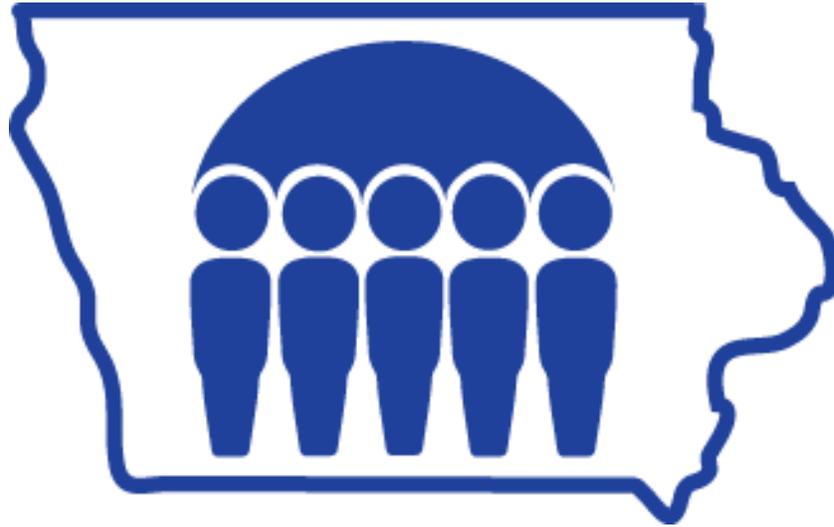


Iowa Department of Human Services



State Innovation Model Grant Operational Plan - 2016

January 2016

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Section A. Project Summary

1. Project Summary

Iowa will use the State Innovation Model (SIM) Testing grant to implement and evaluate a sustainable health care delivery and payment system that will improve population health, improve patient care, and bend health care cost trends. Through the SIM program, **Iowa will align and equip communities to address population needs** by collaborating with payers, providers and public health entities. The SIM Test aligns Iowa payers in payment reform that focuses on value; equips Iowa providers with tools to perform in value based, population focused models; and aligns and integrates public health strategies into how healthcare is delivered. Together, these approaches ensure a robust, statewide transformation to achieve Iowa's SIM vision; **Transforming Healthcare to Improve the Health of Iowans**.

Background:

Iowa started our SIM R2 Test proposal with the intent to implement an ACO model in the Medicaid population that is aligned with Medicare's ACO programs and Wellmark BCBS of Iowa's ACO programs. Both Wellmark and Medicare have been conducting ACO activity in Iowa since 2012. Medicaid, with a similar focus, began to introduce ACO concepts in 2014 with the expansion population (Wellness Plan, 0-100% FPL). Together, Medicare, Medicaid, and Wellmark cover 86% of Iowans and over 70% of primary care is connected to an ACO model.

In January of 2015, the Governor announced the strategic shift to modernize Medicaid and move to a full Managed Care model starting January 2016. This strategic shift in Medicaid changed a few of the secondary drivers and actions in our SIM model test Operational Plan from the original proposal, but does not change the SIM vision or overarching aims to Improve Population Health, Transform Healthcare, and Promote Sustainability. As stated recently by DHS Director Palmer, "The shift to managed care is not the end game, but the means to the end that supports and aligns with the state's vision and commitment of a healthier Iowa." Medicaid is still committed to the original SIM aims and will leverage the partnership with the new MCOs to carry out and achieve our aims and goals.

Funded through state appropriations, two Community Care Teams were piloted in 2014 to explore the integration of community resources into community level health care delivery systems to determine if such models could improve health outcomes and reduce costs. An additional four areas were funded in 2015 for a total of six communities. The funding for the initial two years was appropriated to a Safety Net Collaborative that was administered by Iowa's community health center association. SIM funding was extended to the six pilots during SIM year one to advance the Community Care Team (CCT) pilot project and transition toward the State Innovation Model (SIM) focus areas which include but are not limited to diabetes, obesity and tobacco. Successes and lessons learned from the pilots will provide a foundation that will be built upon for what we refer to now as "Community Care Coalitions (C3) to move forward in the SIM model test years.

On December 17, 2015 the state received notification from CMS regarding the ability to authorize the 1915(b) waiver requests with a possible March 1, 2016 effective date, assuming a series of conditions are satisfied. This delay to the MCO start date allows Iowa to continue communication with providers, MCOs, and stakeholders in Iowa to ensure a strong 2016 model test year. Iowa does not believe the

new MCO start date negatively impacts the SIM Operational Plan driver diagram or actions to carry out our SIM model test. There are four milestone dates linked to the VBP driver that are updated, however the majority of the work already in motion, continues without delay. For example, Iowa will continue to:

- Provide a VIS quality score for the Medicaid population through an online dashboard,
- Provide SWAN alerts to the providers we contracted with for VBP,
- Work with the MCOs to engage and develop processes to promote VBP readiness,
- Develop community care coalitions,
- Rollout community-based performance improvement processes for the delivery system,
- Develop a plan to improve population health and
- Develop and implement statewide population health strategies

From a SIM perspective, the delay in implementation of Medicaid managed care has a minimal impact. Iowa's initial SIM grant application in 2014 did not consider the subsequent shift to a comprehensive managed care approach, but it was relatively simple to reconcile the two strategies because they share a core alignment aimed at driving population health outcomes. The SIM primary driver of Value Based Purchasing (VBP) was already implemented within Medicaid's FFS delivery system with Medicaid expansion on January 1, 2014 via the Value Index Score (VIS) used for measuring quality. The other three primary drivers in our SIM plan (the Plan to Improve Population Health, Care Coordination and Community Based Performance Improvement) are all largely payer-independent and should continue on their current paths. While there is confidence that the managed care strategy will ultimately accelerate SIM aims for the Medicaid population, the additional time will be valuable to continue the orientation, education and alignment of the MCO plans around SIM and should result in a smoother roll-out when managed care goes live.

On December 23, 2016 members of Iowa's Core SIM Team participated in a conference call with CMMI where the CMMI project officer told Iowa to start preparing for a No Cost Extension (NCE) that would be at least 60 days, and likely longer, due to the MCO delay within Medicaid. A SIM NCE would have a ripple effect to the existing work that is already established or primed to start early in 2016 related to VIS quality score, SWAN alerts, and the development of community care coalitions. The phone call alone on 12/23 had some effects on the planned start and can be found in the master timeline found in Section A.4.

On December 28, 2016 the Iowa Core SIM Team conducted a conference call with CMMI project officer where we came to a set of communications that could help Iowa continue our grant as originally planned, without a NCE. At this time we are submitting the following 2016 Operational Plan with a timeline that indicates our SIM Model two test year starting on 2.1.2016.

2. Driver Diagram

Iowa's driver diagram captures the following components:

1. A vision statement that incorporates what Iowa is trying to accomplish
2. Three aims that break down the overarching vision statement into tangible targets
3. Goals that are a measurable proxy to Iowa's overall success
4. Drivers that indicate the path in which Iowa will pursue the goals
5. Secondary drivers that identify approaches and components for each driver to advance the goal

Within the SIM Operational Plan, Iowa also describes actions, milestones, and accountability targets. Actions are execution-focused activities that Iowa uses to carry out the secondary drivers. A milestone links a set of tasks within a project work plan and signifies the completion of a significant stage of the plan. Accountability targets are a set of core metrics that underpin Iowa's overarching SIM goals with specific quarterly or annual targets assigned during the three model test years. Actions, in combination with milestones, and accountability targets ensure Iowa is advancing at the right speed, toward the goals, aims, and overarching vision.

The Iowa SIM Vision: Transforming Health Care to Improve the Health of Iowans



3. Core Metric and Accountability Targets

Further details on the Iowa SIM Goals as outlined in the driver diagram above:

Goal	2015 Baseline	2016 Accountability Target	2017 Accountability Target	2018 Accountability Target
1.A Tobacco: Increase the percentage of adult smokers who have made a quit attempt in the past year	55.2%(BRFSS, 2014)	56%	57%	58% (BRFSS 2018)
1.B Obesity: Decrease the adult obesity prevalence rates	30.9% (BRFSS, 2014)	30.6%	30.3%	30% (BRFSS, 2018).
1.c Diabetes: Increase the percentage of adults (aged 18 years or older) with diabetes having two or more A1c tests in the last year	80.7% (BRFSS, 2014)	81.7%	83%	84%(BRFSS, 2018)
2. Reduce preventable Readmissions in Medicaid and Wellmark Populations	Medicaid = 7.36%	5% reduction to baseline	15% reduction to baseline	20% Reduction
3. Reduce preventable ED Visits in Medicaid and Wellmark Populations	Medicaid = 71.78%	5% reduction to baseline	15% reduction to baseline	20% Reduction
4. Increase amount of healthcare payments linked to value in Iowa	In process	25% of \$ linked to VBP	40% of \$ linked to VBP	50% of \$ linked to VBP

NOTE: Although the readmission measure methodology and measure specifications used by Medicaid and Wellmark differ slightly from what is used by Medicare in their ACO programs, the goal remains the same; to reduce the rate of preventable readmissions. The Medicaid and Wellmark populations use the measurement of Potentially Preventable Readmissions in 30 days (Risk-Adjusted Percent Difference) included in the Chronic and Follow-up Care Domain in the VIS. The potentially preventable rates are calculated for PCP attributed members where there are at least ten Candidate Admissions for Attributed Members. If a PCP has less than 10 but at least six Candidate Admissions, the PPR rate for the PCP will be the weighted average of the PPR rate for the PCP's Candidate Admissions and the PCP's group (or ACO) PPR rate. The measure is the percent difference from actual and expected PPR rates. PPR rates for mental health/chemical dependency (MH/CD) readmissions are significantly higher. If the discharge data includes MH/CD diagnosis, the PPR expected rate is modified to reflect the increased probability of readmission associated with these conditions. The Medicare population currently uses the All Cause Readmission measure in the PQRS program. This measure looks at the rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among beneficiaries assigned. This measure targets care coordination as a means to reduce all cause readmissions. Additional readmission measurement in the Medicare population typically involves a targeted subset of chronic conditions such as AMI, COPD, and HF as an example. While there are differences that need to be considered, the purpose of these measures in support of value based purchasing and system transformation are strongly aligned.

Please see the detailed R2_Reporting_Metrics_Op2016 xls, provided separately for detailed measure specs.

Key Goal (s)	Key Primary Driver	Metric Area	Metric Title	2016 Accountability Targets	2017 Accountability Targets	2018 Accountability Targets	Measure Frequency	When reported
Model Participation Metrics								
3	VBP	Model Participation_Beneficiaries	Population Impacted by SIM (by model)	Medicaid lives in VBP = 116,000 (increase of 58,000 or a 100% improvement from 2015) Medicaid lives in Health Home = 35,000 increases by 6,000 or 20%)	Medicaid lives in VBP = 190,000 Medicaid lives in HH = 42,000 (20% increase)	Medicaid lives in VBP = 350,000 Medicaid lives in HH = 46,000 (10% increase)	Annual	On the Annual Report in April
3	VBP	State Health Care Landscape_Beneficiaries	Population impacted by value-based purchasing and alternative payment models	Iowa lives in VBP = 515,200 (increase of 3% or 94,000 from baseline)	Iowa lives in VBP = 1,000,000	Iowa lives in VBP = 1,200,000	Annual	On the Annual Report in April
3	VBP	Model Participation_Providers	Providers Participating in SIM (by model)	Medicaid PCPs in VBP increases by 5%	Medicaid increase VBP by 2%	Medicaid increase VBP by 2%	Annual	On the Annual Report in April
3	VBP	State Health Care Landscape_Providers	Providers participating in value-based purchasing and alternative payment models	Iowa PCPs participating in VBP increase by 5%	Iowa PCPs increase by 2%	Iowa PCPs increase by 2%	Annual	On the Annual Report in April
1, 2	Care Coordination	Providers Participating in C3s (Care Coordination Driver)	Providers Participating in C3s	Establish 2016 baseline			Annual	On the Annual Report in April

1, 2	Care Coordination	Providers Participating in SWAN (Care Coordination Driver)	Providers Participating in SWAN	Establish baseline of alerts being generated. (Secondary accountability target - All Medicaid VBP affiliated hospitals reporting ADTS and VBP organizations are receiving alerts)	Annual	On the Annual Report in April
1,2, 3	RCPI/TA	Stakeholder Participation (RCPI Driver)	Stakeholder Participation	Establish 2016 baseline	Annual	On the Annual Report in April
Model Performance Metrics						
2	Care Coordination	Model Performance_Utilization	Ambulatory Care: Emergency Department Visits (HEDIS)	Establish 2016 baseline less than 5.0%	Decrease by 5% Decrease by 10%	Annual On the Annual Report in April
1	Care Coordination	Model Performance_Utilization	Plan All-Cause Readmissions	Establish 2016 baseline	Annual	On the Annual Report in April
3	VBP	Model Performance_Cost	Cost of care: total cost of care population-based per member per month (PMPM) index	Establish 2016 baseline	Annual	On the Annual Report in April
1	Care Coordination	Model Performance_Quality	Preventable Readmissions	Medicaid Baseline 7.36% Decrease baseline by 5%	Decrease rate by 15% from baseline Decrease rate by 20% from baseline Annual	On the Annual Report in April
2	Care Coordination	Model Performance_Quality	Preventable ED Visits	Medicaid Baseline = 71.78% Decrease baseline by 5%	Decrease rate by 15% from baseline Decrease rate by 20% from baseline Annual	On the Annual Report in April
3	VBP	Model Performance_Quality	Value Index Score	Establish 2016 baseline	Annual	On the Annual Report in April

1	PopHealth	Model Performance_Population Health	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Preventive Care & Screening: Quitline	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Establish 2016 baseline	Annual	On the Annual Report in April
1	PopHealth	Model Performance_Population Health	Hemoglobin A1c Management	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Weight Assessment and Counseling Children and Adolescents	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Health Literacy related to patient centered communication	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Elective Deliveries	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Healthcare Acquired Infections (HAI)	Establish 2016 baseline	Annual	On the Annual Report in April
?	PopHealth	Model Performance_Population Health	Adverse Drug Events	Establish 2016 baseline	Annual	On the Annual Report in April

4. Master Timeline:

The master timeline contains milestones that are linked to the approved budget narrative scope of work (SOW). To better understand the data please note the following items:

- **Baseline Start and Baseline Finish date columns** represent the date a task was targeted to be complete when the Ops plan was originally submitted on November 30th, 2015.
- State and Finish date columns represent the date the task is currently targeted to be complete (as of January 2016).
 - There are four tasks highlighted in yellow (179,190,192. and 212) that have changed their target date due to the delay implementation of Managed Care in Medicaid.
 - There are 11 tasks highlighted in orange (134-142, 242,244) that have changed their target date due to a phone call with CMMI on December 23, 2015. During this phone call, CMMI project officer told Iowa to start preparing for a No Cost Extension (NCE) that would be at least 60 days, and likely longer, due to the MCO delay within Medicaid.
 - December 23, 2015 was also the submission deadline for Iowa's Community Care Coalition (C3s) RFP. Based on that phone call, Iowa made the decision to extend the RFP submission due date, while we worked through the impact of the NCE to our SIM grant. The change in the RFP due date, pushes back several other dates including the 11 identified milestones established in our Operational Plan.
- Iowa has since communicated through close collaboration with our CMMI Project Offer that the MCO delay did not require a NCE. Iowa is well prepared to start the Year two SIM grant on February 1, 2016. As Iowa works through the details of this discussion with CMMI, this milestone list in this document communicates the impacts to those two events that have occurred since the original submission of the 2016 Ops Plan. Both impacts have been defined and are clearly representing a minor shift in a small number of tasks, **but ultimately have no impact to the overall financial budget for 2016.**

SIMRoundTwoProjectPlan_20151231Baseline

ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
1	Iowa SIM Initiative	20%	Tue 9/16/14	Fri 6/28/19	Tue 9/16/14	Fri 6/28/19		Yes	
2	Grant and IME Program Administration	29%	Tue 12/16/14	Tue 4/30/19	Tue 12/16/14	Tue 4/30/19		No	
3	Perform Project Management	45%	Fri 1/30/15	Thu 1/31/19	Fri 1/30/15	Thu 1/31/19	Grant Administration	No	
4	Operational Plan 2016	94%	Thu 10/1/15	Mon 2/15/16	Thu 10/1/15	Mon 2/15/16	Grant Administration	No	
6	Milestone - Submit Operational Plan to CMS by 12/1/15	100%	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Grant Administration	Yes	Telligen SOW 1
7	Milestone - Receive Written Approval of Operational Plan from CMS	0%	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	Grant Administration	Yes	
8	Milestone - Establish 2016 Talking Points for SIM for Public Speaking events	0%	Mon 2/15/16	Mon 2/15/16	Mon 2/15/16	Mon 2/15/16	Grant Administration	Yes	Telligen SOW 1
9	Milestone - Establish a Video from Dr Cha to promote SIM	0%	Mon 2/1/16	Mon 2/1/16	Mon 2/1/16	Mon 2/1/16	Grant Administration	Yes	
10	Operational Plan 2017	0%	Mon 8/1/16	Wed 1/31/18	Mon 8/1/16	Wed 1/31/18	Grant Administration	No	
14	Milestone - Submit Operational Plan year 2	0%	Thu 12/1/16	Thu 12/1/16	Thu 12/1/16	Thu 12/1/16	Grant Administration	Yes	Telligen SOW 1
15	Milestone - Receive Written Approval of Operational Plan from CMS	0%	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Grant Administration	Yes	
16	Milestone - Establish 2017 Talking Points for SIM for Public Speaking events	0%	Wed 2/15/17	Wed 2/15/17	Wed 2/15/17	Wed 2/15/17	Grant Administration	Yes	Telligen SOW 1
17	Operational Plan 2018	0%	Tue 8/1/17	Thu 1/31/19	Tue 8/1/17	Thu 1/31/19	Grant Administration	No	
21	Milestone - Submit Operational Plan year 3	0%	Fri 12/1/17	Fri 12/1/17	Fri 12/1/17	Fri 12/1/17	Grant Administration	Yes	Telligen SOW 1
22	Milestone - Receive Written Approval of Operational Plan from CMS	0%	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Grant Administration	Yes	
23	Milestone - Establish 2018 Talking Points for SIM for Public Speaking events	0%	Thu 2/15/18	Thu 2/15/18	Thu 2/15/18	Thu 2/15/18	Grant Administration	Yes	Telligen SOW 1
24	Write, Amend and Execute Vendor Contracts	88%	Fri 1/30/15	Thu 12/31/15	Fri 1/30/15	Thu 12/31/15	Grant Administration	No	
31	Milestone - All Contracts Amended and Executed	74%	Fri 1/30/15	Thu 12/31/15	Fri 1/30/15	Thu 12/31/15	Grant Administration	Yes	Telligen SOW 1
32	Milestone - Hire/Train SIM Project Manager 1	100%	Mon 8/31/15	Mon 8/31/15	Mon 8/31/15	Mon 8/31/15	Grant Administration	Yes	Telligen SOW 1
33	Milestone - Hire/Train eHealth staff Member	100%	Tue 3/31/15	Fri 5/15/15	Tue 3/31/15	Fri 5/15/15	Grant Administration	Yes	IDPH SOW 1
34	Milestone - Hire/Train IDPH EO2	100%	Sat 8/15/15	Mon 8/31/15	Sat 8/15/15	Mon 8/31/15	Grant Administration	Yes	IDPH SOW 1
35	Milestone - Hire/Train SIM Project Manager 2	0%	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	Grant Administration	Yes	Telligen SOW 1
36	Milestone - Hire/Train SIM Project Assistant	0%	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	Grant Administration	Yes	Telligen SOW 1
37	Milestone - Hire/Train PPI for IDPH	100%	Tue 6/30/15	Fri 10/30/15	Tue 6/30/15	Fri 10/30/15	Grant Administration	Yes	IDPH SOW 1
38	Milestone - Hire/Train CHC for IDPH	100%	Tue 6/30/15	Fri 10/30/15	Tue 6/30/15	Fri 10/30/15	Grant Administration	Yes	IDPH SOW 1
39	Perform Required CMS grant monitoring activities	99%	Thu 1/1/15	Thu 1/31/19	Thu 1/1/15	Thu 1/31/19	Grant Administration	No	
40	IME Program Administration	100%	Thu 1/1/15	Fri 1/29/16	Thu 1/1/15	Fri 1/29/16	Grant Administration	No	
41	Manage Vendor Contracts	100%	Thu 1/1/15	Fri 1/29/16	Thu 1/1/15	Fri 1/29/16	Grant Administration	No	
46	Milestone - At least 9 regular Contractor Meetings	100%	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Grant Administration	Yes	Telligen SOW 1 - 4
47	Milestone - At least 9 regular Contractor Meetings	100%	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	Grant Administration	Yes	Telligen SOW 1 - 4
48	Manage Stakeholder Process	99%	Tue 12/16/14	Thu 1/31/19	Tue 12/16/14	Thu 1/31/19	Grant Administration	No	
49	Conduct SIM Core Planning team meetings	100%	Fri 5/1/15	Thu 1/31/19	Fri 5/1/15	Thu 1/31/19	Grant Administration	No	
51	Milestone - Governance Structure	100%	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	Grant Administration	Yes	Telligen SOW 1
52	Milestone - Vision/Goals/Objectives	100%	Fri 7/31/15	Fri 9/4/15	Fri 7/31/15	Fri 9/4/15	Grant Administration	Yes	Telligen SOW 1
53	Milestone - Revise Driver Diagram	100%	Tue 12/16/14	Fri 12/14/18	Tue 12/16/14	Fri 12/14/18	Grant Administration	Yes	Telligen SOW 1

ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
54	Conduct SIM Leadership Meetings	100%	Tue 12/16/14	Fri 12/14/18	Tue 12/16/14	Fri 12/14/18	Grant Administration	No	Telligen SOW 1 - 4
55	Milestone - Schedule Establish	100%	Tue 12/16/14	Fri 7/31/15	Tue 12/16/14	Fri 7/31/15	Grant Administration	Yes	Telligen SOW 1 - 4
56	Milestone - At least one SIM Leadership meeting	100%	Fri 12/14/18	Fri 12/14/18	Fri 12/14/18	Fri 12/14/18	Grant Administration	Yes	Telligen SOW 1 - 4
57	Engagement Team Strategy	86%	Thu 1/1/15	Thu 1/31/19	Thu 1/1/15	Thu 1/31/19	Grant Administration	No	
58	Conduct Quarterly Wellmark/IME Alignment meetings	75%	Thu 1/1/15	Thu 1/31/19	Thu 1/1/15	Thu 1/31/19	Grant Administration	No	
59	Milestone - Conduct at least 1 Wellmark/IME alignment meeting	100%	Thu 4/30/15	Thu 4/30/15	Thu 4/30/15	Thu 4/30/15	VBP	Yes	Telligen SOW 1 - 4
60	Milestone - Conduct at least 1 Wellmark/IME alignment meeting	100%	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	VBP	Yes	Telligen SOW 1 - 4
61	Milestone - Conduct at least 1 Wellmark/IME alignment meeting	100%	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	VBP	Yes	Telligen SOW 1 - 4
62	Milestone - Conduct at least 1 Wellmark/IME alignment meeting	0%	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	VBP	Yes	Telligen SOW 1 - 4
63	Conduct Quarterly SIM Public Forums	99%	Fri 7/31/15	Thu 1/31/19	Fri 7/31/15	Thu 1/31/19	Grant Administration	No	
64	Milestone - Establish Schedule by June 30	100%	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	Fri 7/31/15	Grant Administration	Yes	Telligen SOW 1 - 4
65	Milestone - Conduct at least 3 Engagement Meeting	100%	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Grant Administration	Yes	Telligen SOW 1 - 4
66	Milestone - Conduct at least 3 Engagement Meeting	100%	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	Fri 1/29/16	Grant Administration	Yes	Telligen SOW 1 - 4
69	Model Test Reporting	0%	Thu 1/1/15	Tue 4/30/19	Thu 1/1/15	Tue 4/30/19	Grant Administration	No	
70	Pre-Implementation Year Reports to CMS	62%	Thu 4/30/15	Fri 4/29/16	Thu 4/30/15	Fri 4/29/16	Grant Administration	No	
71	Federal Financial Reports (FFR)	100%	Thu 4/30/15	Thu 4/30/15	Thu 4/30/15	Thu 4/30/15	Grant Administration	Yes	
72	Quarterly Progress Report 1	100%	Fri 5/29/15	Fri 5/29/15	Fri 5/29/15	Fri 5/29/15	Grant Administration	Yes	Telligen SOW 1 - 4
73	Federal Financial Reports (FFR)	100%	Thu 7/30/15	Thu 7/30/15	Thu 7/30/15	Thu 7/30/15	Grant Administration	Yes	
74	Quarterly Progress Report 2	100%	Fri 8/28/15	Fri 8/28/15	Fri 8/28/15	Fri 8/28/15	Grant Administration	Yes	Telligen SOW 1 - 4
75	Federal Financial Reports (FFR)	100%	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Fri 10/30/15	Grant Administration	Yes	
77	Milestone - Submit 2016 Accountability Targets to CMS	100%	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Grant Administration	Yes	Telligen SOW 1 - 4
78	Request a non-Competing Continuation award (SF-424, SF-424A, Budget Narrative and updated Operational Plan)	100%	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Tue 12/1/15	Grant Administration	Yes	Telligen SOW 1 - 4
79	Quarterly Progress Report 3	100%	Mon 11/30/15	Mon 11/30/15	Mon 11/30/15	Mon 11/30/15	Grant Administration	Yes	Telligen SOW 1 - 4
80	Federal Financial Reports (FFR)	0%	Sat 1/30/16	Sat 1/30/16	Sat 1/30/16	Sat 1/30/16	Grant Administration	Yes	
81	Quarterly Progress Report 4	0%	Tue 3/1/16	Tue 3/1/16	Tue 3/1/16	Tue 3/1/16	Grant Administration	Yes	Telligen SOW 1 - 4
82	Annual report 1 to CMS	0%	Fri 4/29/16	Fri 4/29/16	Fri 4/29/16	Fri 4/29/16	Grant Administration	Yes	Telligen SOW 1 - 4
83	Annual FFR to CMS	0%	Fri 4/29/16	Fri 4/29/16	Fri 4/29/16	Fri 4/29/16	Grant Administration	Yes	
84	Model Testing Year 1	0%	Mon 5/30/16	Fri 4/28/17	Mon 5/30/16	Fri 4/28/17	Grant Administration	No	
85	Quarterly Progress Report 1	0%	Mon 5/30/16	Mon 5/30/16	Mon 5/30/16	Mon 5/30/16	Grant Administration	Yes	Telligen SOW 1 - 4
86	Quarterly Progress Report 2	0%	Tue 8/30/16	Tue 8/30/16	Tue 8/30/16	Tue 8/30/16	Grant Administration	Yes	Telligen SOW 1 - 4
87	Request a non-Competing Continuation award (SF-424, SF-424A, Budget Narrative and updated Operational Plan)	0%	Wed 11/23/16	Wed 11/23/16	Wed 11/23/16	Wed 11/23/16	Grant Administration	Yes	Telligen SOW 1 - 4
88	Quarterly Progress Report 3	0%	Wed 11/30/16	Wed 11/30/16	Wed 11/30/16	Wed 11/30/16		Yes	Telligen SOW 1 - 4

SIMRoundTwoProjectPlan_20151231Baseline

ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
89	Quarterly Progress Report 4	0%	Thu 3/2/17	Thu 3/2/17	Thu 3/2/17	Thu 3/2/17		Yes	Telligen SOW 1 - 4
90	Annual report 2 to CMS	0%	Thu 12/15/16	Fri 4/28/17	Thu 12/15/16	Fri 4/28/17	Grant Administration	Yes	Telligen SOW 1 - 4
91	Model Testing Year 2	0%	Tue 5/30/17	Mon 4/30/18	Tue 5/30/17	Mon 4/30/18	Grant Administration	No	
97	Annual report 3 to CMS	0%	Fri 12/15/17	Mon 4/30/18	Fri 12/15/17	Mon 4/30/18	Grant Administration	Yes	Telligen SOW 1 - 4
98	Model Testing Year 3	0%	Wed 5/30/18	Tue 4/30/19	Wed 5/30/18	Tue 4/30/19	Grant Administration	No	
103	Annual report 4 to CMS	0%	Fri 12/14/18	Tue 4/30/19	Fri 12/14/18	Tue 4/30/19	Grant Administration	Yes	Telligen SOW 1 - 4
104	Final model test report to CMS	0%	Tue 1/1/19	Tue 4/30/19	Tue 1/1/19	Tue 4/30/19	Grant Administration	Yes	Telligen SOW 1 - 4
113	1. Population Health Improvement	18%	Sun 2/1/15	Thu 1/31/19	Sun 2/1/15	Thu 1/31/19	Pop Health	No	
114	Project Management (including necessary staffing at IDPH OHT)	18%	Sun 2/1/15	Thu 1/31/19	Sun 2/1/15	Thu 1/31/19	Pop Health	No	
118	Report to SIM leadership details of Finalized Pop Health Improve. Plan	0%	Thu 1/31/19	Thu 1/31/19	Thu 1/31/19	Thu 1/31/19	Pop Health	Yes	IDPH SOW 1
119	Milestone - Complete analysis of and report on 100% of county CHNAs.	0%	Mon 8/1/16	Mon 8/1/16	Mon 8/1/16	Mon 8/1/16	Pop Health	Yes	IDPH SOW 3
120	Milestone - Elicit feedback regarding health improvement strategies from at least 50 stakeholder groups including other statewide health improvement initiatives.	0%	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	Pop Health	Yes	IDPH SOW 3
121	Milestone - Analyze 100% of county HIPs to identify the number of counties with hospitals integrated in their HIP.	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Pop Health	Yes	IDPH SOW 3
122	Milestone - Identify the number of lowans covered by a HIP that includes SIM focus areas of diabetes, obstetrics, healthcare – associated infections, medication safety, tobacco, and obesity strategies.	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Pop Health	Yes	IDPH SOW 3
123	Milestone - Analyze 100% of county CHNA&HIPs to understand how social determinants of health are being addressed statewide by July 2016.	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Pop Health	Yes	IDPH SOW 3
124	Milestone - Complete 2017 Healthy Iowans state health improvement plan.	0%	Tue 2/28/17	Tue 2/28/17	Tue 2/28/17	Tue 2/28/17	Pop Health	Yes	IDPH SOW 1
125	Milestone - Provide Iowa SIM statewide strategy plans to a minimum of five counties identifying a SIM statewide strategy in the Health Improvement Plan.	0%	Sun 4/30/17	Sun 4/30/17	Sun 4/30/17	Sun 4/30/17	Pop Health	Yes	IDPH SOW 2
126	Milestone - Compile list of current efforts and address at least two of the the SIM statewide strategies for the plan to improve population health	0%	Mon 7/31/17	Mon 7/31/17	Mon 7/31/17	Mon 7/31/17	Pop Health	Yes	IDPH SOW 1
127	Milestone - Receive input from stakeholders for the Roadmap to Improve Health.	0%	Sun 12/31/17	Sun 12/31/17	Sun 12/31/17	Sun 12/31/17	Pop Health	Yes	IDPH SOW 1
128	Milestone - Complete initial draft of Plan to Improve Population Health.	0%	Mon 4/30/18	Mon 4/30/18	Mon 4/30/18	Mon 4/30/18	Pop Health	Yes	IDPH SOW 1
129	Milestone - Complete final draft of Plan to Improve Population Health	0%	Sun 9/30/18	Sun 9/30/18	Sun 9/30/18	Sun 9/30/18	Pop Health	Yes	IDPH SOW 1
130	2. Transform HealthCare Delivery	28%	Thu 1/1/15	Thu 1/31/19	Thu 1/1/15	Thu 1/31/19		No	
131	Support Delivery System (CBPI/TA)	6%	Tue 8/18/15	Thu 1/31/19	Tue 8/18/15	Thu 1/31/19		No	

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ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
132	Milestone - Conduct Statewide in person TA Event - SIM Kick-off	100%	Tue 8/18/15	Tue 8/18/15	Tue 8/18/15	Tue 8/18/15	Rapid Cycle Improve	Yes	IDPH SOW 5
133	Milestone - Convene the 2nd SIM Learning Collaborative	0%	Tue 3/8/16	Tue 3/8/16	Tue 3/8/16	Tue 3/8/16	Rapid Cycle Improve	Yes	IDPH SOW 5
134	Milestone - Assign Quality Improvement Advisors to C3s	0%	Mon 2/1/16	Mon 2/1/16	Fri 4/15/16	Fri 4/15/16	Rapid Cycle Improve	Yes	IDPH SOW 5
135	Milestone - Implement a collaborative strategy for C3 communication, interactions, and assistance	0%	Mon 2/1/16	Mon 2/1/16	Fri 4/1/16	Fri 4/1/16	Rapid Cycle Improve	Yes	IDPH SOW 5
136	Milestone - C3s finalize charters	0%	Fri 2/26/16	Fri 2/26/16	Fri 4/15/16	Fri 4/15/16	Rapid Cycle Improve	Yes	IDPH SOW 5
137	Milestone - Complete baseline assessment for all C3s	0%	Fri 2/26/16	Fri 2/26/16	Fri 4/29/16	Fri 4/29/16	Rapid Cycle Improve	Yes	IDPH SOW 5
138	Milestone - Initial C3 project work plans in place	0%	Fri 4/1/16	Fri 4/1/16	Fri 5/6/16	Fri 5/6/16	Rapid Cycle Improve	Yes	IDPH SOW 5
139	Milestone - IHC SIM Project reporting database operational	0%	Fri 4/1/16	Fri 4/1/16	Fri 5/6/16	Fri 5/6/16	Rapid Cycle Improve	Yes	IDPH SOW 5
140	Milestone - IHC Communications Platform Active	0%	Mon 5/2/16	Mon 5/2/16	Fri 5/6/16	Fri 5/6/16	Rapid Cycle Improve	Yes	IDPH SOW 5
141	Milestone - All C3s signed up and reporting data to IHC SIM database	0%	Wed 6/1/16	Mon 12/26/16	Fri 7/8/16	Fri 7/8/16	Rapid Cycle Improve	Yes	IDPH SOW 5
142	Milestone - Identify and promote C3 success stories	0%	Fri 7/1/16	Fri 7/1/16	Fri 7/8/16	Fri 7/8/16	Rapid Cycle Improve	Yes	IDPH SOW 5
143	Milestone - Convene the 3rd SIM Learning Collaborative	0%	Tue 7/12/16	Tue 7/12/16	Tue 7/12/16	Tue 7/12/16	Rapid Cycle Improve	Yes	IDPH SOW 5
144	Milestone - Align C3 projects with CHNA/HIP priorities	0%	Fri 7/29/16	Fri 7/29/16	Fri 7/29/16	Fri 7/29/16	Rapid Cycle Improve	Yes	IDPH SOW 5
145	Milestone - C3 project data baselines established	0%	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Rapid Cycle Improve	Yes	IDPH SOW 5
146	Milestone - Convene the 4th SIM Learning Collaborative	0%	Wed 11/9/16	Wed 11/9/16	Wed 11/9/16	Wed 11/9/16	Rapid Cycle Improve	Yes	IDPH SOW 5
147	Milestone - Annual report on progress for SIM TA projects	0%	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	Rapid Cycle Improve	Yes	IDPH SOW 5
148	Milestone - Conduct Round 2 C3 Kick-Off meetings	0%	Wed 2/1/17	Wed 2/1/17	Wed 2/1/17	Wed 2/1/17	Rapid Cycle Improve	Yes	IDPH SOW 5
149	Milestone - Annual Reports for 2017	0%	Wed 1/31/18	Wed 1/31/18	Wed 1/31/18	Wed 1/31/18	Rapid Cycle Improve	Yes	IDPH SOW 5
150	Milestone - Annual Reports for 2018	0%	Thu 1/31/19	Thu 1/31/19	Thu 1/31/19	Thu 1/31/19	Rapid Cycle Improve	Yes	IDPH SOW 5
151	Expand VBP Models to Full Medicaid (through MCOs)	41%	Thu 1/1/15	Fri 9/28/18	Thu 1/1/15	Fri 9/28/18	VBP	No	
152	VBP Agreement to share data with Delivery System	98%	Mon 3/2/15	Thu 9/1/16	Mon 3/2/15	Thu 9/1/16	VBP	No	
155	Milestone - Publish VBP Data Sharing Agreement	100%	Fri 11/6/15	Fri 11/6/15	Fri 11/6/15	Fri 11/6/15	VBP	Yes	Telligen SOW 1.C
156	Milestone - VBP Data Sharing Agreement Posted to IME Website	100%	Fri 11/6/15	Fri 11/6/15	Fri 11/6/15	Fri 11/6/15	VBP	Yes	Telligen SOW 1.C
157	Milestone - Start Sharing Claims data with Providers in VBP arrangements with MCOs	0%	Thu 9/1/16	Thu 9/1/16	Thu 9/1/16	Thu 9/1/16	VBP	Yes	Telligen SOW 1.C
158	Milestone - Start Sharing real-time (ADT) alerts with MCOs	0%	Mon 5/2/16	Mon 5/2/16	Mon 5/2/16	Mon 5/2/16	VBP	Yes	Telligen SOW 3a
159	Milestone - Share Real-time (ADT) alerts with Providers in VBP in Medicaid	0%	Mon 5/2/16	Mon 5/2/16	Mon 5/2/16	Mon 5/2/16	VBP	Yes	Telligen SOW 3a
160	Develop and Approve Iowa Administrative Rules	99%	Mon 2/23/15	Thu 12/31/15	Mon 2/23/15	Thu 12/31/15	VBP	No	Telligen SOW 1.C
163	Milestone - IAC Approved	0%	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	VBP	Yes	Telligen SOW 1.C
164	Establish TCOC and VIS baselines with Full Medicaid model	45%	Thu 1/1/15	Mon 5/16/16	Thu 1/1/15	Mon 5/16/16	VBP	No	
167	Milestone - Sign off on TCOC and VIS Baseline Methodologies	100%	Sun 11/1/15	Fri 11/20/15	Sun 11/1/15	Fri 11/20/15	VBP	Yes	Telligen SOW 1.C
168	Milestone - Report TCOC and VIS Baseline scores to PCPs for 2016	0%	Mon 1/18/16	Mon 1/18/16	Mon 1/18/16	Mon 1/18/16	VBP	Yes	Telligen SOW 1.C

ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
173	Milestone - Compile a 2016 baseline with LTC and Medicare A, B and D data	0%	Mon 5/16/16	Mon 5/16/16	Mon 5/16/16	Mon 5/16/16	VBP	Yes	3M SOW 2
174	Track Requirements for MCOs to report Encounter Data to support VIS	19%	Wed 10/14/15	Thu 6/30/16	Wed 10/14/15	Wed 8/31/16	VBP	No	
179	Milestone - MCO Encounter data moved into production VIS dashboard	0%	Thu 6/30/16	Thu 6/30/16	Wed 8/31/16	Wed 8/31/16	VBP	Yes	3M SOW 2
180	Rollout VBP Strategy with each MCO	100%	Sat 8/1/15	Mon 11/30/15	Sat 8/1/15	Mon 11/30/15	VBP	No	
184	Milestone - Conduct SIM and VBP meeting with MCOs	100%	Mon 11/30/15	Mon 11/30/15	Mon 11/30/15	Mon 11/30/15	VBP	Yes	Telligen SOW 1.C
185	Revise VIS Dashboard to Accommodate MCO view	12%	Wed 7/1/15	Thu 11/2/17	Wed 7/1/15	Thu 11/2/17	VBP	No	
190	Milestone - MCO Access to the VIS dashboard is available	0%	Mon 5/30/16	Mon 5/30/16	Fri 7/29/16	Fri 7/29/16	VBP	Yes	3M SOW 2
191	Milestone - Share with MCOs the 2% withhold requirements for 2017	0%	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	VBP	Yes	Telligen SOW 1.C
192	Milestones - 3M Dashboard updated with MCO Scorecard	0%	Wed 11/2/16	Wed 11/2/16	Fri 12/30/16	Fri 12/30/16	VBP	Yes	3M SOW 2
193	Milestone -3M Dashboard updated for MCO Scorecard for 2018	0%	Thu 11/2/17	Thu 11/2/17	Thu 11/2/17	Thu 11/2/17	VBP	Yes	3M SOW 2
194	Grow Health Home model with MCOs	74%	Thu 10/15/15	Mon 7/30/18	Thu 10/15/15	Mon 7/30/18		No	
195	Milestone - Share HH Expectation and Program guidelines with MCOs	100%	Thu 10/15/15	Thu 10/15/15	Thu 10/15/15	Thu 10/15/15	VBP	Yes	Telligen SOW 1.C
198	Milestone - Compile Health Home Enrollment for 2016 growth rate	0%	Fri 7/29/16	Fri 7/29/16	Fri 7/29/16	Fri 7/29/16	VBP	Yes	Telligen SOW 2
199	Milestone - Compile Health Home Enrollment for 2017 growth rate	0%	Fri 7/28/17	Fri 7/28/17	Fri 7/28/17	Fri 7/28/17	VBP	Yes	Telligen SOW 2
200	Milestone - Compile Health Home Enrollment for 2018 growth rate	0%	Mon 7/30/18	Mon 7/30/18	Mon 7/30/18	Mon 7/30/18	VBP	Yes	Telligen SOW 2
201	Integrate Special Populations in VBP (LTC/BH/Dental/CYSHCN)	17%	Fri 1/1/16	Fri 6/29/18	Fri 1/1/16	Fri 6/29/18	VBP	No	
202	Milestone - BH Population Integrated in delivery system	100%	Fri 1/1/16	Fri 1/1/16	Fri 1/1/16	Fri 1/1/16	VBP	Yes	3M SOW 2
203	Milestone - LTC and Duals Data integrated into VIS QMs	0%	Mon 5/16/16	Mon 5/16/16	Mon 5/16/16	Mon 5/16/16	VBP	Yes	3M SOW 2
204	Milestone - Compile report of Special Populations quality for 2016	0%	Tue 4/4/17	Tue 4/4/17	Tue 4/4/17	Tue 4/4/17	VBP	Yes	3MSOW 4
205	Milestone - Make recommendations for QMs to integrate Special Populations	0%	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	VBP	Yes	
206	Milestone - Compile report of Special Populations quality for 2017	0%	Mon 4/2/18	Mon 4/2/18	Mon 4/2/18	Mon 4/2/18	VBP	Yes	3MSOW 4
207	Milestone - Make recommendations for QMs to integrate Special Populations	0%	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	VBP	Yes	3MSOW 4
208	Implement SDH integration and research	3%	Mon 11/30/15	Fri 9/28/18	Mon 11/30/15	Fri 9/28/18	VBP	No	
209	Milestone - AssessMyHealth NCQA Certified as an initial health screening tool	0%	Mon 2/29/16	Mon 2/29/16	Mon 2/29/16	Mon 2/29/16	VBP	Yes	3M SOW 6

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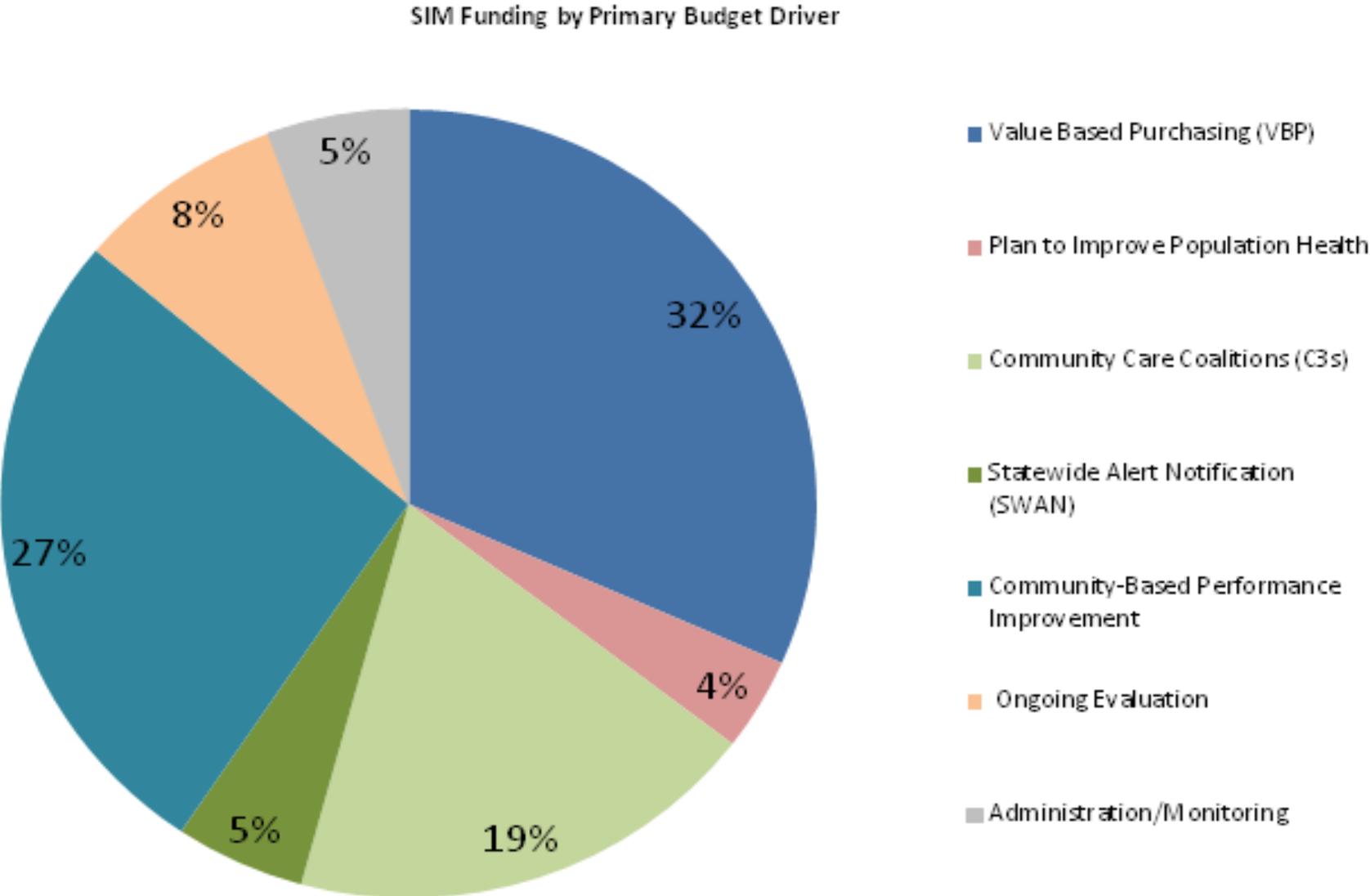
ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
212	Milestone - 50% of Initial Health Screenings use tool that shares SDH and Patient Confidence data with PCPs	0%	Fri 9/30/16	Fri 9/30/16	Wed 11/30/16	Wed 11/30/16	VBP	Yes	
213	Milestone - 75% of Initial health Screenings use tool that shares SDH and Patient Confidence data with PCPs	0%	Thu 9/28/17	Thu 9/28/17	Thu 9/28/17	Thu 9/28/17	VBP	Yes	
214	Milestone - 80% of Initial health Screenings use tool that shares SDH and Patient Confidence data with PCPs	0%	Fri 9/28/18	Fri 9/28/18	Fri 9/28/18	Fri 9/28/18	VBP	Yes	
215	Milestone - Share Aggregated SDH and patient confidence data for 2016	0%	Thu 3/30/17	Thu 3/30/17	Thu 3/30/17	Thu 3/30/17	VBP	Yes	3M SOW 4
216	Milestone - Share Aggregated SDH and patient confidence data for 2017	0%	Fri 3/30/18	Fri 3/30/18	Fri 3/30/18	Fri 3/30/18	VBP	Yes	3M SOW 4
218	Milestone - Release finding on SDH data for Risk Adjustment in VBP models	0%	Fri 12/29/17	Wed 2/28/18	Fri 12/29/17	Wed 2/28/18	VBP	Yes	3M SOW 7
219	Align with Other Payers	7%	Thu 1/1/15	Mon 12/31/18	Thu 1/1/15	Mon 12/31/18	VBP	No	
221	Milestone - Conduct quarterly alignment meetings with Wellmark on VIS Dashboard and other VBP strategies	0%	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	VBP	Yes	Telligen SOW 1- 4
224	Milestone - Release Plan for Public Reporting of VIS Quality in Medicaid	0%	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	VBP	Yes	Telligen SOW 1- 4
225	Milestone - Publish Star Rating	0%	Mon 1/1/18	Mon 1/1/18	Mon 1/1/18	Mon 1/1/18	VBP	Yes	Telligen SOW 1- 4
226	Milestone - Add at least one non-Medicaid population to real-time alerts (SWAN) system	0%	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	VBP	Yes	Telligen SOW 1- 4
227	Milestone - Add at least two non-Medicaid populations to real-time alerts (SWAN) system	0%	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	VBP	Yes	Telligen SOW 1- 4
228	Equip Delivery System for Care Coordination	0%	Sat 10/31/15	Wed 1/31/18	Sat 10/31/15	Wed 1/31/18	C3s	No	
238	Milestone - Develop a minimum of one informational document highlighting the C3 communities and the planned initiatives, planned social determinants of health interventions, and applicable health improvement plan elements.	0%	Fri 4/1/16	Fri 4/1/16	Fri 4/1/16	Fri 4/1/16	C3s	Yes	IDPH SOW 1
239	Milestone - Disseminate C3 informational document to a minimum of six partners (i.e., CDC 1305 Partnership Grant for Diabetes, Nutrition and Physical Activity; Division of Tobacco Use Prevention and Control; IDPH, IHA)	0%	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	C3s	Yes	IDPH SOW 1
240	Milestone - Develop a minimum of one informational document on the successes and lessons learned of Year 1 CCT pilot and Year 2 C3 communities first and second quarter reporting.	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	C3s	Yes	IDPH SOW 1
241	Milestone - Develop draft Iowa Community Care Coalition Model	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	C3s	Yes	IDPH SOW 1
242	Milestone - Prepare funding opportunity announcement	0%	Sat 12/31/16	Sat 12/31/16	Wed 11/30/16	Wed 11/30/16	C3s	Yes	IDPH SOW 1
243	Milestone - Complete SIM year two C3 contracts	0%	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	C3s	Yes	IDPH SOW 1
244	Milestone - Prepare funding opportunity announcement	0%	Sun 12/31/17	Sun 12/31/17	Thu 11/30/17	Thu 11/30/17	C3s	Yes	IDPH SOW 1
245	Milestone - Complete SIM year three C3 contracts.	0%	Wed 1/31/18	Wed 1/31/18	Wed 1/31/18	Wed 1/31/18	C3s	Yes	IDPH SOW 1
246	3. Payment and Service Delivery Models - See Sctn 2	0%						Yes	

ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
247	5. Health Information Technology	7%	Tue 9/16/14	Mon 12/31/14	Tue 9/16/14	Mon 12/31/18		No	
251	Deploy an IHIN Alerting system	12%	Tue 9/16/14	Mon 12/31/14	Tue 9/16/14	Mon 12/31/18		No	
252	Milestone - Conduct Kick-off call with IDPH/ICA and IME	100%	Thu 10/30/14	Thu 10/30/14	Thu 10/30/14	Thu 10/30/14	SWAN	Yes	IDPH SOW 6
254	Milestone - Have concept paper/marketing ready for ACO stakeholders	100%	Fri 1/30/15	Fri 1/30/15	Fri 1/30/15	Fri 1/30/15	SWAN	Yes	IDPH SOW 6
255	Deploy an alerting system for ADT information for ACOs and other primary care providers, including reporting	100%	Wed 9/30/15	Wed 9/30/15	Wed 9/30/15	Wed 9/30/15	SWAN	Yes	IDPH SOW 6
259	Milestone - At least one user from every ACO signed up and ready to receive Alerts 1/1/2016	0%	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	Thu 12/31/15	SWAN	Yes	IDPH SOW 6
260	Milestone - Set up 5 connections to SWAN in by April 30, 2016.	0%	Fri 4/1/16	Fri 4/1/16	Fri 4/1/16	Fri 4/1/16	SWAN	Yes	IDPH SOW 6
261	Milestone - Conduct webinar for hospitals not yet engaged in SWAN	0%	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	Sun 7/31/16	SWAN	Yes	IDPH SOW 6
262	Milestone - Set up 5 connections to SWAN	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	SWAN	Yes	IDPH SOW 6
263	Milestone - Send out survey to those participating in SWAN.	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	SWAN	Yes	IDPH SOW 6
266	SWAN Communication Plan	21%	Tue 9/16/14	Mon 12/31/14	Tue 9/16/14	Mon 12/31/18		No	
270	Milestone - Annual review and update of communication Plan	0%	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	Thu 3/31/16	SWAN	Yes	IDPH SOW 6
271	Milestone - Annual review and update of communication Plan	0%	Fri 3/31/17	Fri 3/31/17	Fri 3/31/17	Fri 3/31/17	SWAN	Yes	IDPH SOW 6
287	8. Monitoring and Evaluation Plan	3%	Tue 11/24/15	Fri 6/28/19	Tue 11/24/15	Fri 6/28/19		No	
289	Collaborate with CMMI Evaluator(s) for Cross-State Evaluation	13%	Tue 11/24/15	Tue 11/24/15	Tue 11/24/15	Tue 11/24/15	Eval	No	
290	Conduct Kick-off call with CMMI Evaluators	100%	Tue 11/24/15	Tue 11/24/15	Tue 11/24/15	Tue 11/24/15	Eval	Yes	PPC SOW 2
298	State Evaluation of SIM (outside of Cross-State Evaluation)	0%	Mon 2/29/16	Fri 6/28/19	Mon 2/29/16	Fri 6/28/19		No	
299	Milestone - Identify and refine study measures and deliverable	0%	Mon 2/29/16	Mon 2/29/16	Mon 2/29/16	Mon 2/29/16	Eval	Yes	PPC SOW 1
300	Finalize and disseminate data needs to the sources of data (i.e., Iowa Healthcare Collaborative (IHC), Iowa Department of Public Health (IDPH), Iowa Medicaid Enterprise (IME), and Wellmark)	0%	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Eval	Yes	PPC SOW 4
301	Milestone - Develop a data clearinghouse	0%	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	Eval	Yes	PPC SOW 3
302	Identify, collect, and organize the 2015 (baseline) data.	0%	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Eval	Yes	PPC SOW 3
303	Identify and study (C3) and control counties	0%	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Eval	Yes	PPC SOW 3
304	Develop questions for statewide consumer/patient survey	0%	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Eval	Yes	PPC SOW 3
305	Identify and negotiate subcontracts	0%	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Eval	Yes	PPC SOW 1

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ID	Task Name	% Complete	Baseline Start	Baseline Finish	Start	Finish	Primary Driver	Milestone	Budget Narrative Mapping
306	Execute data sharing agreement with Wellmark and C3s	0%	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Thu 6/30/16	Eval	Yes	PPC SOW 5
307	Complete Interim report on data adequacy	0%	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Fri 9/30/16	Eval	Yes	PPC SOW 3
308	Make adjustments to list of measures to be used	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Eval	Yes	PPC SOW 3
309	Begin contextual analysis	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Eval	Yes	PPC SOW 3
310	Investigate and understand BRFSS, YBRS, and birth certificate data	0%	Sat 10/1/16	Sat 10/1/16	Sat 10/1/16	Sat 10/1/16	Eval	Yes	PPC SOW 3
311	Establish data sharing with IHA	0%	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	Wed 8/31/16	Eval	Yes	PPC SOW 1
312	Complete Field statewide consumer/patient survey	0%	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Mon 10/31/16	Eval	Yes	PPC SOW 3
313	Contextual analysis: Assessment of the implementation activities for Year 1	0%	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Eval	Yes	PPC SOW 3
314	Develop provider survey items	0%	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Fri 12/30/16	Eval	Yes	PPC SOW 3
315	Plan Year 2 evaluation activities after review of Year 1 activities and adjustments	10%	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	Tue 1/31/17	Eval	Yes	PPC SOW 1
316	Complete Data assessment and planning Year 2	0%	Tue 2/28/17	Tue 2/28/17	Tue 2/28/17	Tue 2/28/17	Eval	Yes	PPC SOW 1
317	Complete Field provider interviews	0%	Mon 1/2/17	Tue 1/3/17	Mon 1/2/17	Tue 1/3/17	Eval	Yes	PPC SOW 3
318	Complete First year report	0%	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	Fri 6/30/17	Eval	Yes	PPC SOW 3
319	Conduct primary goal outcome analyses	0%	Sat 9/30/17	Sat 9/30/17	Sat 9/30/17	Sat 9/30/17	Eval	Yes	PPC SOW 3
320	Conduct ongoing contextual analyses	0%	Sat 9/30/17	Sat 9/30/17	Sat 9/30/17	Sat 9/30/17	Eval	Yes	PPC SOW 3
321	Complete Claims data cleaning, assimilation, analyses	0%	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Eval	Yes	PPC SOW 3 and 4
322	Contextual analysis: Assessment of the implementation activities for Year 1	0%	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Fri 12/29/17	Eval	Yes	PPC SOW 3
323	Complete Field provider interviews	0%	Mon 1/1/18	Mon 1/1/18	Mon 1/1/18	Mon 1/1/18	Eval	Yes	PPC SOW 3
324	Complete Outcomes analyses	0%	Mon 12/31/18	Mon 12/31/18	Mon 12/31/18	Mon 12/31/18	Eval	Yes	PPC SOW 3
325	Submit second year report	0%	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	Fri 6/29/18	Eval	Yes	PPC SOW 3
326	Complete field statewide consumer/patient survey	0%	Wed 10/31/18	Wed 10/31/18	Wed 10/31/18	Wed 10/31/18	Eval	Yes	PPC SOW 3
327	Submit Final Report	0%	Fri 6/28/19	Fri 6/28/19	Fri 6/28/19	Fri 6/28/19	Eval	Yes	PPC SOW 3
328	9. Alignment with State and Federal Innovation	0%						Yes	
329	Regular agenda item at SIM Leadership and Quarterly SIM Public Forums	0%	2014	2019	2014	2019		Yes	PPC SOW 2
330	Internally monitor within DHS, IME and IDPH areas of alignment with SIM	0%	2014	2019	2014	2019		Yes	PPC SOW 3 and 4

5. Budget Summary Table for 2015 - 2018:



Notes: Budget drivers are color coded to a corresponding primary driver. Both shades of Green represent the primary driver care coordination. Administration and Monitoring and Ongoing Evaluation are budget drivers, but not primary drivers.

SIM Vision: Transforming Healthcare to Improve the Health of Iowans

Improve Population Health			Transform Healthcare			Promote Sustainability			
	Value Based Purchasing (VBP)	Plan to Improve Population Health	Community Care Coalitions (C3s)	Statewide Alert Notification (SWAN)	Community-Based Performance Improvement	Ongoing Evaluation	Administration/Monitoring		
Objective	Develop reimbursements that incent both quality and value in a manner aligned across payers to achieve provider scalability.	Implement statewide strategies that impact the long-term projector of health outcomes.	Build capacity (and prove value) in coordinating social services identified as determinants of improved health.	Leverage technology to provide real-time information to improve patient outcomes.	Support delivery system and communities in transformation.	Evaluate both State objectives and work with Federal Evaluator for CMMI objectives.	Manage SIM Grant activity and ensure compliance with CMMI and SIM objectives.		
Vendor/Partner	3M	IDPH	IDPH	IDPH/ICA	IDPH/Iowa Healthcare Collaborative	University of Iowa Public Policy Center	Telligen	State Travel/supplies /actuary	Grant Totals
Total SIM Test Budget	\$ 13,500,000.00	\$ 1,622,775.00	\$ 8,045,000.00	\$ 2,206,000.00	\$ 11,400,000.00	\$ 3,550,000.00	\$ 2,384,055.00	\$ 371,743.00	\$ 43,079,573.00
Calendar Yr 2015 Allocations	\$ 3,300,000.00	\$ 279,661.00	\$ 545,000.00	\$ 551,500.00	\$ 2,225,000.00	\$ 475,000.00	\$ 417,760.00	\$ 194,743.00	\$ 7,988,664.00
Calendar Yr 2016	\$ 3,300,000.00	\$ 428,021.00	\$ 1,550,000.00	\$ 551,500.00	\$ 3,225,000.00	\$ 1,075,000.00	\$ 642,505.00	\$ 69,000.00	\$ 10,841,026.00
Calendar Yr 2017	\$ 3,500,000.00	\$ 447,192.00	\$ 2,650,000.00	\$ 551,500.00	\$ 3,225,000.00	\$ 850,000.00	\$ 655,315.00	\$ 54,000.00	\$ 11,933,007.00
Calendar Yr 2018	\$ 3,400,000.00	\$ 467,901.00	\$ 3,300,000.00	\$ 551,500.00	\$ 2,725,000.00	\$ 1,150,000.00	\$ 668,475.00	\$ 54,000.00	\$ 12,316,876.00

Section B. Detailed SIM Operational Plan

1. Narrative Summary of Component /Project

The State has four primary drivers of the Iowa SIM Test: Population Health Improvement; Care Coordination; Community-Based Performance Improvement; and Value Based Purchasing. Those drivers can be broken down into six specific budget drivers: Value Based Purchasing; Population Health Improvement; Community Care Coalitions (C3s); Statewide Alert Notification (SWAN); Community-Based Performance Improvement; and Ongoing Evaluation. Together, these drivers each play an important role in advancing Iowa toward the goals and vision of our Model Test.

Developing a **plan to improve population health** establishes a framework and strategy to improve health around the prevention and control of diabetes, obesity, and tobacco use, with both short term and long term impacts. Embedding process improvements within the delivery system will lead to earlier detection, reduced severity and the potential for chronic disease prevention. The plan to improve population health, when implemented effectively, has a long term return on investment that will last years past the SIM model Test in Iowa and supports sustainability.

Equipping the delivery system with **care coordination** tools provides new innovative processes to transform how healthcare is delivered in Iowa. Iowa's SIM model will equip the delivery system with two new tools. First, the state will foster the development of Community Care Coalitions (C3s) to provide assessment and referrals to needed community and social services that are often left underutilized by our current delivery system. The C3s also act as a community convener that will drive rapid cycle performance improvement strategies. Secondly, the state is investing in a technology infrastructure to develop a statewide network of hospital ADT data to provider real-time alerts to provider organizations in value-based payment arrangements. This system is known as SWAN, the Statewide Alert Notification system. These alerts inform providers during critical transitions of care which is a proven tool to achieve better healthcare utilization and outcomes. Ultimately these two care coordination tools equip the delivery system to improve population health, transform how healthcare is delivered and positively impact the cost of healthcare in Iowa.

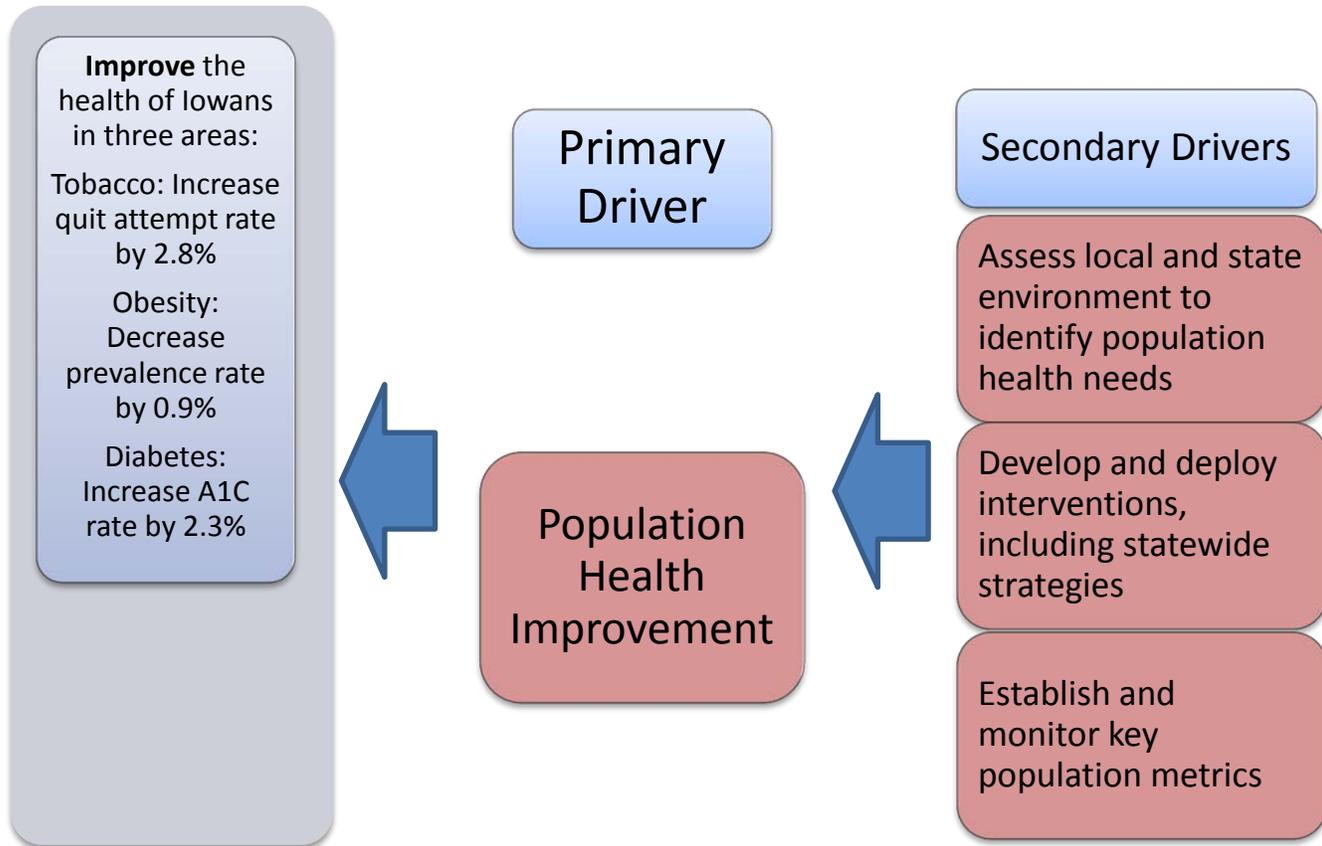
Developing a statewide approach to payment reform using **value-based purchasing** (VBP) continues to be a goal of the Iowa SIM. Aligning payment reform initiatives across payers ensure that the delivery system is engaged and working in the same direction for their entire panel of patients. This payment alignment helps providers reach the scale, necessary for transformation. This VBP approach is the foundation for developing sustainable change of the Iowa healthcare system.

Community-Based Performance Improvement (CBPI) is a critical driver in the transformation process. Providing Technical Assistance (TA) to Iowa's Community Care Coalitions (C3s) in the form of training, communications and Quality Improvement (QI) support services build capacity and promote improvement projects across Iowa. Central to QI services is the advancement of Rapid-Cycle Performance Improvement (RCPI) methodology in practice transformation initiatives. RCPI uses the PDSA cycle to implement and test change over abbreviated project timelines, which are critical to addressing transformation in an emerging value-based healthcare system.

2. SIM Component Summary Table

Primary Driver: Population Health Improvement

Approach: The Plan to Improve Population Health approach assesses and integrates local and state population health needs to establish, monitor and evaluate key population health metrics. Statewide strategic plans, developed in collaboration with existing health improvement programs, will be promoted to align interventions focused on the Iowa SIM statewide strategies. Coordination with existing health improvement efforts will prevent duplication and maximize resources. Although this driver impacts all three aims, the chief goals impacted are the improved health status for the population across Iowa.



ACTIONS:	RESPONSIBLE PARTY(S)	MILESTONES
Develop an integrated, sustainable local and state-level Community Health Needs Assessment and Health Improvement Planning (CHNA&HIP) process (including payers, hospitals, public health, non-profit organizations, and other stakeholders).	IDPH	118 – 129
Assure that social determinants of health are integrated into the IDPH CHNA&HIP process.	IDPH	123, 144
Integrate existing CHNA&HIPs into the Healthy Iowans state health improvement plan.	IDPH	121, 124
Establish mechanisms (e.g., rapid cycle performance improvement process) to assure the continuous evaluation and improvement of community health needs assessments and health improvement	IHC	118, 120

plans.		
Share data in communities to implement population health statewide strategies for focus areas: medication safety, obesity, diabetes, obstetrics, healthcare associated infections, and tobacco use.	IDPH	125,238
Maximize other statewide health improvement initiatives to support SIM focus areas of diabetes, obstetrics, healthcare – associated infections, medication safety, obesity and tobacco use, Iowa’s Healthiest State Initiative, as well as the state’s quality improvement network (Telligen), HEN, and TCPI.	IDPH	122,126,127

Implementing Population Health Actions:

The population health actions will lead to the completion of the SIM Plan to Improve Population Health that will be sustained beyond the SIM funding period. The processes and lessons learned from implementing the population-based, community-applied interventions from the Iowa SIM statewide strategy plans in C3s and other communities will be used in developing the Roadmap to Improve Population Health section of the Iowa SIM Plan to Improve Population Health.

Population Health Definitions:

Healthy Iowans: Iowa’s State Health Improvement Plan (SHIP). The current Healthy Iowans Plan for Health Improvement is located at http://idph.iowa.gov/Portals/1/Files/HealthyIowans/plan_2012_2016.pdf.

Plan to Improve Population Health: Iowa’s SIM Population Health Improvement Plan scheduled for completion in SIM Test Year 3. The Plan to Improve Population Health will align with the Healthy Iowans formatting and will be integrated into the Healthy Iowans State Health Improvement Plan to assure long-term sustainability.

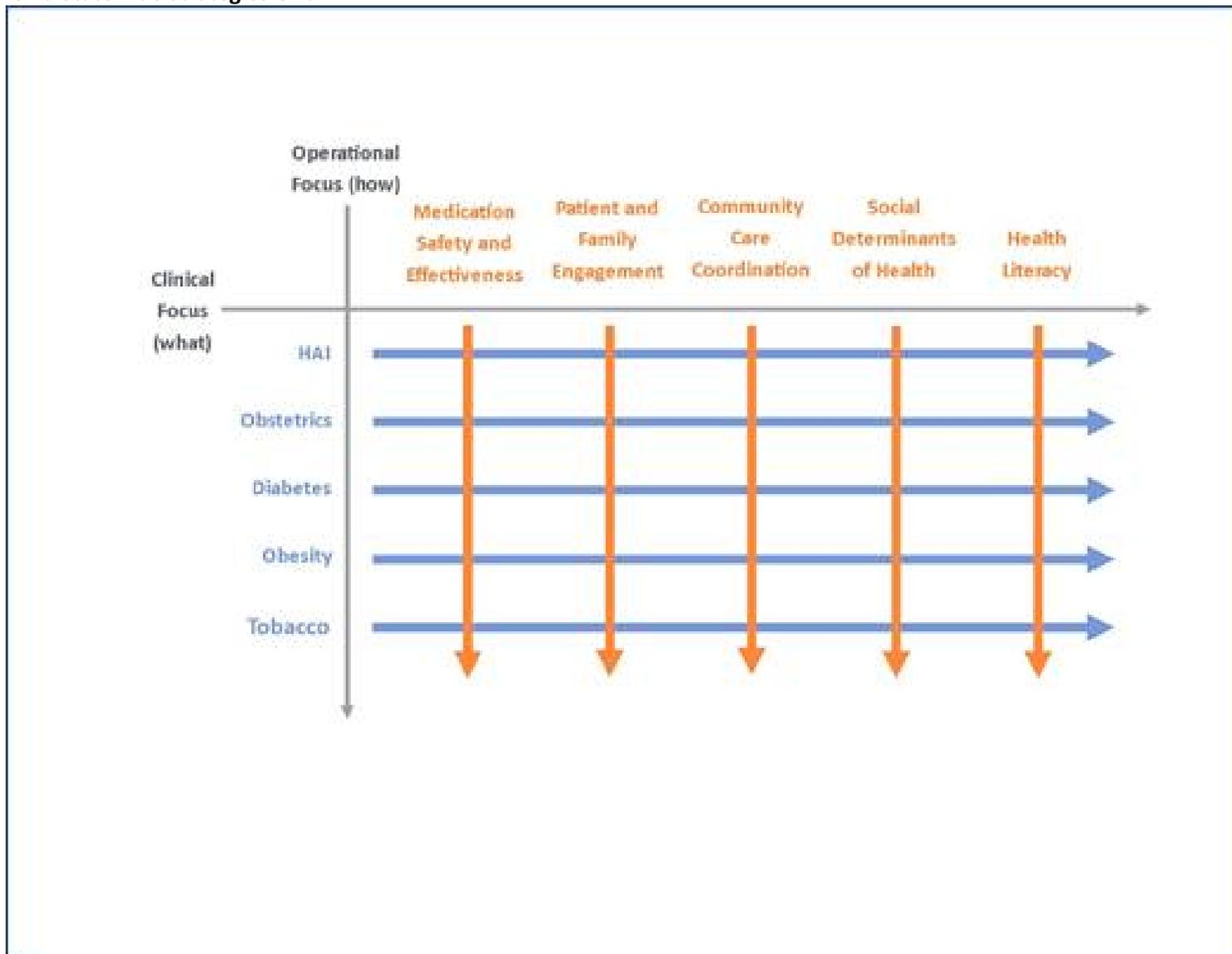
Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP): A process that local boards of health and community partners complete every five years in each of Iowa’s 99 counties. The submitted assessments and plans are one data source used to identify Iowa’s most critical health needs in Healthy Iowans: Population Health Improvement Plan.

Iowa SIM Statewide Strategies: The focus areas of Tobacco, Obesity, Diabetes, Obstetrics, Healthcare Associated Infections.

Iowa SIM Supplemental Statewide Strategies: The supplemental strategies of Social Determinants of Health, Medication Safety and Effectiveness, Person and Family Engagement, Health Literacy, and Care Coordination are used in addressing the statewide strategies. See the Iowa SIM Statewide Strategies Grid below.

Iowa SIM Statewide Strategy Plans: The plans for each of the Iowa SIM Statewide Strategies that include interventions to impact the Statewide Strategy <http://idph.iowa.gov/SIM>. See the Iowa SIM Statewide Strategies Grid below.

Iowa Statewide Strategies Grid



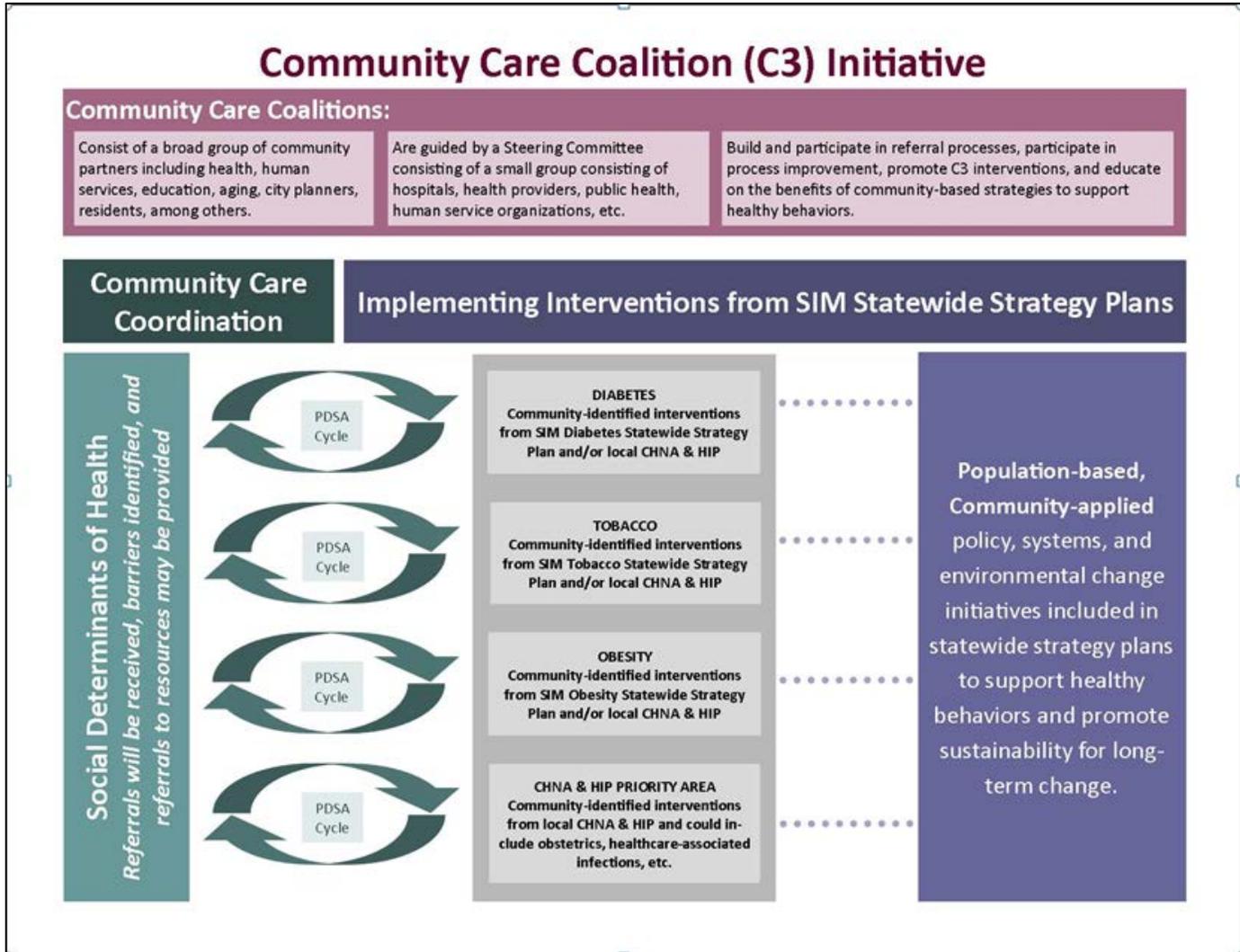
Community Care Coalition (C3): C3s are locally-based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. The C3s will have two primary functions: 1) addressing social determinants of health through care coordination; and 2) implementing population-based, community-applied interventions related to the Iowa SIM Statewide Strategies. These initiatives are intended to 1) enhance care coordination for both providers and patients by identifying population risks and addressing barriers to health such as social determinants of health by connecting patients (and providers) to community resources, and 2) develop and/or implement strategies to address tobacco, obesity, and diabetes. The C3s will also be encouraged to address the other SIM Statewide Strategies and Supplemental Strategies of medication safety, patient and family engagement, community resource coordination, social determinants of health, hospital acquired infections, and obstetrics.

Improvement in these areas will advance the Iowa SIM project toward meeting the goals of improved health and reduction of preventable inpatient readmissions and ED visits

The **C3 Diagram** below describes:

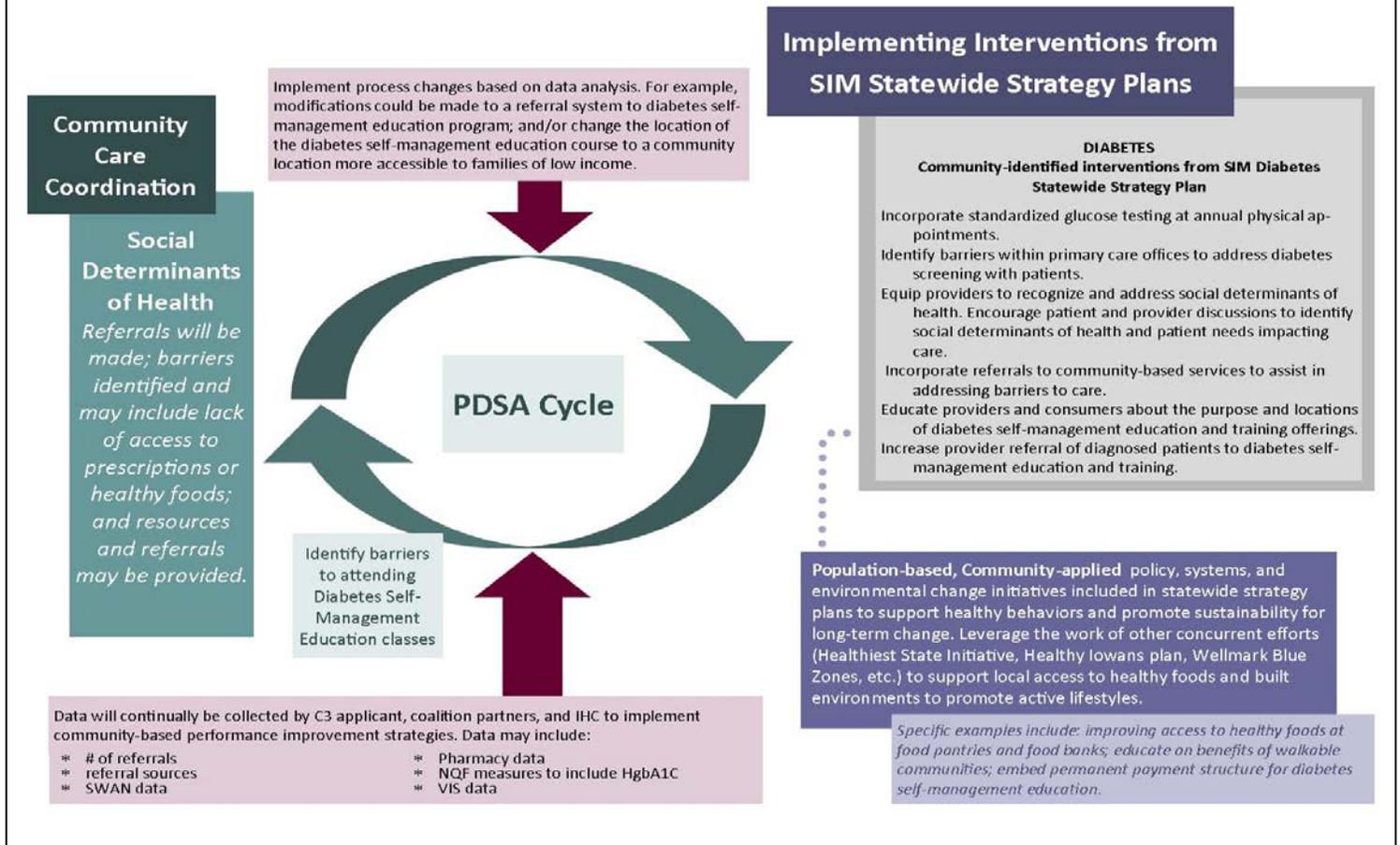
- The composition, leadership and general functions of a C3 (pink).
- Community Care Coordination identifying population risks and addressing barriers to health such as social determinants of health by connecting patients (and providers) to community resources (green).
- Implementing interventions contained in the Iowa SIM Statewide Strategy Plans. Interventions will be assessed using the Rapid Cycle Improvement Process of Plan-Do-Study-Act (PDSA). A broad illustration of C3 implementation is shown in the **C3 Diabetes Example** below.

C3 DIAGRAM



Community Care Coalition (C3) Diabetes Example

Example of a community-selected intervention from the SIM Diabetes Statewide Strategy Plan



ACTION: Develop an integrated, sustainable local and state-level Community Health Needs Assessment and Health Improvement Planning (CHNA&HIP) process (including payers, hospitals, public health, non-profit organizations, and other stakeholders).

The Community Health Needs Assessment & Health Improvement Plan (CHNA & HIP) process is completed by local boards of health and their community partners every five years in each of Iowa's 99 counties. The next CHNA & HIP submission is February 29, 2016. IDPH SIM staff will provide the Iowa SIM Statewide Strategy Plans and resources to counties that have identified a SIM Statewide Strategy or Supplemental Strategy as a priority. Updates to local CHNA & HIPs may be made on an annual basis. Additionally, innovative processes learned during the three SIM model test years will be integrated into the 2021 CHNA & HIP process to sustain interventions, especially community-clinical linkages, beyond the SIM project period.

ACTION: Assure that social determinants of health are integrated into the IDPH CHNA&HIP process.

Social determinants of health are currently included as part of the CHNA&HIP process

<http://idph.iowa.gov/chnahip/reporting> but will be enhanced through SIM activities. Local CHNA&HIPs that are submitted by February 29, 2016 will be reviewed to determine which counties have integrated social determinants of health strategies into the local health improvement plan. Resources and learning community trainings will be offered in the area of Social Determinants of Health throughout the SIM project period. For example, many

communities may have completed the CHNA prior to the release of the CDC website: Social Determinants of Health: Know What Affects Health. Updates to local CHNA & HIPs may be made on an annual basis.

In addition, assessments and interventions implemented during the three SIM model test years will be integrated into the 2021 CHNA & HIP process to enhance existing data sources and provide action items addressing Social Determinants of Health.

ACTION: Integrate existing CHNA&HIPs into the Healthy Iowans state health improvement plan.

CHNA&HIPs are one of five data sources used to determine critical needs to include in Healthy Iowans, Iowa's State Health Improvement Plan. The next five year submission of the CHNA&HIPs is February 29, 2016. IDPH SIM staff will submit and commit to reporting on the progress of SIM goals and accountability targets that align with the critical needs identified. The clinical indicators included in Healthy Iowans will be enhanced by including progress on the SIM metrics.

ACTION: Establish mechanisms (e.g., rapid cycle performance improvement process) to assure the continuous evaluation and improvement of community health needs assessments and health improvement plans.

Quality Improvement (QI) Advisors will be assigned from IHC to each of the C3 communities. CHNA&HIPs will be reviewed and aligned with C3 interventions. IHC QI Advisors will provide technical assistance and QI tools to C3 communities throughout the project period.

ACTION: Share data in communities to implement population health statewide strategies for focus areas: medication safety, obesity, diabetes, obstetrics, healthcare associated infections, and tobacco use.

The local health improvement plans will be analyzed to determine which counties have identified the SIM Statewide and Supplemental Strategies of diabetes, tobacco, obesity, obstetrics, healthcare-associated infections and medication safety as a priority. In addition, the submitted plans will be reviewed to determine which counties have integrated hospitals into the local health improvement plan and which have integrated social determinants of health strategies into the local health improvement plan. IDPH SIM staff will provide the Iowa SIM Statewide Strategy Plans and resources to counties that have identified a SIM Statewide Strategy or Supplemental Strategy as a priority. IDPH SIM staff will also complete informational documents highlighting C3 initiatives that may be replicated in other locations.

ACTION: Maximize other statewide health improvement initiatives to support SIM focus areas of diabetes, obstetrics, healthcare – associated infections, medication safety, obesity and tobacco use, Iowa's Healthiest State Initiative, as well as the state's quality improvement network (Telligen), HEN, and TCPI.

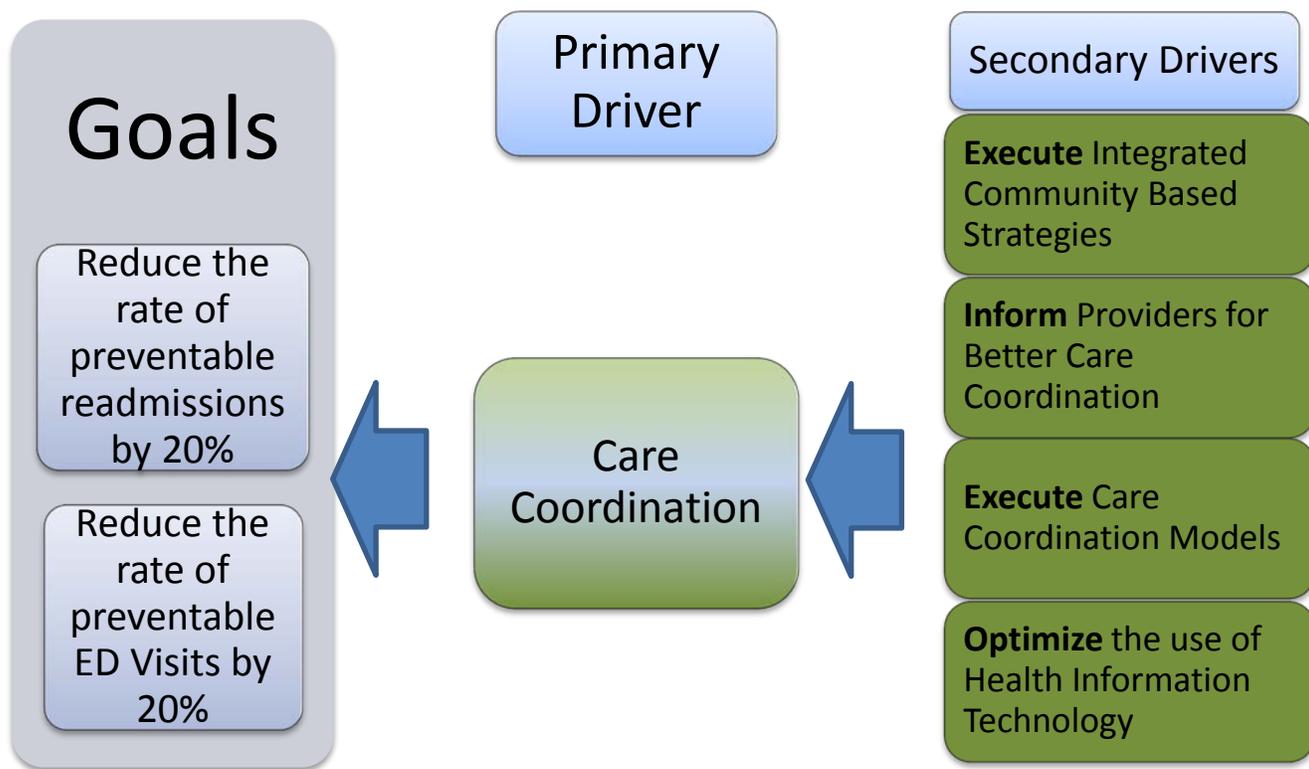
IDPH SIM staff will collaborate with other statewide health improvement efforts to further enhance the existing SIM Statewide Strategy Plans and develop additional plans for the SIM Statewide Supplemental Strategies.

The local health improvement plans and stakeholder input to the Healthy Iowans process will be analyzed to determine which counties have identified the SIM Statewide and Supplemental Strategies of diabetes, tobacco, obesity, obstetrics, healthcare-associated infections and medication safety as a priority. The number of Iowans covered by a Health Improvement Plan having the SIM Statewide Strategies or Supplemental Strategies as a focus will also be determined.

Existing efforts that address the SIM Statewide Strategies and Supplemental Strategies will be tracked through review of submitted CHNA&HIPs and contributions to Healthy Iowans from a wide-range of health-related private and public organizations and advisory groups. Partner organizations will also be invited to participate in the development of the Roadmap to Improve Health section of the Iowa SIM Plan to Improve Population Health.

Primary Driver: Care Coordination

Approach: Care Coordination is a driver to positively impact preventable ED visits, preventable readmissions and improve the health in the three areas of diabetes, tobacco and obesity. Getting care coordination right will transform how healthcare is delivered in Iowa. The Iowa SIM initiative will work to align the healthcare delivery system by equipping communities, informing stakeholders, and executing statewide strategies. C3 communities will engage local networks of community partners to lead person-centered coordination of care addressing clinical and SDH needs. The SWAN aims to facilitate coordination during critical transitions of care (ED and Inpatient events). RCPI and TA support will align and equip communities and health providers to increase effectiveness and accelerate results during the Iowa SIM Initiative.



ACTIONS:	RESPONSIBLE PARTY(S)	MILESTONES
Executing Integrated Community Based Strategy Actions:		
Utilize Local Public Health (LPH) expertise to mobilize community partnerships.	IDPH	238,240
Link people to needed personal health services through Community Care Coalitions.	IHC	238 - 245
Incorporate policy-systems-and environmental change strategies to strengthen community-clinical linkages.	IDPH	125, 127

Equip community partners and providers to transform the health system through IHC TA.	IHC	142-158
Informing Providers for Better Care Coordination Actions:		
Connect all Iowa hospitals ADT files to SWAN	IDPH	260,261,263
Deploy real-time notifications for ED and inpatient events	IDPH	255 - 263
Engage Medicare, Wellmark and MCO's in using the SWAN	IDPH	226, 227
Deploy multiple alert notification methods as needed	IDPH	274,281,282
Establish other notification events and sources to improve health outcomes	IDPH	251
Executing Care Coordination Model Actions:		
Identify components from Model A CCTs and SIM test year one C3s to create Iowa's C3 model	IDPH	240, 241
Integrate C3 strategies in traditional health care systems.	IHC	135,138,144
Enhance strategies to address social determinants of health within each C3.	IDPH	215,216,238,241
Align C3s with additional population health efforts and the Learning Community Events.	IHC	
Maximize other statewide health improvement initiatives that support the SIM focus areas of diabetes, obesity and tobacco.	IDPH	127, 239
Integrate HRA content into Patient and Family Engagement strategies.	IHC	135,138,144
Optimizing HIT Actions:		
Use community Technical Assistance to explore and promote the application of HIT resources to address identified gaps. (i.e.SWAN and the Iowa Health Information Network (IHIN).	IHC	137, 138, 142
Assist C3 Communities as they develop a data strategy to track progress and drive improvement.	IHC	135, 139,141,145
Develop and collect local process and outcomes data for SIM improvement cycles in the C3 communities.	IHC	139, 141,145

Care Coordination

C3s are locally-based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. The definition of C3s, a C3 Diagram outlining the functions of a C3, and a C3 Diabetes Example are found in Section B.2 of the Revised Operational Plan, Primary Driver: Plan to Improve Population Health. The C3 Diabetes Example shows that a broad variety of interventions focused on diabetes may be incorporated in a C3 and how the delivery of one specific initiative, Diabetes Self-Management Education, could potentially be changed to improve health outcomes.

Executing Integrated Community Based Strategy Actions:

ACTION: Utilize Local Public Health (LPH) expertise to mobilize community partnerships.

When the LPH agency is not the lead applicant for the C3 initiative, IDPH SIM staff will request LPH agencies located within C3 regions engage existing community partnerships, where possible. IDPH SIM staff will also involve state-level associations and stakeholders to assure their local partners are aware of C3 activities. An informational document of planned activities and success stories will be shared with the local public health regions to share best practices that may be replicated.

ACTION: Link people to needed personal health services through Community Care Coalitions.

A primary goal of the Community Care Coalitions will be to establish multi-stakeholder, cross-discipline, collaborative care partnerships in local communities. Through the provision of technical assistance support, established Community Care Coalitions will be encouraged and equipped to identify and engage partners and entities throughout the community who provide varied health services, inclusive of both clinical and non-clinical services. The resulting community collaboration will facilitate resource and service linkages among stakeholders that will enable referrals and further linkage of patients and community members to needed health services.

ACTION: Incorporate policy-systems-and environmental change strategies to strengthen community-clinical linkages.

The Iowa Statewide Strategy Plans may be found at <http://idph.iowa.gov/SIM>. The plans include a variety of interventions addressing several levels on the Health Impact Pyramid (Frieden, 2010¹) including direct services, group education, promotion, policy, systems and environmental level changes. For an example of how a broad variety of interventions focused on diabetes will include patients, providers and communities, please refer to the C3 Diabetes Example in Section B.2 of the Revised Operational Plan, Primary Driver: Plan to Improve Population Health. Each C3 community will select the interventions from the Iowa SIM Statewide Strategy Plans based on the needs identified in the CHNA & HIP and community engagement of specific interventions. Technical Assistance on the Rapid Cycle Improvement Process provided to C3 communities will further tailor interventions to specific populations.

Interventions included in the Iowa Statewide Strategy Plans will also be shared with counties identifying the SIM Statewide Strategies as priority needs in their communities.

Interventions and processes implemented during the SIM project period and input from stakeholders on other successful interventions that improve population health will be included in the Roadmap to Improve Health section of the Plan to Improve Population Health.

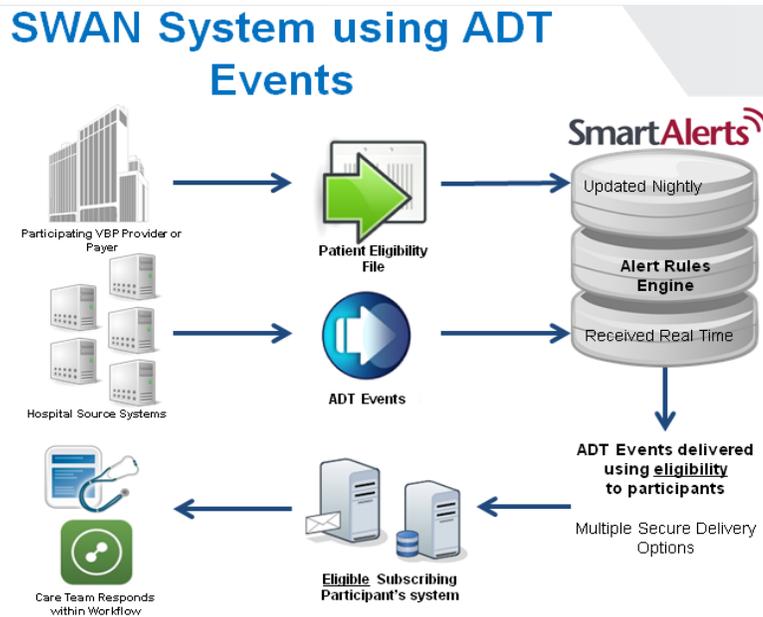
ACTION: Equip community partners and providers to transform the health system through IHC TA.

Healthcare providers and their partners throughout the state are entrenched in the throes of healthcare transformation. The goal within SIM is to equip providers and partners to actively engage in the transformation process leading to value-based and sustainable systems to provide the highest quality, person-centered care possible. This system-based approach requires that partners and providers from across the healthcare spectrum, inclusive of clinical and non-clinical, are well-connected and collaborative partners. IHC's TA provisions will specifically and intentionally include strategies to facilitate development and strengthening of such collaborative relationships, as well as the processes to introduce and implement operational and care processes and protocols to ensure the incorporation of such practices at a system-level. The end result of such effort will be whole systems of care that provide care to the whole person.

Informing Providers for Better Care Coordination Actions:

¹ Frieden, T.R., A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health 100(4):590-595, 2010.

SWAN deploys a statewide alert system aimed specifically at providers engaged in transforming into a value-based system. To execute this care coordination strategy, Iowa will establish a statewide network of ADT files attached to a Smart Alert engine as described below and in more detail in the HIT section of this document:



ACTION: Connect all Iowa hospitals ADT files to SWAN.

IDPH SIM staff will continue to promote the benefits of SWAN to hospitals not yet connected. IDPH SIM staff will provide information about SWAN at the IHC Learning Community events. In addition, a webinar will be provided to hospitals not yet participating. IDPH SIM staff has set milestones of adding five SWAN connections each quarter in SIM Test year one.

ACTION: Deploy real-time notifications for ED and inpatient events.

IDPH will work with ACO's to ensure alerts being sent are useful and include actionable data. As we determine the alerts being sent are useful, IDPH will work to determine a process to change the alerts from a daily batch to real time.

ACTION: Enable Medicare, Wellmark and MCO's to use SWAN.

IDPH will engage Medicare, Wellmark and MCO's to use SWAN by gathering success stories and sharing those to show the payers how the alerts are beneficial for the Medicaid population and could be beneficial for other populations. IDPH will work with each payer to determine steps needs to get them connected to the SWAN and who would receive the alerts.

ACTION: Deploy multiple alert notification methods as needed.

IDPH SIM staff will continually be communicating with ACOs and hospitals connected to SWAN to share best practices between organizations. A survey will be developed and sent to participating ACOs and hospitals as one method of receiving information. The communication plan will be updated annually to support this action.

ACTION: Establish other notification events and sources to improve health outcomes.

As the SWAN system develops, additional event notification and information sources will be explored. Information received through surveys, learning communities, and SWAN implementation will be tracked to identify potential areas for improvement.

Executing Care Coordination Model Actions:

ACTION: Identify components from Model A CCTs and SIM test year one C3s to create Iowa's C3 model.

The final reports submitted by the Model A CCTs and the quarterly reports from the SIM test year one C3s will be analyzed to determine commonalities for successes and lessons learned. An informational document will be developed and shared with statewide groups and local communities to promote replication of best practices. In addition, a draft C3 model will be developed and modified based on implementation in SIM test years two and three.

ACTION: Integrate C3 strategies in traditional health care systems.

Efforts to establish care coordination practices through SIM are intended to expand beyond the identified C3 communities. Care coordination models, best practices, and promising strategies identified and demonstrated through the C3s will be disseminated to statewide stakeholders through ongoing education offerings, including Learning Community events and web-based content. Dissemination of successful C3 strategies will also be aligned with ongoing, coordinated efforts within additional improvement initiatives underway within the state, such as the Hospital Engagement Network, Transforming Clinical Practice Initiative, etc.

ACTION: Enhance strategies to address social determinants of health within each C3.

Resources and learning community trainings will be offered in the area of Social Determinants of Health throughout the SIM project period. For example, resources from the CDC website: Social Determinants of Health: Know What Affects Health will be routinely provided to C3 communities. Technical assistance provided through the quality improvement process will assure Social Determinants are considered and barriers addressed as interventions are implemented and modified as needed.

One RFP was released (fall of 2015) for addressing social determinants of health (SDH) and implementing population-based, community applied interventions. Applicants for the C3 RFP will complete separate action plans and budgets for each of the two functions of the C3 project (i.e., one budget for SDH and one budget for population-based, community-applied interventions.)

Eligible C3 applicants include nonprofit organizations, governmental agencies, and educational institutions.

Each C3 awardees will provide quarterly progress reports and will report accountability target measures for interventions related to diabetes, tobacco, obesity, and SDH.

ACTION: Align C3s with additional population health efforts and the Learning Community Events.

Alignment of efforts across and throughout initiatives is vital to the successful execution and sustainability of SIM. Particular emphasis will be placed on alignment of strategies and efforts promoted through the C3s with population health efforts additionally underway through concurrent and collaborative initiatives throughout the state. Alignment efforts will ensure the most comprehensive and appropriate use of resources across programming, facilitate spread of successes experienced, and enable shared learning from lessons learned. This alignment of activities and content will extend to SIM Learning Communities events, as well. Learning Community events will be

designed to be reciprocal and shared learning events that will both disseminate best practices and strategies from within C3s and promote those derived from additional population health efforts and evidence-based models and recommendations.

Maximize other statewide health improvement initiatives that support the SIM focus areas of diabetes, obesity and tobacco.

Iowa SIM Statewide Strategy Plans have been developed for diabetes, tobacco, obesity, healthcare-associated infections and medication safety. Interventions in each plan align with existing programs such as the Center for Disease Control and Prevention's 1305: State Public Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant. Ongoing communication will occur between program staff to assure resources are enhanced and not duplicated. IDPH will develop C3 informational documents and disseminate to program staff, state associations and other stakeholders. IDPH SIM staff will collaborate with other statewide health improvement efforts to further enhance the existing SIM Statewide Strategy Plans and develop additional plans for the SIM Statewide Supplemental Strategies.

Integrate HRA content into Patient and Family Engagement strategies.

Successful execution of Patient and Family Engagement (PFE) strategies centers upon awareness and understanding of the patient and family beyond the clinical interaction. Information and data made available through Health Risk Assessments (HRAs) can be extremely valuable in helping healthcare providers and community partners in both better understanding their patient populations and identifying opportunities to further support their patients (and their families) in becoming partners in their health and wellbeing. Information and data provisioned through HRAs will be utilized to help prioritize PFE strategies to be encouraged and implemented through SIM. Integration of HRA content will also enable customization of PFE strategies to be implemented at the community-level to enhance buy-in, fit, and adoption. Through technical assistance support offered to the C3s, use of HRA data and information at the community-level and across community and care settings will be highly encouraged and supported.

C3 Communities are engaged with technical assistance support to improve performance in value-based payment models by better utilizing HIT (SWAN and RCPI data), but they are also engaged in community care coordination to lessen the impact of social determinants on health outcomes. This SDH health coordination requires dedicated resources to engage community partners, form relationships with community providers and develop a system to accept referrals, assess member needs and coordinate community services.



Optimizing HIT:

Modern healthcare improvement initiatives have largely been characterized by the application of HIT-based solutions and/or the use of advanced communications platforms. We anticipate a continuation of that trend with our C3 projects. Many C3 interventions will focus on the operational coordination of community resources to improve both the quality of care and the community health status.

This process of building accountable care communities requires enhanced communications and information sharing. As process and communication gaps or opportunities are identified in the improvement process, Iowa offers a variety of existing HIT and communications tools to possibly address those needs; tools like the SWAN and the IHIN.

In recognition of the abbreviated SIM timeline, IHC will work diligently with C3 project leaders to identify opportunities to accelerate project activities by applying rapid cycle change methodology. IHC supports the formation of Rapid Action Teams (RATs) with practical guidance, education, and examples

RCPI builds off the statewide population health strategies and the need for providers to improve in care coordination and value-based purchasing models. As the services move up on the pyramid below, more specific TA and one-one-one assistance if available to providers and communities

Whenever possible, C3 project-specific metrics will be collected in the SIM Reporting Database; a secure, web-accessible reporting platform that supports SIM project performance and data reports. This platform is modeled after the Iowa Hospital Engagement Network (HEN) Reporting Database, which was also built and supported by IHC. Projects with a notable HIT component will collect, monitor and report applicable HIT measures. HIT project-relevant data may include:

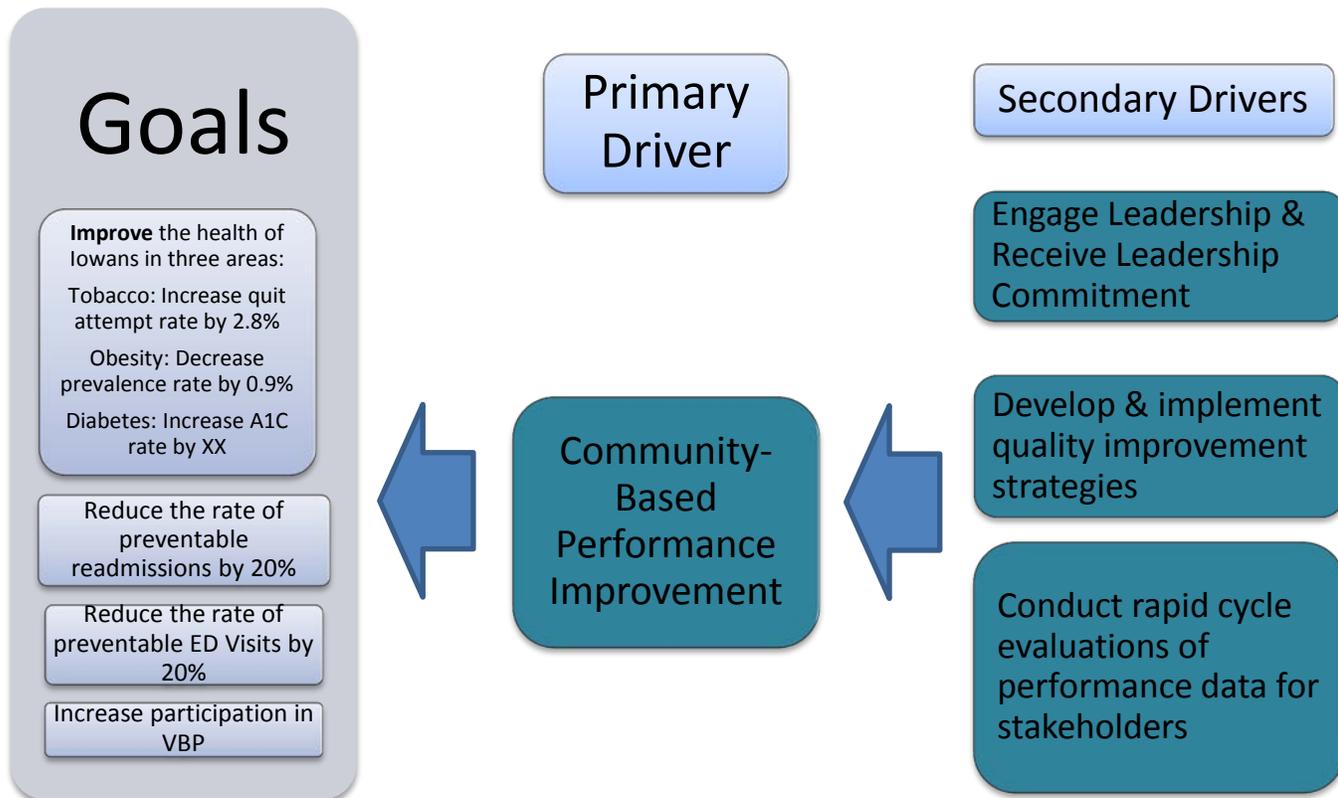
- HIT usage data, such as the rate of electronic prescribing, use of electronic lab or diagnostic results, or use of electronic clinical reminders.
- The potential use of Iowa’s Health Information Network (IHIN) by C3 community pharmacists and the resulting notification or care plan adjustments initiated through this system.

- EHR effectiveness monitoring, such as computerized provider order entry (CPOE) and clinical decision support (CDS) usage data or the percentage of clinical documentation functions that are fully populated. (i.e. electronic discharge summaries, patient demographics, provider notes, medication lists, discharge summaries, or advance directives)

Primary Driver: Community-Based Performance Improvement

Approach: Align and equip Iowa communities to improve quality, safety, and value by positioning themselves as high-performers under value-based reimbursement. IDPH has contracted with the Iowa Healthcare Collaborative (IHC) to provide Technical Assistance (TA) to Iowa's C3s in the form of training, communications and performance improvement support services. The goal is to build project management competencies and promote health care coordination and improvement projects across Iowa. Central to IHC's project management strategy is the advancement of RCPI methodology to effect an accelerated change model. RCPI uses the Plan Do Study Act (PDSA) cycles to implement and test change over abbreviated project timelines, which are critical to addressing transformation in an emerging value-based healthcare system. In addition to QI support IHC will provide educational opportunities, facilitate C3 communications, and establish systems for securely capturing project specific data and requests for assistance.

Funded through state appropriations, two Community Care Teams were piloted in 2014 to explore the integration of community resources into community level health care delivery systems to determine if such models could improve health outcomes and reduce costs. An additional four areas were funded in 2015 for a total of six communities. The funding for the initial two years were appropriated to a Safety Net Collaborative that was administered by Iowa's community health center association. SIM funding was extended to the six pilots during SIM year one to advance the Community Care Team (CCT) pilot project and transition toward the State Innovation Model (SIM) focus areas which include but are not limited to diabetes, obesity and tobacco. Successes and lessons learned from the pilots will provide a foundation that will be built upon moving forward.



ACTIONS:	RESPONSIBLE PARTY(S)	MILESTONES
Engage Leadership & Receive Leadership Commitment	IHC and IDPH	
Support the initial stages of C3 community engagement with meeting facilitation and charter development.	IHC and IDPH	132 - 141
Promote the SIM among potential partners and non-C3 Iowa communities, highlighting the benefits of value-added health care strategies in a changing landscape.	IHC and IDPH	132, 134, 142, 143, 144, 146, 148
Develop & Implement Quality Improvement Strategies		
Influence C3 communities to align activities with complimentary programs (e.g., HEN, TCPI, State Public Health Strategies)	IHC and IDPH	135, 137, 138
Identify improvement activities that drive C3 initiatives to align with SIM goals and Statewide PH Strategies.	IHC and IDPH	135, 137, 138
Convene learning communities and produce topical webinars, each focusing on key topics and strategies (e.g., Care Coordination Strategies, Data-Driven Improvement, Health Equity)	IHC	132, 135, 133, 142, 143, 146, 148
Assist C3s in aligning CHNA & HIP efforts of hospital and public health communities.	IHC & IDPH	135, 137, 138, 144
Guide alignment of local community strategies with Iowa statewide strategies to capitalize on the momentum of existing activities.	IHC & IDPH	135, 137, 138, 144
Use community needs identified by assessment efforts (i.e. CHNA/HIP, HRA, provider plans, etc) to drive C3 project selection.	IHC	137, 138, 144
Align data collection and reporting strategies to reduce data collection burden	IHC	135, 137, 139, 138
Establish a project reporting database to support C3 performance tracking	IHC	135, 139, 141

ACTIONS: Support the initial stages of C3 community engagement & promote the SIM among potential partners and non-C3 Iowa communities

IHC will cultivate the development of our community coalitions (C3s) by providing expertise in Performance Improvement (PI) and Technical Assistance (TA). IHC's TA package encompasses an array of educational offerings and support services. IHC's QIAs will work closely with Iowa's C3s to promote the use of these resources. This assistance package will support the C3s as they work to assess community needs, develop plans and capabilities, and execute solution-based initiatives.

IHC will provide C3 partners with access to a comprehensive toolkit of risk management and performance improvement resources to support project selection, execution, and evaluation. IHC will equip communities to use quality improvement strategies, such as the PDSA cycle and Rapid Cycle change management principle to drive the specific improvement projects undertaken in each community. The resources developed for these pilot communities will be made available to all Iowa communities in an effort to engage every community in SIM improvement efforts.

ACTION: Influence C3 communities to align activities with complimentary programs

Iowa is carefully aligning our SIM activities with the ongoing transformation efforts driven by the HEN, PfP, TCPI, and QIN programs. Beyond that, Iowa has long been at the forefront of care transformation efforts. Proof of that remains in the ongoing efforts of the “Iowa Healthiest State” initiative. The Iowa SIM will build and reinforce linkages with programs and organizations at the State and local level to help C3s align their activities. Iowa recognizes the critical needs of coordinating these activities so that our providers and communities are not overwhelmed with disparate messaging and data requests.

ACTION: Convene learning communities and produce topical webinars

As part of the support to be provided to deploy SIM, IHC will convene in-person educational events, called learning communities, throughout each project year. These events will be open to stakeholders from across the state to participate, inclusive of C3 representatives and attendees from beyond the identified C3 communities. In addition to in-person learning events, web-based education will be provided to allow for virtual engagement and on-demand access to reach audiences beyond those available for in-person connection. Content will focus on dissemination of evidence-based best practices for care coordination, community health, collaborative care models, patient and family engagement, and other topical areas prioritized by SIM (such as diabetes, obesity, and tobacco cessation). Many of these offerings will allow for highlighting of experienced successes within SIM through C3 actions, as well as bring content and knowledge of evidence-based practices and recommendations to statewide stakeholders. The goal of the learning community and web-based educational offerings will be to offer multiple and varied opportunities to access comprehensive content to enable broad stakeholder engagement and participation in the SIM initiative.

ACTION: Guide alignment of local community strategies with Iowa statewide strategies

Iowa’s state population health strategies address a series of priority population health issues. The SIM’s focus on these strategies requires our C3 communities to focus their efforts on the central targets of obesity, diabetes, and tobacco cessation. By narrowing the focus to these strategies, we create a manageable concentration of efforts across all the C3s, improving alignment across the communities and increasing the opportunity to attribute overall SIM evaluation to specific SIM interventions

Iowa has been proactive in developing population health interventions for many years. The obesity, diabetes, and tobacco cessation focus areas were not targeted as “low-hanging fruit”, but instead because they contribute greatly to the considerable impact of chronic conditions on the efficiency of our healthcare system and the health status of our communities. Iowa SIM is designed to deliver the most significant impact possible to Iowans in the abbreviated 3 year project timeline. We believe this targeted approach will “move the dial” on our core statewide evaluation metrics and position Iowa's healthcare system to thrive in the midst of system transformation.

ACTION: Use community needs to drive C3 project selection

Our Community Care Coalitions (C3s) are required (at a minimum) to introduce initiatives that focus on reducing obesity, diabetes, and tobacco use. However, they also have the flexibility to address the unique population health and health system needs of their communities. This approach is consistent with the CMS Round Two Cooperative Agreement Announcement, which stressed a call for “innovation with broad stakeholder input and engagement;” making the point that true innovation does not happen in a restricted environment. Therefore, we have provided our communities with a certain amount of project flexibility, but maintaining the expectation that projects must be data driven and fully engaged in the RCPI process whenever possible.

SIM projects, whether provider-facing or community-focused, will be managed with proven QI science and techniques. SIM projects will utilize the PDSA framework, using quantitative and qualitative indicators to steer SIM

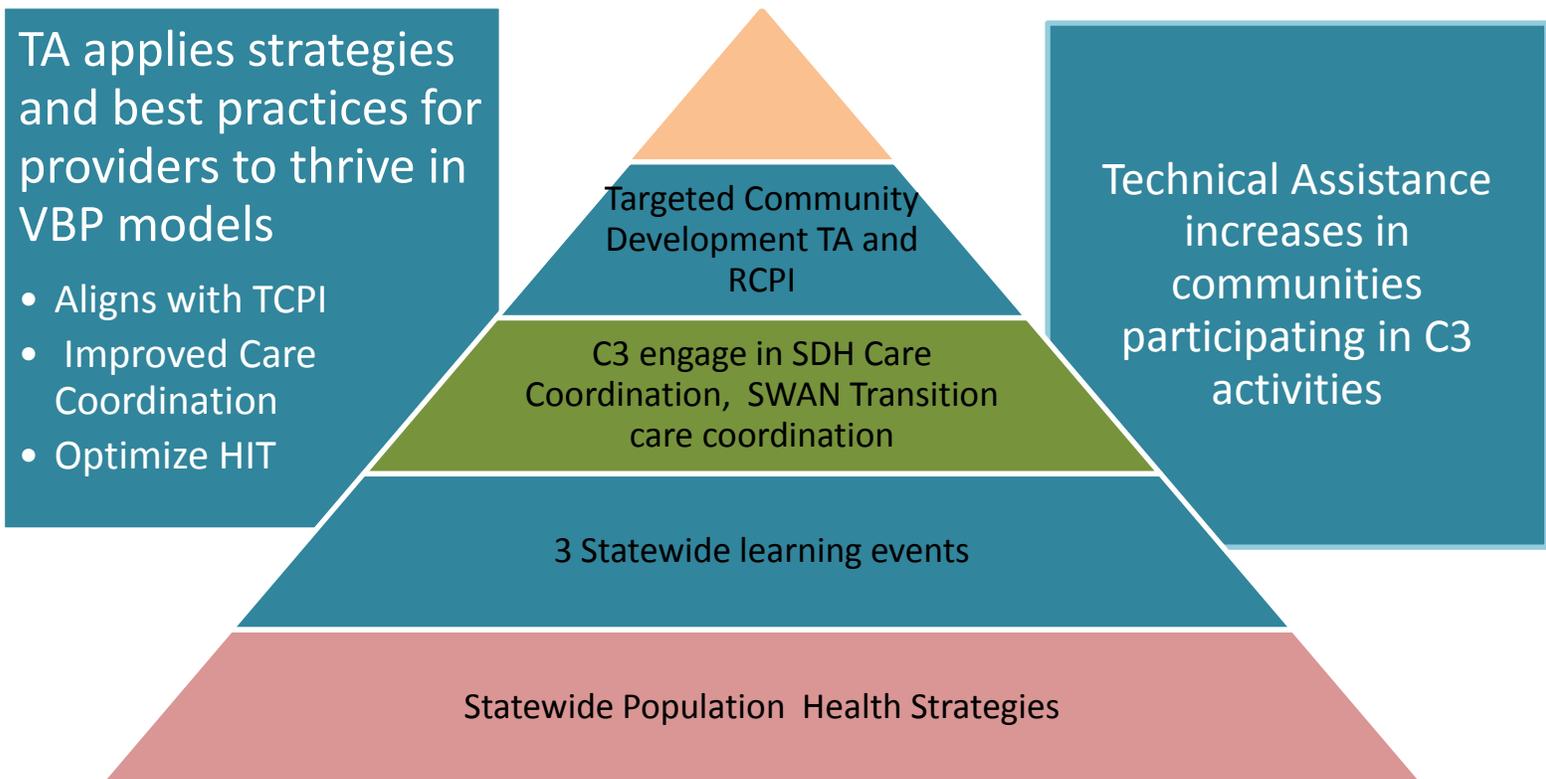
initiatives to achieve their identified project-specific goals. Our most successful SIM interventions will be selected as "best practices" and promoted for adoption in other Iowa communities, building sustainability of these improvement innovations beyond the SIM.

A Rapid Cycle Performance Improvement (RCPI) methodology will be applied to accelerate project development whenever the data supports such an approach. IHC QI Advisors will support C3 project leaders with RCPI instruction, data support, and process guidance, building their capacity to apply performance improvement tools, such as FOCUS-PDCA and root cause analysis, on an accelerated basis.

ACTIONS: Align data collection and reporting strategies & Establish a C3 project reporting database

C3 project data will be collected in the SIM Reporting Database; a secure, web-accessible reporting platform that supports SIM project performance data reports. This platform is modeled after the Iowa Hospital Engagement Network (HEN) Reporting Database, which was also built and supported by IHC. The SIM data strategy and the SIM Reporting Database, provided and managed by IHC, are designed to minimize reporting resources and operational impact on providers and partners. With this in mind, Iowa's SIM, TCPI, and HEN data strategies have been closely aligned. By aligning these data strategies, participants will be positioned to provide needed program and project evaluation data while reducing the commitment of resources.

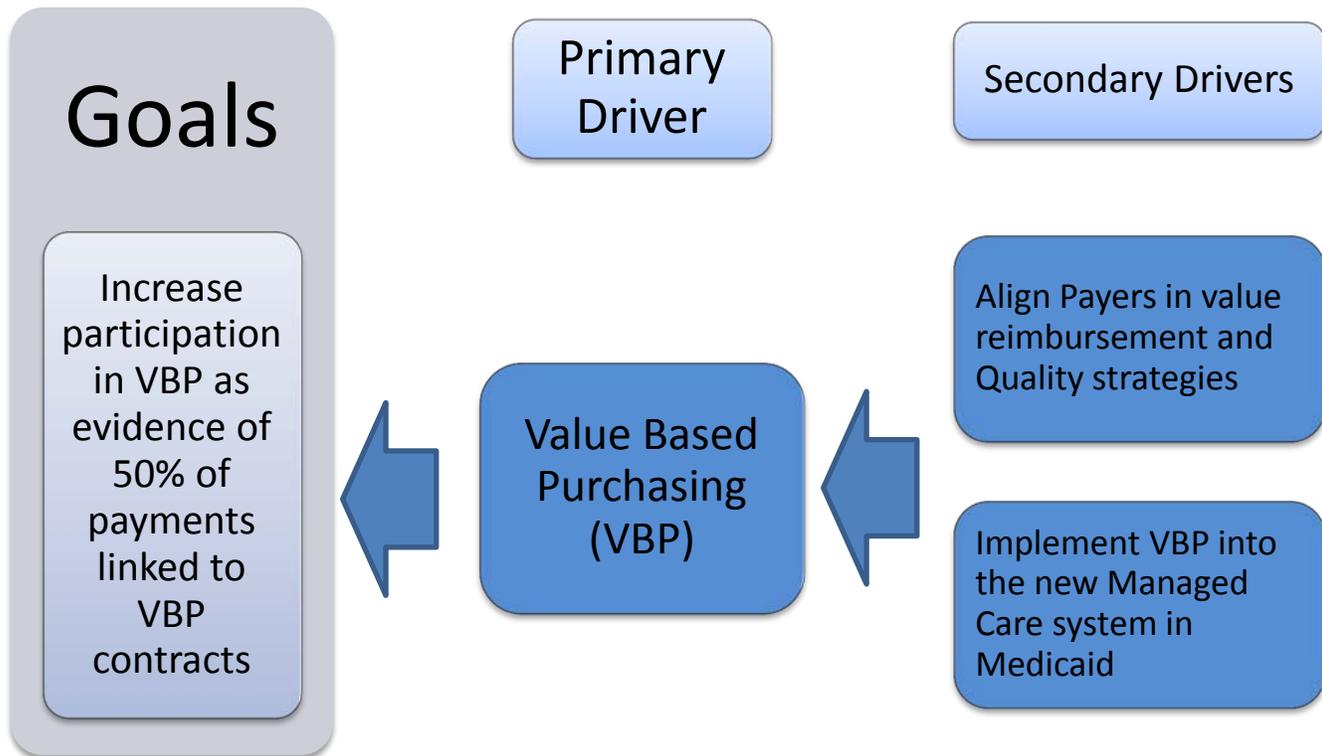
Improved Health, Transformed Health, Sustainable Health System



Primary Driver: Value Based Purchasing (VBP)

Approach: Linking provider payment to improved performance by health care providers is called Value Based Purchasing. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers, in a way consistent with overarching goals announced by U.S. Department of Health and Human Services on January 26, 2015.

Value Based Purchasing is a driver to improve all three state aims, but mainly VBP helps promote sustainability within our healthcare system and can be linked to the goal of increasing VBP payments in Iowa. VBP is also a key strategy specific to how Medicaid is implementing Managed Care. The SIM grant enables Iowa to focus on the implementation of VBP in Medicaid through MCOs and also on how the Medicaid implementation of MCOs fits into the larger healthcare market in Iowa.



ACTIONS:	RESPONSIBLE PARTY(S)	MILESTONES
Medicaid VBP and MCO Actions:		
Refine dashboard reporting to meet provider and MCO needs as the system progresses in VBP strategies	Medicaid to provide business rules, 3M to implement updates to dashboard	Tasks 175 - 184 Tasks 185-190 Tasks 196 -204
Introduce value-centric strategies in Medicaid with MCOs	Medicaid	Tasks 191-195 Tasks 196-204
Transition and grow Health Home program into the MCO model	Medicaid MCOs	Tasks 205-211
Integrate BH, LTC, Dental, CYSHCN populations in Medicaid VBP and	Medicaid MCOs	Tasks 212-218

quality models		
Introduce Social Determinants of Health (SDH) data and patient health confidence data into primary care providers engaged in VBP strategies	Medicaid to promote use AMH tool and 3M to update tool and perform analysis of SDH data collected .	Tasks 208 - 218
Provide claims data and real-time alerts data to providers in VBP to support better care coordination development	MCOs – to send encounter data 3M to process the data and scrub data and send to providers	Tasks 185-190 Task 168
Review and refine VBP quality measures annually to ensure special pop focus for Medicaid	Medicaid	Annually
All Payer Alignment Actions:		
Provide Quality Measure reports in an online dashboard model to inform delivery system performance. (tool used in alignment between Medicaid and Wellmark in Iowa)	3M to maintain dashboard, Medicaid and Wellmark to align	Task 221
Develop VIS public reporting strategies	Medicaid and Wellmark to align	Tasks 222 – 225 Tasks 66 - 70
Support the growth of primary care providers participating in value-based payment models in Iowa	Medicaid	
Promote the use of quality tools (VIS) and care coordination tools (C3s,SWAN) to improve patient outcomes and lower costs	Medicaid, IHC, IDPH	Tasks 263 – 265 Tasks 227 – 282 (3 statewide learning events year year)
Promote the use of SDH data to improve patient outcomes and lower costs	Medicaid, IHC, IDPH	(3 statewide learning events year year)
Facilitate partnerships among payers to align VBP programs across Iowa	SIM Leadership	Tasks 62 - 64

Implementing Medicaid VBP and MCO Actions:

Medicaid uses a dashboard to display quality reports, utilization reports and TCOC reports. The dashboard is refreshed monthly and available to providers participating in VBP arrangements.

VIS Background:

VIS used by both Wellmark and Medicaid is a composite measure based upon six critical primary care domains, derived from 16 measures of key processes and outcomes that lead to value in healthcare. It clearly quantifies how well a provider takes care of his or her entire patient population within a system of care. This gives VIS great value for enhancing understanding of overall provider and system performance, which helps providers and ACOs to accelerate (and prioritize areas for) improvement.

Value Index Scores (VIS)

Key Performance Measure	Rolling 12 months 10/2011-09/2012
Value Index Score	39.8 %
Primary and Secondary Prevention	43.3 %
Tertiary Prevention	31.2 %
Panel Health Status Change	66.2 %
Continuity of Care	47.5 %
Chronic & Follow-up Care	29.8 %
Efficiency	53.9 %

Budget Basis

Base risk score	0.999
Current risk score	1.191
Base budget	\$339.80
Current budget	\$405.10
VIS Best Practice Target	80.02 %
VIS All Domain Target	51.80 %
VIS All Domain Score	39.84 %

Value Index Score Key Features

BENEFITS

- Low administrative burden because it is built from claims data (no special, costly data collection required)
- Holistic system measurement that can influence the IHI Triple Aim
- Risk-adjusted when appropriate to account for differing panel composition

FEATURES

- Measures primary care accountability within the healthcare system
- Offers transparent access to domain and measure values that drive the composite
- Aligns micro and macro aspects of care delivery
- Provides continuous evaluation and feedback

CAPABILITIES

- Develop incentive-based programs to reward high performers, complementing cost savings
- Identify opportunities for system improvement and transform interactions
- Inform the design of narrow networks to ensure goals can be met
- Support the migration from volume to value-based delivery systems

The VIS measures every PCP contracted with Medicaid that has at least 19 members in their panel. To earn a VIS score, the PCP must also have enough claims data to score on at least 5 of the 6 domains. The dashboard displays information at the PCP level, the group Level (Tax ID) and the ACO Level. Even with the ACO contracts dissolving on 12/31/15, the ACOs can still utilize the dashboard to view their performance across the Medicaid population.

ACTION: Medicaid is working closely with 3M to refine the dashboard reporting to meet both provider and MCO needs. Activities to support this action are highlighted in the Milestone section of this document, tasks 191 – 204. This is a repeatable process that Medicaid has been performing with 3M since 2014. The changes captured in this operational plan include the modifications to that process to incorporate the MCOs into the model. Some of those detail steps include:

- Collect encounter data from MCOs in a standardized format
 - Communicate encounter data requirements and format to the new MCOs
 - Test new data files to meet format and completeness requirements
 - Process encounter data through Medicaid MMIS system
 - Load encounter data into the Medicaid data warehouse

- Compile and send data files to 3M
- Display new encounter data in the 3M dashboard
 - Validate input files with new MCO encounter data
 - Ensure member data has appropriate MCO tags
 - Stage data – (attribution to PCP, calculate VIS score, calculate MCO panels, etc....)
 - Update 3M dashboard platform with MCO security access

VIS is also calculated for every PCP that is contracted with Wellmark BCBS. They use a similar method to identify PCPs and require similar minimums to qualify for a VIS ranking. Preventable Readmission, Preventable ED visits and the VIS score will be calculated for both Medicaid and Wellmark by 3M and then shared with Public Policy Center to inform their evaluation. This detail is found in the R2_Reporting MetricsOps2016 supporting document submitted with the Operational Plan.

ACTION: Introduce value-centric strategies into the MCOs is one step the state has taken to develop a Value-Based Purchasing definition. The VBP definition is used as an operational guide for MCOs to development VBP contracts with ACOs. This definition has been shared with both MCOs and ACO provider organizations and can view below. Some of the detailed steps to implement this Action include:

- Develop a VBP definition
- Communicate that definition to MCOs and Provider organizations (including 2015 ACO provider groups)
- Require all VBP agreements between an MCO and a Provider organization be approved by Medicaid
- Require MCOs to report number of lives in VBP
- Require MCOs to do a PCP assignment for all lives in an VBP agreement
- Require MCOs to compile with SIM by establishing a plan to collaborate
- Establish regular meetings to discuss SIM activities and collaboration points (stakeholder engagement approach)
- Establish an MCO scorecard to track quality of each MCO's population.

The State is also charged with overseeing how each MCO performs for their population. Medicaid is working with policy staff and our analytic partner 3M to develop a VIS scorecard that measures the performance of each MCO. The RFP clearly laid out the performance targets for the 2% withhold for 2016, and clearly gives the state the authority to update those performance targets for 2017. Medicaid will align the VIS tool used to measure the performance of the delivery system in providing care to members, to also measuring how each MCO performs for the population they serve. The state is working out the details of that scorecard and how to present it to the MCOs for the 2017 pay for performance program. Aligning MCOs, to the same set of quality standards that providers are held too, only strengthens Iowa's desire to achieve the SIM aims of better population health, transformed healthcare delivery, and sustainability. These tasks are outlined in milestone tasks 196- 204.

Value-Based Payment (VBP) Models

Definition and Qualifying Criteria for Determining Eligible Models

Purpose of the Definition: A definition of VBP is necessary to support the objectives of the State Innovation Model and to guide Medicaid in approving VBP models proposed by MCOs to be used to achieve the requirement of “40% of covered lives within a VBP model”.

RFP VBP Definition: Linking provider payment to improved performance by health care providers is called Value Based Purchasing. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers, in a way consistent with overarching goals announced by U.S. Department of Health and Human Services on January 26, 2015.

VBP Operational Guidance for MCOs: The VBP models implemented by MCOs shall include but are not limited to risk sharing including both shared savings and shared costs between the MCO and the participating provider organizations, and bonus payments to providers for improved quality on a population basis.

Both the bonus payment for improved quality and any risk sharing shall be evaluated using a Total Cost of Care (TCOC) Methodology and the state’s approved set of risk adjusted quality measures, Value Index Score (VIS).

A TCOC calculation at a minimum includes a comprehensive set of services approved by the state that spans across the continuum of care, including inpatient, outpatient, pharmacy, mental health, and Long Term Care Supports and Services (LTSS).

Examples of Qualifying VBP models:

- Shared Savings/Shared Risk contract with an MCO, which tracks TCOC and quality for a defined population of attributed members. (E.g., ACOs, Bundled Payments). Quality must either improve or remain constant during the reporting period.
- Upfront care coordination payments for a specific population assigned, with the intent of achieving a specific outcome, a risk-based component of that up-front payment could be included if quality and TCOC results are not realized. (E.g., Health Homes)

Examples not Qualifying VBP models:

- Shared Savings/Shared Risk contract with an MCO, which tracks TCOC that does not also consider the impact of VIS.
- Bonus payments to providers for lowering costs for specific services that do not consider the impact to the TCOC.
- Payments made to providers that lowered total cost of care, but VIS declined during the same reporting period.

Note: Leveraging VBP programs already established in Iowa that are in use by other payers in Iowa helps providers get to scale and achieve true delivery system transformation which supports the objectives of SIM.

ACTION: Provide Claims Data and real-time alerts is an action to confirm Medicaid is committed to sharing data to support VBP activities, a data sharing agreement has been developed by the state and is found [here](#). Medicaid has implemented this process in 2014 with existing ACOs. The action involves establishing the mechanism to continue this process once the ACO contract is dissolved. Steps to support this action include:

- Developing a data sharing agreement with provider organizations participating in VBP
- Communicate that agreement with Provider organizations (including 2015 ACO provider groups)
- Post that agreement to the website
- Continue to promote the agreement with the delivery system during regular meetings as needed (stakeholder engagement approach)

ACTION: Transition and grow the Health Home model is an action for Medicaid to oversee the MCOs and ensure they are actively working with providers and seeking members that will benefit from Health Home services. MCOs are contractually required to ensure HH services are delivered with quality, are culturally appropriate, are person and family driven, and to encourage additional participation. MCOs must report Health Home enrollment data to Medicaid to ensure Medicaid has oversight and to support the State in tracking SIM activities and reporting requirements to CMS. Steps to support this action include:

- Establish HH requirements in the MCO RFP
- Establish HH requirements in the MCO contracts
- Develop HH reporting requirements of the MCO
- Set up Medicaid and MCO on boarding meetings (stakeholder engagement strategy)
 - Communicate existing HH program information with MCOs
 - Discuss areas of collaboration
 - Discuss operational transition details (list of providers, list of members associated to each provider)
- Update SPA and Iowa Administrative Code to support shift to MCOs
- Continue to promote and manage HH programs with MCOs through regular meetings as needed (stakeholder engagement approach)

ACTION: Integrate special populations into VBP and quality models. Medicaid is working to integrate special populations into VBP and quality models. Working closely with 3M, Medicaid is focusing on the LTC population, and incorporating duals data and institutional data into the 3M VIS dashboard. This work will be validated by 3M for accuracy and completeness. These activities are highlighted in the Milestone section of this document, tasks 212 – 218. Steps to support this action include:

- Include MH/BH populations into VIS quality model
- Include LTSS populations into VIS quality model
 - Get access to Medicare A, B and D, Duals data (more than half of LTSS is a dual)
 - Establish business rules for 3M to incorporate the LTSS institutional data from Medicaid to dashboard)
 - Establish business rules for 3M to incorporate the Duals Data into the dashboard)
 - Baseline VIS score to include LTSS data
 - Evaluate the impact of VIS scores when LTSS data is included
- Conduct stakeholder meetings to discuss LTSS and BH and other populations and the appropriate quality measurements in a VBP world (examples of options that state could implement)
 - SIM Leadership group
 - Appointed work groups

- MCO and provider workgroup

ACTION: Introduce SDH data and Patient Health Confidence Data into the primary care setting. Medicaid will provide a tool that introduces SDH data and Patient Health Confidence Data into the primary care setting. This tool, known as AssessMyHealth, has been used by primary care providers in Iowa since 2014. Members can complete the AssessMyHealth health risk assessment (HRA) online at home, by calling Member Services or while at the doctor's office. The Assessment then sends an email to the clinic staff alerting them a member has completed an HRA. The clinic staff logs onto the 3M dashboard and retrieves a Patient Summary. Providers use this information to adjust how they deliver care. For example, if the member identifies they believe their medicines are making them ill, this will require an intervention to ensure medicines are being taken appropriately.

For the Iowa Health and Wellness Program, members are incentivized to complete the HRA to avoid cost sharing in the following year. The State also incentivized providers to complete the HRAs by offering bonus payments. With the shift to MCOs, Medicaid has a contractual requirement that the MCOs complete an initial health screening for each new members. The state is presenting the AssessMyHealth HRA as a free tool to accomplish this goal.

AssessMyHealth includes a measure of the members Health Confidence, which is a key indicator of a person's ability to engage and improve their health, which can be a great benefit to a provider looking to prioritize coaching opportunities. AssessMyHealth also has social determinant of health questions, but the state is interested in reviewing and updating those questions as deemed necessary. The state has engaged the MCOs in the use of this tool and currently working to establish a path for consistency use across MCOs. The anticipated progress for this action is highlighted in the Milestone section of this document, tasks 208 – 218. Steps to support this action include:

- Update AMH to meet include Patient Confidence measurement
- Update AMH to include additional SDH questions, as needed
- Require MCOs to conduct Initial Health Screenings
- Pursue AMH certification with NCQA as a health screening tool
- Promote AMH to MCO (stakeholder engagement approach)
 - Conduct Onboarding meeting
 - Provide access to AMH without financial impacts (through SIM test years)
- Promote AMH to providers involved in VBP (stakeholder engagement approach)
 - Discuss benefits of a common tool across MCOs
 - Discuss benefits of direct access to Patient Summary Information
 - Discuss benefits of knowing a member's level of health confidence to improve care
 - Discuss benefits of knowing the social determinants of a member to improve care

All Payer Alignment Actions

ACTION: Align quality measurement tools. The state will continue to align our quality measurement tool, VIS for the delivery system (ACOs and other provider participating in VBP) with the dashboard reports that Wellmark BCBS providers to the delivery system. Medicaid is using the same vendor 3M and is committed with Wellmark in helping providers get to scale. This is demonstrated in the Milestones section, task 232 and discussed in the SIM Stakeholder Engagement Plan submitted in March of 2015. To do this, IME will have regular meetings with Wellmark and ensure that we are utilizing the 3M vendor to keep the programs rules together, as appropriate.

ACTION: Develop Public Reporting strategies. Iowa will meet regularly with Wellmark to discuss opportunities to align in rolling out a publicly reported VIS score for PCPs in Iowa. This process will be communicated and vetted with the delivery system prior to posting publically. Although these milestones have been loosely defined to date, Medicaid will continue to refine this process and timeline as we move forward with VBP in Iowa.

ACTION: Support the growth of primary care in VBP. Medicaid will support this growth by continuing to provide a stakeholder engagement strategy with the ACOs developed in Iowa by having regular meetings to support them through data exchange; continuing to leverage policies to grow VBP with our MCOs (the 40% requirement); support other initiatives in Iowa, like the TCPI projects that equip providers to enter into VBP contracts, participate in the SIM statewide learning events, to promote VBP. These are examples of activities that Medicaid will do to support this action in Iowa. Steps to support this action include:

- Conduct regular meetings with providers in VBP (stakeholder engagement strategy)
 - Discuss data sharing to support providers for Medicaid populations
 - Engage MCOs in this communications
 - Promote the community-based TA approach funded by SIM through IHC
- Discuss success stories of providers in VBP in larger venues (MAAC, Website, Association meetings (Stakeholder engagement strategy)
- Collect and report data on number of primary care providers participating in VBP
- Collaborate with TCPI providers in Iowa graduating by providing education, etc...
- Develop a data sharing agreement with provider organizations participating in VBP
- Communicate that agreement with Provider organizations (including 2015 ACO provider groups)
- Require MCOs to participate in VBP (the 40% requirement)

ACTION: Promote the use of quality tools (VIS) and care coordination tools (C3s,SWAN) to improve patient outcomes and lower costs. This is a primary driver of the SIM. IHC will help equip C3s to use these tools as well as promote these tools in the statewide learning events each year. Medicaid will support these topics during the learning events and work to promote these uses in regular calls with provider groups identified in the stakeholder engagement strategies submitted to CMMI. Steps to support this action include:

- Conduct regular meetings with providers in VBP (stakeholder engagement strategy)
 - Discuss data sharing to support providers for Medicaid populations that includes access to SWAN alerts
 - Promote the community-based TA approach funded by SIM through IHC
 - Discuss the importance of SDH care coordination
 - Discuss VIS scores with provider organizations, providing access to VIS and education on the scoring methods

ACTION: Promote the use of SDH data to improve patient outcomes and lower costs. Medicaid will support these topics during the learning events conducted by IHC and will work to promote these uses in regular calls with provider groups identified in the stakeholder engagement strategies submitted to CMMI. Medicaid is also working closely with 3M to provide the AssessMyHealth HRA (funding through SIM) and offered to providers and MCOs. IHC. Steps to support this action include:

- Conduct regular meetings with providers in VBP (stakeholder engagement strategy)
 - Promote the community-based TA approach funded by SIM through IHC
 - Discuss the importance of SDH care coordination
- Discuss success stories of providers coordinating SDH issues in larger venues (MAAC, Website, Association meetings (Stakeholder engagement strategy)
- 3M will use the stages of Exploration of Risk Adjustment to evaluation and determine if SDH is a valid source to do RA. (Milestones tasks 219 – 229 capture this activity at the milestone level)

ACTION: Facilitate partnerships among payers to align VBP programs across Iowa. Mostly through the stakeholder engagement processes, Medicaid will align with other payers through quarterly meetings and the Leadership meetings to promote and strengthen partnerships with other payers.

3. Risk Assessment and Mitigation Strategy

The SIM Core Team and Implementation team conducted a series of risk identification and mitigation strategy meetings focused on each primary driver of the SIM (Population Health, Care Coordination, Rapid Cycle Performance Improvement, VBP, and Evaluation). The below table is a list of identified risks, priority ranking, and subsequent mitigation planning.

Each identified risk was prioritized using a scale of high (3), medium (2), and low (1), looking at both the likelihood of the risk occurring and impact if the risk did occur. From that list, the state established mitigation plans for each risk identified with a medium or high likelihood of occurring with either a medium or high impact if it did occur. A priority assignment of high, medium or low was assigned to the risk based on the average likelihood/impact assessment (rounded up as needed).

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
VBP: MCO Engagement							
The calculation of VIS is skewed because of the quality of the MCO encounter data reported to IME.	3	3	3	<ol style="list-style-type: none"> 1. Establish a QA process at IME that validates the encounter data prior to importing it into the data warehouse. 2. Confirm the 837 file format requirements for the MCOs are in line with fields needed to support VIS. Note: This mitigation strategy has been implemented. IME shared the 837 requirements with 3M on 10/28. 3. Send test file to 3M early with 1st delivery of data . 	IME	<ol style="list-style-type: none"> 1. Rick Riley is following up on the feasibility of implementation. We have basic validation of the file but not validation for VIS. 2. This mitigation strategy has been implemented. IME shared the 837 requirements with 3M on 10/28. 3. Project Plan anticipates the file to go to 3M by 2/28/2015. 	March 2016
The reporting of VIS is delayed due to untimely reporting of encounter data from the MCOs.	3	3	3	<ol style="list-style-type: none"> 1. Provide Communication with the delivery system regarding delays and updates to prevent disengagement. 2. Monitor and enforce MCO adherence to contractual requirements. 	IME	<ol style="list-style-type: none"> 1. This mitigation is being implemented and has been identified as a stakeholder engagement strategy. 2. This mitigation strategy will be implemented when the risk is realized. 	March 2016

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
MCOs choose to not use AssessMyHealth, which creates a gap in data to link Pop Health measures, claims data and member experience within the delivery system	2	3	3	<ol style="list-style-type: none"> 1. Create awareness through planned communication to MCOs regarding the importance of having “Health Confidence and Social Determinant Data” to primary care provider. 2. Promote Assess My Health to MCO’s. 	IME	Both mitigation plans will begin during the 11/30/15 MCO meeting.	January 2016
MCOs do not follow continuity of care processes when assigning Members to PCPs	2	2	2	<ol style="list-style-type: none"> 1. IME will share previous PCP/Member assignments with the MCOs 2. IME will share previous 3M attribution history with MCOs 	IME	Both mitigation plans are being vetted by IME internal staff for feasibility. Members always have a choice to override what they are assigned.	February 2016
MCO Implementation causes confusion within the Delivery System and slows VBP and transformation activities	3	3	3	<ol style="list-style-type: none"> 1. Engage MCOs in SIM concepts by inviting them to Medicaid leadership, SIM Leadership and Technical Assistance meeting 	IME/IHC	This mitigation plan is being implemented	February 2016

VBP: Provider Engagement

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
Delivery System is not engaged in VIS	2	3	3	1. IHC is contracted with the SIM to provide technical assistance on continual basis to the delivery system. They are to promote the use of VIS and processes that improve VIS scores, focuses on a community approach to drive better health systems. 2. Continue to engage in provider feedback with Wellmark and 3M to ensure that VIS evolves and improves in the delivery of data to motivate changes. 3. Regular communication to ACOs regarding SIM and VIS results, utilizing the VIS dashboard, etc.	IME	1. This mitigation plan is in process through the SIM. 2. This mitigation plan is in process through the SIM and has been noted as a stakeholder engagement strategy 3. This mitigation plan is in process through the SIM and has been noted as a stakeholder engagement strategy.	June 2016
Delivery System providers are not engaged in Medicaid VBP evidenced by not entering into contracts with MCOs	2	2	2	1. Medicaid will conduct an in-person Delivery System meeting to promote transparency and willingness to partner in VBP in Iowa (as well as ongoing communication through phone conferences and email as noted in the stakeholder engagement plan submitted in March 2015) 2. Medicaid will develop a Value Based Purchasing definition established for MCO's that aligns with how providers are organized today.	IME	1. This mitigation strategy is in process, a meeting planned for early 2016. 2. This mitigation strategy is in process	June 2016
VBP: Payer Alignment							
Medicare, Medicaid and Wellmark pursuing own program goals without collaboration	2	3	2	1. SIM team engaged is engaged with IME in VBP strategy and IME and Wellmark have committed to quarterly meetings. In addition the SIM team engages with CMS through the CMMI project officer as needed.	IME	1. This mitigation plan is in process	Ongoing
VBP: General							

Risk Factors	Probability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
SIM Partners not educated on VIS concepts and methodology (IHC, IDPH-C3's, CMMI, etc.)	3	2	2	<ol style="list-style-type: none"> The SIM team will form ongoing stakeholder engagement materials, internal talking points and documentation. The SIM team is engaging in a Website makeover to assist all stakeholders, including internal partners in training and education of SIM in Iowa. Note: This is an ongoing mitigation plan 	IME	This is an ongoing mitigation plan	Ongoing
Care Coordination: C3s							
Payers and providers are not aligned on VBP policy/strategies	2	3	3	<ol style="list-style-type: none"> SIM will implement and reinforce payer/provider alignment of performance measures on cost, quality and patient experience and eliminate barriers to VBP models through Technical Assistance by: <ul style="list-style-type: none"> - standardization of data analytic feeds and support to providers - alignment of risk methodology, PCP assignment, financial modeling, contract requirements 	IHC	This is an ongoing mitigation plan	Ongoing
Limitations in partner communication: Sharing information for C3 and stakeholders; communication between diverse stakeholders; etc.	2	3	3	<ol style="list-style-type: none"> Stakeholder agreements for HIPAA. Request TA from CMS. 	IDPH	<ol style="list-style-type: none"> Is being implemented now. Implement at first sign of risk occurring 	April 2016
There is a low response to the C3 RFP	2	3	3	<ol style="list-style-type: none"> Draft Round 2 RFP Promote success stories of CCT pilot communities through stakeholder communications and press releases 	IDPH		January 2016
Care Coordination: SWAN							

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
Not all Hospitals connect to SWAN	2	3	3	Promote success stories of connection early and often. - promote on websites, meetings, and reports to public stakeholders	IDPH	This is an ongoing mitigation strategy	February 2016
Delivery system does not effectively utilize the alerts being sent to them.	2	3	3	1. SIM is providing technical assistance to the delivery system to support the adoption and use of this tool 2. Alerts are being rolled out at a higher level (at the ACO) to prevent individual doctor alert fatigue. This allows leadership to determine how to respond and integrate the information into their workflow. 3. Facilitate survey to better understand delivery system barriers	IDPH	This is an ongoing mitigation strategy	June 2016
Population Health Improvement							
Hospitals not required to complete a CHNA may be less willing to participate in LPHA CHNA and HIP.	2	3	3	Share success stories and develop talking points on how the Health Improvement Plan will improve the health of the patient population.	IDPH	All mitigation strategies are being implemented to avoid or lessen impact of identified risks on SIM	September 2016
Annual Health Improvement Plan revision process not fully utilized to reflect changing needs.	2	2	2	Share success stories and develop talking points on changing the Health Improvement Plan to respond to Rapid Cycle Improvement strategies.	IDPH		October 2016
Ongoing Evaluation							

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
Sharing of identifiable data: lack of access to names and contact information for consumer or provider surveys, (of those who might have been impacted by SIM interventions.)	3	2	3	Use convenience sampling or potentially using only aggregated data.	PPC	These issues will be identified during the first year of the evaluation so that we can revise our sampling plans if needed. Wait for risk to occur before implementing mitigation.	Aug-16
Access to secondary data: Risk of not having a timely executed data sharing agreement with data owners.	2	3	3	Mitigation will consist of adaptation of outcome measures to a smaller population which limits the generalizability of the results to the state.	PPC		Aug-16
Access to secondary data: Data may not be provided in a timely manner, making the milestones impossible to meet. Also, the data that is provided may not be prepared for analyses, requiring additional time and work on our side to format and clean	3	3	3	Should either or both of these occur we will ask to extend the milestone completion date to ensure the data is adequate.	PPC		Ongoing

Risk Factors	Prob-ability	Impact	Priority Level	Prioritized Risk Mitigation Strategies	Lead Entity	Next Steps	Target Realization Date
<p>Survey timing: The surveys may rely on subcontracts with vendors. Though we have completion dates listed for the surveys. Vendors may be unable to accommodate the surveys into their schedules.</p>	3	2	3	Alter the completion dates. Early identification and negotiation with vendors should be sufficient to mitigate this risk.	PPC	Early identification and negotiation with vendors should be sufficient to mitigate this risk.	Ongoing

Section C: General SIM Operation and Policy Areas

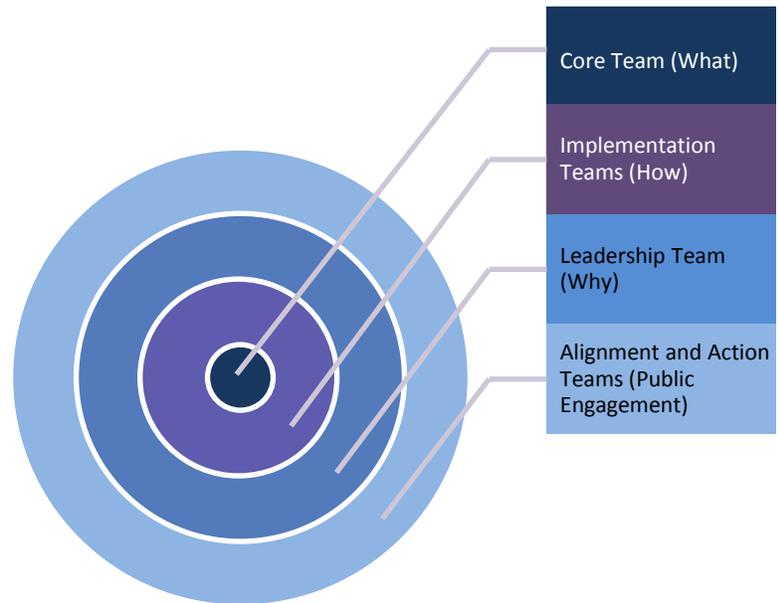
1. Stakeholder Engagement

The State will use the convening of Providers, Payers, Public Health and community stakeholders to advance the goals of Iowa's SIM Test through a series of four teams: Core Planning team, Implementation teams, Leadership Team and Alignment and Action Teams. In addition to convening these four groups, the state is investing in community level technical assistance (rapid cycle performance improvement) to accelerate statewide health transformation. More information on Rapid Cycle Performance Improvement is found in the Component Section of this document.

The **Core Planning team** represents the three the major stakeholder types for SIM; payers, public health, and providers and should be a safe place to communicate ideas and establish aligned goals and objectives for the SIM project. The SIM Core team defines and manages the strategic focus for SIM, and acts as a coordination point or hub on project execution steps.

Current Members:

Mikki Stier – IME, Chair Payer
Gerd Clabaugh- IDPH, Chair Public Health
Tom Evans – HC, Chair - Provider
Bob Schlueter - IME
Debbie Johnson - IME



Marni Bussell - IME
Kala Shipley - IDPH
Jeff McKinney – IHC
Pete Damanio – PPC (Evaluation)

The **Implementation teams** provide input on the implementation of the strategies and daily operations of the SIM grant. This group includes specific SMEs within the key departments of the SIM Leadership team and will be deployed to support the Leadership, Core, and Alignment and Action team activities.

Implementation Team Partners:

Iowa Department of Human Services - DHS
Iowa Medicaid Enterprise - IME
Iowa Department of Public Health - IDPH
Iowa Healthcare Collaborative - IHC
Iowa PCA
3M

Milliman
Public Policy Center - PPC
Wellmark
Medicaid MCOs

The **SIM Leadership** team represents key stakeholders within the payers, providers and public health communities. The SIM Leadership team is established to ensure alignment with key initiatives driving healthcare transformation in Iowa. This group provides the Core Planning team with input on SIM activities in order to make quick course corrections as deemed necessary, and helps identify and remove barriers. Members are expected to advise and take action within their constituencies to help achieve the goals of the SIM Initiative.

Current Members:

Chuck Palmer (DHS): Chair
Sam Wallace (DHS Council)
Mikki Stier (IME)
Gerd Clabaugh (IDPH)
Tom Evans (IHC/Provider)
Laura Jackson (Wellmark/Payer)
Donna Harvey (Department of Aging)
Chris Atchison (State Hygienic Laboratory at the University of Iowa)
Patrick Schmitz (MH Provider)

The **Alignment and Action team** represents stakeholders in Iowa that experience direct and/or indirect impacts from SIM activities. They are influencer with constituents in the payer, provider and public health sectors. The SIM Engagement teams will participate in public forums, workgroups as appointed, and establish speaking engagements for SIM Core and Operational staff. Engagement is the primary communication strategy to promote this group's alignment with SIM objectives and to inspire action within each's organizations and constituents. The core of engagement for this group begins with the utilization of the Medicaid Assistance Advisory Council (MAAC). MAAC members and Executive Committee members are legislatively mandated. More information can be found at:

http://dhs.iowa.gov/ime/about/advisory_groups/maac

Alignment and Action Team Partners:

MAAC Associations (Executive and Full MAAC)
Healthiest State Initiative Strategic Planning Committee

Associations for:

- Pharmacy
- Dental
- Hospital
- IMS
- Safety Net
- Member Advocacies
- LTC/BH
- Child Family Health
- Public at large
- MCOs
- Others as identified

The state has outlined 9 stakeholder engagement strategies in the document submitted to CMMI in March of 2015. This document serves as additional details in the state's ability to actively engage and commit action toward our SIM goals throughout the SIM Test.

Payer Participation

As described in the VBP Component of this operational plan a secondary driver of the Iowa SIM is to align and engage payers in Iowa to participate in VBP. Both Wellmark and Medicare, two of the three primary payers in Iowa are committed to VBP through ACO agreements with providers in Iowa. Wellmark started their ACO program in 2012 and Medicare has been engaged with Iowa in ACO development since the launch of the Pioneer ACO program in 2012. Medicaid recently started to engage providers in VBP through the expansion of the Medicaid program in early 2014. With Medicaid's move to Managed Care starting January 2016, the State has established a requirement that each of the selected MCOs must participate in SIM with the specific requirement of achieving at least 40% of their covered lives into a VBP contract by 2018. Based on early commitments from each MCO, the state expects to have more than 60% of Medicaid lives in a VBP arrangement by 2018.

Provider Participation

The Iowa SIM program will have various levels of provider participation in one or more of the five primary drivers. Although SIM provider participation is not legislatively mandated statewide, one of Iowa's strengths is that we already have widespread adoption of VBP and transformation activities. There are currently over 1800 primary care providers participating in the Wellmark ACO program. Here are a few levers that the State is using to encourage participation in various SIM programs:

- To participate in the Medicaid data sharing arrangements (includes real-time alerts, monthly claim data feeds, and access to online quality dashboards), provider organizations must engage in a VBP arrangement with at least one Medicaid MCO.
- To receive community focused technical assistance (rapid cycle performance improvement), a community must be organized into a recognized Community Care Coalition (C3). This includes hospital and provider commitment
- Iowa will leverage the partnership with IHC, a provider led organization to engage and develop communities to participate in SIM activities including statewide learning events.

Provider and Payer Data Sharing Agreements

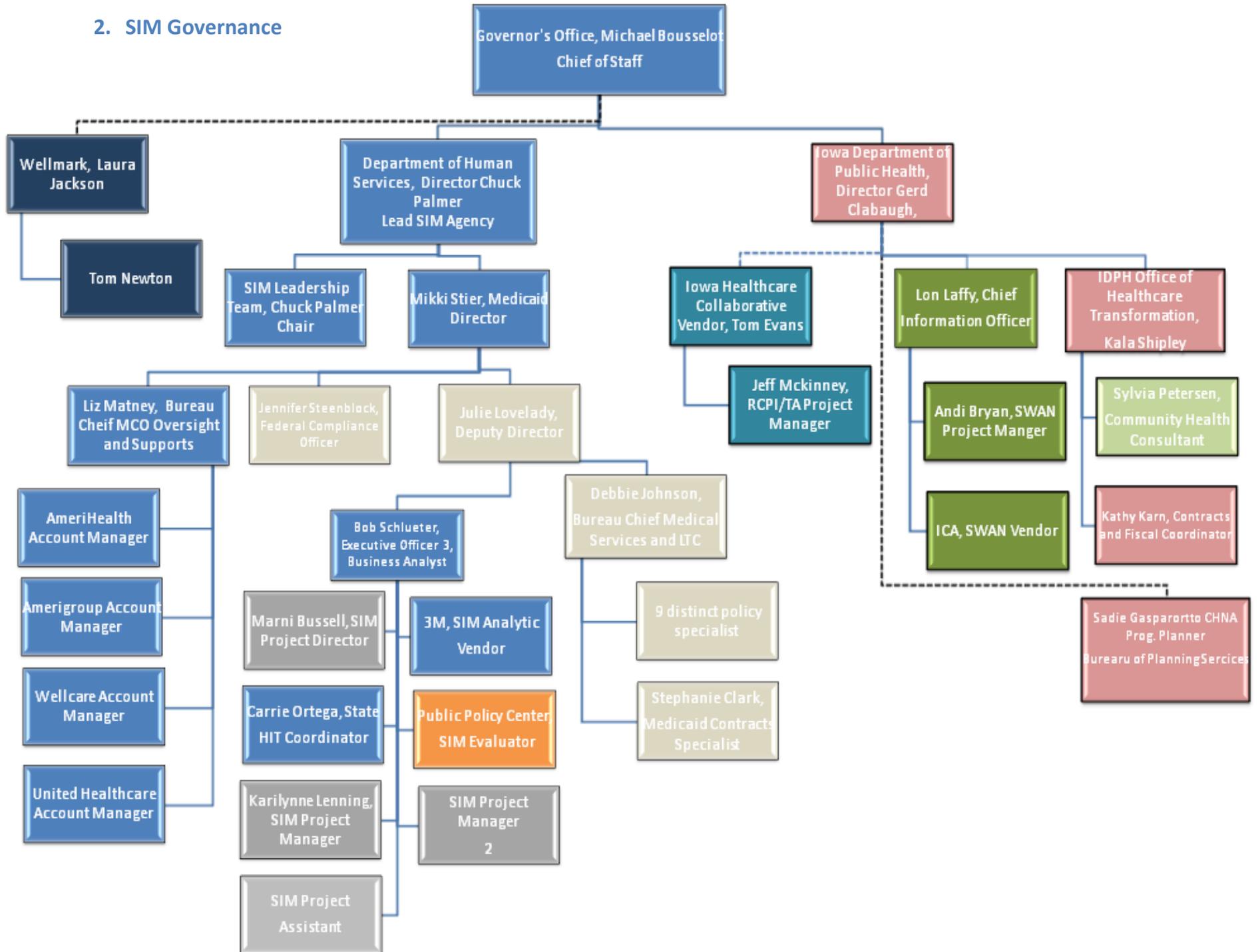
The Department of Human Services is convening a data sharing agreement discussions between the State Evaluator (UofI Public Policy Center) and Wellmark. This is to ensure access to data to complete the state and federal evaluation.

Additionally, the state has developed a **Value-Based Purchasing Data Use Agreement** to be used for any provider organization that is engaged in VBP in Medicaid with at least one MCO. The agreement ensures the provider organization is a business associate and responsible to ensure the security and appropriate use of data. The VBP MOU can be found [here](#).

The **SWAN** ensures appropriate data sharing arrangements by requiring participating hospitals and ACOs to complete a participant agreement and a business associate agreement prior to implementation. As each SWAN participant is brought into the alerting project, whether they are a hospital sending ADT's or an ACO or another receiver, the IDPH eHealth team ensures the appropriate paperwork is completed.

The **C3 communities** are also tasked with ensuring appropriate access to data. The C3 Request for Proposals describes the role local public health partners provide to the coalition including assessment information about community health issues. The scope of work included in the draft C3 contracts includes data collection and assistance with the SIM evaluation process.

2. SIM Governance



Governance and Management Structure

The Governor's office is engaged in the SIM Test grant by designating daily oversight by two cabinet level departments and regular reports back to the governor's office. In addition to oversight by the governor's office, DHS and IDPH also engage legislators on SIM activities. Senate file 505 requires DHS to report to a legislative committee on SIM activities annually, however IDPH and DHS engage legislators on a more frequent basis as needed.

Mechanisms to coordinate private and public efforts around key test model components.

Iowa will use the Stakeholder Engagement Planning effort described in Section 3 of this document to share information with stakeholders, engage stakeholders to action, and align with other initiatives going on.

Three examples of coordination with private and public efforts include:

- **IDPH** has engaged their entire staff to implement and align SIM with other public efforts to improve population health. IDPH SIM staff members meet bi-weekly with IDPH program staff working on the Center for Disease Control and Prevention's 1305/State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health; and Office of Smoking and Health initiatives. Staff members assigned to the State Health Improvement Plan (SHIP) also attends the IDPH SIM bi-weekly meetings. Collaboration among programs prevents duplication and provides greater impact of health improvement initiatives.
- **Both DHS and IDPH** have engaged the Healthiest State Initiative (HSI) by joining the Strategic Planning committee to align with SIM and the HSI. The HSI is a governor supported, public/private partnership of community leaders working to make Iowa the Healthiest State in the nation.
- **DHS is engaged with Wellmark** in coordinating VBP models in Iowa to allow the delivery system to get to scale. DHS and Wellmark have met quarterly for the last two years in an effort to increase accountable care in Iowa and achieve the 3 part aim.

As Iowa presents SIM in various forums for the Alignment and Action Teams, more opportunities to align private and public programs to SIM will arise. Leveraging this communication strategy is the mechanism to statewide coordination and alignment. SIM presentations need a common theme and format to both address the overall objectives of SIM and educate stakeholders. The Core Planning team is developing a dynamic set of talking point as a basis for every SIM engagement with stakeholders. This set of talking points will evolve as the SIM Test progresses through the three model test years.

The Iowa SIM governance structure includes the direct participation from two members of the Governor's cabinet: Director of the Department of Human Services and the Director of the Department of Public Health. Together in partnership, these two directors work with the Executive branch and the Legislative branch to ensure the goals and objectives of SIM are both understood and integrated to the vision of Iowa. Both the Department of Human Services and the Department of Public Health have the authority to support, oppose and submit legislative packages and they each have the authority to update Iowa Administrative Code to ensure alignment with SIM and execute activities as needed. Although, Iowa typically takes a more grass roots approach to promoting change, this is an authority that can be exercised as needed in the established governance structure of the SIM grant.

Name	Current Role/Background/Roles and Responsibilities (R/R) under SIM Initiative
Michael	Michael serves as Chief of Staff to Governor Branstad and Lt. Governor Reynolds. R/R: Guide and

Name	Current Role/Background/Roles and Responsibilities (R/R) under SIM Initiative
Bousselot	direct SIM project under the Governor's authority.
Chuck Palmer	Chuck was appointed Director of the Iowa Department of Human Services by Governor Branstad and Lt. Governor Reynolds in 2011. Previously, Chuck served as President of the Iowans for Social & Economic Development (ISED) from 1999-2011. R/R: Guide and direct SIM project under the Governor's authority.
Mikki Stier	Mikki was hired as the State Medicaid Director in May 2015. Prior to being named Director, Mikki operated as Vice President of Government and External Relations at Broadlawns Medical Center in Des Moines, IA. R/R: Guide and direct SIM project under the Governor's authority, collaborate with other payers on VBP development, and seek areas of alignment where possible. Provide overall SIM program oversight.
Laura Jackson	Laura Jackson is the Executive Vice President, Healthcare Innovations and Business Development for Wellmark BCBS. R/R: She also serves on the SIM leadership team to provide insight into VBP alignment and SIM strategies.
Tom Newton	Tom is the Vice President, Network Engagement at Wellmark BCBC. He provides leadership over ACO development and operations, provider quality initiatives, and innovative provider payment research and development. R/R: Guide and direct SIM project under the Governor's authority, collaborate with IME and other payers on VBP development, and seek areas of alignment.
Gerd Clabaugh	Gerd was appointed as the Director of IDPH in May 2014, and has served in many capacities within IDPH, including Deputy Director, Director of Health Promotion and Chronic Disease Prevention, and Director of Acute Disease Epidemiology and Emergency Response. During the early 1990s, he was appointed Director of the Center for Health Policy. R/R: Guide and direct SIM project under the Governor's authority, overseeing the SIM Population Health Improvement Plan, Technical Assistance and RCPI activities, Care Coordination Activities, eHealth/IHIN initiatives and will use other programs within IDPH as required to conduct SIM initiatives, such as the IDPH Tobacco Division and Bureau of Nutrition and Health Promotion.
Tom Evans	Tom Evans, M.D., is the President & CEO of the Iowa Healthcare Collaborative (IHC). He has served as President of both the Iowa Medical Society and the Iowa Academy of Family Physicians. R/R: Manage the operations and strategic planning around Delivery System technical assistance, including the deployment of learning communities and webinars to facilitate improved population health measures.
Jeff McKinney	Jeff McKinney, MHA, MPP, is the SIM Program Manager at the Iowa Healthcare Collaborative. Jeff previously served as the State of Iowa's Homeland Security Program Officer. Prior to that, Jeff worked as Planning Director at Broadlawns Medical Center in Des Moines, IA and Planning Coordinator at the University of Wisconsin Hospital and Clinics. R/R: Jeff is responsible for the daily operations around Delivery System technical assistance, including the deployment of learning communities and webinars to facilitate improved population health measures.
Kala Shipley	Kala has worked with IDPH for ten years where she served as the IDPH Administrative Rules and Certificate of Need Program Manager, Health Promotion Team Lead and Iowa Community Transformation Grant Project Manager; and Community Health Consultant for the WIC and SNAP-Ed initiatives. R/R: Manage the daily operations around the SIM Population Health Improvement Plan and Care Coordination initiatives including the local C3s and the Statewide Alert Notification system; and coordinate supporting initiatives such as the provision of technical assistance and implementation of the SIM statewide strategies
Sylvia Petersen	Sylvia is currently a Community Health Consultant for the SIM Initiative, and has worked for the Iowa Department of Public Health as the state Outreach Coordinator for Iowa's Children's Health Insurance Program for the past three years. R/R: Manage the local C3 contracts and provide technical assistance to the local C3 communities and communities identifying one of the SIM statewide strategies as a health improvement priority.
Kathy Karn	Kathy joined IDPH in October, 2015 as the SIM Program Planner II. She came to us from the Homeland Security and Emergency Management Department where she worked with the startup of

Name	Current Role/Background/Roles and Responsibilities (R/R) under SIM Initiative
	the Homeland Security initiative in Iowa prior to moving over to the state E911 program. R/R: Serve as contracts and fiscal coordinator for IDPH SIM initiatives.
Sadie Gasparotto	Sadie will join IDPH in November, 2015 as the Community Health Assessment Planner. R/R: Coordinate a comprehensive State Health Improvement Plan process and enhance the Healthy Iowans Health Improvement Plan by integrating clinical indicators.
Lon Laffey	Lon currently serves as the Chief Information Officer and Interim Director of Iowa Health IT. He has over thirty years in the Information Technology field having served as the Associate Vice President of Application Development at a health insurance company prior to coming to the State of Iowa. He was also a Project Manager, Systems Analyst and Developer during his career. R/R: Manage the daily operations around e-Health and IHIN initiatives, specifically the testing of the ADT Alerting System to support the delivery of SWAN alerts to the healthcare system.
Andi Bryan	Andi joined IDPH in January 2015 as the Project Manager for the Statewide Alert Notification System (SWAN) for the SIM grant. R/R: She is working with the hospitals and ACO's in the State of Iowa to get real time alerts to be sent to the ACO's to assist providers with patients transition of care and help reduce readmissions. She will manage the process going forward to ensure that the alerts are useful and implement any changes needed
ICA	ICA is the vendor providing SWAN services to the delivery system. R/R: Onboarding and technical assistance to Hospitals connecting ADT data as well as system oversight, quality assurance and maintenance of SWAN operations.
Marni Bussell	Marni joined IME in 2010. She is currently operating as the Project Director for SIM and leads both HH and ACO initiatives. She has over thirteen years of experience in HIT, working on both state and national government projects. She earned her PMP certification in 2009. R/R: Manage the daily operations of the SIM Initiative and VBP development work; seek approval of needed State Plan and waiver authorities. Provide contract oversight of SIM grant funds.
Karilynne Lenning	Karilynne is a SIM Project Manager with IME since September 2015. Karilynne has previous experience working with quality measurement in the ACO Medicare Shared Savings program and the Partnership for Patients campaign. She is a licensed social worker and has spent 20 years working in that capacity in Iowa hospitals. R/R: She manages the daily operations of the Medicaid VBP strategy, working directly with the delivery system and assisting in the transition to the MCO VBP programs. She also works on provider outreach and education and is closely aligned with the Rapid Cycle Performance Improvement and technical assistance events led by IHC and IDPH.
Carrie Ortega	Carrie is the Medicaid HIT Coordinator. She joined IME in January of 2015. She has previous experience establishing the Iowa HITREC team and working on national reporting system for the Division of National Systems. R/R: Manage the daily operations of ERH Incentive Payment program and participate in the SIM activities around e-Health and IHIN development.
Treo Solutions/ 3M	The team will include Bob Pirtle, Engagement Leader; Paul LaBrec: Director of Research; Herb Fillmore, Vice President Strategic Innovations; Gordon Moore, MD, Chief Medical Officer; John H. Wasson, MD, Dartmouth Medical School; Dr. Norbert Goldfield, MD, Medical Director, 3M HIS Clinical and Economics Research, 3M; Dr. Rosenthal, MD, Professor of Internal Medicine and Health Management and Policy at the University of Iowa and Director of the Institute of Clinical and Translational Science. R/R: Perform data analytics to inform rapid cycle evaluations, oversee the daily operations of HRA and VIS, calculate TCOC budgets, and develop a MCO scorecard with guidance from the State.
Public Policy Center, Health Policy Research Center	The Health Policy Research Program (HPRP) of the PPC has been investigating the effects of policy initiatives and government activities on cost of, access to and quality of health care systems and their effects on consumers, health care providers, and consumers since 1991. The team will include Peter C Damiano, Director; Elizabeth T Momany, Research Scientist; and Suzanne E Bentler, Research Scientist. R/R: Function as the State's Evaluation contractor, collaborating with CMS selected evaluators and performing an in-state evaluation of the SIM program

Name	Current Role/Background/Roles and Responsibilities (R/R) under SIM Initiative
IME Policy Staff Roles and Responsibilities: Function as a Medicaid Policy advisor and assure SIM initiatives are aligned with IME Programs. Supports the Medicaid Director and Medicaid Deputy Director in the daily operations of IME.	
Bob Schlueter	Bob Schlueter, Business Analysis, Executive Officer level 3 at IME has spent the last sixteen years in various positions with Iowa Medicaid including the Bureau Chief of Adult and Children’s Medical Services and the Provider Services Unit Manager. R/R: Provide direction and strategic vision for VBP in Medicaid and general oversight of the Office of Healthcare transformation within Medicaid
Julie Lovelady	Julie began her duties as Medicaid Deputy Director in January 2009. She has worked at Iowa Medicaid for the past twenty years in various roles with previous vendors. Prior to being Deputy Medicaid Director, Lovelady served as the Account Manager for IME Provider Services Unit. R/R: Provide Medicaid policy guidance and oversight of Medicaid daily operations.
Liz Matney	Liz is the Bureau Chief of Managed Care for Medicaid and oversees account specialist, provider and member specialists and actuarially services relating to managed care.. R/R: For SIM, Liz will ensure MCOs are meeting contractual requirements for VBP activities as well as assisting MCOs in aligning strategies that help providers transform how they delivery care to lowans.
Debbie Johnson	Debbie is the Chief Bureau of policy for Iowa Medicaid and has worked for the Iowa DHS for nearly two decades. Experience includes serving individuals with disabilities as they strive for independent living, including background and education in vocational rehabilitation services. Debbie has also completed the Certified Public Managers training.
Jennifer Steenblock	Jennifer Steenblock is the Federal Compliance Officer for Medicaid. She has spent the last five years assisting Medicaid and DHS with implementing the Affordable Care Act. R/R: Manage the activities of Medicaid innovation ensuring compliance with federal regulations.
Stephanie Clark	Stephanie has worked for the IME for 4 years. She currently works in the Contract Administration Office and has administrative oversight and responsibility for all contracts within IME. R/R: Manages contracts and grant submissions for IME and provides oversight and management of the SIM grant budget.
SIM Roles TBD Roles and Responsibilities under the SIM Initiative	
SIM PM 1	Manage the daily operations of the Medicaid VBP program for IME, with a focus on reporting to inform both internal rapid cycle evaluations and assist with SIM grant reporting requirements of the grant administration.
Project Assistant	Support the SIM Project Director and SIM Project Managers in the daily operations of the SIM grant, including the SIM contract administration activities.
Nine Medicaid Policy Roles, TBDs	Medicaid is in the process of determining roles for staff as they transition from the current delivery system to the new managed care delivery system in Medicaid. Interviews are currently being conducted.

Iowa is using a combination of several processes to **recruit staff** and contractors as identified in the SIM budget.

- Sole Source Contracting** - The State has utilized sole source contracting methods with established vendors or with vendors that have a specific set of products critical to the operation of the Iowa SIM initiative. In each sole source relationship, the state has provided and received acceptance of a sole source justification.
 - State Hiring processes** - The four IDPH SIM positions are contract-covered under the collective bargaining agreement between the American Federation of State, County and Municipal Employees

(AFSCME) and the State of Iowa. Creating and hiring for new positions follows an established procedure. Creating new positions requires the approval internally at the Iowa Department of Public Health by the Director and Division Director of Administration and Professional Licensure. New position requests must then be approved by the Iowa Department of Management. Once approved for creation, the Iowa Department of Administrative Services determines the appropriate classification for the position. The classification is determined through review of the Position Description Questionnaire which describes the work to be performed, the purpose of the position, and essential functions. After the classification is determined, the Iowa Department of Management reviews and must approve the request to fill the vacant position. Per the collective bargaining agreement, there is a 12 step process with both mandatory and optional steps to be followed by the hiring manager. Before a vacancy can be posted to recruit candidates outside of state employment, several mandatory steps need to be exhausted in the selection process such as contract transfers within the employing unit, recall within the employing unit, and contract transfer between employing units and between state agencies.

- **RFP** – The state has uses established RFP processes to identify Community Care Coalitions (C3s) to assist the state in driving transformation at the community level.

Iowa Medicaid Enterprise: IME establishes has an established orientation program for state and contracted employees that include a combination of basic orientation and mentorship.

IDPH: New employees at IDPH attend a series of three new employee orientations sessions. Each member of the IDPH SIM team received a division orientation and training notebook, were provided orientation rotations with existing staff, and were assigned a staff mentor.

IHC: IHC ensures a thorough orientation process for all employees. All staff members are adequately briefed on all IHC initiatives and activities to ensure programmatic awareness and enable aligning of resources and actions. SIM team members, including Program Manager, Education Lead, Data Program Lead, and Improvement Advisors, participate in a tailored Quality Improvement training program, led by IHC faculty, highlighted by an opportunity to sit for an accredited Healthcare QI certification exam. The established orientation and training process equips all staff members to facilitate performance improvement in a rapid-cycle, real-time landscape.

The SIM Core Planning team has established a Rapid Cycle Performance Improvement as a key driver of the SIM initiative. Metrics from the C3s will be collected three times a year and will be publically reported and presented at SIM leadership and stakeholder events to promote continuous improvement. In addition, the state has established a project management methodology to ensuring compliance with SIM grant administration activities including the execution of the approved SIM Operational Plan. Iowa plans to conduct regular status meetings with SIM partners to ensure accountability to meeting quarterly targets and milestones as well as use contractual requirements within vendor agreements.

3. Plan for Improving Population Health

Population Health:

The Iowa SIM Plan to Improve Population Health will prioritize needs identified by local communities and stakeholder groups, describe current population health initiatives, and concentrate on three strategies to improve population health. By enhancing the existing Healthy Iowans State Health Improvement Plan with clinical indicators and innovative patient-centered care related to the SIM statewide strategies, the SIM Plan to Improve Population Health will be sustained beyond the SIM funding period.

The strategy for developing the three components of the Iowa SIM Plan to Improve Population Health is described below:

State Health Needs Assessment and Priority Setting

Healthy Iowans is Iowa’s State Health Improvement Plan (SHIP). The current Healthy Iowans Plan for Health Improvement is located at http://idph.iowa.gov/Portals/1/Files/HealthyIowans/plan_2012_2016.pdf. The critical needs addressed in Healthy Iowans are the result of careful analysis of: 1) the Community Health Needs Assessment and Health Improvement Planning process that local boards of health have conducted for over 20 years in each of Iowa’s 99 counties; 2) contributions from a wide-range of health-related private and public organizations and advisory groups; 3) state data; 4) national resource information; and 5) considerations of social and built environments, special populations and the life cycle. Organizations are then asked to submit and commit to strategies and objectives that focus on the critical needs identified.

Local boards of health in all 99 counties will submit community health needs assessments and health improvement plans by February 29, 2016. The local health improvement plans will be analyzed to determine which counties have identified the SIM focus areas of diabetes, tobacco, obesity, obstetrics, healthcare-associated infections and medication safety as a priority. In addition, the submitted plans will be reviewed to determine which counties have integrated hospitals into the local health improvement plan and which have integrated social determinants of health strategies into the local health improvement plan. A program planner included as part of IDPH SIM staff will be tasked with enhancing the current Healthy Iowans process.

Existing capacity and efforts aimed at population health

The table below provides a listing of known, current initiatives with strategies that align with the Iowa SIM statewide strategies. Additional projects will be incorporated into the table following the analysis of the community health needs assessments and health improvement plans and the contributions provided by statewide organizations and advisory councils. Iowa SIM staff will routinely communicate with representatives from the projects listed below to enhance existing efforts and prevent duplication.

Existing Efforts	Description
Iowa Quality Improvement Network/Organization (QIN-QIO) 11 th Scope of Work	Reduce leading causes of mortality; Population health management; Improve hospital admit/readmit rates; Reduce adverse drug events; Improve patient & family engagement; Support participation in value modifier program.
Hospital Engagement Network 2.0 (HEN)	Provides hospitals a wide array of initiatives, activities, and technical assistance focused on patient safety and reducing readmissions.
Regional Extension Center (REC)	Assist providers with implementation and meaningful use of certified EHRs, Optimize use of health IT for improvement initiatives such as patient centered medical home and ACO readiness, Electronic clinical quality measures submission (IT barriers and data format), Telehealth
Transforming Clinical Practice Initiative (TCPI)	Provides direct quality improvement support to clinicians, driving real-time, measureable improvement strategies.
Community-based Care	Implement local community strategies to promote care coordination and

Existing Efforts	Description
Transition Programs	readmission reduction
IPCA Performance Improvement Learning Collaborative	State of Iowa funded initiative to promote community care coordination through FQHCs in six communities
Center for Disease Control and Prevention's 1305: State Public Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant	Community strategies to improve hypertension control and/or diabetes management; promote walkable communities; and improve healthy food access.
Centers for Disease Control and Prevention's Office of Smoking and Health initiatives	Thirty-seven Community Partnerships serve 94 of the 99 Iowa counties. The Community Partnerships serve as a resource to individuals, schools, worksites, and healthcare organizations to encourage cessation, reduce second hand smoke exposure, and reduce tobacco use initiation.
Iowa Healthiest State Initiative	The Healthiest State Initiative is a privately led public initiative intended to inspire Iowans and their communities throughout the state to improve their health and happiness.

Iowa SIM statewide strategy plans for diabetes, tobacco, obesity/nutrition and physical activity, obstetrics, healthcare-associated infections, and medication safety have been developed and are posted to the IDPH SIM website <http://idph.iowa.gov/SIM>. The Tobacco, Diabetes, Nutrition and Physical Activity plans were developed by the respective CDC-funded program staff at IDPH. The IDPH CDC-funded program staff, SHIP staff, and SIM staff comprise the IDPH SIM team. The group meets bi-weekly to align efforts and ensure synergy between programs.

Roadmap to improve population health

The SIM Plan to Improve Population Health will be divided into three main areas:

1. **Clinical:** A gap in the existing Healthy Iowans process is the lack of integration of clinical strategies and indicators. The SIM partnerships and assimilation of clinical indicators and strategies will enhance Iowa's SHIP, Healthy Iowans, well beyond the SIM project period.

Initially, clinical partners will be invited to contribute to the Healthy Iowans process that will be undertaken in early 2016. Clinical strategies and indicators included as core measures and accountability targets for SIM that also address identified needs will be provided to Healthy Iowans. Data gathered through the SIM Rapid Cycle Improvement process and core measures collection will inform Healthy Iowans of the progress achieved toward the clinical goals.

Components of SIM clinical strategies and indicators that are identified as useful will be incorporated into the Healthy Iowans process beyond the SIM project period. The enhancement of Healthy Iowans with clinical information will serve as a guide for health needs beyond the SIM focus areas of diabetes, tobacco, obesity, obstetrics, healthcare-associated infections and medication safety.

2. **Innovative Patient-Centered Care:** The SIM Plan to Improve Population Health will include strategies for addressing Social Determinants of Health, Person and Family Engagement, Health Literacy, and implementing Community Care Coalition approaches. The interventions and processes that are the most

effective in addressing these strategies will be included in the “Innovative Patient-Centered Care” section of the Plan to Improve Population Health.

3. **Community-Wide Health:** Strategies included in the Iowa SIM statewide strategy plans for diabetes, tobacco, obesity/nutrition and physical activity, obstetrics, healthcare-associated infections, and medication safety will serve as the framework for the Community-Wide Health plan. The plans include a variety of interventions addressing several levels on the Health Impact Pyramid (Frieden, 2010²) including direct services, group education, promotion, policy, systems and environmental level changes. For an example of how a broad variety of interventions focused on diabetes will include patients, providers and communities, please refer to the C3 Diabetes Example in Section B.2 of the Revised Operational Plan, Primary Driver: Plan to Improve Population Health. Recommended strategies and best practices identified in public health resources, such as those included in the Guide to Community and Preventive Services and the University of North Carolina’s Center for Training and Research Translation websites, provide the bases for many of the interventions included in the Iowa SIM statewide strategy plans.

Interventions in the community-wide health section of the plan will highlight successful strategies implemented in the C3 communities and will contain programmatic, policy, systems, and environmental change strategies. Common elements and best practices among C3 communities will be noted and may include items such as geographic commonalities and coalition composition. Iowa’s community-wide health strategies will align with the National Prevention Strategy.

The Roadmap to Improve Population Health section of the plan will include measures identified in the 2017-2021 Healthy Iowans Plan for Health Improvement and additional measures included in the core measures and evaluation sections of the Iowa SIM Operational Plan. Additional measures identified through the SIM implementation may be used to further enhance the population health measures.

Input from state and local stakeholders will be gathered throughout the development of the Roadmap to Improve Population Health section of SIM Plan to Improve Population Health. The IDPH CDC-funded program staff working on the Iowa SIM statewide strategies, including the Iowa Chronic Disease Director, will remain integral partners in completion of the plan.

4. Health Care Delivery System Transformation Plan

Provider participation and integrated system

A primary driver of the Iowa SIM Test is the ability to engage providers in transformation. Delivery system transformation is one of our three SIM goals. Iowa is committed to develop VBP strategies that align across payers and that spreads statewide so that SIM activities have the greatest reach and improve the care for all Iowans. One of our core accountability targets is to track the progress of providers participating in VBP across the state, focusing on Medicare, Medicaid and Wellmark. The chart below reflects projections and SIM Accountability targets for 2016, 2017 and 2018 regarding provider participation in VBP in Iowa.

² Frieden, T.R., A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health 100(4):590-595, 2010.

Payer	2015			2016		2017		2018	
	Total Lives (D)	Covered lives (N)	%	Proj. %	Target	Proj. %	Target	Proj. %	Target
Medicaid	570,000	58,971	10%	23%	20%	38%	33%	66%	61%
* Amerigroup	142,500	-	-	0%		30%		40%	
* AmeriHealth	142,500	-	-	35%		55%		75%	
* United	142,500	-	-	15%		25%		50%	
* Wellcare	142,500	-	-	40%		70%		100%	
Wellmark	1,800,000	196,000	11%	12%	12%	35%	33%	35%	35%
Medicare	531,209	166,000	31%	36%	36%	41%	41%	46%	46%
Others	200,000	-	-	-		-		-	
Total Iowans	3,101,209	420,971	14%	17%	17%	34%	32%	40%	39%
* percentages projected in MCOs responses to RFP									

As Medicaid implements managed care statewide, it is anticipated that some elements of SIM, such as VBP contracting and development of the VIS may not see full priority with providers as they work aggressively with the MCOs to establish contracts, navigate new business process and ensure they continue to get paid. By using a common dashboard with Wellmark, and providing claims/encounter data, the Medicaid agency will support the delivery system during this transition by maintaining consistent tools and integrated data sets for the regular and ongoing tracking of quality.

As VBP becomes more mature in Iowa, providers across the continuum will participate in an integrated delivery model. Medicaid, the primary payer of LTC (institutional and HCBS) services, is working to incorporate LTC and Duals data into the VIS quality scores and online dashboard in 2016.

SIM is also focused on creating integrated health systems at the community level. Community driven solutions to better care, better health and lower costs is a repeatable theme throughout the Iowa SIM Test, however it is most visibly seen in Rapid Cycle Performance Improvement with a C3.

Through a contract with the Iowa Healthcare Collaborative (IHC), the Iowa SIM will provide a wide array of Quality Improvement (QI) resources for providers and their C3 partners. IHC is a provider-led, patient-focused nonprofit organization, dedicated to transforming healthcare by promoting, supporting, and aligning quality improvement efforts. IHC's primary touchpoint with the SIM Coalition Communities is with a staff of Quality Improvement Advisors (QIA). SIM QIAs will provide face-to-face assistance, helping C3s develop project ideas and execute work plans to move QI interventions forward. The QIAs will steer projects towards "population-focused, community-applied" strategies, with measurable performance measures. The following is a general overview of that process:

- C3s commit to engaging patients and communities to improve health outcomes.
- QIAs identify primary points of contact for each C3 community and assist them in initial partner engagement and coalition building efforts.
- QIAs participate in and (when needed) facilitate C3 meetings and calls.
- Support local assessments, aimed at identify local health needs and opportunities for care transformation and coordination-focused innovations.
- Work with C3 project staff to develop strategies to address the Social Determinants of Health, including access to care, proper utilization, prevention, etc.
- As each unique SIM project is linked with data drivers, C3s will obligate each data collection point to report on a monthly basis, using results to monitor, drive, and steer progress.
- QIAs promote educational activities and best-practice sharing (e.g., periodic SIM webinars/phone conference calls; PDSA cycle learning sessions, etc.) to support project development.

- Incorporate evidence-based best practice resources to improve care delivery and to move through phases of transformation.
- QI Advisors will assist practices with using reported data to drive improvement, moving towards a Rapid Cycle Improvement methodology.
- Data reports will drive topics for SIM Learning Communities, C3 meetings, webinars, and workgroup activities.

Linkage to Value in the Delivery System

In addition to the VBP models promoted in Iowa to-date (ACOs), Medicaid is also promoting alternative payment models (PMPM) for individuals with chronic conditions through the Health Home model. Iowa has two State Plan Amendments approved for providers to deliver Health Home services to specific members in Iowa. An accountability target for 2016 is to increase HH enrollment by 20%. The State will accomplish this in year one by leveraging the experience from the Medicaid MCOs coming into the environment. Iowa is also focusing on linking providers to VBP. The number of providers participating in VBP is an indicator for getting to scale and making improvements that impact all Iowans. Iowa is tracking PCP participation in VBP as a core accountability metrics.

Primary Care Provider for every Resident

In the Medicaid program, the state is requiring the combination of VBP arrangements and direct PCP assignment. Therefore, as value-based purchasing grows in Medicaid, the number of covered lives assigned to a PCP will also grow. The combination of VBP arrangements and direct PCP assignment establishes a direct link connecting the member to a PCP who will be accountable for both a quality outcome and a lower total cost of care.

Care Coordination is a primary driver of Iowa's SIM test to help us accomplish the three part aim. The SIM Test grant is funding the development of two approaches to improve care coordination in Iowa:

- The C3s provide services that reduce the impact of social determinants on patient health outcomes.
- A statewide alert notification system (SWAN) using ADT files from Iowa hospitals (See Care Coordination Component section) provide time sensitive data during critical transitions of care.

To safeguard that we equip, inform, and execute on care coordination models, the SIM grant is funding the concept of rapid cycle performance improvement, provided with onsite technical assistance to selected c3 communities. This community level TA works with communities to build the relationships needed to move care coordination to the level needed to drive changes in our delivery system working with not only hospitals and primary care, but also community leaders, the local education system, long term care providers, mental health providers, and local public health communities.

Technical assistance is also provided state-wide to help improve care coordination to all Iowa providers and communities with three state-wide learning events. The technical assistance will work to provide tools and education to be effective at coordinating care that drive performance.

Patient Engagement and Patient Experience

The IME has discussed using a Member Experience survey and linking those results to VBP agreements. There is the potential to add Member experience as a seventh domain to the VIS score. IME as made the decision to hold on adding the member experience domain into the VIS with the implementation of managed care in 2016. The state will still survey members for experience in the healthcare delivery system as part of the ongoing evaluation of SIM. The decision to move forward with linking member experience data and a VBP financial agreement will hold and be evaluated in 2017.

Patient and Family Engagement is also a focus of the RCPI projects with the C3s. IDPH will be releasing a statewide strategy to improve patient and family engagement in the healthcare setting. Medicaid is also providing a tool to track patient health confidence levels (AssessMyHealth, HRA). This data provided to primary care providers and then applied to how healthcare is delivery can impact outcomes for individuals and overall improvements in population health.

Use of HIT

One of Iowa's primary drivers is to improve care coordination by deploying a statewide alert notification system (SWAN). More details can be found on how Iowa providers can leverage this tool to improve quality by reviewing the Care Coordination Component or HIT sections of this document.

Some additional quality attributes of Iowa's HIT landscape:

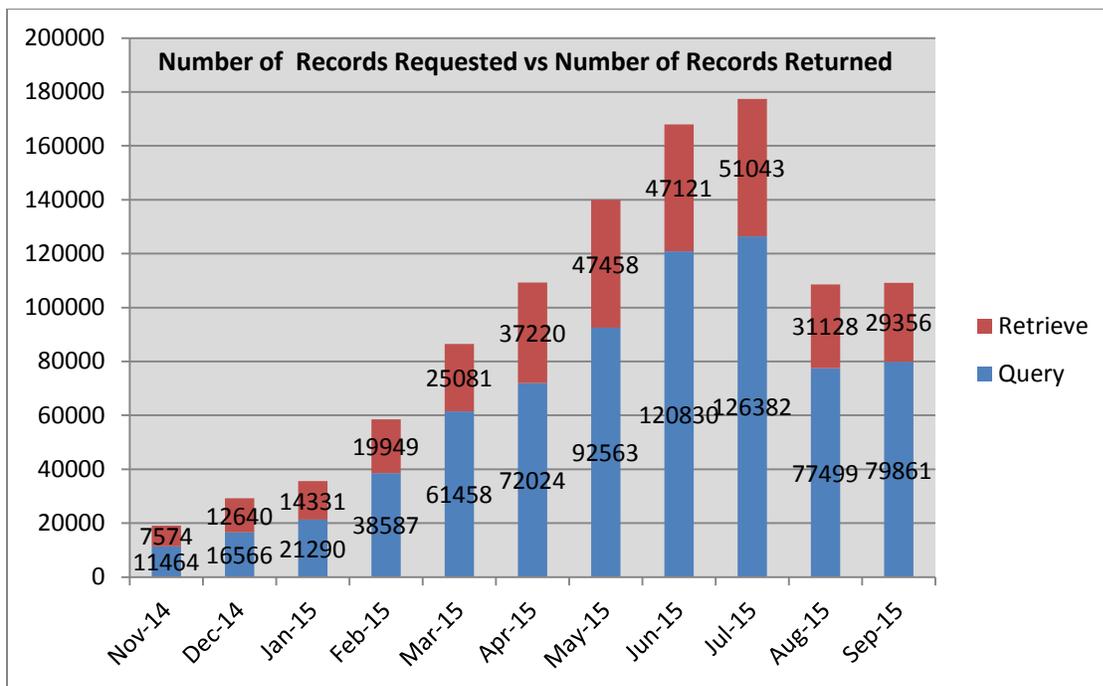
- Iowa providers continue to adopt and improve their level of Meaningful Use in Iowa:
 - As of August, 2015 nearly 19% of Iowa's participating providers in the Medicaid EHR Incentive Payment program have achieved Meaningful Use State 2.
 - All 117 hospitals have attested as meaningful users of EHRs for either or both Medicare and Medicaid EHR Incentive Payments.

The figure below shows a clear progression of providers moving on from the adoption and implementation stage to meaningful use of EHRs.

EHR Incentive return rate of provider participation:

Provider Type	Provider Count (Pay Year 1)	Provider Count (Pay Year 2)	Return Rate % Pay Year 2 / Pay Year 1	Provider Count (Pay Year 3)	Return Rate % Pay Year 3 / Pay Year 2	Provider Count (Pay Year 4)	Return Rate % Pay Year 4 / Pay Year 3
Certified Nurse - Midwife	27	17	62.96%	11	64.71%	3	27.27%
Dentist	174	3	1.72%	1	33.33%		0.00%
Doctor of Optometry	2	0	0.00%	0	0.00%	0	0.00%
Nurse Practitioner	359	192	53.48%	107	55.73%	42	39.25%
Physician	1031	622	60.33%	386	62.06%	254	65.80%
Physicians Assistant practicing in FOHC or RHC led by a PA	18	15	83.33%	11	73.33%	7	63.64%
Totals for All Providers	1611	849	52.70%	516	60.78%	306	59.30%

- Growth rate of query activities for the statewide health information exchanged (IHIN) from November 14 to now:



Total Participation Agreements: 172
 Total Patients opted-out: 34

- Iowa Medicaid conducted an HIT environmental scan during 2015; final results of this scan are being compiled for review in December of 2015. The use of this information will help guide the implementation of SWAN, the outreach of the EHR Incentive Payment program and continued growth of the IHIN

Population Health Measure Integration

Population health improvement is a primary driver of Iowa’s SIM and a key part of delivery system transformation. Population health measures are being integrated by using two concepts. First, through VBP models, the state is using the **VIS quality measurement** tool as a way to introduce population health concepts into the fee for service world. VIS measures providers on the population they are attributed, not just those that walked through the door. This population focus is a shift in the fundamentals of measuring quality for our nation’s healthcare system and requires technical assistance. Iowa is using SIM grant dollars to teach the delivery system how to implement processes that focus on the needs of the people within their community, how to engage patients and families and how to prioritize and outreach to high risk patients.

Secondly, Iowa’s SIM is using **C3 Communities** to equip and execute on population health strategies aimed at Tobacco, Obesity, Diabetes, Medication Safety, Patient and Family Engagement, Healthcare Associated Infections and Obstetrics. Each C3 will be engaged in rapid cycle performance improvement and community level technical assistance. Throughout the model test, the SIM will work to develop and grow more C3 Communities, as well as, promote the population health strategies, statewide.

Data Driven Processes

Sustainability of transformation is ensuring the system ends up better off than it is today. Data-informed decision making helps guide our vision statement: “Transforming Health Care to Improve the Health of Iowans”. Here are a few ways in which Iowa’s SIM Test is using data to drive decision making:

- **Rapid Cycle Performance Improvement establishes** a plan, do, study, act methodology driven by data at the community level.

- **Ongoing Evaluation** is a primary driver of the Iowa SIM Test. The ability to review annually and assess those results to inform and guide our path ensures we are know where and what transformation looks like in our system at the community level and at state level.

5. Payment and/or Service Delivery Models

Iowa is implementing a VBP strategy across payers. The primary payers participating are Medicaid, Medicare and Wellmark BCBS of Iowa. VBP is defined as linking provider payment to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers, in a way consistent with overarching goals announced by U.S. Department of Health and Human Services on January 26, 2015.

Wellmark BCBS has an ACO program in place since 2012. We have projected increases in the number of covered lives within the VBP program identified below.

Medicare has established ACO programs in Iowa including both a Pioneer ACO and several MSSP ACOs. The below table identifies the number of covered lives in a Medicare ACO program and a modest projected increase of 5 percent each year during the model test years.

Medicaid is implementing managed care organizations in 2016. Those MCOs must also offer a VBP program to cover a minimum of 40 percent of their covered lives. The below table reflects each’s MCO’s commitments to grow VBP within their plans during the model test period and builds off the table previously displayed.

Payer	2015			2016				2017				2018			
	Total Lives (D)	Covered lives (N)	%	Projected (N)	Proj. %	Target	Target	Projected (N)	%	Target	Target	Projected (N) 2018	%	Target	Target
Medicaid	570,000	58,971	10%	128,250	23%	116,000	20%	213,750	38%	190,000	33%	377,625	66%	350,000	61%
* Amerigroup	142,500	-	-	0	0%			42,750	30%			57,000	40%		
* AmeriHealth	142,500	-	-	49,875	35%			78,375	55%			106,875	75%		
* United	142,500	-	-	21,375	15%			35,625	25%			71,250	50%		
* Wellcare	142,500	-	-	57,000	40%			99,750	70%			142,500	100%		
Wellmark	1,800,000	196,000	11%	208,000	12%	208,000	12%	625,000	35%	600,000	33%	625,000	35%	625,000	35%
Medicare	531,209	166,000	31%	191,235	36%	191,235	36%	217,795	41%	217,795	41%	244,356	46%	244,356	46%
Others	200,000	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Iowans	3,101,209	420,971	14%	527,485	17%	515,235	17%	1,056,545	34%	1,007,795	32%	1,246,981	40%	1,219,356	39%

Although any state Medicaid program can expect a little unrest in the delivery system while switching to a managed care approach, Iowa has already rooted VBP strategies within the delivery system through the active participation by providers in ACO programs to-date. This ensures that although 2016 will come with challenges, we can continue to progress down the path of VBP during our three model test years by leveraging payer alignment in Iowa.

The VBP strategies being developed by the Medicaid MCOs and the ACO program already developed by Wellmark will share the same set of quality measures, the Value Index Score (VIS). The VIS set of quality measures use a similar attribution methodology and the same approach to risk adjustment. The VIS measurement system comes with an online dashboard updated monthly and available to ACO and MCOs to monitor quality. Although Medicare uses a different set of quality measures for their ACO program there are several areas of alignment as previously identified in Appendix A, Accountable Care Models, a comparison between Iowa and the MSSP submitted to CMMI in the fall of 2014.

Medicaid initially identified January 2016 as the start date to introduce a Member Experience Survey into VIS score. The state has decided to not implement the Member Experience domain in 2016. With the implementation of Medicaid Managed care, we feel this is something to evaluate at a later time. Although Medicaid is not tying member experience data to the quality payments within VBP in 2016, Medicaid will still track and report member experience data through the Evaluation component of the SIM Test.

Medicaid is using a TCOC methodology developed by 3M that looks at all claims data, risk categories, stop loss, and persistent weighting logic to establish a PMPM TCOC expected. The TCOC calculation is updated with each dashboard refresh and is provided to providers participating in VBP. Wellmark BCBS uses a similar model with their TCOC calculation in the VIS dashboard.

TCOC is calculated for Medicaid in the VIS dashboard for 2015 as the sum of all allowed amounts for all medical claims for a member. These allowed amounts are summed regardless of the submitting provider's group, system affiliation or site of service. It is designed as a calculation to represent the true cost of medical claims accumulated for an individual for a specified 12 month timeframe. All inpatient, outpatient, professional, and RX claims are included in the TCOC calculation for the standard Medicaid population.

TCOC is represented as a % of Expected by aggregating information for all members included in an age, gender, and Clinical Risk Group specific cohort to establish an expected average TCOC. Each member of a given cohort is compared to the average TCOC for the entire cohort to establish a % difference from expected. This variance from expected is calculated at a member level but is also aggregated to attributed physicians, physician groups, clinics, and ACOs within the dashboard.

Total Cost of Care 	
Key Performance Measure	Rolling 12 months 2014/06-2015/06 
Variance from Budget (PMPM \$)	(\$15.72)
Variance Inpatient (PMPM \$)	(\$0.41)
Variance Outpatient (PMPM \$)	(\$18.97)
Variance Provider (PMPM \$)	(\$4.11)
Variance Rx (PMPM \$)	\$7.78

There are some exceptions to the TCOC calculations in the 2015 dashboard for a subset of the IME member population to ensure accurate and fair reporting of TCOC calculations. Any member listed as COB, having a coordination of benefits, in which a secondary payer is responsible to pay claims for that member, is currently excluded from influencing the Expected calculations of TCOC within a clinical cohort. Also, for members identified as being Long Term Care (LTC) members in an institution, the dollars associated with their LTC facility claims are not currently included in their TCOC calculations. These LTC members are also excluded from influencing the expected TCOC calculations for the general Medicaid population. In the near future, TCOC calculation will include Medicare Dual Eligible members as well as the entire costs of LTC members' experience due to the additional claims Medicaid will supply to 3M. This inclusion of LTC data is further explained in Section 7 Quality Measurement Alignment.

Stop loss is another tool Medicaid will include in the 2016 calculation of TCOC to account for outliers that may skew the TCOC performance from a provider or system perspective. For the standard population, Medicaid has selected a \$150,000 per individual stop loss level. This stop loss applies to the creation of expected TCOC calculations as well as the comparison of actual to expected. When the state includes the LTC data into the

TCOC calculation, we will apply customized stop loss levels based on member type. Members receiving LTC services will have a separate customized stop loss level to account for outliers cases.

Starting in the 2016 year the state will begin using a persistent weight set embedded the dashboards that will allow for time series comparisons of TCOC performance. This persistent weight set is created using 3 years' worth of claims information to establish expected TCOC ratios for all clinical cohorts. The weights are kept consistent for a defined period of time in order to accurately assess the movement of TCOC performance over time.

The Iowa SIM will also calculate a Total Cost Index annually using the CMS supplied measure from Model Performance Metrics. This measure will be calculated using Medicaid and Wellmark BCBS data. If the state can obtain the complete set of Medicare data for Iowa (Medicare A, B and D) that includes duals and nondual Medicare beneficiaries), we will calculate TCI on that population as well. Iowa does not have an All Payer Claims database. The state does have a limited all- payer claims data set for Inpatient and outpatient events within a hospital setting. This will not help us calculate TCOC, however it can be used to measure other aspects that inform delivery system transformation during our model test.

The 2016 Medicaid VIS baseline and TCOC calculations will not initially include LTC and Dual eligible data. However, once Medicaid has thoroughly tested the LTC and Duals data with our vendor 3M, we will rebaseline 2016 with LTC and duals included. If testing goes as planned, the rebaseline of the 2016 quality data will occur before July 31. At this point the Medicaid agency will use this rebaseline data as a means to inform providers how the incorporation of LTC impacts their quality and TCOC scores. The 2017 baseline VIS and TCOC calculations will include LTC and Duals.

As mentioned above, Iowa is interested in collecting an entire set of claims data on the Medicare population (Part A, Part B, and Part D) and running this through the VIS to establish quality scores for the purpose of SIM Ongoing Evaluation. This is a request in process; to-date the state only has access to Dual Eligible Part A, Part B, and Part D data. **Leveraging Regulatory Authority**

Certificate of Need is a regulatory review process that requires application to the Department of Public Health for and receipt of a certificate of need (CON) prior to the offering or development of a new or changed institutional health service. Projects proposed by project sponsors are reviewed by department staff and the State Health Facilities Council (Council) against the criteria specified in the law. The State Health Facilities Council is a five-member body appointed by the governor and confirmed by the State Senate. In determining whether to issue a certificate of need, the Council considers the eighteen criteria listed in Iowa Code section 135.64(1)(a) to (r) and the four factors listed in Iowa code section 135.64(2)(a) to (d).

The Iowa CON process currently requests that applicants address Social Determinants of Health. The existing criteria include the need of the population to be served, "...the proposed institutional health service in meeting the needs of the medically underserved, including persons living in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly...."

The Iowa SIM staff will meet routinely with IDPH Certificate of Need staff to identify potential process changes to better align CON with accountable care and delivery system transformation. For example, the community health needs assessment and health improvement plan could be a tool that is utilized in describing the need of the population to be served in the application. Quality, including readmissions, is another potential area that could be addressed in the CON application.

A Health Workforce Program Analysis is being conducted by the University of Iowa, College of Public Health Rural Policy Research Institute. IDPH, in partnership with policymakers and stakeholders, should be better positioned for decision-making on resource allocation and policy changes that are needed to address the health workforce needs in Iowa following the release of the workforce analysis and report. The IDPH SIM staff will monitor the workforce needs identified and educate on the strategies identified to assure all Iowans have access to quality health services.

The State leveraged its recent RFP process to implement managed care statewide for the majority of the Medicaid population by requiring that each selected MCO have 40% of their covered lives in VBP by 2018. The state has further required the MCOs to report their covered lives statistics to ensure the state is compliant with grant reporting requirements. The state is in the process of developing an MCO scorecard that will track quality and TCOC and tie components of that scorecard to the 2% withhold quality payment starting in 2017.

The state does not currently have requirements on academic medical centers and professional schools to integrate transformation-based teaching onto medical education programs, however there is evidence of these centers and schools participation in VBP models. Medicaid has residential program enrolled as Health Home providers and Academic Medical Centers participating in the 2014 and 2015 ACO program.

7. Quality Measurement Alignment

The VBP strategies being developed by the Medicaid MCOs and the ACO program and those already developed by Wellmark will share the same set of quality measures, the Value Index Score (VIS). The VIS set of quality measures use a similar attribution methodology and the same approach to risk adjustment. The VIS measurement system comes with an online dashboard updated monthly and available to ACO and MCOs to monitor quality. The VIS measures are claims based measures which have no administrative reporting burden on providers.

Although Medicare uses a different set of quality measures for their ACO program there are several areas of alignment as identified and submitted to CMMI in Appendix A, Accountable Care Models, a comparison between Iowa and the MSSP.

Medicaid initially identified January 2016 as the start date to introduce a Member Experience Survey into VIS score. The state has decided to not implement the Member Experience domain in 2016. With the implementation of Medicaid Managed care, we feel this is something to evaluate at a later time. Although Medicaid is not tying member experience data to the quality payments within VBP in 2016, Medicaid will still track and report member experience data through the Evaluation component of the SIM Test.

The state has committed to establishing workgroups to develop recommended quality measures around special Medicaid populations like CYSHCNs, LTC, Dual Eligibles, etc... Those recommendations would then be evaluated on overall effectiveness in VBP and administrative reporting burden prior to implementing into a VBP. Some recommended measures may be considered for incorporation in the State-level evaluation plan as well. The timeline to establish these workgroups has been adjusted with the implementation of Medicaid Managed Care in 2016, so we can coordinate the work with the new MCOs. The state will establish workgroups and recommendations during the 2nd and 3rd quarters of 2016.

Finally, IME continues to work closely with Wellmark to develop a star rating system based on VIS performance, similar in concept to Medicare that enhances transparency to consumers and competition among providers. This activity is in the initial planning stages. However Medicaid will have to evaluate the impact of Managed

Care on the delivery system prior to implementing a public reporting system. Public Reporting of VIS in Medicaid will likely not occur in 2016, but will remain a goal for the SIM model test.

8. SIM Alignment with State and Federal Initiatives

SIM initiatives are intended to complement and reinforce practice transformation and data reporting efforts that already underway. IHC will work with C3 communities to inventory and align with other transformation initiatives. C3's will design their SIM projects to minimize duplication of efforts and avoid market confusion. From a statewide perspective, the initiatives in Table 1 will be part of every C3 inventory. This list will be expanded to include local projects.

Table 1: Existing Transformation Initiatives

Existing QI/Health Reform Effort	Projected Results	How will efforts be incorporated and support SIM?
IA QIN-QIO 11th SoW	Reduce leading causes of mortality, Pop. health mgmt., Improve hospital admit/readmit rates, Reduce adverse drug events, Improve patient & family engagement, Support participation in value modifier program	Promote participation in QIO-sponsored programs, Align content and messaging to reduce duplication and market confusion
Hospital Engagement Network 2.0 (HEN)	Provides hospitals a wide array of initiatives, activities, and technical assistance focused on patient safety and reducing readmissions.	HEN resources and data will be engaged when C3 projects are hospital focused. IHC's involvement in both programs will facilitate direct alignment.
Regional Extension Center (REC)	Assist providers with implementation and meaningful use of certified EHRs, Optimize use of health IT for improvement initiatives such as patient centered medical home and ACO readiness, Electronic clinical quality measures submission (IT barriers and data format), Telehealth	Consult practices that do not have an EHR on adoption/meaningful use or have difficulty submitting to increase chances of success moving through the transformation phases
Transforming Clinical Practice Initiative (TCPI)	Provides direct quality improvement support to clinicians, driving real-time, measureable improvement strategies.	Align SIM content to engage TCPI providers and maximize sustainability; use common stakeholders to drive improvement.
Community-based Care	Implement local community strategies to	Align strategy and content

Existing QI/Health Reform Effort	Projected Results	How will efforts be incorporated and support SIM?
Transition Programs	promote care coordination and readmission reduction	in participating communities
IPCA Performance Improvement Learning Collaborative	State of IA funded initiative to promote community care coordination through FQHCs in six communities	Align strategy and content in participating communities
Center for Disease Control and Prevention's 1305: State Public Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health grant	Community strategies to improve hypertension control and/or diabetes management; promote walkable communities; and improve healthy food access.	Collaborate with and enhance existing efforts in participating communities.
CDC Office of Smoking and Health initiatives	Thirty-seven Community Partnerships serve 94 of the 99 Iowa counties. The Community Partnerships serve as a resource to individuals, schools, worksites, and healthcare organizations to encourage cessation, reduce second hand smoke exposure, and reduce tobacco use initiation.	Collaborate with and enhance existing efforts in participating communities.
Meaningful Use EHR Incentive Payment Program	Providers invest in certified electronic health record systems to achieve interoperability and ultimately better health outcomes at a lower cost.	Providers with high functioning EHR systems have the technology to transform how they deliver care and perform in VBP arrangements
Section 2703 Health Home	Provide comprehensive coordinate care for members with chronic conditions to reduce ED Visist and Impatient stays will improving the overall health of members enrolled in the program.	Medicaid will promote and track Health Home program growth as a secondary indicator of transformation of the delivery system
Medicare Shared Savings programs	Deliver System transforms into accountable entities that deliver better quality care at a	Medicaid will promote and track VBP program

Existing QI/Health Reform Effort	Projected Results	How will efforts be incorporated and support SIM?
	lower cost	growth as a key indicator of transformation of the delivery system that leads toward sustainability

9. Workforce Capacity Monitoring

1. Stakeholder engagement plans demonstrating participation of academic medical centers, community colleges, professional associations and trade groups in efforts to build the health care workforce capacity.

Direct Care Worker Task Force

The Direct Care Worker Task Force was created by the Iowa General Assembly and Governor in 2005 and includes representation from the Iowa Board of Nursing, Iowa Health Care Association, Iowa Department on Aging, the University of Iowa- College of Nursing, among others.

Medical Residency Training State Matching Grant Program

In the development and implementation of the state-funded, Medical Residency Training State Matching Grant Program, input was gathered from medical schools and hospitals providing medical residency training programs in Iowa.

2. Studies or other documentation of current workforce capacity issues, systematic data collection and state studies of supply and demand by discipline

A Health Workforce Program Analysis was conducted in September, 2015 by the University of Iowa, College of Public Health Rural Policy Research Institute. The report provides a literature review and environmental scan of workforce policies and programs in the United States. The report also includes strategies to recruit and retain healthcare providers in rural areas including:

- 1) Pipeline programs,
- 2) Medical training programs,
- 3) Community-based initiatives, and
- 4) Specialized training in mental health and dentistry.

A second report will be released in December, 2015. The evaluation will include barriers to program success, identify gaps in the scope and availability of the programs and associated health workforce data, and make recommendations to improve outcomes. From here IDPH, in partnership with policymakers and stakeholders, should be better positioned for decision-making on resource allocation and policy changes that are needed to address the health workforce needs in Iowa.

The IDPH SIM staff will monitor the workforce needs identified and educate on the strategies identified to assure all Iowans have access to quality health services.

3. Legislative, regulatory or executive actions related to removing barriers to practice or developing recommendations/taking action on health care workforce issues, including scope of practice changes and payment reforms

Direct Care Worker Task Force

The Direct Care Worker Task Force was created by the Iowa General Assembly and Governor in 2005. (HF 781) The Governor-appointed Task Force was charged with identifying types of direct care workers (DCW) and education and training requirements for each type of worker. A key product that has come out of this legislative charge is the creation of the Prepare to Care curriculum.

The Prepare to Care curriculum is a comprehensive, cross-discipline training package that prepares people to work in a variety of direct care settings. The curriculum includes a Core training course, which provides basic foundational knowledge and an introduction to the profession, and five advanced training courses. IDPH's Office of Healthcare Transformation is currently working to incorporate this training in Iowa's current workforce initiatives through collaboration with Iowa's Department of Aging, Iowa's Workforce Department (IWD) and Iowa's Developmental Disabilities Council.

Medical Residency Training State Matching Grant Program

For physicians the state has embarked on a Medical Residency Training State Matching Grants program to provide matching state funding to sponsors of accredited graduate medical education residency programs in this state to establish, expand, or support medical residency training programs.

4. Documentation of health workforce capacity programs (including education in areas such as team based practice, care coordination and population health) in state employment training programs, community

The program staff implementing the CDC, 1305/State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health program (1305) is contracting with the Iowa Pharmacy Association and the University of Iowa College of Pharmacy to promote Physician-Pharmacist Care Coordination efforts. The 1305 program is also contracting with the Iowa Primary Care Association to promote the care coordination training for Federally Qualified Health Center staff.

A program to promote care coordination between Iowa dentists and physicians screens patients for hypertension at the dentist office and, when needed, refers to a primary care provider. The initiative is currently being funded through the Health Resources and Services Administration, Oral Health.

10. Health Information Technology

HIT Rationale

As specifically described in the Care Coordination Component section of this document, the state is implementing the SWAN system which in combination with the other SIM components like the Rapid Cycle Performance Improvement/Technical Assistance programs with C3 Communities and ongoing HIT activity in Iowa, can achieve state-wide transformation. A copy of the State's current State Medicaid HIT Plan can be found [here](#).

The capacity of HIT to improve communication and information sharing makes it a critical tool for community care coordination. The use of Health Information Technology (HIT) in C3 communities will hinge on both project-applicability and the HIT capacity of local providers. Iowa's provider communities, both rural and urban, have long used HIT resources like the Iowa Health Information Network (IHIN) and the Iowa Hospital Association's (IHA) Dimensions and ChimeMaps tools to support operational planning and performance improvement. We expect these resources will be used extensively in where HIT-derived performance measurement provides relevant feedback.

HIT Governance and Policy/Regulatory Levers

Iowa has been a leader in HIT. In 2008, the Iowa Legislature enacted House File 2539, which established eleven advisory councils charged with making recommendations for health reform in Iowa. One of the eleven advisory councils is the Iowa e-Health Executive Committee and Advisory Council administered by

the Iowa Department of Public Health (IDPH). In 2009, Iowa *Health IT Plan* served as a foundation for the development of the *Iowa e-Health Strategic and Operational Plan*, a required deliverable of the State HIE. The IHIN began offering Direct Secure Messaging to pilot sites in July 2012. IHIN began the process of onboarding pilot sites for IHIN Query-based HIE in January 2013; enough Participants had been fully onboarded to IHIN by January 2014 that Query-based HIE was enabled. In 2016 an intended transition to move IHIN out of IDPH and to a non-profit health care organization to be determined through a request for proposals (RFP).

The IME's HIT Coordinator is accountable for tracking overall progress of the IME's SMHP and the submission of the Implementation Advance Planning Document (IAPD). The IME has experienced turnover with its HIT Coordinator, and looks to make major updates to the State Medicaid Health IT Plan in 2016 to align HIT initiatives and flesh out the Health IT To-Be HIT Landscape and Health IT Roadmap, while aligning with national HIT and quality strategy goals. The IME originally established four primary goals to maximize the quality and efficiency of the healthcare services our members receive:

Increase provider adoption of electronic health records and health information exchange

- Improve administrative efficiencies and contain costs
- Improve quality outcomes for members
- Improve member wellness

Central to the IME's HIT strategy is the need for clinical information in electronic format. The IME encourages Iowa's providers in gathering clinical information at the time of care through use of EHRs.

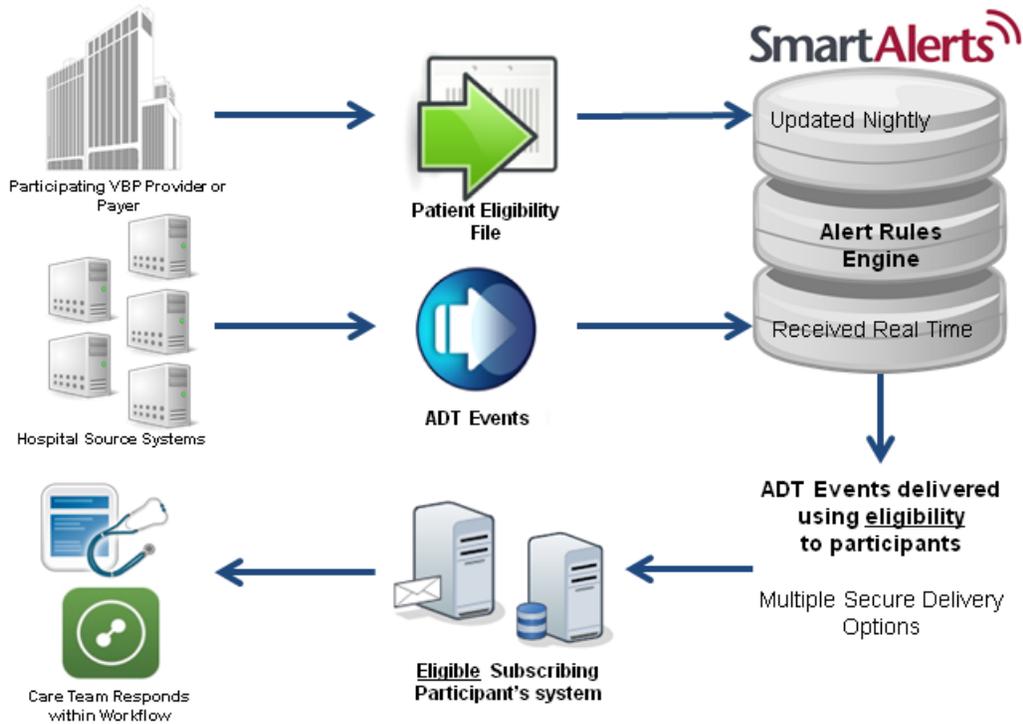
Objectives which support the Health IT goals of IME and the SIM SWAN project are as follows:

- Providers will capture medical clinical information electronically and exchange the information with other providers.
- Support Iowa's Health Information Network (IHIN); Support the National Health Information Network (NHIN) connectivity model.
- Utilize the IHIN and EHRs where possible to provide information to providers.
- Utilize the IHIN where possible to eliminate the need for mailing or faxing of medical information between providers and the IME.
- Provide access to the IHIN for targeted providers where quality improvements yield cost reductions or containment for Medicaid.
- Improve care transitions between provider settings.
- Decrease hospital readmissions from Long Term Care Facilities. Provide Discharge Instructions and Continuity of Care information real-time from Hospitals to LTC via EHR & HIE adoption.
- Decrease LTC readmissions from Home Health Services. Provide Discharge Instructions and Continuity of Care information real-time from LTC to Home Health Services via EHR & HIE adoption.
- Utilize Health Information Technology to expand the application of evidence based treatment.
- Capture Quality Measures for monitoring provider performance.
- Determine if correlations between quality measures and underserved populations exist.
- Provide Medicaid member's care teams with clinical information.
- Create a Medical Home model that promotes healthy outcomes and manages the member's chronic health conditions.
- Support patient/home health collection of relevant vitals via HIE patient/home health portals.

HIT Infrastructure funding by SIM

HIT Infrastructure funded by the SIM is the SWAN system, which is described in the Care Coordination Driver of this document. Below is a dataflow diagram which describes how SWAN collects ADT files from Iowa hospitals and distributes alerts to providers participating in VBP strategies.

SWAN System using ADT Events



Using the expertise of e-Health staff, IDPH is well-positioned to develop and implement a new HIT tool to assist PCPs in coordinating care of their patients by facilitating notification of inpatient and ED discharges. The Statewide Alert Notification (SWAN) system was developed in collaboration with ICA in year one of the Iowa SIM.

IDPH eHealth staff will partner with hospitals statewide to start sending inpatient admission and discharge and emergency department discharge (ADT) information to the Smart Alert Engine. These ADT's will then create alerts that will be sent to the Iowa Medicaid ACO's. In order to assure efficient coordination of care following discharge and ultimately decrease readmissions, alerts will be sent to the ACO's daily and ultimately in real time. Sending ADTs will further support the coordination of care by informing ACO's and PCP's of patients visiting hospitals outside of their network.

As of November 11, 2015, five hospital systems are sending ADTs to the Smart Alert Engine, 11 hospitals are in the review phase, and four of the five Medicaid ACO's are prepared to receive alerts. The ACO's are scheduled to receive alerts by December 31, 2015 with the onboarding of the fifth ACO.

Success stories and lessons learned will be shared broadly to engage additional hospitals and involve more ACOs. Benefits of the SWAN will be communicated to other payers to encourage participation in the system.

The ADT's received will continually be monitored and modified to ensure ACO's are being alerted on the events which are most important and useful. Monthly meetings for SWAN user groups will be held to share best practices and identify adjustments needed to make the alerts more effective. Additionally, the Iowa Healthcare Collaborative (IHC) will educate C3 communities on using Rapid Cycle Improvement strategies to assure effective utilization of the SWAN.

HIT Technical Assistance

Health information technology (HIT) plays a central role in building efficient and effective patient care. Wired healthcare has become a priority of many Iowa health systems, with HIT initiatives under way in nearly every Iowa hospital.

The C3 Community project assessments conducted with assistance from the IHC Quality Improvement Advisors will address technology gaps, the potential value of enhanced HIT use, and barriers to implementation. SIM Technical Assistance will include decision support tools for HIT consideration when needed.

The technical assistance QI Advisors will promote enhanced use of hit resources whenever possible, recognizing the significant resources that go into HIT development and the need to achieve optimal utilization. In the case of C3 community projects that impact providers, data from Electronic Health Records will be used heavily in Rapid Cycle Improvement (RCI) and Plan-Do-Study-Act (PDSA) cycles. Alternatively, some C3 projects may focus on potential HIT contributions to delays, errors, and unnecessary process components.

11. Program Monitoring and Reporting

Please see the detailed R2_Reporting_Metrics_Op2016 xls that will be provided separately for detailed measure specs.

12. Data Collection, Sharing and Evaluation

Ongoing Evaluation is the transparency and accountability that any lasting change needs. In addition to collaboration with the federal evaluation, Iowa is establishing a rigorous evaluation plan. There are two parts to this evaluation: 1) an assessment of the implementation/impact and process of the SIM interventions (intermediate outcomes) and 2) an assessment of the core SIM goals (primary outcomes) on three levels; a statewide evaluation of improvement, a community level evaluation of improvement, and a community level evaluation of process changes.

SIM Evaluation Plan

Scope

This evaluation describes and documents the implementation of the key model interventions (secondary drivers for each goal) and how we propose to assess the innovation model's impact on the primary aims of improving population health, transforming health care, and promoting sustainability. The approach to the overall evaluation includes qualitative and quantitative designs incorporating multiple data sources and

collection methods to capture information from many areas of the health care system (local, regional, and state-level; patient, provider, and stakeholder).

Independent Entity

The State will work within policies and procedures established under the Iowa Code to contract with an independent entity to complete these evaluation activities. In the past, The University of Iowa Public Policy Center (UI PPC) has conducted many independent evaluations of Medicaid changes (please see: <http://ppc.uiowa.edu/health>). The PPC meets the requirements of an independent entity under these policies and procedures. In addition, the University of Iowa brings the ability to meet the prevailing standards of scientific and academic rigor as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and the reporting of findings. The PPC has in the past, and will continue, to use the best available data; use controls and adjustments for and reporting of limitations of data and their effects on results; and discuss the generalizability of results.

Core Evaluation Components

This two-part evaluation 1) assesses the implementation/impact and process of the key SIM interventions (secondary drivers) and 2) assesses the core SIM goals and/or aims (primary outcomes used to measure the success of the SIM). The implementation/impact studies evaluate the main SIM structural components (secondary drivers) that are intended to affect the goals. The core goal study evaluates the outcomes affected by the aims: improve the health of the population with regards to diabetes, obesity, tobacco use, obstetrics, healthcare associated infection, medication safety, and social determinants of health (SDH); transform health care by reducing the rates of preventable emergency department (ED) visits and inpatient admission; and promote sustainability by increasing the number of providers participating in value-based purchasing arrangements. Supplemental analyses may include additional outcomes and measures that relate to the primary goals. These measures will be added during the first year as information is gathered during the preliminary SIM activities (i.e., social determinants of health, patient and family engagement, care coordination, etc.).

Part 1: Implementation/Impact Studies

The objectives of the implementation/impact studies are to describe the structure of the interventions being utilized in the SIM model and the characteristics of the communities and settings which are impacted by the SIM. To do this, we will gather both qualitative and quantitative data from stakeholders, providers, consumers, and health systems to evaluate how the SIM model is being used, who is using the interventions and to what degree, and the successes and challenges experienced by the populations most affected by the SIM strategies. In addition to providing the contextual structure of the SIM activities, this study also describes the environment surrounding the SIM in Iowa by compiling information on statewide activities taking place outside of the SIM prior to and during implementation that may also affect the primary outcomes.

The key research questions addressed by these studies include:

1. How are the SIM interventions being implemented around the state of Iowa? To what extent are each of the SIM interventions being implemented consistently and what is the level of diffusion? – Structural context

2. What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?
– Environmental context
3. How effective has the implementation of SIM been? Level of use by impacted groups? - Procedural context
4. What system, practice, and consumer level factors may contribute to SIM outcomes? Changes within the health care system in Iowa through SIM are widespread and variant, however, we will attempt to describe which intervention may have contributed to the meeting of aim or goal.

Specific actions/interventions (secondary drivers) are planned to promote the SIM primary drivers for health system change that will, in turn, impact the goals of the evaluation. The specific interventions that will be included as a part of the implementation/impact portion of this evaluation are the following: Plan for Population Health Improvement actions including Statewide Strategies and Community Health Needs Assessments (SS & CHNA/HIP), Care Coordination actions including Community Care Coalitions (C3) and a Statewide Alert Notification System (SWAN), Community-Based Performance Improvement using Technical Assistance (TA) and rapid cycle performance improvement (RPCI) methodology, and Value Based Purchasing (VBP) through the use of risk-adjusted quality measures called Value Index Scores (VIS). Each of these SIM actions that derive from the secondary drivers impacts one or more of the aims and goals and will be evaluated individually in this study of SIM implementation and process. The following describes the activities proposed and the evaluation methods (methods, level of evaluation, potential data sources, possible pitfalls, etc.) for each of these activities.

Population Health Improvement

Statewide Strategies (SS) & Community Health Needs Assessment (CHNA)/Health Improvement Plan (HIP)

Statewide, the SIM model will implement several strategies targeting the core population health improvement areas of diabetes, tobacco, obesity, healthcare associated infections, medication safety, and obstetrics. These plans employ a various tools to reach their stated objectives with regard to each health goal. The specifics of those state plans can be found [here](#).

In addition, the state (particularly the Iowa Department of Public Health) will be developing a sustainable and statewide Community Health Needs Assessment (CHNA) and Health Improvement Planning (HIP) initiative that will use the currently established processes for county-level CHNA/HIP (as described [here](#)) to encourage and implement the statewide strategies described above. During this process, the SIM will use the county-level CHNA/HIPs to identify and understand how social determinants of health are being addressed statewide. For both of these approaches, the SIM will use data sharing, a SIM Community Health Consultant (CHC), TA, and learning collaboratives to encouraging the use and implementation of the statewide strategies. Implementation/impact measures under consideration for the CHNA/HIPs include communities completing the CHNA/HIP by due date, proportion of CHNA/HIPs incorporating social determinants, provider awareness of statewide strategies, and C3 use of statewide strategies.

Care Coordination

Community Care Coalitions (C3)

C3 initiatives are intended to be locally-based coalitions of health and social service stakeholders collaborating to promote the coordination of health and social services across care settings and systems of care. These initiatives are intended to enhance care coordination 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. C3s are required to develop and/or implement strategies to address tobacco, obesity, and diabetes but are encouraged to address the other SIM goals of medication safety, patient and family engagement, community resource coordination, social determinants of health, hospital acquired infections, and obstetrics. In addition, C3s will engage with local public health efforts by demonstrating how their Community Health Needs Assessments and Health Improvement Plans (CHNA/HIPs) will be used to improve community health in their region. Implementation/impact measures under consideration for the C3 include describing the composition of the C3 stakeholder members, attendance at learning collaboratives, completion of C3 plan, and awareness of C3 activities by providers and consumers. We will add additional measures to determine the success of the C3 initiatives after review of the C3 plans and an understanding of expected outcomes. These could include changes in BMI and changes in tobacco use as reported in the BRFSS or consumer survey.

Statewide Alert Notification System (SWAN)

The SWAN is a statewide system using hospital health information technology to send alert notices to providers when their patients use an emergency department or are admitted to a hospital. The SWAN is intended to give providers a real-time tool to monitor their patients' major health events. The role of SWAN in SIM is to help providers better coordinate their patients' care and especially their care as they transition from the ED or hospital setting back into the community. This enhanced care coordination should result in an overall reduction in preventable ED visits and inpatient readmissions. Implementation/impact measures under consideration for this component include number of alerts provided, average time between utilization and alert, and provider awareness and utilization of SWAN alerts.

Community-Based Performance Improvement

Technical Assistance (TA)

The SIM provides technical assistance (TA) in local communities and through learning collaborative events across Iowa to help community partners and providers with health system transformations such as those encouraged by the C3, SWAN, and statewide strategies for population health improvement. Ongoing TA and three learning collaborative events per year will focus on providing strategies that communities can use to impact the primary goals identified to improve population health (tobacco cessation, obesity, diabetes, healthcare acquired infections, medication safety, obstetrics, social determinants of health, and other health priorities as identified by C3 stakeholders). Implementation/impact measures under consideration for the TA include hours and personnel dedicated to TA activities, attendance at learning collaboratives, and requests for TA across the state.

Value Based Purchasing (VBP)

VBP is intended to link provider payments to improved health care provider performance. As part of the SIM activities, VBP is being utilized by both Wellmark and Medicaid to try to achieve delivery system transformation. SIM outcomes related to VBP include increasing the number of attributed members and

providers in VBP across the state. Secondary outcomes of interest include an evaluation of whether there are concurrent shifts in utilization (increased use of non-physician primary care providers, decreased use of specialists, etc.). Implementation/impact measures under consideration for VBP are fairly limited, but may include provider understanding of VBP and diffusion analyses through geocoding of providers in VBP plans across the state over time.

Value Index Score (VIS) – Risk-Adjusted Quality Measures

The VIS is the overall score derived from the aggregation of a series of risk-adjusted quality measures. There are six domains (chronic and follow-up care, primary and secondary prevention, tertiary prevention, continuity of care, population health status, and patient experience) with 18 measures. The VIS is a claims-based measure that will be used by the SIM in VBP for the bonus payments for improved quality and risk sharing. We will evaluate who accesses and uses the VIS and look at the VIS at several levels of the health care system (Providers, Hospitals, Accountable Care Organizations, etc.). Implementation/impact measures under consideration for the VIS include weekly average number of hits to the provider dashboards and provider awareness of VIS.

Methods

We have a variety of methods for evaluation which are dependent on the scope of the particular activity. However, the methods can be summarized in three general categories: 1) descriptive, 2) impact, 3) effectiveness. The *descriptive assessment* includes the 'who', 'what', 'when', 'where', and 'how' of each SIM intervention, providing a broad overview of the scope of each activity as they unfold over the course of the SIM. To gather this information, we will rely on document review (policies and procedures, membership/stakeholder lists, identification of non-SIM activities that could also impact outcomes) and stakeholder interviews. *Impact* is evaluated by gathering information about awareness and use of SIM activities, identifying potential barriers to use, and identifying where SIM activities may overlap and align (i.e., did C3s use the SWAN). We will utilize surveys and interviews of stakeholders, providers, and patients to gather data for this assessment.

Finally, the *effectiveness* of the SIM interventions in meeting the goals will be assessed. Each SIM intervention may have its own intermediate goals related to the intention of the activity. For example, was care coordination improved in C3 regions? Did patients in the C3 regions experience appropriate referrals for care or resources? In areas with the SWAN, did emergency department use or inpatient admissions decline? Were providers more or less willing to participate in VBP? Were there improvements in social determinants of health? We will use patient and provider surveys to gather this information and, where appropriate will use data sources already collected and available (i.e., BRFSS).

Some SIM interventions may involve only local-level evaluation while others will employ statewide strategies. For example, the C3s will be working at a local/regional level to implement their activities. Thus, the implementation/process evaluation of the C3s will be at the local level. However, the evaluation of the outcomes of the C3 initiative will be statewide if we are able to choose and access data about counties/regions who did not apply for or were not chosen for the C3 funding and compare them to the C3 regions. However, VBP and SWAN are being implemented statewide and will be evaluated at that level.

The following table provides a summary of the methods, level of evaluation, data sources, and measures we propose to use to evaluate each activity.

Implementation/impact measures

SIM Intervention	Level of Evaluation	Data Sources	Initial Measures
C3	Local	Document Review	Composition of C3s
	Statewide, if possible	Stakeholder Interviews	Awareness of C3 plans
		Statewide Consumer survey	Attendance at TAs
		Local Patient Experience Survey	Changes in BMI
		Provider Surveys/Interviews	Changes in tobacco use
	BRFSS	Others to be developed	
SWAN	Statewide	Provider Surveys/Interviews	Location of SWANs
		SWAN-specific data	Number of alerts
		Claims	Awareness of SWAN Utilization of SWAN
TA	Local	Document Review	Hours & Personnel
	Statewide	Stakeholder Interviews	Attendance at TAs
		Provider Surveys/Interviews	Requests for TA
SS & CHNA/HIPs	Local	Document Review	Number of counties with SS as part of CHNA/HIP
	Statewide	Provider Surveys/Interviews	Number of counties with social determinants as goals
		Stakeholder Interviews	Awareness of SS
		BRFSS	Use of SS
VBP	Statewide	Provider Surveys/Interviews	Awareness of VBP
		Medicaid provider data	Location of VBP providers
VIS	Local	VIS scores	Awareness of VIS
	Statewide	Provider Surveys/Interviews	Use of VIS by various stakeholders

Part 2: Evaluation of Core Goals

Primary goals of the SIM include a) improving population health, b) transforming health care, and c) promoting sustainability. Outcomes that are intended to be affected by the SIM activities are provided under each goal.

Improve Population Health

The state of Iowa has outlined six areas of population health improvement including diabetes, obesity, tobacco cessation, healthcare acquired infections, medication safety, and obstetrics. The goal of the SIM is to affect at least 4 of the 6 over the three-year project period at the state level. Data will be collected and assimilated from different sources to address the following research questions.

Diabetes

Research Question 1: Do SIM efforts improve the care of people with diabetes?

Hypothesis 1.1: The statewide diabetes rate will be reduced by 0.2% over the three years of the SIM.

BRFSS data will be used to trend diabetes rates over the three years of the SIM.

Hypothesis 1.2: The hospitalizations related to the long-term and short-term complications of diabetes will be reduced.

IHA data will be used to trend long-term and short-term complications for diabetes over the 3 years prior to and 2 years following implementation of the SIM.

Hypothesis 1.3: ER visits for diabetes related issues will be reduced.

IHA data will be used to trend ER visits related to diabetes over the 3 years prior to and 2 years following implementation of the SIM.

Hypothesis 1.4: Providers will integrate the statewide strategies for the care of diabetes.

Provider survey regarding patient care, qualitative interviews with ACO leaders and clinic managers.

Hypothesis 1.5: Glucose monitoring will increase.

Utilize claims data to determine Hemoglobin A1c rates.

Research Question 2: Do SIM efforts improve the quality of life for people with diabetes?

Hypothesis 1.5: People with diabetes will experience improved quality of life (QoL).

Survey based questions about how much diabetes interferes with daily life, perceived glucose control, understanding of negative outcomes.

Obesity

Population will include the following age categories-5-12, 13-18, 19-21, 22 and above.

Research Question 3: Does the SIM improve the quality of life and outcomes of care for people with obesity?

Hypothesis 2.1: People with obesity will have decreased BMI over the 3 years of the SIM.

BRFSS data/IHHS data will be used to trend BMI over the three years of the SIM.

Hypothesis 2.2: People with obesity will experience improved quality of life.

Survey based questions about how much obesity interferes with daily life, perceived glucose control, understanding of negative outcomes.

Tobacco use

Population will include the following age categories-11-18, 19-21, 22 and above.

Research Question 3: Does the SIM decrease the use of tobacco?

Hypothesis 3.1: There will be an increase in the proportion of people interested in reducing tobacco use.

Utilize data from the Iowa Quitline and/or claims data for smoking cessation.

Hypothesis 3.2: The rate of tobacco use will decrease by 3% over the 3 years of the SIM.
BRFSS and YRBS or data will be used to trend tobacco use over the three years of the SIM.

Obstetrics

Research Question 4: Does the SIM improve obstetrics outcomes?

Hypothesis 4.1: The rate of elective C-sections and early elective deliveries will be reduced.

Utilize claims data/HEN data/IHA data to determine rates of elective C-sections and early and elective deliveries.

Hypothesis 4.2: Rates of low birth weight newborns will decrease over the 3 years of the SIM.

Birth certificate date will be used to determine the birth weight rates.

Healthcare-Associated Infection

Research Question 5: Does the SIM reduce the rates of healthcare-associated infection?

Hypothesis 5.1: The rate of surgical site infections will be reduced.

Utilize Claims data/IHA data/HEN to determine the rates of surgical site infections over the three years of the SIM.

Medication Safety

Research Question 6: Does the SIM improve medication safety?

Hypothesis 6.1: The rate of Narcane use outside the hospital will be reduced.

Utilize claims data to determine Narcane use rates.

Hypothesis 6.2: Glucose monitoring will increase.

Same as Hypothesis 1.5.

Transform Health Care

C3s, technical assistance, the SWAN, value-based purchasing, the VIS and the CHNA/HIPs are designed to change the way we provide healthcare. Ultimately, the structural components of the SIM should lead to changes in the rates of avoidable health care utilization. For example, by providing statewide strategies for treating and managing diabetes, we anticipate that the SIM will drive providers to a higher quality of care reflected in fewer emergency room visits and inpatient admissions. We will utilize IHA data and claims data to address the questions listed below.

Preventable readmissions

Research Question 7: Does the SIM transform health care in a manner that results in fewer preventable readmissions?

Hypothesis 7.1: The SIM will reduce the annual rate of preventable readmissions by 20% by the third year.

Utilize IHA and claims data to determine the rate of readmission within 7 and within 30 days of discharge.

Preventable emergency department visits

Research Question 8: Does the SIM transform health care in a manner that results in fewer preventable emergency department visits.

Hypothesis 8.1: The SIM will reduce the annual rate of preventable emergency department visits by 20% by the third year.

Utilize IHA and claims data to determine the rate of preventable ED visits as defined by the NYC Billings algorithm.

Promote Sustainability

Changes in health care are not sustainable unless they provide a more affordable system. Through the SIM system changes it is anticipated that costs of care will be reduced.

Reductions in cost of care

Research Question 9: Does the SIM reduce the total cost of care per member in Iowa below the national average.

Hypothesis 9.1: The total cost of care per member in Iowa will be reduced below the national average by the third year.

Utilize national trend data and the estimated cost for care based on Medicaid, Wellmark and Medicare data to determine whether the cost of care has been reduced.

Research Question 10: The SIM will increase participation of primary care providers in value-based purchasing.

Hypothesis 10.1: The proportion of provider payments linked to value-based purchasing contracts will increase to 50% by the third year.

Utilize Wellmark and Medicaid data to determine the proportion of primary care providers in VBP determining whether it matches the estimates provided in the SIM document for each of the project years.

Hypotheses and measures

Hypothesis	Measure	Data Source	Outcome Target date
The statewide diabetes rate will be reduced by 0.2% over the three years of the SIM.	Statewide diabetes rate	BRFSS	12/31/2018
The hospitalizations related to the long-term and short-term complications of diabetes will be reduced.	Admissions due to long-term and short term complication from diabetes	Iowa Hospital Association (IHA) inpatient file	12/31/2017
ER visits for diabetes related issues will be reduced.	ED visits due to long-term and short term complication from diabetes	IHA outpatient file	12/1/2017

Providers will integrate the statewide strategies for the care of diabetes.	Number of providers who integrate statewide strategies	Provider survey	12/1/2017
People with diabetes will experience improved quality of life (QoL).	Patient quality of life questions (to be determined)	Statewide consumer survey	11/1/2016 and 6/30/2018
Glucose monitoring will increase.	Hemoglobin A1c rates	Medicaid and/or Wellmark claims data	6/30/2017 and 6/30/2018
People with obesity will have decreased BMI over the 3 years of the SIM.	Weight and height measure	BRFSS/YRBS	6/30/2017 and 6/30/2018
People with obesity will experience improved quality of life.	Patient quality of life questions (to be determined)	Statewide consumer survey	11/1/2016 and 6/30/2018
There will be an increase in the proportion of people interested in reducing tobacco use.	Number of people requesting information from the Quitline	Iowa Quitline data and claims data	6/30/2017 and 6/30/2018
The rate of tobacco use will decrease by 1% over the 3 years of the SIM.	Rate of reported tobacco use	BRFSS/YRBS	6/30/2017 and 6/30/2018
The rate of elective C-sections and early elective deliveries will be reduced.	Rate of C-sections and early elective deliveries	IHA inpatient file	6/30/2017 and 6/30/2018
Rates of low birth weight newborns will decrease over the 3 years of the SIM.	Low birth weight rates	Birth certificate data	6/30/2017 and 6/30/2018
The rate of surgical site infections will be reduced.	Rate of surgical site infection	IHA inpatient file perhaps use National Healthcare Safety Network (NHSN)	6/30/2017 and 6/30/2018
The rate of Narcan use outside the hospital will be reduced.	Narcan use rates	Medicaid and/or Wellmark claims data	6/30/2017 and 6/30/2018
Monitoring of anti-coagulation medications will increase.	Protime rates	Medicaid and/or Wellmark claims data	6/30/2017 and 6/30/2018
The SIM will reduce the annual rate of preventable readmissions by the third year.	Avoidable readmissions at 7 days and 30 days (HEDIS)	IHA inpatient data	6/30/2017 and 6/30/2018
The SIM will reduce the annual rate of preventable emergency department visits by the third year.	Rate of preventable ED visits as defined by NYC Billings algorithm	IHA outpatient file	6/30/2017 and 6/30/2018

The total cost of care per member in Iowa will be reduced below the national average by the third year.	Cost of care per person in Iowa	Either provided by third party vendor or calculated from Medicaid/Wellmark/Medicare claims data	12/31/2017 and 12/31/2018
The proportion of provider payments linked to value-based purchasing contracts will increase to 50% by the third year.	60%	Medicaid provider dataset	12/31/2018

Outcome targets

Hypothesis	2016	2017	2018
The statewide diabetes rate will be reduced by 0.2 percentiles over the three years of the SIM.	No change	Decrease 0.1 percentile	Decrease 0.1 percentile
The hospitalizations related to the long-term and short-term complications of diabetes will be reduced.	No change	Decrease 2%	Decrease 5%
ER visits for diabetes related issues will be reduced.	No change	Decrease 2%	Decrease 5%
Providers will integrate the statewide strategies for the care of diabetes.	50% of providers	60% of providers	75% of providers
People with diabetes will experience improved quality of life (QoL).	No change	No change	Increase 10%
Glucose monitoring will increase.	Increase 5%	Increase 10%	Increase 10%
People with obesity will have decreased BMI over the 3 years of the SIM.	No change	Decrease 0.2 percentiles	Decrease 0.3 percentiles
People with obesity will experience improved quality of life.	No change	No change	Increase 10%
There will be an increase in the proportion of people interested in reducing tobacco use.	12,441	12,541	12,689
The rate of tobacco use will decrease by 1 percentile over the 3 years of the SIM (cigarettes).	No change	Decrease 0.5 percentiles	Decrease 0.5 percentiles

The rate of tobacco use will decrease by 1 percentile over the 3 years of the SIM (smokeless).	No change	Decrease 0.5 percentiles	Decrease 0.5 percentiles
The rate of elective C-sections and early elective deliveries will be maintained/reduced.	No change	No change	No change
Rates of low birth weight newborns will decrease over the 3 years of the SIM.	Decrease 1%	Decrease 2%	Decrease 2%
The rate of surgical site infections will be reduced.	Decrease 1%	Decrease 2%	Decrease 5%
The rate of Narcane use outside the hospital will be reduced.	No change	Decrease 1%	Decrease 2%
The SIM will reduce the annual rate of preventable readmissions by the third year.	No change	Decrease 8%	Decrease 13%
The SIM will reduce the annual rate of preventable emergency department visits by the third year.	No change	8% reduction to baseline	12% reduction to baseline
The total cost of care per member in Iowa will be reduced below the national average by the third year.	No change	8% reduction to baseline	12% reduction to baseline
The proportion of provider payments linked to value-based purchasing contracts will increase to 50% by the third year.	Proportion of payments to Medicaid providers in VBP contracts	Medicaid provider dataset	12/31/2018

ACTIONS: ANALYTIC EVALUATION OF DELIVERY SYSTEM QUALITY:

Finalize and disseminate data needs to the sources of data (i.e, Iowa Healthcare Collaborative (IHC), Iowa Department of Public Health (IDPH), Iowa Medicaid Enterprise (IME), and Wellmark)
Execute data sharing agreements
Develop questions, formats and sampling strategies for provider and consumer surveys
Compile and report annually to stakeholders results of evaluation
Assist the federal evaluators in compiling a national evaluation

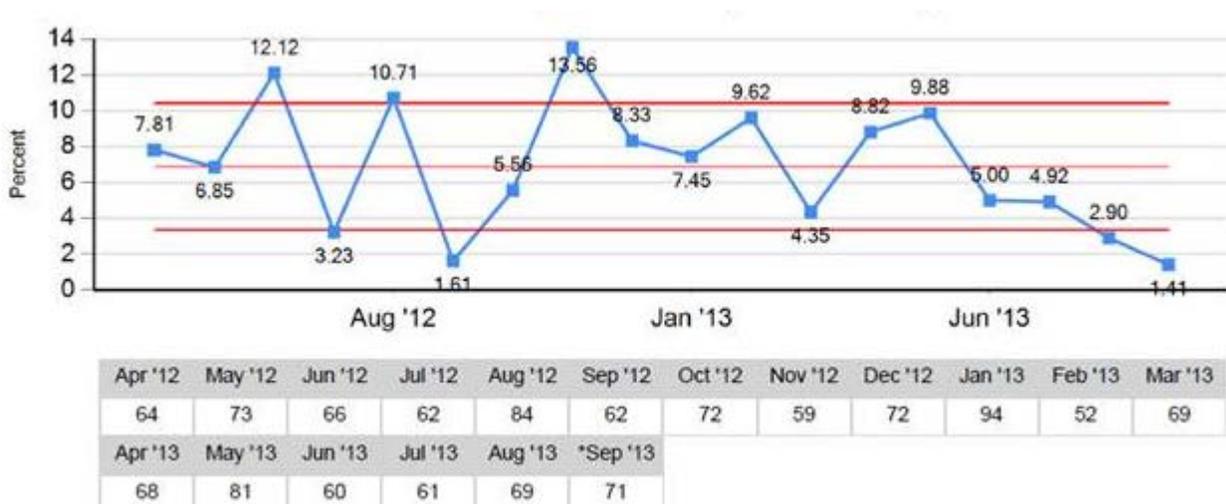
Data Sharing:

In addition to the SIM evaluation plan, the state will use a rapid cycle performance improvement approach to collect and share data with communities. IHC will build a web-based SIM Reporting Database to track and monitor progress towards operational and quality improvement. This reporting database design

supports the management of IHC’s SIM activities and its features will support necessary operational monitoring of provider-facing SIM projects.

The developed SIM Reporting Database will enable reciprocal tracking and performance monitoring by both IHC and the SIM C3 communities. The database will allow access by contacts identified by each C3, such as designated project leaders within each community, to securely enter and analyze project metrics and data.

The database will feature a profile component to support work plan development and monitoring of specific SIM project activities within each community, including both quantitative metric-related data and qualitative intervention activity details. Users may generate on-demand run charts showing results for each measure. The run charts will be a vital tool to be shared during team meetings to communicate and support improvement efforts. It is anticipated that comparative and benchmark data will offer participants an enhanced capability to analyze performance. See below for an example of a database-generated run chart.



The Reporting Database will allow IHC SIM Improvement Advisors and other technical assistance staff to accomplish a variety of project management functions. IHC staff will utilize database reporting functions to communicate program performance to fulfill SIM reporting requirements, both to participant communities and to CMS and/or CMS-contractors. To ensure appropriate data collection and reporting functions, IHC will secure all necessary data use agreements to support performance tracking, project reporting, and program evaluation at all levels.

In some cases, clinical data may not serve as a relevant performance tracking tool. In those circumstances, IHC will identify pertinent performance indicators, exploring opportunities to use additional tools, such as surveying, interviewing, and/or sampling techniques as necessary and appropriate. Identification of performance measures and specific indicators throughout the project will facilitate access to meaningful performance data to drive improvement and ensure the provision of valuable ongoing technical assistance support.

13. Fraud and Abuse Prevention, Detection and Correction

The state is collecting quality data through a claims based submission process that falls under the guidance of our Program Integrity unit. Claims data are validated and audited to meet strict federal and state guidelines to prevent fraud and abuse.

Medicaid is implementing VBP strategies through our selected Managed Care programs. Managed Care programs are also validated and audited to meet strict federal and state guidelines and contractual requirements to prevent fraud and abuse.

Due to the method we are using, we feel there are no new exposures introduced for fraud and abuse that do not currently exist.

Medicaid contracts with Optum Insight to provide Program Integrity and Special Investigation Unity (SIU) oversight which includes running data analysis on prepaid and post-paid claims for potential fraud, waste, and abuse. If fraud, waste, or abuse is identified, Optum conducts a desk audit or an on-sight audit as appropriate. Optum will continue to support Medicaid throughout the SIM Model Test.