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Iowa Medicaid Health Home Providers:

A qualitative examination of the implementation of the Iowa Medicaid Health Home

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Executive Summary

This study is a qualitative examination of the implementation of the Iowa Medicaid Health Home program from the clinic perspective. The study was designed to document challenges, successes and clinic processes related to becoming an effective Health Home.

Methods

Interviews were conducted with staff in 11 Iowa Medicaid Health Homes throughout Iowa. The staff interviewed were often administrators or nursing staff. Most often the staff person was the official contact person for the Iowa Medicaid Program. The in-depth interviews were conducted by a University of Iowa Public Policy Center researcher using open-ended questions. Interviews were recorded with the respondents' permission, transcribed and coded to reflect common themes.

Key findings

- The transition to becoming an Iowa Medicaid Health Home was less challenging for those clinics that already met criteria for being a patient-centered medical home (PCMH) or were currently working to achieve PCMH recognition.
- Cost—financial or otherwise-- is a universal issue across clinics.
- Clinic staff for the most part are excited about the changes, and remain optimistic that these changes will benefit their patient populations.
- Clinics sampled for this study represent a range along the continuum of advancement toward health home implementation.
- Many clinics are interested in reducing ED visits and hospital readmissions. Some already have systems in place to address this; others are just starting to think about these issues.
- With regard to scheduling practices, challenges, and successes, every clinic is unique. Many clinics have already developed and implemented practices to address changes to scheduling needs, but some have not yet begun this process.
- Not all clinics have a designated staff person to address tasks related to care coordination, care management and case management. Additionally, there is some confusion over what each of these roles actually entails.
- Some clinics struggle against a lack of access to data outside of their provider network and/or electronic patient database.
- Recruitment of patients into the health home is a challenging

component of implementation.

- Clinics continue to struggle with this patient population, many of whom face significant socioeconomic barriers to health and wellness.
- Many clinics reported that Iowa Medicaid Health Home implementation has or will have an effect beyond that on the target population.
- Successes related to health home implementation were evident at the clinic, provider and patient levels.

Recommendations

- Establish a method for sharing Health Home best practices across providers beyond telephone conferencing-- through conferences, mentoring or other hands-on methods.
- Provide informed ROI estimates for clinics based on the number of members enrolled and the number of staff hired or reassigned to Health Home specific activities.
- Education for on-site staff with a focus on the long-term benefits for members and health homes should be provided, perhaps through video conferencing.
- Provide a mentoring program for new health homes that matches them with the local hospital or other entity that has been successful at care coordination.
- Develop and distribute consistent information regarding care coordination, case management and care management through an entity such as the Iowa Chronic Care Consortium.
- Work to create and provide a broad community resource guide that can allow for locality specific additions for communities across the state or create formal relationships between the health homes and the Community Care Teams.
- Develop a more active role for Medicaid in the enrollment of members into the health home or provide additional materials to providers attempting to enroll members.
- Expand the number of IME health home staff who are visiting and advising providers on the implementation of health home activities.
- Provide additional funding based on performance measures that are easily understood and take into account the improvement in the individual members.

Introduction

What is the Iowa Medicaid Health Home Program?

The Iowa Medicaid Health Home program enables health care providers in the state of Iowa to offer additional services for their Medicaid patients (adults and children) who have specific chronic conditions. The Iowa Health Home model was authorized under a state plan amendment approved by the Centers for Medicare and Medicaid Services with providers enrolling eligible Medicaid members beginning on July 1, 2012.

A Health Home is a specific designation under section 2703 of the Patient Protection and Affordable Care Act. It is a care model that provides patient-centered, whole person, coordinated care for all stages of life and transitions of care specifically for individuals with chronic illnesses. To be eligible for the Health Home, Medicaid enrollees must have at least two chronic conditions or one chronic condition and be at risk for developing a second condition from the following list:

1. Hypertension

2. Overweight

   a. Adults with a Body Mass Index of 25 or greater

   b. Children in the 85th percentile

3. Heart disease

4. Diabetes

5. Asthma

6. Substance abuse

7. Mental health problems

In addition, enrollees may not be in IowaCare, PACE, Iowa Family Planning Network, Medicare, an HMO, or be a presumptively eligible child or adult.

Health Home practices include but are not limited to: physician clinics, community mental health centers, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs). They are capable of providing enhanced personal, coordinated care for Medicaid enrollees meeting program eligibility criteria (Map Figure 1). In return for the enhanced care provided, the Iowa Medicaid Enterprise (IME) offers providers monthly care coordination payments (see Table 1) and the potential for annual performance-based incentives designed to improve patient health outcomes and

lower overall Medicaid program costs. Additional information about the programmatic obligations of Medicaid Health Home providers can be found at Iowa Medicaid Enterprise Health Home Provider Standards (http://www.ime.state.ia.us/docs/HealthHome_ProviderStandards.pdf).

Table 1. Tier definitions

Tier	Sum of chronic conditions	Monthly payment
1	1-3	$12.80
2	4-6	$25.60
3	7-9	$51.21
4	10 or more	$76.81

Figure 1. Map of the counties with Health Home providers as of July, 2014.
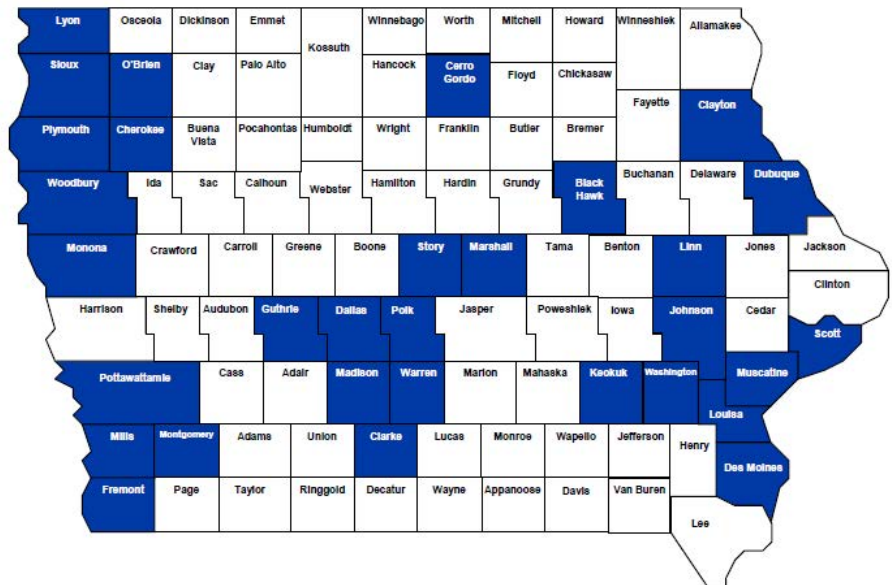
(Map: Courtesy of the Iowa Department of Human Services)

This study was part of the larger evaluation of the Iowa Medicaid Health Home program. The evaluation included surveys of Medicaid Health Home members about their experiences with the program as well as claim-based evaluations of member health and utilization outcomes and cost analyses. The purpose of this evaluation activity was to describe the implementation process from the perspective of the provider clinics, including the challenges and successes.

Methods

In-depth, qualitative telephone interviews with clinic staff members were completed to gather information about program implementation.

From the 29 Medicaid health homes in the state, a sample of 18 was chosen. The sample was selected to provide the most diverse group of potential respondents, including rural and urban settings. Each health home received an email from the Iowa Department of Human Services inviting them to participate in the interviews. The emails were addressed to the program staff contact at the clinic. This email was followed up by emails from the University of Iowa Public Policy Center.

A total of 11 health homes participated, but one of the interviews was not included in the main analysis because the entity did not have any patients enrolled in the Iowa Medicaid Health Home program. Most of the interviews were conducted with the health home contact staff member, but some of the interviews included additional clinic staff with expertise in different areas of the program implementation. The program contact person was often an administrator or nurse.

The interviews lasted between 20 minutes and 1 hour. The questions were open-ended to allow the health homes to describe their experiences. The interviews were recorded and transcribed. Analysis was conducted based on predetermined themes related to implementation.

Results

The health homes that participated in the interviews represented federally qualified health centers (FQHC) (4), rural health centers (2), and clinics connected to larger hospital systems (5). The respondent health homes were based in urban areas and remote rural areas.

Patient-Centered Medical Home

Some clinics had begun the process of becoming a Patient-Centered Medical Home (PCMH) or were already recognized as a PCMH before becoming an Iowa Medicaid Health Home. In fact, some had already been recognized by NCQA as a Level 3 PCMH. A respondent from one clinic summed up the experiences of those working towards NCQA recognition, stating, '*We're working on it. It's a huge undertaking and it's not going as quickly as we had hoped, be we are working on it…but I think we have a lot of work yet left to do.*'

Other respondent clinics did not start the process of becoming a PCMH until the decision was made to become an Iowa Medicaid Health Home. Compared with clinics that had already received PCMH recognition, the process of implementing the requirements for the Iowa Medicaid Health Home were more difficult for those clinics that were just beginning the PCMH process.

While the process of becoming an NCQA-recognized PCMH is incredibly challenging for many clinics, respondents from these clinics were unable to readily articulate what the Iowa Medicaid Enterprise (IME) could do to better support them in this process. After additional probing during the interviews, a few clinics were able to identify some specific areas of need where the IME could provide assistance. Cost was raised as one such issue; for example, one clinic thought IME could help with the cost of training health coaches:

Honestly, our hugest obstacle in becoming a patient-centered medical home is having the resources as far as staff. Having a patient-centered medical home takes a lot of time and is not reimbursed. So, you know, the Health Home helps with that a little bit, but of course not nearly enough to cover putting all those people into place, and we truly get the fact that that is good medical care, and that is what's best for our patients, but at the same time you have to be able to pay staff to be able to accommodate all that work.

Other clinics reported that they would have benefited from further technical assistance. More than one clinic suggested that additional guidance would have helped them better tackle the challenges of becoming a PCMH:

Maybe more training with better examples of how other clinics have done it. That's one of the things we've really struggled with is trying to figure out how to do stuff, and then what the best way is and trying not to reinvent the wheel. We certainly collaborate with our state aid, our state group, and then the IME does have those monthly meetings. But just more true examples that other clinics have done, I think would be helpful.

Changes made to become an Iowa Medicaid Health Home

For most clinics that were not previously involved in the process of becoming a PCMH, the clinic-level changes made to provide care as an Iowa Medicaid Health Home were significant. Many respondents commented that the changes were too numerous to list. Clinics that had been working towards PCMH status or were already recognized as a PCMH also had to make some changes. One respondent commented that every medical home was different and every program had different requirements; as a result, there were always changes that needed to be made.

Most of the changes were related to hiring additional staff and changing clinic processes. Usually respondents mentioned hiring health coaches when describing the need for additional staff.

…my own position is a health coach and a care coordinator. That role is in place. With care coordination we have a team in our office with a physician champion that protocols for us to monitor those patients that are within our Health Home on their certain kind of conditions, making sure that we're

able to call them back into the office when they're needed to. We have a referral tracking process in place now that we hadn't had before. Our labs, we are tracking our labs as well, making sure that every order that goes out has a result that comes back, or making sure the patient is able to do that. Those are the high points with our Health Home right now.

Many of the process changes mentioned were broad and often included maximizing the use and scope of the electronic health record. In general, process changes included making better use of existing data to inform care and track referrals and implementing team-based care provision.

I'll just highlight maybe a couple of things. Really focusing on chronic conditions and patient education, patient engagement, patient's health management. And so just putting more emphasis on meeting the patient's needs at their level of understanding, I guess. And then of course a lot of reporting systems in place in terms of additional follow-up processes. So following up on labs, following up on referrals. Gosh, what else?

1. Data

I think another issue is just making better use of data that exists as a result of maintaining data and electronic health records. I think we all know that there is an abundance of information that can be made available, but certainly in the context of the medical home with that specific focus we were able to design and deliver more meaningful data in the form of reports that support the medical home functions

2. Referrals

We changed our method of tracking our referrals and getting documentation back. We set up a whole new process with that in our order tracking module within our EMR. And we set up codes for specific, tagged to referrals, like an orthopedic referral, a (urology) referral, that kind of thing. So we would "order them" and send the referral information to the specialist, and then when we received the report back from the specialist, we attached that to that order and it automatically goes right to the physician, so they can see what those, the responses from the specialist and that kind of stuff. And then we're able to go in and see which of those referrals we have not heard back from, are they something that we definitely need to hear to be able to manage that patient's care, or is it something that, is there an ongoing specialist visit that we don't necessarily need to see every single time they go, that we can just put that into a reviewed status kind of thing.

3. Team

Yeah, that's changed significantly too. We have a care team structure in place that's much different than what we had before. Our care teams consist generally of a physician and a mid-level provider, an RN care coordinator who has sort of a dual role. And then each provider has a medical assistant

that works with them who is responsible for (rooming) patients. And then a care coordination assistant for each care team, which is basically a medical assistant that's working at a higher level, they're doing a lot of the follow-up work after. So it's checking to see if the patient went to that referral or had that lab work done. A lot of the medical records piece, just putting our medical record documentation into the system in a way that is the most useful.

Changes related to reducing emergency department use and hospital readmissions

Two of the intended outcomes of providing health homes to these higher-risk Medicaid patients were to reduce inappropriate or unnecessary emergency department visits and hospital readmissions. Some clinics were able to identify specific changes being made to reduce emergency department visits and hospital readmissions, but many clinics were not far enough along in the implementation process to have started working on these areas in a significant way. Most of the changes were related to communication and clinic processes. Barriers to successful changes were related to clinics lacking strong relationships with local hospitals or not having electronic access to records at those institutions. Those clinics that reported the greatest success in making changes were connected to larger health care systems.

4. Clinics that have not started addressing these challenges

We do have a physician that's on call 24/7. So hopefully with phone advice and the patient coming into the [ER], they actually direct the patient to the practice if at all possible.

5. Clinics beginning the process

Well, we actually have just started; that is, we just barely have touched on that. We just were thinking, you know the patients that actually leave the hospital, now we're going to work out a process so that we direct those patients to [name of health coach] so that she can review when they need to come back and make sure that they have that follow-up visit set up and make sure that they come for that visit. We have not, we don't have a procedure in place for that at this time. We just barely talked about it within the last couple weeks…

6. Good communication with hospitals

We actually receive calls. We have a process set up with both of our local hospital systems to receive that information. And basically the patient is entered into our system in sort of a recall process. So the hospital tells the patient they need to follow up with their primary care provider in so many days. We put basically a reminder in our electronic health record system, so if the patient does not follow up as they've been directed, then they actually

receive follow-up calls from us reminding them they need to do that.

7. Challenging communication with local hospitals

Well, we don't get a whole lot of cooperation from hospitals. I've been asking for information about that for I don't know how long. But one hospital is better than the other one in giving us information that a patient has visited an emergency department, but it's always after the fact.

Working with the hospitals it was hard for us to know, because within our adult population none of our providers go to the hospital and do rounds, and so it is very hard for us to know, number one when the patient was hospitalized, when they're discharged. Unless there was a phone call between us for a follow-up hospital visit. So we had asked for the hospital to send us lists of our patients who were actually in the hospital for whatever reason, and that has been very difficult….That was really hard for us to even, I mean we find out after the fact that they were in the hospital. Yeah, so that's been a difficulty that we've been striving to get better.

8. Follow-up after discharge

We have implemented follow-up calls from discharges. At least if they come to our hospitals we're given information on daily discharges, we're able to follow-up and utilize the new TCM measure-- the transitional care measure as far as getting patients back into the clinic to see their primary care physician, within seven days ideally.

Making sure they're getting their medicine. We're hoping that that is going to reduce hospital admissions as well, because the patients that are in the Health Home, we have been following them, making sure that if they have a chronic condition that they are coming back when they are supposed to be, and that sort of thing. So hopefully with that follow-up it does reduce hospital admissions.

…what we're doing is we're making sure that when a patient is discharged in the hospital, we're making sure that they're being seen within three days from discharge at the clinic. If they don't show or whatever, we also have somebody calling them to follow up on them. They've put together color-coded, laminated sheets that they give to the patient, especially if they have like congestive heart failure, that tells them where they are, in their red zone, yellow zone, or green zone, you know this is when you should call the doctor, this... Because otherwise the patients may not call us if they have an appointment, they'll just wait for the appointment and by then they're really sick again and they have to go back in. So it gives them guidelines, like what to look for, so that they don't get into that bad of shape so that they have to go back in the hospital. So then we trained our nurses on our side too, so that when the patient does come in for follow-up, we pull out that color-coded sheet and we're like, well what color are you in, do you understand this, when to call us, and not to be afraid to call us. So that's part of what they're working on.

Many of the clinics reported that it was simply too soon to tell if these changes would prove effective on a large scale. Some clinics did possess some limited information about successes related to these changes; however, many of the efforts aimed at reducing rates of emergency department use and hospital readmissions are new and respondents had concerns about the extent to which data related to any changes in these outcomes were interpretable. Frequently, though, respondents were able to relay patient anecdotes and examples that reflected their process and any successes.

We created a multidisciplinary team made up of nurses from the hospital, social workers, and then myself from the clinic, as well as physicians and ED providers. And our discharge coordinator has identified several patients that would benefit. We had one patient in particular that was in the ER several times a month for nonessential things and wasn't taking his medication, wasn't taking care of himself. We created care conferences weekly with this patient, where we set goals, we talked about how we can improve his health, and six months down the line he's been in ED twice for only diabetic emergencies, and currently his diabetes is well controlled, he has a job which he never had before, and his mental health conditions are under control. He's making all of his appointments now and so we're just really proud of the success we've had with the program. We have expanded it now to several other patients, they are kind of in early stages but we are starting to see some significant changes in the patient.

Costs related to changes

Respondents were asked about the costs of making these changes, including but not limited to the financial expenses. Respondents primarily identified financial costs, staff frustration, and staff education as costs of implemented changes related to becoming a PCMH.

Seems like at least once a week if not twice a week we're coming with a new policy and new ways that we have to do things, and how they're entering stuff into the computer, because if they're just manually typing in information instead of hitting bullets, then our computer doesn't recognize it so it can't print out the data that we need. So since we've been part of the hospital in 2012, we've had a lot of changes, and I think our employees are just really frustrated. They're willing to keep doing what we ask, but I know that there's been so many changes that it's not hard-wired into them yet, so I know they might start this new one today, but then last week they forgot about it and they're not doing it. We just keep coming back and reminding them, oh you didn't do this, and then, yeah... But I think the MAs coming on board is going to help because they're trying to make phone calls back and they're trying to keep up with the doctor, and then we're asking them to do this other stuff…..I get the hammer down pretty hard when we have overtime. But yet they're asking us to do this extra work on top of our everyday work and, you know for me I'm salaried so it's nothing for me to put in 50 hours a week but the rest of staff are hourly, so that's a frustration for

me. And I know that that's not, we're spending more money, well I guess not spending more money because they're not getting overtime, but we're asking them to do more but we know down the road that there's not going to be more reward or better pay reimbursement for all the work that we're doing. So that's tough to get people to buy into that. If they knew that, oh yeah our reimbursement's going to go up once we become this, then it might be a little easier to get them to do stuff. So I guess all of that is frustration…

1. Staff frustration

Staff time is a big one. Just trying to do the education with the patients of why they need to stay out of the emergency room and why they need to contact their primary caregiver for everything, is time consuming. I mean there's been patients that we feel like we go round and round with, of why they need to stay out of the ER, and there's a few that it doesn't seem to do very good. Sometimes we feel those patients have an ulterior motive to be going to the ER, for possible medications that their PCP won't give them.

I don't think there's really been any frustrations per se with the staff. I think one of the biggest obstacles that we've had is just making sure that the entire clinic team understands the Health Care Home model, and that's something that we've embedded into all of our clinic staff meetings, our provider meetings. And not only just the clinic, but we have a patient advisory council as well that we oftentimes talk about our Health Care Home. And just making sure that not only our staff but the community understands what resources we have available.

I think probably one of my biggest challenges as a manager is educating my staff on what is a PCMH, and getting them all on board that it is a good thing.

Because it overlaps with meaningful use stuff. They feel like every time I come to them I'm telling them that they have to do this, have to do this, and that it's mandated by some insurance company, and they're not always seeing the purpose in having to do the extra steps. There is a lot of extra documentation by nurses and physicians that they get frustrated with, but that's not just because of this, it's with meaningful use, with the Health Home stuff, it's with the PCMH stuff, it's with the ACO that we belong to. And trying, for them to keep all of that straight, of what is what and what the purpose is, very difficult. It's a lot of stuff.

You know? And so getting our staff buy-in and our physicians buying in, they automatically have this assumption because of all the regulations that are out there, that it's just one more regulation. It's "Obama Care, and he's making us do all of this crap and there's really no purpose in it." And at this point I haven't been able to show them any numbers. I mean financially wise, is this making a difference? Is it reducing health care costs? Because in their mind all it's doing is shifting the cost onto the clinic and the hospital. You know what I mean?

The one thing is, the care team, the physician and their two nurses, and

their PSCs, they really take ownership of those patients. And so now we've got this new person coming in, and while I see it as trying to help them manage these patients, they sometimes see it as her monitoring them on their performance and telling them what they have to do. And so, that's been a challenge, and we're working on that, and [name of care coordinator] has been doing a great job with being tactful of how she approaches them and that kind of stuff, but that can be a challenge. They sometimes interpret it as, why, because she's not right there within the care team all the time, so that it's hard for them to get the feel that she is working with them

2. Financial

And so I guess it's that financial shift where we're still, it's still, (encounter) rates. And ultimately still sort of a productivity pay system, not just specifically with Iowa Medicaid but with all of our (payor) sources. So it's still focused on the quantity of patients you see, not necessarily all of the work that you're doing to make them as healthy as they can be.

...it's costing us a lot of money, 30 some thousand a year to have a patient portal. It costs us to add, our particular software has a PCMH reporting module, it cost us to buy that. Of course we had to add the health coach position, so there was a cost there. So yeah it's definitely cost us.

Scheduling

Scheduling is key to ensuring patients' access to their health care provider in a timely fashion. Some clinics had not yet addressed the issue of scheduling, while others had completely revamped their scheduling system to allow patients same day or next day access.

1. Not yet addressed scheduling

Um, if they have that same-day appointment available, if their provider has that same-day appointment available, they can of course use that. If they want to sit and wait for that provider as a walk-in, they're welcome to do that as well. We are looking at empanelment, with the thought process of setting up teams. We have a new provider coming on in August, and we were kind of waiting until that provider came on and that future schedules were set, so that those providers were actually working as more of a team and could cover each other's patients so that the patient didn't only have a connection with one provider but we were hoping three providers.

Well, it's going to depend on what their problem is. If the doctors' been seeing them and all the sudden, you know they've been having a history of kidney stones or whatever, and this one all the sudden thinks she has a urinary tract infection, that doctor very well could see them the same day. But if it's just something like, I just haven't been feeling good for a month and a half but I want to get in, they probably won't get in today. But percentage wise? I wouldn't even know what to guess on that…I do know that my senior docs, the three male doctors that I have, if somebody wants to call in for a routine thing and the doctor's not on call, I know it is probably, I

would say five weeks out at least to get in for a routine med refill or physical or whatever.

2.   Currently making changes to scheduling

And we're actually in the process of changing this a little bit, so I'll give you the updated version. But it's basically advanced access scheduling. So patients can call our clinic and receive a same-day appointment or they can schedule up to two more days out. There are some exceptions to that rule so they can schedule further out if we're scheduling a procedure or if a patient has translation needs or transportation or, you know different barriers where they might need some additional time to schedule it a little bit further out. But we schedule, it's basically same-day or following two days.

3.   Walk-in appointments

My clinic's unique because we also have urgent care, so it's essentially walk-in for acute-type visits. There's no schedule for that, patients are pretty well aware of that service that we provide. But scheduling for primary care physicians, we have left pretty loose, here at my clinic anyway. And we try not to limit the amount of time that we have because, of course, access is always an issue and we do provide same-day access as well as our 24-hour triage. We use a system called My Nurse so patients always have access to speak to at least a nurse by phone 24/7 and then that staff also has the ability to schedule next-day. For instance, if it's 2:00 in the morning, that patient calls, and that person triages it and determines if it is something that they should be seen the next day, they have the ability to schedule on our provider schedules for the following day.

4.   Challenges related to scheduling

No, we leave slots open, there's a minimum, from my providers at least, for 15-minute slots per day that we can't, we're not supposed to schedule into those until the next morning, or the day of. So we have that same-day access…Um, oh boy, that's tough. One of my providers is many weeks out for anything but same-day, so I would say, I would like to think that 50 percent of my patients that call are able to get in with their actual primary care physician provider that day.

… so then we decided that we were going to go with everybody 15 minutes, and then every three-quarters of the hour, so like 9:45, 10:45, 11:45, was going to be blocked out. So it's greyed out, staff cannot schedule in that time slot unless that doctor says they can, so if they run behind in those first three appointments they have that 15-minute cushion to get caught up, and then they were hoping to be able to get a lot of their documentation done in that timeframe so that they won't have so much at the end of the day. So they're the ones that would say, well I have two ear infections and I really don't need to block that spot, so you can put in a sore throat there, or whatever. But that also helps with medical home to have blocks available or time available every day by each doctor, so patients don't have to wait so long. I

don't remember what they call that, but availability or whatever. And we're not real sure that's working or not because the doctors still have been so busy, but then like I pointed out to them last week in their frustration, well think about it, you're taking seven spots out of everybody's schedule because it's blocked and we can't use it. So you're going to be crazy busy. I don't know. I think we have, a PA just started two weeks ago and then we have another doctor coming the 11th of August, so I think that's going to help a lot because we'll have more help here, and then I think the pains will get better because they won't be so crazy.

5. Metrics

We have about 40 percent same-day open access.

It's probably two to three days out. But I haven't measured that lately. We usually do the third next available appointment, that's what we track. And we'll be having another meeting on... let me see here... August 8th and we'll have that information specifically for this current time period-- currently at 68 percent, I believe.

6. System changes

They call directly to their care team, so that PSC knows their patient. They've developed a relationship, so they know, when they call in, if it's John Doe and he's got this problem, this problem, this problem, and if your schedule is completely full, she knows if this is going to be somebody she can go ahead and work in, in between a couple other patients, or no, this guy's going to take a good 30 minutes, we've got to get him in in another slot. If that physician is completely full, or they're going to be on vacation, or there's some issues with that, they utilize the other clinicians in the practice, mid-levels and stuff. So we always, we try to get them in as soon as we can. We do, each physician tries to save a few of what we call same-day slots on their schedules just for that purpose. So if there's calls in that need to be seen that day they can work them in. But we also have, for a backup plan, we also have a provider on office call every morning and every afternoon. And that rotates between all of our providers. So if they can't get in with their PCP, which is the first place we try to get them in with, then if it's considered an urgent-type appointment or something that qualifies. You know if it's a depression or just coming in for med reviews and that kind of stuff, that's not something that has to be done the same day, so we don't work those in in that on-call schedule. But it's more for sore throats than more urgent-type things.

And because of our medical home we were able to revamp our provider schedules so that we have same-day appointments, so we've had a lot of patients able to get care the same day. And I would say anything from acute all the way to a physical, chronic follow-up, that type of thing…So we have either their provider or the provider's care team, so the provider is made up of an MD and then there's a mid-level as the care team, and so roughly our patients are seeing their provider care team 93 percent of the time.

7. Details of how it works

If everything is filled up except for those, we call it administration spots, if that's the only thing we have left, I have a large whiteboard, a wipe-off board in the business office, and I have each doctor's name listed and then the time slots down each column. And we have X's through everything. And then the nurse will round or huddle with their doctor or provider in the morning and look at their schedule, and if the doctor says well I can see somebody in these timeslots, they'll come out to the whiteboard and they'll put a circle in it and take the X out, so we know that we can use those if we need to.

8. Time allowed for seeing patients

Most respondents laughed when asked if their providers believed that they had enough time to spend with their Iowa Medicaid Health Home patients. Many reported that the providers do not believe they have enough time to spend with any of their patients. At least one clinic reported that they scheduled Iowa Medicaid Health Home patients differently to ensure that the providers had enough time to spend with them.

Well, I think that they feel like their chronic care visits are just fine. We are working very hard on our physicals. The physicals, you know all those patients are eligible now for a well visit every year. We've done our best to make that easy for the provider with our electronic health records so that by age, each patient, whatever that patient may need, is in a protocol in the electronic health record. I will say that we are struggling just a little bit with that because providers are finding that there's a lot of work that needs to be done during that physical, and we might have to, we're getting feedback from that, maybe having to adjust the time for those physicals. Maybe increase the time for the physicals, maybe, I mean we're just talking, right now we're in the process of getting feedback on that.

We've implemented the huddle as well, with the nurse and the provider in the mornings, and so what the nurses and the provider are doing during that huddle, they're actually looking to see if the patient has had a physical well visit that year, and instead of going through all the preventative stuff that day during the chronic visit, they're asking the patient to schedule that well visit and come back for it so that they can separate that out and focus specifically on their preventative care. When we're doing their preventative care, somebody is actually going through the chart ahead of time and identifying everything that the patient needs as far as their preventative care goes, so it's very easy for the provider, they don't have to dig through the chart to look to see when the last mammogram was, when the last PAP was, all of those things. It is already identified for them. They just have to sit with the patient to see if it's something that they want done or not. Like the PSA is kind of up in the air, things like that.

A physician, he's supposed to see 19 patients a day but he complains about

that all the time. But we hired a float nurse to help with that, care coordinators, and a health educator. He just has to get used to doing what he absolutely needs to do with his license and let everybody else work up to the level of their license. And I just don't think he's gotten there yet. Even after all of the training and talking that we've done.

No I don't. No, I don't think they feel like they do. There's too many needs that a lot of them have that they can't address in a single visit. Behavioral health is definitely one of those needs and we don't have very good places to refer those people. We have recently added behavioral health to our clinic which is going to be helping them, but that was just a change that started this month. And that will help the providers to feel like they will have more time because they will be able to refer them and house for behavioral health. But the patients that are in the program are very ill.

My docs, they take the time that they need. And that's why they get running late and they have to work until 10:00 at night. I don't know if we're a rare breed or what, but they just, they take the time that they need and they want with their patients. And our patients know that there might be a wait in the lobby, because our surveys all show that the wait time is terrible, but they also make the comment that I know once I get in there, I'll get the time that I need. So I think they feel that they have the time that they need with their patients, it's just that documentation on the computer stuff that goes with it.

Care coordination, care management, and case management

During the interview, respondents were asked to discuss which tasks were completed by which staff members related to care coordination, care management, and case management. The clinics were provided with the following definitions and asked if anyone at the clinic was responsible for these tasks, what this person's title was, and the person's levels of training:

- Care coordination is helping patients with scheduling and navigating the health care system by coordinating among multiple providers.

- Care management is helping patients manage their chronic health conditions by, for example, educating them about home care, compliance, and medication adherence.

- Case management is helping patients connect to community resources such as dieticians, wellness programs, public health, housing resources, or other assistance programs.

Clinics reported using these terms and others such as *health coach* to encompass a range of tasks. Some clinics had one person who did all or most of the activities covered by these definitions, while others broke these activities up over a range of people.

There was no clear consensus about which of these activities needed to be done. Some clinics did not have anyone assigned to some of the tasks. It was very common for the clinics to break up these tasks over multiple people. Most of the staff members charged with these tasks were RNs, LPNs or MAs. For many of them, attending to these tasks was their only or main job responsibility, but for a few clinics these tasks were assigned to someone in addition to their more traditional role of nurse or MA.

A few clinics had no formal assignment of these tasks and indicated that everyone did these. *Health coach* was the term most commonly used by the clinics, but each clinic defined this role differently.

Tasks related to care coordination, care management, and case management were operationalized by clinic respondents in the following ways:

- Care coordination (helping patients with scheduling and navigating the health care system by coordinating among multiple providers)

For care coordination all but one clinic had a designated staff member assigned to the tasks in the definition of this role. Many clinics have these tasks divided among multiple people. Most clinics call the person who does the majority of these tasks a *health coach*. One clinic calls the person a case manager.

- Care management (helping patients manage their chronic health conditions by, for example, educating them about home care, compliance, and medication adherence)

The person assigned to these tasks was called a health coach, a care coordinator or a health coach care coordinator. There was one clinic where no one was assigned these tasks.

- Case management (helping patients connect to community resources such as dieticians, wellness programs, public health, housing resources, or other assistance programs).

This role and set of tasks were the least commonly covered among respondents. It was highly likely that no staff member was assigned to these tasks among the clinics.

Not specifically. I think, of course, the care coordinator would do that if needed but our clinical staff, that's not necessarily designated as one person, has those resources to be able to pass off to the patient if needed.

I would say that actually falls with all three positions. A lot of that, and we actually have outreach enrollment staff here on-site. We have social workers here on-site. So I would say that functionality falls in all of the above places.

We do not have someone in clinic; because we are a department of the hospi-

tal, we use the hospital's social worker. So if we have patients that need that kind of help, we just call her, she comes down and works with the patient.

Well the care coordinators are pretty good about that. They know a lot about community resources. We aren't a huge community so it's pretty simple. I used to work at DHS and for a local social service agency, so if anybody has any questions about stuff they can come to me and I usually know who to contact and how to get ahold of stuff.

It's kind of a, we have a homeless outreach worker and we also have social workers who do a lot of that, which is mainly directed by our care coordinators who, in the interim that they deem that these patients may need some extra help with things, then their names, their phone numbers are given to the people who actually coordinate that type of thing. Cabs, bus tickets, that type of thing.

Challenges to being an Iowa Medicaid Health Home

Clinics identified a range of challenges to being an Iowa Medicaid Health Home. Challenges mentioned include: patients, lack of services in county, limited or no access to health records outside of their system, data from Medicaid and the IMPA system for recruitment, educating patients, educating clinic staff.

1. No access to patient data & health records outside the system

So we just don't have access to patient data outside of our organizations. So as patients are receiving care elsewhere, if they're hospitalized, if they go to the ER, some of those things especially when we're talking about ER diversion and trying to treat primary care issues in primary care offices.

2. Recruitment data & recruitment challenges

One of the greatest barriers that we're having problems with is data from Iowa Medicaid. And also being able to get onto the IMPA system. Because the data isn't clean, the addresses aren't clean. It makes it really difficult. Like if you tell me we have 2,000 people in our Medicaid Health Home, and we try to reach out through a mailing, or an address, and granted we know this population is transient, but the data is not clean. The other issue is, we've gotten better with Iowa Medicaid, but if they're sending out a communication and they're mailing it, we've said look, give us copies of what you're giving them, because 9 times out of 10 they don't open the mail, they're not paying attention to it. If they're here within our clinic and they're waiting for us, we can have a care coordinator say, 'hey, did you see this letter today? Do you see how this is impacting your care? And if they say, 'no I've never seen it,' we can give them another one and give them education on it. The population doesn't respond to the typical way of which you communicate. But then on IMPA, what's really hard is again, it seems like it takes a lot to get it authorized, to get people to have access for that system, and that's the system where the care coordinators have to go online

and say, yes this person's a Medicaid Health Home, they're a Level 1, 2, 3, or 4, you know we've been able... And we've really had troubles with that piece of it. It's more the logistics that we've had problems with from the Medicaid side.

But the other barrier that we have, and it's not really anything to do with Medicaid, again is my providers. Our care coordinator will go through the list of the patients, and she'll tell the nurse, now this one can be in the higher lever, or we can enroll him if you will address the obesity and whatever, and so the nurse puts it in the chart and then the doctor doesn't say anything about the obesity. I think that they probably are addressing it, so they don't document, so she has no idea if they were doing it or not. So we lose that opportunity, so again it goes back to we're working with our doctors to be standardized, that if they see this note we really need him to address it, because it's best for the patient. So that's the other barrier that I see with Medicaid Health Home. And just getting everybody on board, educating them. But those are the two that I know that are our biggest ones, is getting NCQA certified and then getting our staff all on board that when she tells them, this person's coming in and they have these diagnoses, you need to address them and getting them to do what she says.

And I think one of the hardest for the staff here is, one of the criteria we have to do is call the patient and ask them to be part of it, where the patient just says, 'well what does that mean, I can't see you anymore, does it change anything?' 'No, no, you know we need your permission, this just means we're going to be your Medical Home, blah, blah, blah.' And I would say probably 80 percent of them say, 'well this is really a stupid phone call.' I mean they do! They're just like, this is really stupid. Well, sorry! And then it's, yeah, it's kind of like, I feel it's a wasted time on our staff's time. If there were letters, you know you've qualified. I think they get a letter afterwards anyway. And then we have them calling back saying, well you told me we're part of you, now they're saying you're a part of, or they just don't get it. Even when you say, this is called, it's through the Iowa Medicaid, so yeah. I would say we spend a large amount of time just in conversing with the patient. I think it does help, and I shouldn't say, and this is only a guess on my part from the few that I've heard, but I think it does make the patient more aware of making sure when they're due for... you know if their Medicaid is going to run out, for making sure they get the papers in. So we're very good at, once we know that that's why denial is, then we make the call and say 'hey, we know blah, blah, blah' and then most of them have said, 'oh my gosh I didn't realize it' and so then they'll get their paperwork in.

3. Education of patients

I think the other thing is just, continuing to explain to patients what a Health Home is…Yeah. And then it's like, 'ooh are you taking my Medicaid benefit away? What does this do for me?'

4. Enrolling clinics in program

I just recently enrolled seven of our clinics and it was a very lengthy process in trying to get it accurate and finalized.

5. Educating clinic staff

Um, I guess education of clinics has been challenging for me on what exactly it is, this program is in comparison to our newly established ECO contract and the Iowa Health and Wellness, everything from IME seems to be blending a little bit so that's been quite confusing.

6. Patients

[Patients] don't always follow through; they don't always take the best care of themselves so they are a difficult group of patients, a challenging group of patients to work with. But we also feel like there is a huge amount of, when they are successful, we're very proud of that.

Financial barriers for the patient being able to get to specialty physicians. If it's not somebody who comes here to our local hospital, sometimes transportation to specialists and things like that are difficult for them.

Reaching the African American population has been very difficult for us. We could use some guidance on best practice in reaching African Americans and helping reduce their own barriers to care.

Patient compliance. Sometimes they, well that's where my health coaching comes in, but they have to find out that they have to do it. We can't tell them at the provider's office, well you have to quit smoking. They have to determine that. And that's part of my health coach training is to help them through that. But they have to be, they have to want it and want to be compliant as well, we can't do everything for them.

What percentage of your patients' hemoglobin A1Cs are below whatever, and what, all of these. And they set these standards of the hypertension patients, how many of their blood pressures are below 140/80, or 140/90? Like when they had the Wellmark CoQ program, that was one of my frustrations is because you have a patient that maybe has 142/78 blood pressure, and we automatically don't get anything for that because they don't count because they're not under what their threshold was. But they don't realize the patient started at 190/110. And so I wish they could measure, and this is way more difficult to measure, but measure more on the patient, where did they start, where did they end up, versus they've got to be under this number. Well, if they have multiple comorbidities, it may not be feasible for that patient to ever be under that. That's just an example. I wish they would do more incentivizing based on talking the patients into getting their mammograms and actually running certain tests, that kind of thing. I like that idea of, based on education, not weighing on the [unintelligible] use, did you educate this patient, and marking that kind of thing. I think that that's important but somehow you've got to have a way to measure that.

But there's just some [unintelligible] out there. You can educate until you're blue in the face and they aren't going to change. You know? And it's sad, we would love to be able to have control over that. But I don't think that that should reflect on the physician. Those types of patients should not be reflected on the physician. You know what I'm saying?

And also diabetic education. Pre-diabetic education, that's something too that needs to be thought about. Because, for example, Medicare as you know, they offer refresher training to their diabetics every year, where Medicaid does not. So that would be something. And also educating these pre-diabetic people, giving them some sort of money or incentive to complete so that they know what they're doing.

7. Lack of services in county

I think one of the biggest barriers that we have are community services available for our Health Home patients.

8. Internal data

I would say that some of that reporting and data challenges actually falls internally. Our reporting capabilities within our electronic health records are just not as robust as they need to be. So we really need a population management tool that helps us as, an organization, identify gaps in care. It's impossible for us to go through and do chart reviews for all of our patients. So I would say both internal and external data.

9. Cost

Well, it's going to cost us a lot of money to add all of this staff that we've added in the past year and a half, and are continuing to add. We're a small organization and we don't have very many supervisory or management people to actually move this stuff forward. So it's been a struggle but we've managed to get there and keep working on it as we can, bringing on all of the people that we need.

A big barrier is financial, being able to hire the positions that we feel that we need to support it, to support everything that needs to be done for each patient at the level it should be done. And that is definitely something that's held us back from being able to just jump in and do it. We've had to move our processes slower. I don't know, that could be one of the biggest barriers. Because I feel like if we had the finances to hire the staff we needed, we'd be further ahead.

10. Incentives

One thing, and I honestly, we have not gotten into the incentive part of the Health Home thing. …Because I would like to submit our incentive measures. And so I don't know exactly what all of those are. But some of the other insurance companies where we have incentive measures, that's the one thing that is difficult is, they want to measure.

11. Becoming a medical home

The big barrier for us is to become NCQA, which we're working on that. And I think, well once we get that certification I think that a lot of that work is done, but I know we didn't get it done within the year that we were supposed to, and I know we're working on it.

12. Integrated Health Home

I think one of the barriers currently that just started cropping up is that, the overlay between now it's the Integrated Health Home with behavior health, and the IME Health Home…I'm not going to say it's competition, but it's that they need the monies to keep their doors open as far as behavioral health and…we're still pretty much in charge of all their medical care, so it makes it a little difficult as far as the coordination and who does what and that makes it difficult. As far as just the…IME, and we call it the 2703 program, I don't think that's as cumbersome now that we've gotten over that everything now is done through the IMPA, the portal, the billing, all of that, now that we kind of worked out the kinks it's much easier. I know for a time we were having trouble working our denials. But I totally think we've gotten much better at that, knowing what we were doing wrong on our end or what IME could help us with. And I have to say IME was awesome at helping us through those issues.

Positive aspects and success

Successes related to health home implementation were evident at the clinic, provider and patient levels. Clinic staff reported that some changes had affected the efficiency and effectiveness of their organizational practices and delivery of services. Providers remarked on benefits related to ease of patient care and management, namely increased tracking mechanisms for health measures such as blood pressures or Hgb A1C levels for diabetic patients. Patient feedback indicated that patients notice and perceive benefits to many of these changes in their care as well.

Like I said, we've lowered our cost. We actually have, I think sometimes patients even look forward to that high touch of a provider and a care coordinator helping them navigate a health care system like Medicaid. [Unintelligible] so then that they can go to a financial counselor and they can maneuver through all the signing up, enrollment, paper work and oh by the way I can talk to a care coordinator and they're going to help me figure out how to work around schedules and access issues and there's somebody there to help. And I think that that, I think those are very positive things for us.

Boy… Well one of our physicians, just recently with the implementation of the huddle, and kind of giving them an idea of what the huddle is intended for as far as making sure nothing's falling through the cracks for our patients, we have one physician here whose care did allow for patients to fall through the cracks prior to this implementation, and it's like 180 degrees difference. This provider has really made a huge change in the care

that she's providing to those patients, making sure that nothing is falling through the cracks as far as preventative or chronic care. That's been one success story for one of our providers. It has been very, very good. As far as patients, yes. I mean we have had patients that now, like in health coach for instance, and they have their results, or the impact that has had on their health has been good. Yeah, so we have a patient now who I'm health coaching who was falling through the cracks, she couldn't afford her insulin, she's a diabetic patient, couldn't afford insulin, didn't have anywhere to go, she stopped coming to the clinic. She stopped refilling her medicine, she was starting to fall through the cracks, we caught up with her as far as the health coaching and now she is doing wonderful.

1.   Patient successes

We hear patients' stories all the time, about basically patients learning to understand their conditions and what it means to have that condition and how they can cope with it and things of that nature. So absolutely, there are definitely patient success stories out there as a result of the model and being able to place emphasis in the right areas.

I really like how IME holds the monthly calls. I really like, when we're having issues we call, it's been awesome, them helping us through it. They've been so helpful. I think it's a benefit to the patient. I personally feel they don't fall through the cracks as much now, Medical Homes and the electronic health record, I just can't wait until we can all talk to each other through the computer. But I'm sure that's a ways coming down. But I just think it's beneficial, not only to the patient but for an organization.

I think one of the successes is, with the case management and having people really keeping track, making sure we do the touches we call them, which is our calls, and a patient was able to literally for the first time in a long time, their hemoglobin A1C has dropped, their blood sugars are much in control, they're losing weight, and just the experience of somebody which the patient said, that seems to care about me. And to me that's what a Health Home is all about.

Well, positive is, well we're working towards a healthier population by doing all this. I print out lists of people who haven't been seen and I give them to the care team, and we work them in. So hopefully the end result is that we have a healthier population. That's what we're working for. I know it's not going to happen overnight but, hopefully. That's my goal.

We did get some good feedback from the patients because I think the whole health care in general is so confusing, even to us that work in it. I feel bad for the patients out there that are trying to manage on their own, and I think they like the fact that she's calling them and reminding them, you know that you didn't have this bloodwork done, doctor wants you to see this doctor or specialist, so if you need help getting a ride there or whatever, let us know. I think they feel, the patients like that, knowing that they're not just, because a lot of them if they don't know the answer or how to do something, they just ignore it. And this way they know there's a resource, they

can pick up the phone and call and say, I know I'm supposed to go to the doctor but I don't have a ride, or I don't know if I need to take stuff with me, or should I take my pills with me, or you know. We've had a couple patients that had told us that they enjoyed that.

2.   Clinic successes

I think feeling that we are taking care of people better. I think everybody feels that, at the front desk, nursing, and the providers. You know we still feel like we have a long ways to go, but we're making some changes and some good changes in the patients' lives.

I think it's provided us financial resources to have our case managers onsite. I think it's helped us as far as, I feel better being able to develop better reports within our EMR. To learn our EMR better. I feel it's also given us the outlet of the IME staff to know that they're also very helpful and they want us to succeed too.

I think definitely one positive is the ability to attest to the fact that services have been provided for the patients in lieu of submission of a separate charge.

Cost effectiveness

All of the clinics indicated that this program is too new and recently implemented to determine whether or not it is going to be cost effective for clinics.

This is an evolving thing. I mean, I think that as you look at how health reform is rolling out, how things are changing, I think that if you can be flexible for those changes and you can look at efficiencies and you can be creative. You know, eventually at one point, in the long range, and I don't know how long that is.

With the amount of, well again the quality of care we are providing completely overrides everything else, and so that's been a positive. But is it cost-effective as far as our financials go? No. Again, it takes a significant amount of, because of being part of the Health Home you also have to be a patient-centered medical home. It's going to require significant amount of staff to be able to accomplish all those goals. And the only, and because the Health Home is the only person out there right now reimbursing for people doing that work, the amount that we receive for being a patient-centered medical home doesn't come close to the expense that we pay out in order to be able to meet those standards.

[W]e're a private clinic, we don't have hospital resources to tap into. So I mean, is it cost effective? At this point? No. I feel like down the road, once other insurance companies see the benefit of it and get on board and are willing to pay for quality care, hopefully that's sooner rather than later, and I'm hoping that it's a positive and that we'll be well on our way when that happens.

You know, the jury's still out on that I think… But if we could get better information on patients that routinely utilize the emergency department, then we could focus more on those patients. And making sure they understand that we're here and they can get ahold of somebody after hours, just all of that stuff.

Well, right now we've used cost-based reimbursement which, you know is pretty adequate I would say. But when we go to these different risk-based payment mechanisms, it remains to be seen. I mean, the whole world is going to change.

I don't know if I can answer that for sure, but because, I'm going to say just because of the positions that we have put into place, I'm not sure that we are financially compensated for it, for all the extra work in having to have those positions. And I don't mean that in a bad way at all because they're positions that we would want to help take care of people even if it weren't for the program. But financially we aren't compensated for the time and the extra staff.

Oh boy... I would say the further we get into it, as far as working out the "kinks", it's much more cost effective. I think in the front end it was pretty time-consuming, all of that, but I think the more we get into it. And I think it's not only cost effective maybe for the clinic, but also for the patient. To get their blood sugars under control, maybe not have to take as much medications. And able to hit our quality measures

I don't mean to avoid the question, but I think it might be a little too early to answer that definitively. But we've just been on just a few months.

I'm not sure it's going to be cost effective to do this. I think it's the right thing to do, I think it's best for the patient. I think it will be good for us on the clinic side, because if we can keep them out of the hospital, more patients are going to come in here. Hmm...I don't know.

Communication with other providers and services

Communication with other providers and services largely depends on whether the other providers and services in question are in the same network as the clinic or not. Clinics have worked to use the tools available to them like the electronic medical health record to communicate more efficiently within networks. Clinics shared many positive experiences related to this mode of communication.

We do have the communication that a lot of the specialty clinics know that they're expected to communicate back to us because of the program itself. We always have expected that anyway, where if we refer, we want the communication back and their notes back so we know what's going on with the patient. We still have to do follow-up though sometimes to make sure we get those notes back. But there's definitely an awareness that they have. Just what the program is, and what it means and what's expected from Iowa Medicaid. However, that communication, or that knowledge to the

specialty clinics I know was something I know a lot that we had to do, they would call us and say, it says the patient's on Iowa Medicaid Health Home program and they're assigned to you and they had no idea what that meant. So we've had to do a lot of education with the other providers, for them to know what it meant and what it is and what it means.

We have specialists, cardiologist, pulmonologist and stuff that do, either weekly or monthly, visits to our hospital and have satellite clinics. So we are able to send to them. When we make a referral to any of them if they come to Floyd Valley Hospital we make referrals and we've set up a system with our hospital where they can see those orders, you know I told you we'd set those up? They have access to our orders tracking, they only see the orders for those, and they have access to that patient's chart and everything right there. So we have good communication with them. When they dictate that is interfaced with our system so that documentation all comes over auto-matically.

Communication with providers or services outside of the clinic's network without electronic file sharing is very difficult. Some clinics reported trying to work on this in particular with mixed success.

Well, when we first send them, we call them and get an appointment, and then we do the paperwork, the paper trail, we send them all the records. Right now we don't have a good way of tracking whether or not we even hear back from those specialists, but we've got this new software for our computer and it's supposed to be able to track that so that we can make sure that we hear back from the specialist. Because that is a frustration for our doctors, the patient will come in and say, 'well yeah I saw a cardiologist two weeks ago.' And we don't have it. Otherwise we get a letter back and then we scan it into the chart, which is helpful because the doctor can just open it up and read it. But we don't really keep track of if, we hear back from other, we don't keep track that we always hear from everybody.

Patients that are referred to specialists outside of that arena…it's about a 50/50 deal if we get a report back. And we have on our referral form, we specifically say we would like to have information back within three weeks of the patient's visit with you. We would like, would you please send us a response. But sometimes they do, and a lot of times they don't.

And this is a problem because when we do those outside referrals and we don't get the reports back, so then I call the provider that we referred the patient to, and they haven't even dictated the report that was a month ago. How do they even remember what they told, what they talked to the patient about? Well then why am I paying a high-paid nurse, why do I have to pay anybody to call these people and babysit them to get these reports back? That's not cost effective.

Eligibility identification and enrollment process

Clinics described different methods for identification of eligible

patients and enrollment processes. Some clinics actively reviewed their existing patient population and contacted patients to see if they were eligible and interested in health home enrollment. Other clinics reported using the lists the obtained from IME. Some clinics approached patients when they arrived at the clinic for appointments. One institution was only enrolling dual eligible people.

Because the whole goal on this Medicaid Health Home was to get people enrolled in it, it was to just start enrolling people in the Medicaid Health Home. We did a huge strategic initiative in terms of registration, you know you walk in the door and you're Medicaid, hey have you considered being part of the Medicaid Health Home? You go with the financial counselors, and if you're uninsured, we'll get you in Medicaid. Same kind of scripting going on, the clinics were doing scripting. And so we had almost like a command control center with care coordinators and their whole goal was to enroll patients.

We use the tool. Ok so what we do is, we initially get a list from Iowa Medicaid of patients who would be eligible to be in the program. We actually took, there's two people right now who take a look at those patients. One nurse looks through, reviews the patient's chart to see if they would be eligible. They have eligibility requirements to be in the Health Home. From there they also look to see the severity of that chronic condition to see if they still would be eligible to be in the Health Home. After that then I, as the care coordinator, contact that patient to see if they would be willing to be a part of our Health Home.

We also have our billing department for a new Medicaid patient. They let me know if there's a new adult Medicaid patient that could be eligible for the Health Home as well…It's been effective, just slow. It's not immediate where, just because of time and the amount of work that I have to do, it's a little bit slower to get all those patients contacted.

We actually run reports on a monthly basis to see, number one at what tier they're at. And we've kind of set up our own internal, if they're a Tier 4 then we definitely want to make touches, make sure on a monthly basis check their chart, make sure they've been filling their medications, seeing how close they are, seeing when their next appointment is, seeing when their last visit was, if they're having any issues to make a call. So we kind of do those kind of reports just to make sure that we are keeping in touch with them.

Typically our enrollment happens one of two ways. I scrub our schedules every day as part of the care coordination aspect, and I will identify patients that way. And I will speak to them in clinic to kind of explain the process. I usually show them the Iowa Health Home brochure. And then we go through the process of them making the decision to enroll or not to enroll, which all of ours have enrolled. The other way we would typically get patients is our providers will quite often send me referrals if they, they know their Medicaid patients quite well, and they'll send me a referral say-

ing ok I think this patient would benefit. And then the same type of process is followed. Most often it's done face-to-face here in the clinic so that any questions can be answered, and so then I can ensure they have a good understanding of what the program is.

Challenges to enrollment were evident. Some clinics reported difficulty with the online system for enrollment. Some clinics reported that once the program is explained to patients, they are very happy to participate-- but explaining the program is difficult and requires a lot effort from staff members. Other clinics reported feeling like 'used car salesmen' because they had to work hard to 'sell' the program to their patients. One clinic mentioned that some patients confused this program with the Magellan Integrated Health Home initiative, for which enrollment materials went out about the same time as those for the IME medical home program.

More patient education I think, because when I called these patients to enroll them, I feel like a car salesman. [Laughing] Yes. I really, that's completely honest. I had to convince them to be part of Medicaid Health Home. Because…they seemed to have no idea what it is.

The other thing we are running into…is now an IHH, an Integrated Health Home, and we are actually meeting with them August 5 to try to coordinate our efforts a little bit better and stuff. Patients are getting phone calls from us to become a part of our Health Home, and then they're getting phone calls from them to become part of their IHH and they're confused. They have no idea what the difference is. Because they're both called health homes. So…it is confusing for the patients to have the two different options.

Not many clinics have yet experienced people becoming ineligible and having to reenroll them.

The re-enrollment process is pretty simple. In IMPA they keep the diagnosis closed in there, and so basically I can just go back in and re-enroll them.

Identifying and communicating about patient needs

There are a number of methods clinics use to identify patients' needs in advance of an appointment–such as a pre-visit review or scrubbing the schedule.

1. Using the electronic health record

Clinics use their electronic health record systems to set up reminders for tests that are needed.

Well, here in Sheldon I put a note in the appointment notes [on the computer] *quite often, so when the physician opens the chart they can see in the appointment notes if something needs to be done. I do a lot of face-to-face communication, if it's something that really needs to be done right*

away, I will go and talk to the physician just as an additional reminder to get tests completed.

Within our electronic health system, we have one place, I know the RN patient care manager has a tracking system that she can run reports off of. Or look into that, she doesn't have to print reports, we can just create them and look on the computer. And then we also have a tasking system within the electronic health system that they can just send tasks to themselves when something's due to follow up on.

2. Communication about patients within clinic

Some clinics have providers and other staff co-located to ensure coordinated care, while others rely on huddles or meetings or their electronic health record systems.

I would say several different ways. We actually, if [name of staff member] is seeing them as a health coach, she actually will either verbally visit with them, that's the physician, or send them a message in the computer if we need to make the physician aware of something when the patient is coming in, or the nurse will put a message on the, we have the ability to put the message on the chart. Yeah, those are probably the main ways.

Usually it's through the electronic health, well it's definitely through the electronic health record. But if there was something urgent, probably the nurse would go to the provider and discuss it also, or at least make them verbally aware. But mostly just through the system. Through telephone calls or the tasking.

They have huddles twice a day to review the patients that are coming into the clinic and anything else that needs to be covered. So that's the point where there's been some chart prep done, they've identified gaps in care, things of that nature. Talk through complex patients, patients that are not meeting treatment goals. So that's where the RNs then focus their patient education time, things like that.

The nurses huddle first thing in the morning, and then if there's anything that the business office needs to know then they will let us know, usually by a mass email to the business office so everybody gets the information. And then when the doctor comes down, the nurse and the doctor huddles and again one nurse will come and let the business office people know. If the wheels fall off the bus, like we say, if the doctor has to get called to the hospital or whatever, and patients are here and nobody's here to see them then we communicate by email or they'll come out and talk to each of us at our desk just so that we all know what's going on. Other than that, I mean that's what daily we do. We also do, basically we do staff meeting monthly or more often the nurses do usually weekly nurse meetings to talk about different changes and that type of thing.

They all work right together in the same pod, so the physician comes out, he tells the nurse where he's referring them to, what labs to order, she's got

everything right there. And within our software, we have a tasking functionality, so he gets a result, he wants her to call the patient back, he sends her the task, she calls the patient back, and that's all documented within their chart and stuff. And then [name of care coordinator] sends them, I don't know if you do, I think it's monthly reports on maybe the diabetic list of patients that haven't been seen that need to get in, and she'll share that with the PSC and she'll call those patients and try and work them in. Or she'll go over it with her physician and nurses and say ok, now what about this. [T]hey just have constant, real-time communication.

That's kind of, we're working on a pre-visit worksheet, actually in the last week or two, that we're putting together so that's more involved than what we're doing right now. But I anticipate once we get a health coach and stuff on board I think we can do a better job of that.

Community resources and services not available in clinics

Clinics reported a range of systems and sophistication when explaining how their clinic is able to connect people with complex needs to services outside of the clinic. These systems include a network online-accessible database, staff with particular knowledge about services, co-locating with organizations that offer a range of services or having brochures about services available in the area.

For the past year or so, we have actually been meeting with a lot of [name of county] County Public Health office and set up meetings for providers of services in our community. So we're trying to coordinate those services a little bit better. Even just very recently, last week they actually provided a pamphlet of community services in [name of county] that included housing, food pantries, a lot of things like, any services that are available in [name of county]. So we're getting there. As a county we're kind of stepping up what services we provide. So we've been a part of those meetings with the county as well.

I would say this is an area that is a bit of a struggle for us. But it seems like there are more and more resources available. We just found out about a program that is specifically for pediatric patients that is facilitating, the focal is basically a network. And so they can get enrolled in this program and can help families identify what resources are in the community that they're not currently utilizing, things of that nature. So I guess I would say this is ever-evolving. It seems like there are more and more resources coming for this, but it's still a challenge. The need hasn't been completely met or solved.

We can provide [patients] with the phone numbers or the contact information. But we also can help them if they're here at the clinic, make that contact while they're here, especially if phone or transportation are issues for the patient.

We actually have a three-ring binder with it because we also have a homeless outreach worker that takes care of the homeless population in our

community and outlying areas, so he keeps that updated for us so we know food, shelter, where they can get clothing, that type of thing.

Each one of our sites has a community resource book, and we have contacts in the community so then if we identify a need that the patient has, then we will get them in touch with the resource that they need.

Determining patient satisfaction

Most clinics use the Press Ganey patient satisfaction instrument to determine patient satisfaction and receive input from patients. Reports from these surveys are shared on a regular basis formally across the clinic and with particular providers.

We do patient satisfaction surveys and I will tell you we are actually going to be changing that process because it's just gotten way too expensive. We are spending almost $40,000 a year doing patient satisfaction surveys. And the hospital just can't afford it. With all of this trying to reduce hospitalizations and all that stuff, well that money's coming out of somebody's pocket and it happens to be the hospital's and pays our physicians. It pays all of our salaries. So we are going to discontinue that and we are looking at other avenues of doing our own type of surveys, or maybe not doing them quite as often, maybe doing them quarterly rather than, you know we send a list every week right now to Press Ganey. And I get those results back monthly.

Quality improvement

The quality improvement activities in many clinics were numerous, and in some clinics all or some of the activities were determined at a systems level, not by the individual clinic. Often the staff member in charge of quality improvement for the clinic was the respondent for the interview.

Each of our clinics has a PI that's covered. In those the PI plan includes optimal diabetes, optimal [unintelligible] care, hypertension and [unintelligible], that cost effectiveness measure which is the reduction of ED visits.

We're monitoring how quickly the nurses are returning phone calls, because that was a main concern the business office had when we were first talking about QI, business office people were sending nurses messages and then the patient didn't hear anything so then they were calling back, so the business office was taking two and three phone calls from the same person so they were frustrated. So we set up QI indicators for that for returning of phone calls within two hours. And then we just tell them that even if you don't have an answer for the patient, call the patient and tell them that yes I got your message, I'm working on it, I need to talk to the doctor. We're working on that. [pause] Oh gosh..., maybe I can find my book. We set up a prescription line is another thing that we were getting a lot of, patients were calling in for prescription renewals and, if it was done, patient wasn't told so that was one of our indicators, that again they need to call the patient and let them know that it is done. They're sitting there for a day or two waiting,

they haven't heard anything while the prescription's been at the pharmacy and nobody's told the patient. So that's one of our indicators.

Well we use the hospital's QI person, she actually puts together the final reports every quarter and reports them out. Oh and then making sure that the patients are seen within five calendar days from discharge of the hospital. And then we're doing auditing of two charts for each provider month to make sure that the correct code is being billed out, so we're checking that. Making sure the clinical summaries are given to the patients within three business days. And then the medication and the phone calls. So those are five indicators that we started out with.

Trickle-down effect

The vast majority of clinics indicated that the changes they have implemented for the Iowa Medicaid Health Home are universal and that all patients benefit from them. Many stated their basic philosophy was that if the practice was beneficial for one group they would implement that practice with all their patients; they did not wish to treat their patients differently depending on their insurance status.

If we do something, we roll it out to our entire patient population. I would have to say we probably case manage maybe certain chronic diseases more so than other ones, but I would say it's for everybody, it isn't just because you have Medicaid or because you have no insurance…

Although it's a Medicaid-based program, that doesn't mean that we don't still provide that same care and attention to any patient that would need it.

Discussion

Key findings

- The transition to becoming an Iowa Medicaid Health Home was less challenging for those clinics that already met criteria for being a patient-centered medical home (PCMH) or were currently working to achieve PCMH recognition. Clinics that had not implemented changes related to PCMH status before signing on as an Iowa Medicaid Health Home generally faced greater turbulence related to the process of becoming a health home.

- Cost—financial or otherwise-- is a universal issue across clinics. Given that many clinics have made wide-spread changes to their existing organizational structure and practices, many of these changes were and continue to be disruptive to staff, are costly and cause frustration.

- Clinic staff for the most part are excited about the changes, and remain optimistic that these changes will benefit their patient populations. Respondents agreed that greater

coordination and use of patient data is one positive component of the program.

- Clinics sampled for this study represent a range along the continuum of advancement toward health home implementation. Some clinics have complex systems developed; other clinics are further behind and will need more help and support moving forward.

- Many clinics are interested in reducing ED visits and hospital readmissions. Some already have systems in place to address this; others are just starting to think about these issues. This finding may help to explain why there has been little to no evidence of reduction in these rates in the claims-based and patient experience evaluations of these two outcomes (reduction in ED visits and hospital readmissions),

- With regard to scheduling practices, challenges, and successes, every clinic is unique. Many clinics have already developed and implemented practices to address changes to scheduling needs, but some have not yet begun this process.

- Not all clinics have a designated staff person to address tasks related to care coordination, care management and case management. Additionally, there is some confusion over what each of these roles actually entails.

- Some clinics struggle against a lack of access to data outside of their provider network and/or electronic patient database. A lack of access to this information presents an obstacle to patient care and practice management, as clinics are unable to fill in the gaps left when patients obtain treatment at the hospital or with specialty providers.

- Recruitment of patients into the health home is a challenging component of implementation. Many patients do not understand the concept of or rationalization for health home enrollment, and provider/clinical staff understanding of the health home model--and therefore their capacity to explain the new system to patients—varies by degree of knowledge. In addition, lists of eligible patients are incorrect or not sufficiently inclusive; this creates additional work for clinic staff in the form of calling patients or taking time during a patient's visit to explain.

- Clinics continue to struggle with this patient population, many of whom face significant socioeconomic barriers to health and wellness. These larger barriers present challenges to clinics in the forms of recruitment, enrollment, and consistent communication with patients.

- Many clinics reported that Iowa Medicaid Health Home implementation has or will have an effect beyond that on the target population. Clinics perceive that incorporating these

changes into their organization will have benefits for their entire patient base, not only those enrolled in Medicaid.

- Successes related to health home implementation were evident at the clinic, provider and patient levels. Clinic staff reported that some changes had affected the efficiency and effectiveness of their organizational practices and delivery of services. Providers remarked on benefits related to ease of patient care and management, namely increased tracking mechanisms for health measures such as blood pressures or Hgb A1C levels for diabetic patients. Patient feedback indicated that patients notice and perceive benefits to many of these changes in their care as well.

Recommendations/implications

Establish a method to sharing Health Home best practices across providers through conferences, mentoring or other hands-on methods, beyond telephone conferencing.

Clinics that had not worked toward or achieved recognition as a PCMH before becoming an Iowa Medicaid Health Home need more support in this transition than they are currently getting. Clinics that have already completed this transition may be a useful source of advice and support for clinics that are further behind in the process.

Provide informed ROI estimates for clinics based on the numbers of members enrolled and the number of staff hired or reassigned to Health Home specific activities.

Given the universal concern about the cost of program implementation, clinics need to understand the opportunity for return on investment presented by the health home model. It is important to give clinics insight into when implementation might pay for itself or at what point in the process it will be less costly to the clinics.

Educate on-site staff with a focus on the long-term benefits for members and health homes, perhaps through video conferencing.

Because these wide-spread changes are a source of frustration and increased workloads, clinics need to be better equipped to handle challenges like staff frustration, overtime, and confusion related to health home implementation. In addition, many clinics are excited about the opportunities presented by the consolidation of patient data, but need more support to learn how to use this data more easily and effectively.

Provide a mentoring program for new health homes that matches them with the local hospital or other entity that has been successful at care coordination

Many clinics need increased support in the area of care coordination and referrals outside of the health home. Some clinics interviewed already have systems in place; clinics with less advanced or efficient systems maybe benefit from advice and strategies from clinics that are farther along in this area. Additionally, clinics that face obstacles related to lack of access to data from outside of the provider network need help working around this barrier to continuity of care.

Provide opportunities for relationship building for clinics outside of larger hospital systems.

Clinics that are not connected to larger hospital systems have a harder time addressing issues related to emergency department visits and hospital readmissions, and need additional help and support. Efforts in this area might involve motivating local hospitals to work with clinics that are connected with a larger health system. The program should find ways to highlight how forming these relationships may be mutually beneficial for clinics and local hospitals and contribute to better quality and efficiency of patient care, such as relationships with Community Care Teams.

Develop and distribute consistent information regarding care coordination, case management and care management through an entity such as the Iowa Chronic Care Consortium.

Issues related to care coordination, case management, care management- because everyone continues to use different terms and define the same term in different ways- any information communicated about these roles/tasks needs to be done very specifically.

Work to create and provide a broad community resource guide that can allow for locality specific additions for communities across the state and connect clinics to the local Community Care Teams.

Although some clinics already have practices and materials in place to connect patients with community resources (e.g., brochures, provider and staff expertise about these resources), more emphasis needs to be placed on fostering clinic familiarity with local/community resources and how to connect patients with them. For example, some clinics maintain a list or directory of available community and local resources that staff can reference as needed. Promoting provider- and clinic-level familiarity with community resources in such a way can assist staff in connecting patients to resources and services not available within the clinic.

Develop more active role for Medicaid in enrollment of members into the health home or provide additional materials to providers attempting to enroll members.

Identification and recruitment of eligible patients into the program is a struggle for many clinics. Clinics need support from Iowa Medicaid in order to generate accurate, complete lists of patients from within their current base who are eligible for enrollment. Additionally, providers and other clinical staff members need to have a clear understanding of what an Iowa Medicaid Health Home is and what it means for patients in order to articulate this information to their patients.

Expand the number of IME health home staff who are visiting and advising providers on the implementation of health home activities.

It is imperative to get providers and staff at clinics on board with health home implementation. Providers and staff need further education about what a health home is, what changes are necessitated in order to become a health home, and what the changes mean for patients. Provider understanding may have a trickle-down effect into patient enrollment, as providers who are able to clearly address patient questions about the health home may be more effective in enrolling these patients.

Provide additional funding based on performance measures that are easily understood and take into account the improvement in the individual members would be very helpful to the health homes.

As with any clinic serving a large percentage of low-income patients, Iowa Medicaid Health Home clinics need support in order to best serve this population.