communities for all Iowans and establishing effective data sharing that will support healthy communities throughout Iowa.

The Roundtable established a vision that “Working inside and outside the healthcare system, we will create healthier communities and transform the delivery and financing of care to enable all Iowans to live longer and healthier lives.” With this vision, the Roundtable recommended building economically viable healthy communities that enhance the ability of Iowans with complex healthcare needs and high healthcare costs (high needs, high costs populations) to better manage their health conditions and reduce the cost of care while improving their outcomes. The Roundtable also
determined that a cornerstone of building healthy communities is ensuring there is effective data sharing and use of data. This led to an emphasis on promoting data sharing where providers are making informed, real time decisions about the care and services provided to high need high cost Iowans to allow for the transition to care and services in the community and reducing the need for acute medical care that is more costly.

The Roundtable members would like to acknowledge Governor Reynolds for her leadership in establishing a forum to share ideas and build consensus across a variety of public and private leaders. These recommendations are the beginning of an important public-private partnership that can continue to guide Iowa’s path to improving the health and well-being of all Iowans.

GUIDING PRINCIPLES FOR IOWA’S TRANSFORMATION

In building the recommendations identified below, the Roundtable members identified key principles that are critical to achieving success with any health care transformation strategies in Iowa. These principles include:

• Promote accountability, sustainability, high quality care, coordinated efforts, equitable participation, affordability, patient-centeredness, and transparency.

• Consider the impact of all strategies on rural communities because Iowa is a predominantly rural state.

• Maximize opportunity to secure federal funds in support of new services and infrastructure development.

• Minimize administrative and reporting requirements for providers, payers and patients.
To achieve economically viable healthy communities, the engagement of a diverse group of stakeholders in communities is critical to address the economic and societal impact of unsustainable healthcare costs.

Building healthier environments in homes, schools, workplaces, parks, business areas and roads are a longer-term and ongoing goal for Iowa. Much work is underway to focus on broad population outcomes through projects such as Iowa’s Healthiest State Initiative including 5-2-1-0 Healthy Choices Count, Healthy Hometown powered by Wellmark, and the Community and Clinical Care (C3) Initiative under Iowa’s State Innovation Model (SIM). These initiatives, and others focused on building healthy communities, described in Appendix D should continue to be supported and sustained.

To complement these initiatives, we recommend strategies with a shorter-term goal of addressing the rising cost of healthcare. Working with individual communities to enhance the ability of high need, high cost Iowans to more effectively manage their health conditions will reduce the cost of care for the individual and across the system. Among the most vulnerable are those with complex health, behavioral health and social support needs who have limited access to best practice interventions in the community and, therefore, rely on acute care and other costly sites of care for those supports, otherwise known as “high need, high cost” populations.

**KEY STRATEGIES**

**State and Community Engagement Strategy**

Engage relevant managed care partners, clinical and social service providers, state agencies and other members of the community to identify how to leverage existing initiatives and build needed infrastructure to address the needs of this population collaboratively. Adaptable strategies and applications are necessary to ensure holistic interventions that work for all communities. Iowa’s communities come in all sizes and with varying strengths and opportunities. Resources also vary dramatically, from accountable care organizations in urban communities to critical access hospitals and more limited access to primary care in rural areas.

- Statewide and local partnerships are important resources to support community health infrastructure. Through these partnerships, communities can build a system to support high need, high cost populations with community-based services and supports, effective care coordination and navigation assistance across clinical care and community support systems.

- As communities identify barriers, gaps and opportunities, state agencies can coordinate to direct available resources, needed information and technical assistance to support communities in building on what works and filling gaps to achieve health and wellbeing. These agencies include: Department of Human Services, Public Health, Insurance Division, Education, Economic Development, Aging, Workforce Development, Iowa Finance Authority, and others.
**High Need, High Cost Identification Strategy**

Identify specific high need, high cost populations that are defined by potentially preventable high emergency department use and high hospital inpatient use, as well as individuals with multiple chronic conditions whose issues are best addressed with community-based care. A significant number of hospitalizations and resulting healthcare costs are related to chronic disease, especially among the elderly.

- Use medical and pharmacy data for an initial scan, followed by hospital admission, discharge and emergency department data, along with population health and demographic data to identify target individuals.

- Identify those populations with conditions having the highest potential to benefit from community-based best practices interventions that may result in potentially avoidable use of costly sites of care.

**Social Supports Strategy**

Identify the social supports that can positively impact high need, high cost individuals. These supports may include access to primary care, mental health and substance use services, and community-based services and supports outside of the healthcare system such as housing, food, transportation, and others. Many of the largest drivers of healthcare cost fall outside the clinical care environment.

- Conduct individual screening and assessment for mental health, substance misuse, and social support needs.

- Scan the community for opportunities to increase access to primary care services (e.g., extended hours of operation, urgent care clinics, telehealth) and behavioral health services.

- Assess the availability of community resources to address identified social support needs and identify barriers to be addressed by community partners and state agencies.

- Identify evidence-based interventions for the high need, high cost populations and where gaps exist based on what is available.

**Payment and Payer Strategy**

Identify delivery and payment strategies to incentivize best practice interventions, care coordination, and linkages to community resources and ensure sustainability of these activities and resources for high need high cost populations and beyond. Separate approaches in urban and rural communities are needed and it is likely that approaches will also vary among the rural communities. For rural solutions, multi-year glidepaths may be needed for value-based payment: providing time to test, time to realize outcomes and conduct process improvement, and time to adjust to the economic impacts could be necessary.

- Engage payers and community partners to determine what payment models will incentivize how to address gaps in care for high need high cost populations, including patient engagement and moving towards value for providers and plans.

- Engage the Centers for Medicare & Medicaid Services and major commercial payers to determine willingness to adapt value-based payment strategies for rural areas and to address issues encountered within communities where healthcare access is limited.
The cornerstone of transformation toward healthier communities will be to ensure that effective data sharing and data use to support changes in the delivery and payment of care. As a result, the Roundtable identified key strategies to move forward in technology change that will lower healthcare costs and support care coordination, along with supporting the goal of building healthy communities and addressing high need, high cost populations to improve the value of the care they are receiving while reducing costs.

KEY STRATEGIES

Real Time Healthcare Information Strategy

To support economically viable, healthy communities, create a system that enables Iowans to receive the right care at the right time with real time information. Establish a sustainable statewide shared platform to facilitate real time standardized notification at point of service.

- Establish expectation and garner public commitment from entities within the healthcare sector throughout the state (payers, providers, skilled nursing facilities, pharmacy, labs, etc.) to participate in real time and statewide exchange of healthcare information.

- Establish a governance model for data sharing with multi-stakeholder participation that formalizes the service approach of a
federated data sharing model (e.g. no one entity owns all the data and no centralized repository), membership, and funding strategies. Topics to address through the body would include privacy, security, limitations on use of data use, and data standards.

• Initially target the high need, high cost population that is defined by potentially preventable high emergency department and hospital inpatient use and potentially individuals taking high cost medications to promote care coordination and reduce spending.

• Facilitate participation and utilization of data for users with varying data needs, capacity, and technical capabilities by developing functionality for different types of data exchange users (e.g. inclusion of prescription drug monitoring program data), providing technical assistance support for onboarding, identifying funding strategies for operations infrastructure, and maximizing use of information through data user learning networks.

• Phase-in approach to onboarding providers starting with hospitals and primary healthcare providers within the state of Iowa. In subsequent phases, onboard specialists, other entities within the healthcare sector, and community supports outside of the healthcare system, and neighboring states serving Iowans.

Data Privacy Strategy
Facilitate information sharing needed to support healthy communities by supporting efforts to streamline state privacy laws and clarify federal requirements

• Support alignment of state privacy laws with the Health Insurance Portability and Accountability Act (HIPAA) through modification of laws pertaining to confidentiality of information related to HIV and mental health as set forth in Iowa Code 228.2 and 228.7.

• Seek clarification from federal government and issue state guidance clarifying the sharing of substance use information as specified under Code of Federal Regulations 42 Part 2.

Oversight Strategy
Develop a formal multi-stakeholder governance infrastructure for effective information sharing and metrics of success to guide the development and progress of the data sharing and use strategies to achieve goals such as establishing healthier communities.
Ensuring sustainability of strategies to improve the lives of all Iowans

The Roundtable and workgroups had strong consensus on the need to continue this important work that has brought together business leaders, payers, providers and public agency leaders from rural and urban communities. Together these leaders can ensure the implementation of these recommendations and continue to build and maintain a strong public-private partnership and multi-stakeholder process.

KEY STRATEGIES

Sustainability Strategy
Sustain the Healthcare Innovation and Visioning Roundtable to continue to refine and develop implementation steps for these recommendations and future actions. Information on the work of the Roundtable can be accessed at https://dhs.iowa.gov/ime/about/initiatives/newSIMhome/roundtable.

Convening Strategy
Establish a routine frequency for convening the Healthcare Innovation and Visioning Roundtable and provide periodic reporting of progress on implementing recommendations and future actions.

Stakeholder Engagement Strategy
Establish a stakeholder engagement plan, including opportunities for public engagement and interaction of communities and consumers to share community successes and encourage replication and adaptation of successful community approaches.

Evaluation Strategy
Evaluate the impact of work advanced by the Roundtable using measures and milestones of success that are meaningful for stakeholders in communities and reflect what is important to different constituencies in the community. For sustainability of the healthcare system, these measures may include the cost of unnecessary or potentially preventable emergency department use and hospital utilization, cost measures to facilitate calculation of return on investment, as well as primary care utilization.

These strategies are presented to Governor Reynolds and her administration to address the economic challenges occurring both inside and outside Iowa’s healthcare system. Implementing these strategies will ensure that Iowa is a leader in promoting change in the health care system that will reduce cost while improving the lives of all of its citizens.

APPENDICES

A. Roundtable membership
B. Workgroup charges
C. Roundtable process
D. Related initiatives for healthy communities
E. Suggested Focus Areas for Future Multi-Stakeholder Engagement
APPENDIX A: ROUNDTABLE MEMBERSHIP

VISIONING AND INNOVATION ROUNDTABLE MEMBERS

Jerry Foxhoven | Chair | Iowa Department of Human Services
Ted Boesen | Iowa Primary Care Association
Ed Brown | Iowa Clinic
Marni Bussell | Telligen
Gerd Clabaugh | Iowa Department of Public Health
Tom Evans, MD | Iowa Healthcare Collaborative
Matt Everson | National Federation of Independent Business
Michael Flesher | Iowa Medical Society
Nick Gerhart | Farm Bureau
Jamie Haberl | Healthiest State Initiative
Pam Halvorson | Unity Point Accountable Care
Bror Hultgren | UnitedHealthcare
Jessica Hyland | Association of Business and Industry
Laura Jackson | Wellmark Blue Cross Blue Shield
Jeff Jones | Amerigroup of Iowa
Linda Miller | Iowa Department on Aging
Doug Ommen | Iowa Insurance Division
Andrew Perry | McFarland Clinic
Mike Randol | Iowa Medicaid Enterprise
Michael A. Romano, MD | Iowa Medical Society
Dan Royer | Iowa Hospital Association
Mikki Stier | Iowa Department of Human Services
David Swieskowski, MD | Mercy ACO
Paige Thorson | Office of the Governor of Iowa
Georgia Van Gundy | Iowa Business Council
Jennifer Vermeer | University of Iowa Health Care
DATA SHARING AND USE WORKGROUP PARTICIPANTS

Nick Gerhart | Chair | Farm Bureau  
Laura Jackson | Sponsor | Wellmark Blue Cross Blue Shield  
Ted Boesen | Iowa Primary Care Association  
Tom Evans, MD | Iowa Healthcare Collaborative  
Mike Fay | Wellmark Blue Cross Blue Shield  
Nancy Lind | UnitedHealthcare  
Beth McGinnis | Iowa Clinic  
Perry Meyer | Iowa Hospital Association  
Dennis Petersen | Amerigroup of Iowa  
Mike Randol | Iowa Medicaid Enterprise  
Kenneth Ratliff | Des Moines University  
Sarah Reisetter | Iowa Department of Public Health  
Nathan Riggle | Mercy ACO  
Aric R. Sharp, MHA | UnityPoint Accountable Care  
Dennis Tibben | Iowa Medical Society  
Jennifer Vermeer | University of Iowa Health Care  
Alissa Weber | UnitedHealthcare

HEALTHY COMMUNITIES WORKGROUP PARTICIPANTS

Michael A. Romano, MD | Chair | Iowa Medical Society  
Pam Halvorsen | Sponsor | UnityPoint Accountable Care  
Brenda Dobson | Iowa Department of Public Health  
John Hedgecoth | Amerigroup of Iowa  
Beth Hodges | Amerigroup of Iowa  
Mary Lawyer | Wellmark Blue Cross Blue Shield  
KellyAnn Light-McGroary, MD | UnitedHealthcare  
Beth McGinnis | Iowa Clinic  
Chuck Palmer | Iowa Healthcare Collaborative  
Paige Pettit | UnitedHealthcare  
Sarah Reisetter | Iowa Department of Public Health  
Dan Royer | Iowa Hospital Association  
Tom Scholz, MD | University of Iowa Health Care  
Mikki Stier | Iowa Department of Human Services  
Christi Taylor, MD | Iowa Clinic  
Aaron Todd | Iowa Primary Care Association  
Anne Wright | Mercy ACO
HEALTHY COMMUNITIES WORKGROUP CHARGE

The Healthy Communities Workgroup is charged with creating a three (3) year Roadmap that:

• Defines the attributes of a healthy community;
• Outlines partners inside and outside the healthcare system needed to develop healthy communities;
• Recommends strategies and methods for educating and equipping communities which incorporates payer agnostic principles;
• Acknowledges and plans for dependencies and economic impacts with transition; and
• Includes measures and milestones of success.

DATA SHARING AND USE WORKGROUP CHARGE

The Data Sharing and Use Workgroup is charged with creating a three (3) year Roadmap that:

• Defines the attributes of successful use and sharing of data including type of data, resource needs, information exchange needs.
• Outlines the barriers to success for use and sharing of data and recommends strategies for overcoming barriers regarding capabilities, alignment and standards needed to promote data exchange across the following domains:
  - Interoperability at the point of service;
  - Identification of high needs/high utilizers; and
  - Access to claims data for measuring and monitoring total cost of care.
• Acknowledges and plans for emerging technology; and
• Includes measures and milestones of success.
APPENDIX C: ROUNDTABLE PROCESS

The Iowa Healthcare Innovation and Visioning Roundtable is committed to engaging leaders around the state in developing consensus and transforming how the healthcare system operates to best serve the needs of all Iowans. It is working to identify and prioritize elements necessary for reform and will bring recommendations forward that will inform key healthcare market actors as well as recommendations to Governor Reynolds and her administration regarding necessary steps to implement cost-effective reform that improves the health of Iowans. The Roundtable is a 2-year commitment for invited leaders that will help Iowa develop a post-SIM sustainability work plan and is open to the public. The Roundtable began in late 2017.

LEADERSHIP

• DHS Director serves as Chair of the Roundtable

AUTHORITY

• The Roundtable serves an advisory role, making recommendations to the Governor’s Office
• The Roundtable oversees the workgroups
• Workgroups are charged with developing recommendations to be approved by the Roundtable for presentation to the Governor’s Office

DECISION-MAKING

• Decisions are made by consensus of the Roundtable members

COMPOSITION

• Participants are leaders from around the state of Iowa appointed by DHS

MEETINGS

• Meetings are held quarterly, at minimum, but often bi-monthly
APPENDIX D: RELATED INITIATIVES FOR HEALTHY COMMUNITIES

IOWA HEALTHIEST STATE INITIATIVE
http://www.iowahealthieststate.com/

The Healthiest State Initiative is a nonpartisan, nonprofit organization driven by the goal to make Iowa the healthiest state in the nation. It is supported by dedicated members of the community serving on the board of directors, as well as a team of devoted and passionate staff who understand that good health enriches the lives of Iowans and the state’s economy.

The organization works to engage worksites, communities, schools, retail food, organizations, institutions and individuals to inspire Iowans and their communities to improve their health and happiness, and ultimately become the healthiest state in the nation. In addition to providing valuable resources, the Healthiest State Initiative holds several events throughout the year to engage community contributors and leaders in constructive conversation to improve the health and well-being of Iowans.

HEALTHY HOMETOWN POWERED BY WELLMARK
https://www.wellmark.com/about/community/community-health-improvement/iowa

Healthy Hometown Powered by Wellmark is working to provide a way to make Iowa communities an even better place to live, work, and play by using proven strategies and techniques that help make the healthy choice the easy choice. At no cost, individuals can work with Healthy Hometown experts to identify ways to make positive and lasting changes that enhance well-being in the community, such as planting a community garden, improving community walkability or bikeability, or establishing nicotine-free areas. Healthy Hometown experts are available to assist in prioritizing and implementing a plan to make healthy choices that are available and easy for community residents to adopt.
IOWA SIM COMMUNITY AND CLINICAL CARE (C3) INITIATIVE
https://idph.iowa.gov/SIM/Care-Coordination

C3s are multi-sector groups of stakeholders that include clinical-based healthcare providers, other community-based providers, and public health organizations implementing innovative strategies and referral processes to meet the clinical and social needs of a defined population. The C3s addressing social determinants of health through care coordination and implement population-based, community-applied interventions related to the Iowa SIM Statewide Strategies. These initiatives are intended to enhance care coordination and transitions for both providers and patients by identifying population risks and addressing barriers to health, such as social determinants, by connecting patients (and providers) to community resources and developing and/or implementing strategies to address needs.

All C3s address predetermined tactics from Iowa’s Statewide Strategy Plans. The six objectives of the C3s include: identifying target population by risk; improving diabetes management; linking individuals to community resources and clinical-community programs and services; improving healthcare transitions; decreasing the incidence of diabetes; and, addressing community-wide prevention.
APPENDIX E: SUGGESTED FOCUS AREAS FOR FUTURE MULTI-STAKEHOLDER ENGAGEMENT

1. **Promote transition to increased value-based payment strategies for providers**

2. **Consider policies to support a thriving economy across the state**

3. **Evaluate strategies to increase workforce capacity throughout the state**

4. **Identify common mechanisms to calculate total cost of care**

5. **Improve informed consumer decision-making through education**

6. **Increase availability of transparency information using standard quality reporting and cost information**

7. **Maximize opportunity to improve connectivity telehealth- and how does it connect to data sharing**

8. **Consider implications of emerging technology**
## Community and Clinical Care (C3)

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Measure</th>
<th>Baseline</th>
<th>C3 Performance Rate</th>
<th>Peer Performance Rate</th>
<th>Community Trend</th>
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<tbody>
<tr>
<td>Adverse Drug Event</td>
<td>ADE: Blood Glucose Less than 50</td>
<td>0.376</td>
<td>0</td>
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<tr>
<td>Adverse Drug Event</td>
<td>Adverse Drug Event Rate</td>
<td>4.655</td>
<td>7.353</td>
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<td>BMI Screening</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up (Quality ID:128, NQF: 0421, eMeasure ID: CMS69v5, ACO-16 [PREV-9])</td>
<td>NO</td>
<td>72.216</td>
<td>52.362</td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Number of Closed Referrals to Providers</td>
<td>NO</td>
<td>16.912</td>
<td>11.622</td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Preventable Readmissions</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Coordination Inquiry</td>
<td>Provider Organizations participating in SWAN</td>
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<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>Comprehensive Diabetes Care: Blood Pressure Control</td>
<td>77.411</td>
<td>80.17</td>
<td>80.147</td>
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<tr>
<td>Diabetes</td>
<td>Comprehensive Diabetes Care: LDL-C Control &lt;100 mg/dL</td>
<td>NO</td>
<td></td>
<td>19.459</td>
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<tr>
<td>Diabetes</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%)</td>
<td>18.359</td>
<td>15.411</td>
<td>23.897</td>
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<tr>
<td>Diabetes</td>
<td>DSME programs offered</td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>Optimal Diabetes Care - Composite Measure (NQF: 0729)</td>
<td>NO</td>
<td></td>
<td>0</td>
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<tr>
<td>Diabetes</td>
<td>Referrals to a Diabetes Prevention Program</td>
<td>NO</td>
<td></td>
<td>0.604</td>
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<td>Diabetes</td>
<td>Total number of individuals completing DSME</td>
<td>NO</td>
<td></td>
<td>0.619</td>
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<tr>
<td>Diabetes</td>
<td>Total number of patients completing an NDPP/YDPP</td>
<td>NO</td>
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<td>Healthcare Acquired Infections</td>
<td>Hospital-Acquired Conditions – Clostridium Difficile</td>
<td>NO</td>
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<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - BMI (Quality ID: 239, NQF:0024, eMeasure ID: CMS155v5)</td>
<td>NO</td>
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<td>69.539</td>
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<tr>
<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - Nutrition</td>
<td>NO</td>
<td></td>
<td>62.823</td>
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### Focus Area Measure Baseline

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Measure</th>
<th>Baseline</th>
<th>C3 Performance Rate</th>
<th>Peer Performance Rate</th>
<th>Community Trend</th>
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<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - Physical Activity (Quality ID: 239, NQF:0024, eMeasure ID: CMS155v5)</td>
<td>NO</td>
<td></td>
<td>61.049</td>
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<td>Provider Participation</td>
<td>Preventable ED Visits</td>
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<tr>
<td>Provider Participation</td>
<td>Steering Committee Meetings Attendance</td>
<td>0.7</td>
<td>0.426</td>
<td>0.547</td>
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<td>Quality Improvement Activities</td>
<td>Completion of Quality Improvement Plans</td>
<td>NO</td>
<td></td>
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<td>Social Determinants of Health Assessment</td>
<td>Economic Stability</td>
<td>0.291</td>
<td>0.15</td>
<td>0.26</td>
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<td>Social Determinants of Health Assessment</td>
<td>Education</td>
<td>0.022</td>
<td>0</td>
<td>0.001</td>
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<td>Social Determinants of Health Assessment</td>
<td>Health and Health Care</td>
<td>0.305</td>
<td>0.096</td>
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<td>Social Determinants of Health Assessment</td>
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<td>Social Determinants of Health Assessment</td>
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<td>Tobacco</td>
<td>Tobacco Use: Screening &amp; Cessation Intervention (Quality ID:226, NQF:0028, eMeasure ID: CMS138v5, ACO-17 [PREV-10])</td>
<td>NO</td>
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</table>

**SUMMARY**

2017 Q4: Overall screening and diabetes management continues to improve across the community. There was a drastic rise seen in adverse drug events, which may need to be looked into, if trends continue to increase or stay the same.

**UnityPoint data is now being dropped into the scorecards!! Data on Diabetes and Hypertension are from September, October, November and December. BMI data was ONLY received from September and December.**

Each C3 can determine how best to share their scorecard. The Iowa Healthcare Collaborative staff will deliver additional TA as requested by the C3.

**Data Sources pulled:** 4/16/2018
### County Diabetes

<table>
<thead>
<tr>
<th>Patient Segmentation</th>
<th>Members</th>
<th>Inpat.-PPR Admits Preventable</th>
<th>Inpat.-PPR Expected Admits Preventable</th>
<th>Inpat.-PPR Admits %Diff. Preventable</th>
<th>Inpat.-PPA Admits Preventable</th>
<th>Inpat.-PPA Expected Admits Preventable</th>
<th>Inpat.-PPA Admits %Diff. Preventable</th>
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<tbody>
<tr>
<td>40 - At Risk</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>-100.0%</td>
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<tr>
<td>60 - Complex Chronic</td>
<td>181</td>
<td>4</td>
<td>2</td>
<td>100.0%</td>
<td>14</td>
<td>15</td>
<td>-4.1%</td>
</tr>
<tr>
<td>70 - Critical</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
<td>4</td>
<td>3</td>
<td>29.5%</td>
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<tr>
<td><strong>Aggregate</strong></td>
<td>189</td>
<td>5</td>
<td>3</td>
<td>66.7%</td>
<td>18</td>
<td>18</td>
<td>1.6%</td>
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### County preventables

<table>
<thead>
<tr>
<th>Patient Segmentation</th>
<th>Members</th>
<th>Inpat.-PPR Admits Preventable</th>
<th>Inpat.-PPR Expected Admits Preventable</th>
<th>Inpat.-PPR Admits %Diff. Preventable</th>
<th>Inpat.-PPA Admits Preventable</th>
<th>Inpat.-PPA Expected Admits Preventable</th>
<th>Inpat.-PPA Admits %Diff. Preventable</th>
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</thead>
<tbody>
<tr>
<td>10 - Non User</td>
<td>790</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>20 - Healthy</td>
<td>2,744</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>1</td>
<td>-31.8%</td>
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<tr>
<td>30 - Stable</td>
<td>864</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>3</td>
<td>-36.1%</td>
</tr>
<tr>
<td>40 - At Risk</td>
<td>757</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
<td>2</td>
<td>4</td>
<td>-43.9%</td>
</tr>
<tr>
<td>50 - Simple Chronic</td>
<td>282</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
<td>2</td>
<td>4</td>
<td>-50.3%</td>
</tr>
<tr>
<td>60 - Complex Chronic</td>
<td>906</td>
<td>5</td>
<td>7</td>
<td>-28.6%</td>
<td>37</td>
<td>41</td>
<td>-9.5%</td>
</tr>
<tr>
<td>70 - Critical</td>
<td>22</td>
<td>1</td>
<td>1</td>
<td>0.0%</td>
<td>8</td>
<td>6</td>
<td>27.2%</td>
</tr>
<tr>
<td><strong>Aggregate</strong></td>
<td>6,365</td>
<td>8</td>
<td>9</td>
<td>-11.1%</td>
<td>52</td>
<td>59</td>
<td>-12.4%</td>
</tr>
<tr>
<td>Focus Area</td>
<td>Measure</td>
<td>Baseline Period</td>
<td>Performance Period</td>
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<tr>
<td>Adverse Drug Event</td>
<td>ADE: Blood Glucose Less than 50</td>
<td>CY2014</td>
<td>Oct/2017 - Dec/2017</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Adverse Drug Event</td>
<td>Adverse Drug Event Rate</td>
<td>CY2014</td>
<td>Oct/2017 - Dec/2017</td>
<td></td>
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<tr>
<td>BMI Screening</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up (Quality ID:128, NQF: 0421, eMeasure ID: CMS69v5, ACO-16 [PREV-9])</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Ambulatory Care: Emergency Department Visits</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
<td></td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Number of Closed Referrals to Providers</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
<td></td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Preventable Readmissions</td>
<td>TBD</td>
<td>May/2017 - March/2018</td>
<td></td>
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<tr>
<td>Care Coordination Inquiry</td>
<td>Provider Organizations participating in SWAN</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Comprehensive Diabetes Care: Blood Pressure Control (&lt;140/90 mm Hg) (NQF: 0061)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Comprehensive Diabetes Care: LDL-C Control &lt;100 mg/dL (NQF: 0064)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt;9%) (Quality ID:001, NQF:0059, eMeasure ID: CMS122v5, ACO-27 [DM-2])</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>DSME programs offered</td>
<td>CY2016</td>
<td>May/2017 -</td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>Optimal Diabetes Care - Composite Measure</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Referrals to a Diabetes Prevention Program</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>Total number of individuals completing DSME</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Total number of patients completing an NDPP/YDPP</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Diabetes</td>
<td>Optimal Diabetes Care - Composite Measure (NQF: 0729)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Healthcare Acquired Infections</td>
<td>Hospital-Acquired Conditions – Clostridium Difficile</td>
<td>CY2014</td>
<td>Oct/2017 - Dec/2017</td>
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<tr>
<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - BMI (Quality ID: 239, NQF:0024, eMeasure ID: CMS155v5)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - Nutrition (Quality ID: 239, NQF:0024, eMeasure ID: CMS155v5)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Obesity</td>
<td>Weight Assessment and Counseling 3-17 y/o - Physical Activity (Quality ID: 239, NQF:0024, eMeasure ID: CMS155v5)</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Focus Area</td>
<td>Measure</td>
<td>Baseline Period</td>
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<tr>
<td>Provider Participation</td>
<td>Preventable ED Visits</td>
<td>TBD</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Provider Participation</td>
<td>Steering Committee Meetings Attendance</td>
<td>Sep/2016 - Dec/2016</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Quality Improvement Activities</td>
<td>Completion of Quality Improvement Plans</td>
<td>Quarterly</td>
<td>TBD</td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Economic Stability</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Education</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Health and Health Care</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Social and Community Context</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
<td></td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Total number of unduplicated clients</td>
<td>Jul/2016 - Sep/2016</td>
<td>May/2017 - March/2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Social Determinants of Health Assessment</td>
<td>Transportation</td>
<td>Aug/2016 - Oct/2016</td>
<td>May/2017 - March/2018</td>
<td></td>
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</tr>
<tr>
<td>Tobacco</td>
<td>Tobacco Use: Screening &amp; Cessation Intervention (Quality ID:226, NQF:0028, eMeasure ID: CMS138v5, ACO-17 [PREV-10])</td>
<td>Feb/2017 - Apr/2017</td>
<td>May/2017 - March/2018</td>
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