

IOWA'S STATE INNOVATION MODEL

MEASURING POPULATION HEALTH AND DELIVERY SYSTEM REFORMS

2016 TO 2019



HEALTH RISK ASSESSMENT DATA INCLUDING SOCIAL DETERMINANTS OF HEALTH MEASURES

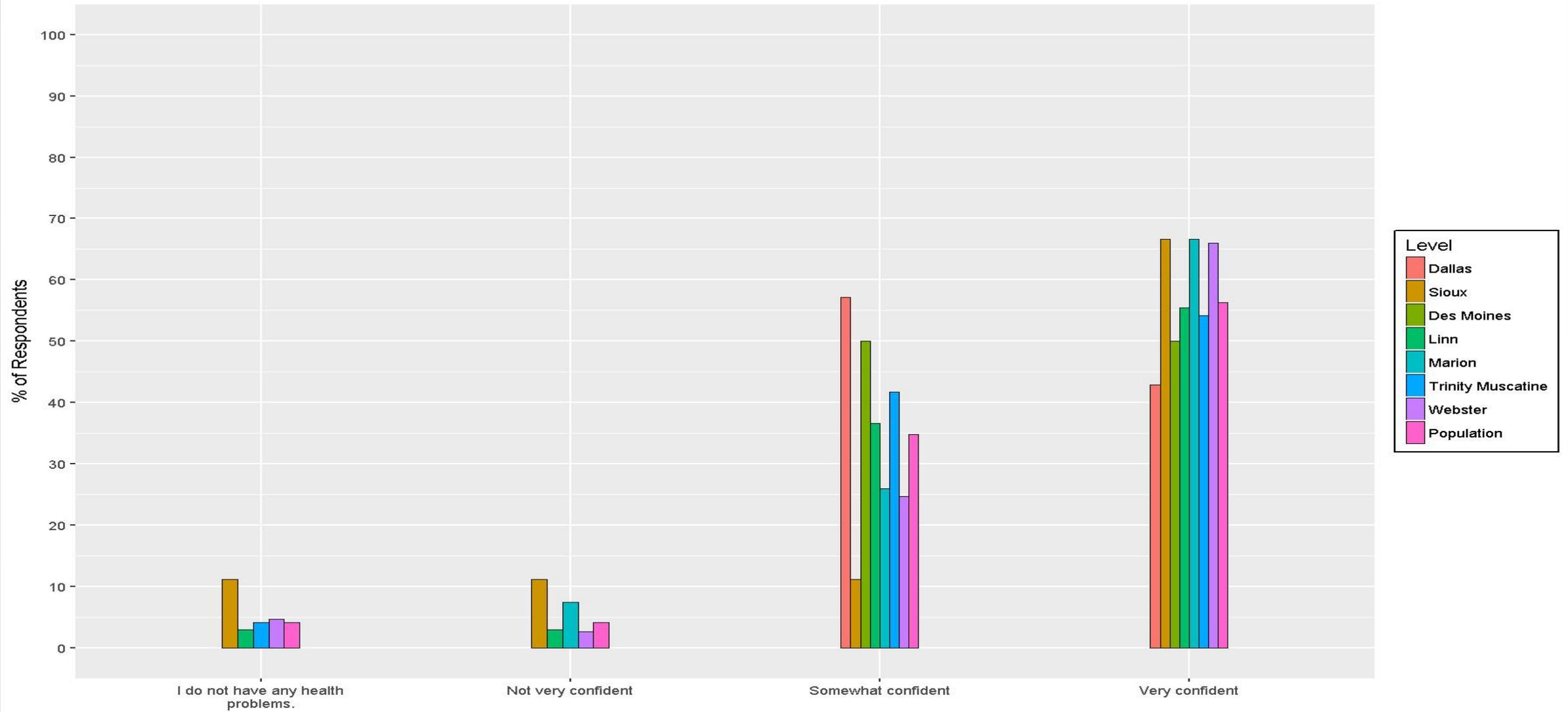
Collected by IME

ASSESSMYHEALTH

- IME version of How'sYourHealth
- Includes some custom questions
- Originally solicited via letters & public health announcements as well as provider pitch
 - Premium waiver for completing the assessment + having a wellness visit with PCP
 - Incentives for PCP
- Currently people with diabetes and those at risk for diabetes are being targeted
 - Community and Clinical Care (C3) initiative: part of SIM grant
 - Financial incentives given to C3
 - [Map of C3 counties](#)
- Based on patient reports
- Administered online and over the phone
- www.assessmyhealth.com

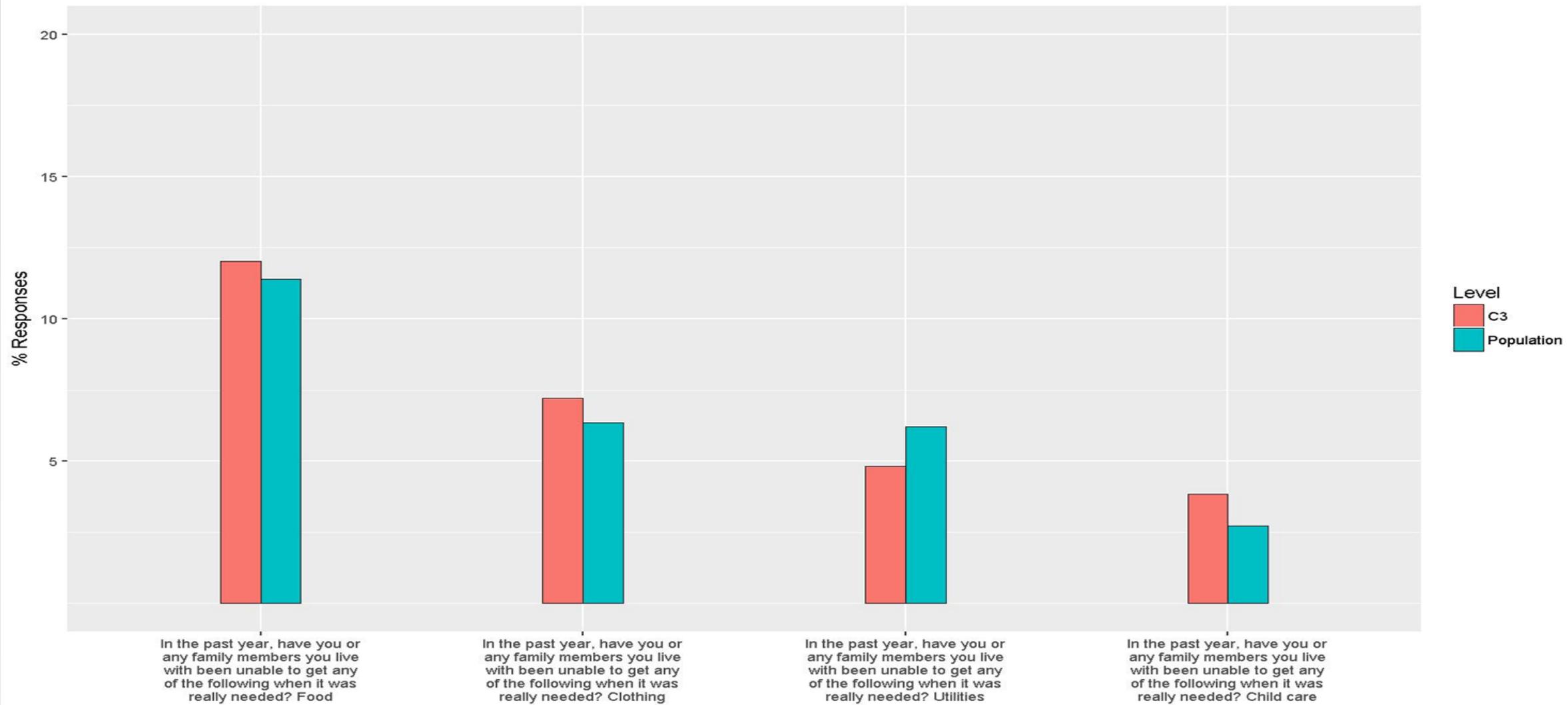
C3 Custom Graph - Health Confidence (control)

How confident are you that you can control and manage most of your health problems?



POVERTY (SDH5_1-SDH5_4)

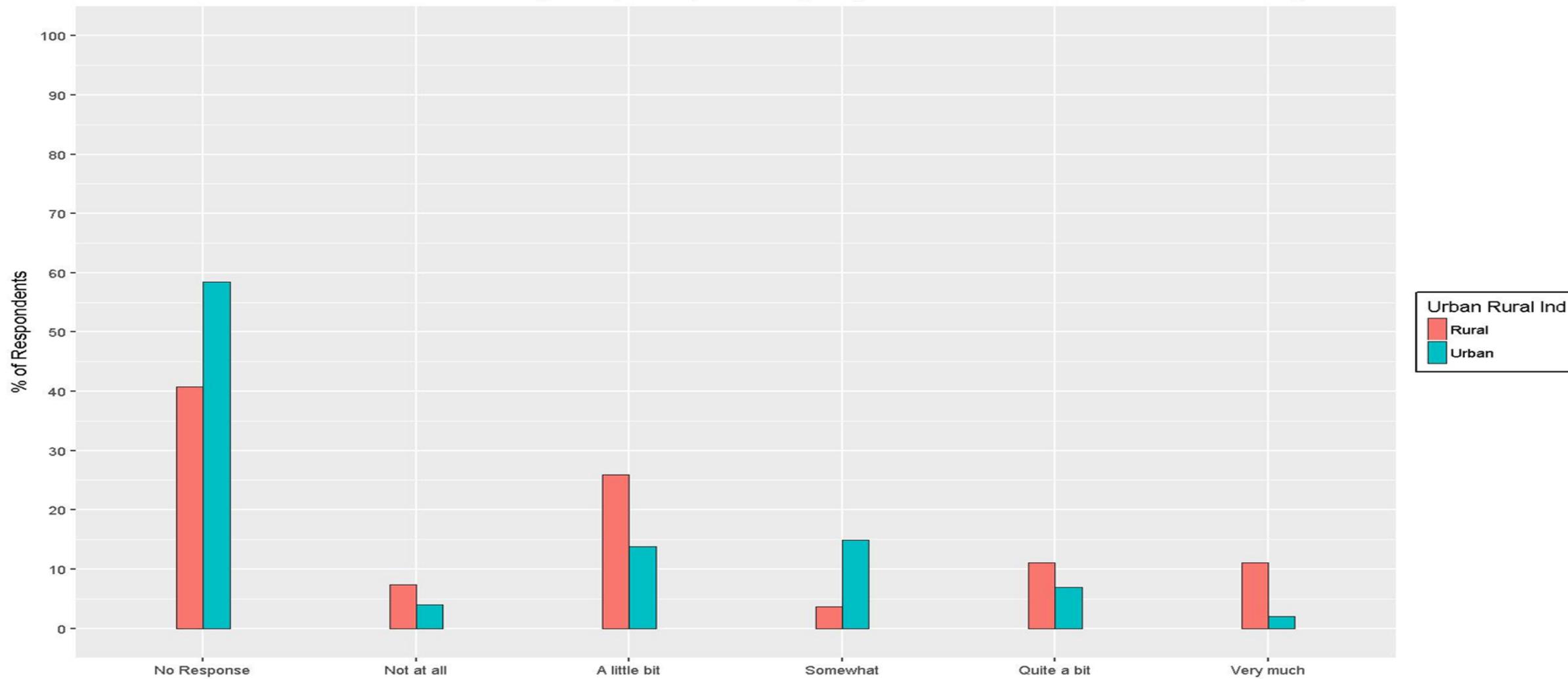
(Bars are the negative-response percentage of that total number)



Urban vs. Rural - Stress (SDH8)

Urban: Linn County / Rural: Marion County

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?



CORE METRICS

Collected by Operational Team Organizations and Shared with CMMI

MODEL PERFORMANCE DATA: POPULATION HEALTH

1. Preventive Care and Screening BMI: Screening and Follow Up
2. Preventive Care and Screening: Tobacco Use: Quitline Utilization
3. Hemoglobin A1c Management
4. Adverse Drug Event Rate
5. Hospital Acquired Conditions: Clostridium Difficile
6. Preventable ED Visits, Diabetes
7. Preventable Readmissions, Diabetes
8. Total Cost of Care, Diabetes
9. Diabetes and Obesity
10. Diabetes and Tobacco Use
11. Diabetes Prevalence
12. NDPP Participation
13. DSME Program Completion
14. Social Determinants of Health Referrals

SUCCESS STORIES

Collected by IDPH



SIoux, DALLAS, GREAT RIVER

- Sioux County C3's Community-Based Care Coordinators have made 298 referrals, which is a 380 percent increase since last year. Referrals have been received from a variety of sources, including providers, self-referrals and community partners. Referrals have been made to address a wide variety of needs with insurance, food assistance, housing, community and social context, and other health care representing the most common referral categories.
- A success for the Dallas County C3 is Dallas County Public Health's (DCPH) role in facilitating communication between care coordinators in clinics, hospitals, public health and payer organizations. This allowed the C3 to better understand existing referral processes, designate defined care coordination roles, and avoid duplication of services among partners. DCPH also invited two individuals from the target population to attend the community coalition meeting and conducted follow-up interviews with these clients.
- As a result of local collaboration of stakeholders who participate within the C3 initiative, the City of Burlington successfully applied for and will be receiving a \$17 million TIGER (Transportation Investment Generating Economic Recovery) grant from the U.S. Department of Transportation. In tandem with the Wellmark Foundation grant, built environment changes have been prioritized that will positively impact safety and physical activity.

LINN, MARION, TRINITY MUSCATINE

- Through a SIM C3 clinical subcontract in Linn County, UnityPoint Health Diabetes and Kidney Center launched a clinic roadshow to increase provider education and referrals to their own services and classes. The roadshow took place at 12 UnityPoint clinics and has already shown a large uptick in patient referrals from primary care physicians to center services.
- A success for the Marion County C3 was the creation of a new mission statement: “The purpose of the Marion County C3 is to work together to consistently serve the whole person by communicating, coordinating, collaborating, and connecting community resources to the client’s needs. This will be done by using clear and simple pathways, as one team coming together from multiple agencies, reducing duplication for the best possible outcome.”
- The Muscatine C3 successfully educated the providers in its area on social determinants of health. Providers were engaged in the topic and were eager to become a part of the process. Referrals to the Diabetes and Wellness Center have tripled in the past three months. Individual and group education sessions and a diabetes support group are components of the American Diabetes Association Recognized Diabetes Self-Management program.

WEBSTER

- The Webster County C3 is taking a proactive approach around mental health and substance abuse, particularly around opioid addiction. A task force has been formulated and plans are being put in place to educate schools and the community around the opioid crisis. The objective of the task force is to decrease the incidence of opioid use and substance abuse.

TECHNICAL ASSISTANCE (TA) SUB-COHORT DATA

COLLECTED BY IHC

C3 TA SUPPORT

Data/Analytics:

- The IHC Data Team works to ensure clear and succinct results are delivered informing progress, measure development, testing and standardization.
- The SIM Data Portal encompasses: HIIN hospital measures, clinic NQF measures, C3 data for Quitline and social determinants of health client referrals and assessment results, process measures, Medicaid Potentially Preventable Admissions data, and affiliated ACO CQMs.
- Goal and trend reports are available. A live data dashboard displays point in time metrics to drive community interventions resulting in improved clinical measures.

SIM PORTAL DASHBOARD – SDOH DATA



SIM Dashboard Dallas

Measure	SIM Improvement	Facility Rate	Community Average	SIM Average	Facility Trend
Economic Stability	*** -72.41	0.50	0.50	0.43	
Education	*** -100.00	0.04	0.04	0.08	
Health and Health Care	** 35.48	0.20	0.20	0.30	
Social and Community Context	* 42.86	0.04	0.04	0.09	
Transportation	* 83.87	0.05	0.05	0.06	

C3 TA SUPPORT

Professional Development:

- IHC staff deliver on-site and virtual coaching and professional development opportunities for pilot regions and stakeholders.
- Focus areas include needs assessments, strategic planning, process improvement and system alignment promoting successful and sustainable practices. This also includes Accountable Communities for Health model application assessment.
- Examples: PDSA performance improvement cycles, medication safety and effectiveness, person & family engagement, social determinants of health, care coordination and referral systems, VBP, SIM data element management and community integration.
- Over 800 onsite and/or virtual coaching sessions in 2018

C3 TA SUPPORT

Training and Consultation:

- Educate, engage and execute. IHC supports the planning and convening of training events surrounding SIM goals.
- Resource distribution is accomplished via conferences, virtual events, toolkits, practice modules and targeted TA for active participation.
- Education is coordinated with and through key partners and national organizations.

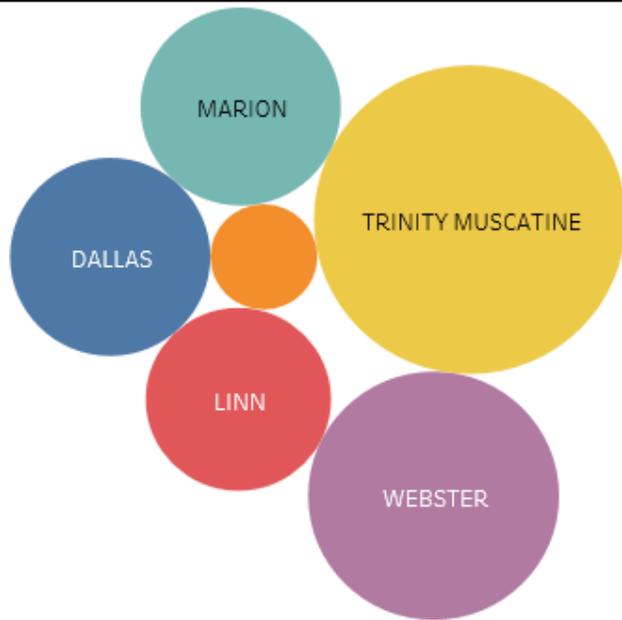
C3 TA SUPPORT

Engagement and Execution:

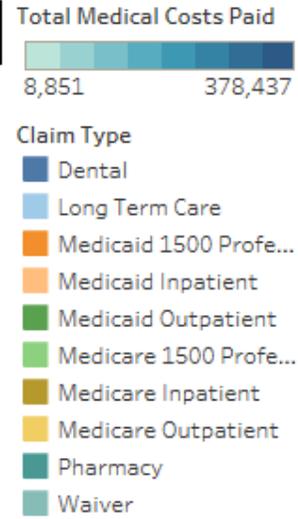
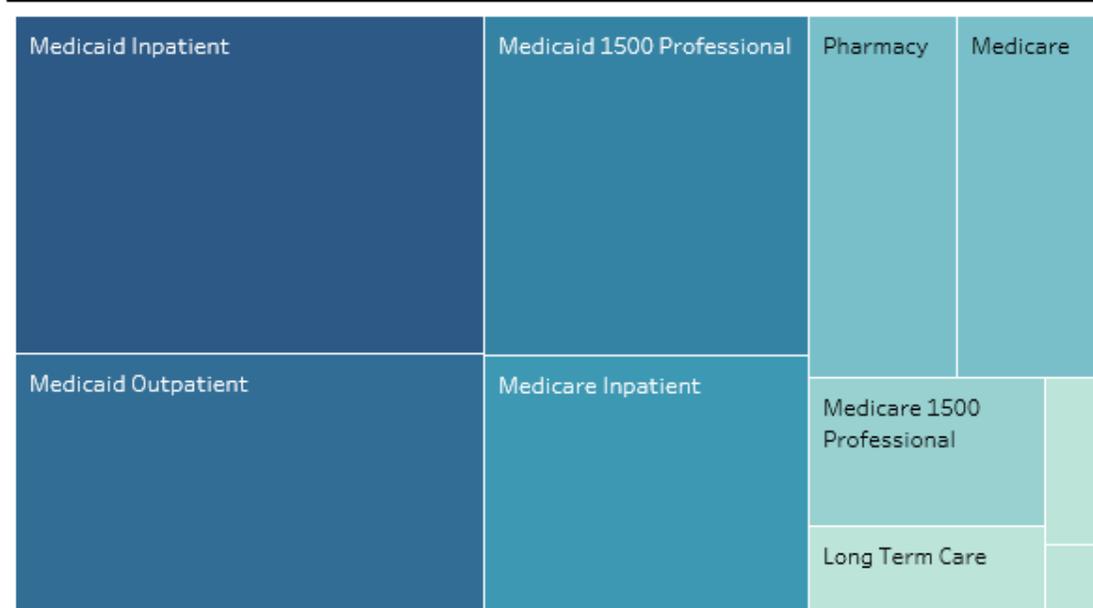
- IHC hosts an on-line SIM Communication Platform and a SIM monthly newsletter, as well as our IHC YouTube Channel, Facebook site, and Twitter accounts for marketing, visibility and dissemination of resources.
- Beyond these tools, IHC faculty experts and networking staff promote programming and seek out opportunities for collaboration, with integrated care delivery and rural environment application as our goal.

YouTube

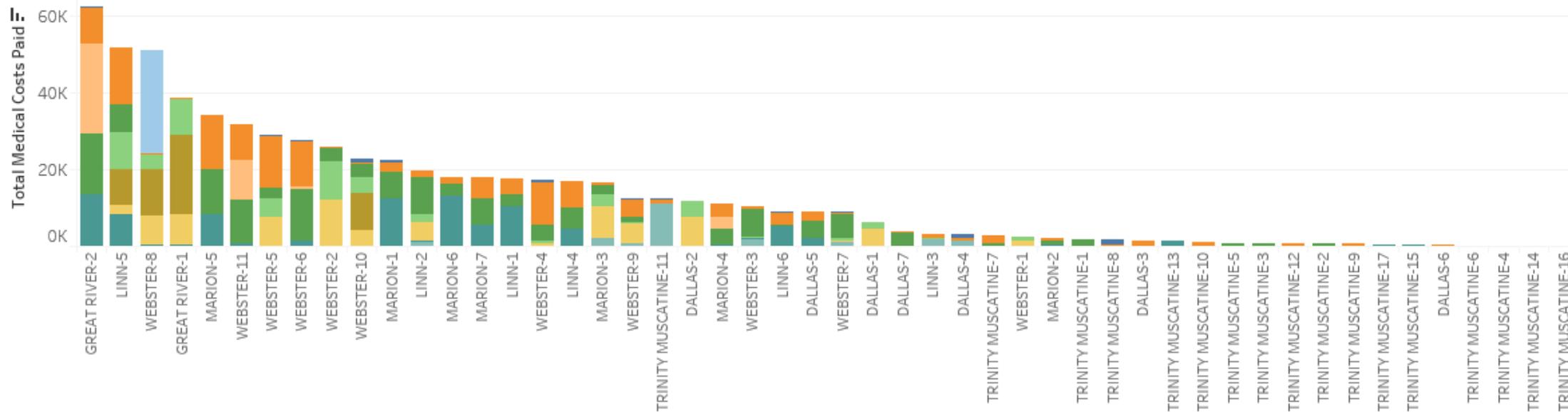
Unique Patient Count



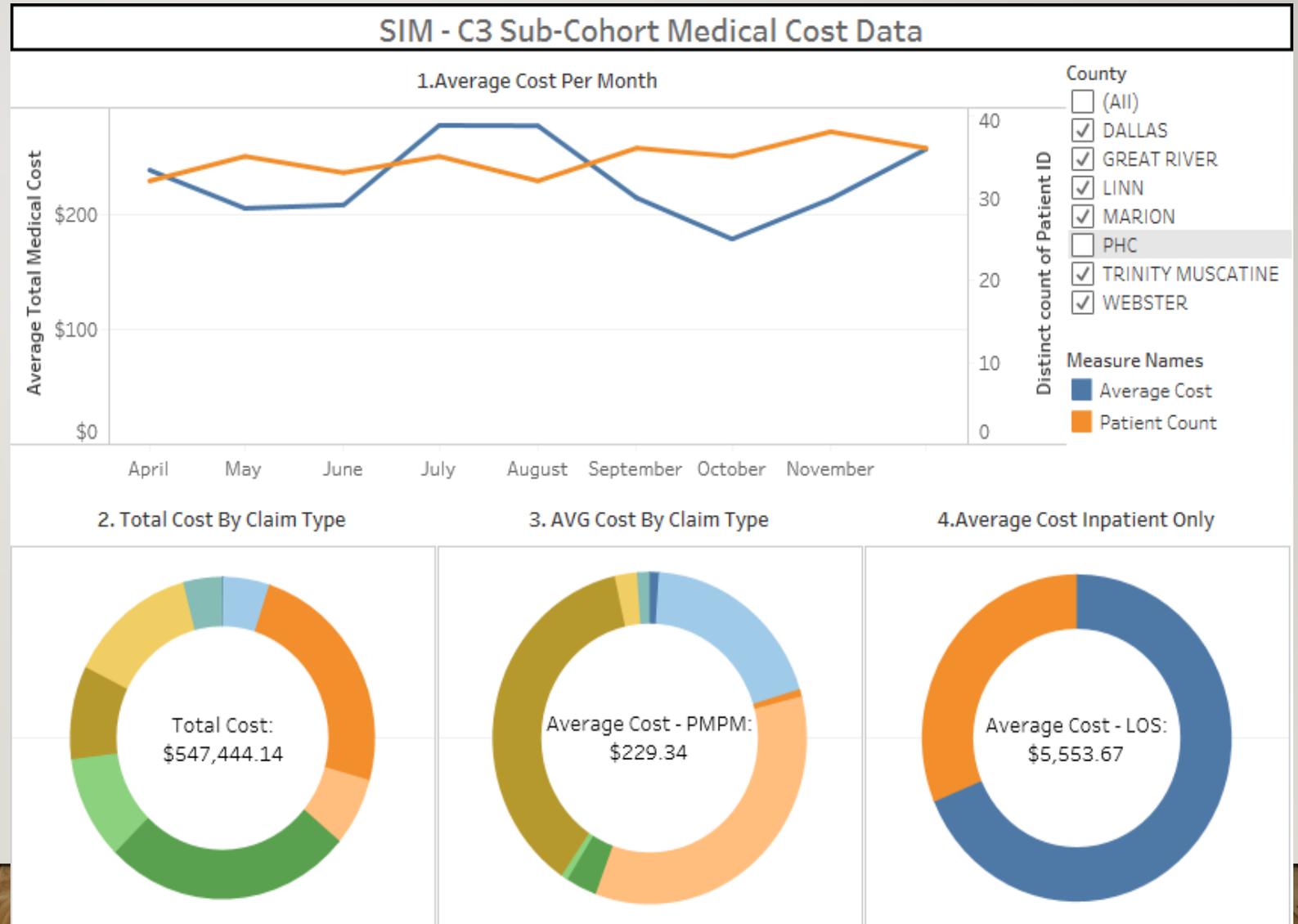
Total Medical Cost Paid by Type



Total Medical Cost By Patient



SIM C3 MEDICAL COST DATA



- https://public.tableau.com/views/C3Sub-cohortMarch2019V2/SIMC3Sub-cohortV2?:embed=y&:display_count=yes