

IOWA SIM

State Innovation Model of Iowa

State Innovation Model (SIM): Baseline Process/Implementation Report

Overview of SIM Activities from February 1, 2015 through September 30, 2016

Suzanne Bentler
Assistant Research Scientist, UI Public Policy Center

Tessa Heeren
Research Assistant, UI Public Policy Center

Rochelle Schultz Spinarski
Principal Consultant, Rural Health Solutions

Elizabeth Momany
Assistant Director Health Policy Research Program and Associate Research Scientist,
UI Public Policy Center

Peter Damiano
Director, UI Public Policy Center

Contents

Executive Summary	3
Introduction	7
Iowa’s State Innovation Model (SIM)	7
Report Focus	9
Methods	9
Foundation of the Iowa SIM	11
Governance	11
Key Stakeholders	11
Stakeholder Engagement	12
Process Evaluation of Implementation Activities	14
Population Health Improvement (PHI)	14
Community Care Coalitions (C3s)	16
Statewide Alert Notification System (SWAN)	22
Value based Purchasing (VBP)	28
Evaluation Next Steps	31
Appendices	32
Appendix A. SIM Metrics Reported to CMMI (Pre-Implementation Year 2015)	32
Appendix B. Stakeholder Engagement Addendum	36
Appendix C. Summaries of the C3 community initiatives	38
Appendix D. Details from Baseline Interviews with C3 Communities	44
Appendix E. Detailed Timeline of TA Activities	51

Executive Summary

This baseline report covers the process and implementation activities of the State Innovation Model (SIM) test grant in Iowa from pre-implementation (2015) through the first three quarters of the first implementation year (2016). The objective of the process and implementation evaluation is to describe the structure of the interventions and actions being utilized in the SIM initiative, along with identifying advances and challenges encountered during implementation.

A variety of methods were used to gather the information provided in this report. The University of Iowa Public Policy Center (PPC) team reviewed documents and collected information from pertinent websites, participated in bi-weekly phone conferences with the state SIM team and the Center for Medicare and Medicaid Innovation (CMMI), participated in monthly phone conferences with the state SIM team and the national evaluators, and conducted stakeholder interviews to understand how the SIM initiative was being implemented during this time period.

SIM year 1 (2015) and year 2 (2016) were development and building years for the SIM initiative in Iowa. A significant amount of time was spent working to facilitate collaborations with the multitudes of stakeholders integral to the successful implementation of the SIM activities. Implementation progress, challenges, and future considerations for all of the five main SIM activities underlying the SIM primary drivers are noted below.

Plan for Population Health Improvement (PHI)

Progress

- Developed and published seven statewide strategy plans to help guide population health initiatives and for use in SIM Technical Assistance (TA) educational and training activities.

Challenges

- Up to this point, efforts to disseminate the Statewide Strategy Plans have been passive and have included posting them to a website and including them in some TA activities. Year 1 was a development year for the Statewide Strategy Plans and, as such, C3 communities were not required to use or follow them. The use of the plans will need to be more actively encouraged among the SIM stakeholders if they are to have an effect on SIM goals regarding PHI.

Future considerations

- Given the potential changes in the design and focus of the Community Care Coalition (C3) initiative, it will be essential to continue to promote the importance of population health and social determinants of health as integral factors to be included within delivery system transformation and payment reform efforts if they are to meet the SIM goals regarding PHI.

Community Care Coalitions (C3s)

Progress

- Selected and funded three developmental and three implementation C3s across the state to promote care coordination across the healthcare delivery spectrum (medical, public health, and social service sectors) focused on supporting the SIM population health improvement areas of diabetes, obesity, and tobacco cessation.
- C3s have had individual successes building the local partnerships and coalitions necessary to carry out their SIM-specific as well as locally relevant population health and care coordination goals.
- All C3s have participated in SIM events and activities and have joined the SIMplify website.

Challenges

- C3s reported challenges in communicating with the Iowa Healthcare Collaborative (IHC), the Iowa Department of Public Health (IDPH), and other C3s during the first year of activity. Specifically five of the six C3 communities reported communication issues involving SIM staff including lack of responsiveness or follow-through, duplicative reporting requirements, and requests for more input into TA topics and resources.
- C3 communities wanted more opportunities to share best practices with each other during the initial implementation.

Future considerations

- C3 communities have made programmatic and systemic changes including, in some cases, the hiring of additional staff to work toward their objectives and fulfill their responsibilities as SIM grant sub-awardees. Given the impending changes to the C3 initiatives being contemplated for the coming years, the challenge will be to continue to support their progress and maintain the positive connections with the C3 communities while instituting potentially different criteria and goals into their operations.

Statewide Alert Network (SWAN)

Progress

- The SIM team was making progress in increasing the number of hospitals sending Admission, Discharge, and Transfer files (ADTs) to the SWAN Smart Alert Engine before having to cease operations because of a data sharing issue.
- All five of Iowa's Medicaid Accountable Care Organizations (ACOs) went "live" with the SWAN and were able to receive alerts.
- Technical assistance was instituted to identify and disseminate best practices for using the SWAN with at least one ACO (Broadlawn) actively using the SWAN information to enhance their care processes.

Challenges

- The SWAN initiative faced a significant challenge when the data sharing was curtailed. During the summer of 2016, it was brought to the attention of SIM staff that the ACOs maybe receiving alerts for Medicaid patients not attributed to that ACO which may have been a violation of the Health Insurance Portability and Accountability Act (HIPAA). In September 2016, all SWAN activity was halted as the SIM team worked with the State of Iowa Attorney General's office to resolve this serious issue.
- Initially, the Smart Alert system received Medicaid patient files from IME but with the advent of the Managed Care Organizations (MCOs) in April 2016, it became clear that the files from IME may not have the most current attribution. As of this report, the SIM initiative has been actively working with all Medicaid ACOs and MCOs to generate and use their own eligibility files for the SWAN to ensure accurate attribution of patients.
- Mechanisms for using the SWAN alerts vary across the ACOs with little understanding of best practices or the opportunity to share them.
- When the SWAN system is active, the actual individual provider-level utilization of the SWAN is unknown with limited evidence of its integration into care coordination efforts at the system level.

Future considerations

- To sustain this effort beyond Medicaid, the SWAN will need to expand to other provider and health system networks such as those that participate in Wellmark and Medicare ACOs and determine ways for these additional entities to share eligibility files with the Smart Alert Engine.

- The ultimate goal is to have all hospitals sending ADTs to SWAN and the SIM initiative made progress throughout 2016 expanding those numbers. However, after SWAN activity was halted, momentum towards obtaining more hospital agreements was lost and it will be important to continue to promote the SWAN and grow the hospital network.
- Progress was made to get all five Medicaid ACOs to go “live” by receiving alerts from the SWAN. The SIM initiative will need to continue efforts to promote the use of the information they receive and ensure the alerts are useful. In addition, to have broader impact in the state, the SIM initiative should consider expanding these efforts to other health systems and providers.

Community Based Performance Improvement (CBPI)

Progress

- Implemented a multi-pronged, multi-modal technical assistance approach to inform, educate, and train the C3 communities.
- Developed and began to use multiple data-based technologies to help the C3 communities engage in quality improvement activities and performance evaluation.

Challenges

- Based on information from the C3 site visit interviews, the Learning Community events did not meet the needs of the C3s. The focus on broad concepts and state-wide implementation was not helpful, rather more emphasis on best practices and local successes were wanted.
- There were significant delays in the implementation of Rapid Cycle Performance Improvement (RCPI) activities.

Future considerations

- Gathering feedback from recipients of the TA to make these efforts more relevant to the individual C3s and incorporating that feedback into future programming will help to provide the most pertinent and timely assistance to the C3 communities.
- With the potential for significant changes to the design of C3 initiatives, it will be important to provide transparent, timely, and meaningful communication to the C3 partners about the changes to ensure that partnerships are maintained going forward.
- Maintaining progress with accurate data collection and analysis for RCPI and Quality Improvement (QI) activities will need to continue to be a focus.

Value Based Purchasing (VBP)

Progress

- A little less than one-half of Medicaid providers and a little over one-half of Wellmark providers are participating in some form of VBP using the Value Index Score (VIS).
- Have made progress with engaging the Medicaid MCOs in implementing VBP through contact requirements and encouraging the use of VIS.

Challenges

- For Medicaid, there was a shift from considering VBP arrangements with ACOs to the MCOs when Medicaid moved to Medicaid modernization and contracted exclusively with the three MCOs.

Future considerations

- Due to the introduction of state-wide managed care coverage for the Medicaid population

and a directional shift to address the Medicare Access and CHIP Reauthorization Act (MACRA), increasing the proportion of provider and members in VBP contracts, especially those outside of the ACOs, will be challenging during the coming years.

Overarching Implementation Challenges

SIM implementation progress came about during a period of significant change within the healthcare delivery landscape in the state of Iowa and a federal legislative change to payment reform strategies that caused timeline delays and some re-prioritization of objectives. There were two specific challenges to SIM implementation that took place during this reporting period. The first, just two months after Iowa's SIM Test award had been publicized, the State announced the intention to move almost all of the Medicaid population into a privately run managed care delivery system. This massive shift in the administration of Medicaid and the management of its beneficiary population was to occur in less than one year. By January 1, 2016, almost all Medicaid populations were to shift to one of three managed care organizations (MCOs) chosen to manage Medicaid. This change had immediate implications for the SIM initiative and a great deal of time was spent reconciling the SIM plans under this new reality. Ultimately, Medicaid managed care of all populations was delayed until April 1, 2016 which presented additional challenges and alterations to SIM processes and implementation.

The second challenge came somewhat later in Year 1 (2016) in response to changes in federal legislation regarding payment. In 2015, legislation called the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in part, to repeal the Medicare sustainable growth rate (SGR) formula and institute changes to the way physicians are paid by Medicare. These changes to payment methodologies included a merit-based incentive payment system (MIPS) and created direct incentives to participate in Alternative Payment Methodologies (APMs). The MACRA legislation also created the potential for entities to engage in advanced APMs which are high risk/high reward payment methodologies that require Patient Centered Medical Homes (PCMHs). The MACRA legislation removed the SGR and replaced it with value based payment methodologies that link Medicare payments to provider performance. Rules for MACRA implementation were being decided over the summer of 2016 with the final rules scheduled to be published in November 2016. On the surface, this change seemed to be in line with the SIM VBP strategies. However, discussions between CMMI and the SIM leadership led to the decision for the state of Iowa SIM to investigate strategies that more closely align with MACRA, which may lead some Iowa VBP programs to become an advanced APM as defined by MACRA. Thus, during the third quarter of Year 2 (2016), the Iowa SIM team has been working to transform the SIM initiative in Iowa to account for this shift in strategy. To that end, Iowa requested and was granted a no-cost extension of its Year 2 activities to have the time to develop its 2017 operational plan to incorporate these design changes.

Introduction

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

Since its inception, CMMI has awarded three types of SIM grants -- Model Design, Model Pre-Test, and Model Test awards.¹ Design grants were awarded to states/entities to design plans and strategies for how to transform healthcare in their states. Test states received awards to implement their plans for comprehensive statewide healthcare transformation. In 2013, Iowa received a Model Design award and in 2015 received a \$43 million Model Test award to implement and test its State Healthcare Innovation Plan over the course of four years. This interim report focuses on Iowa's Model Test Award and implementation of its SIM initiative during 2015 (pre-implementation year) and 2016 (implementation year 1 – Quarters 1 through 3).

Iowa's State Innovation Model (SIM)

The overall vision of the Iowa SIM Test Award during its first two years was to transform healthcare to improve the health of Iowans. To advance this vision, the SIM team proposed several overarching methods of action; namely, to promote a plan to improve population health, encourage care coordination among providers and across the spectrum of health and social services, enact community-based performance improvement strategies, and encourage the implementation of value based purchasing (VBP) into payer and provider contracts. The SIM team also included specific goals for the project in order to monitor how the actions tied to the overarching themes (primary drivers) would result in a transformed healthcare delivery system, improved population health, and sustainable change. These goals included increasing the tobacco quit attempt rate, decreasing the prevalence of obesity, increasing the rate that diabetics had their HbA1c checked, reducing the rates of preventable hospital admissions and preventable emergency department (ED) visits, and increasing provider and payer participation in VBP. The SIM vision for its first two years (2015 pre-implementation and 2016 implementation year 1) is represented in the following driver diagram.

¹ Centers for Medicare and Medicaid Services. State Innovation Models Initiative: General Information. Accessed November 1, 2016 at <https://innovation.cms.gov/initiatives/state-innovations/>

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



The primary implementation strategies used by the SIM to address the aims of the grant center on five main activities. These include the establishment of strategic plans for population health improvement (PHI), funding community care coalitions (C3s) to promote care coordination at the community level, the deployment of a statewide alert network (SWAN) to promote coordinated care at the level of the healthcare delivery system, promote community-based performance improvement (CBPI) and provide technical assistance (TA) to help communities transform how healthcare is delivered, and institute value based purchasing (VBP) as a method of payment reform. The PPC evaluation focuses on these activities and related goals. To get a sense of the starting point for Iowa with regard to the main goals of tobacco cessation, reducing the prevalence of obesity, improving diabetes management, reducing potentially preventable hospital readmissions and ED visits, and increasing participation in VBP, it is important to understand the baseline data for each metric. Based on data from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) survey², around 18% of adults in Iowa reported being a current smoker, 9% had ever been told by a physician that they had diabetes, and around 32% were obese, based on body mass index (BMI). According to metrics reported by the SIM team to CMMI, there were around 6% of potentially preventable hospital readmissions and 71% of potentially preventable ED visits in the Medicaid population. And, around 45% of Medicaid providers and 53% of Wellmark providers were participating in a VBP model in 2015. This equates to approximately 30% of Medicaid payments and 32% of Wellmark payments linked to some type of quality metric that would count as VBP.

Complete baseline data on the SIM outcomes reported to CMMI are presented in a table in [Appendix A](#). The PPC evaluation will track these outcomes over the course of the evaluation period to monitor SIM initiative progress.

2 Iowa Department of Public Health. Behavioral Risk Factor Surveillance System 2015 Annual Report. Accessed November 1, 2016 at <http://idph.iowa.gov/brfss> and <http://idph.iowa.gov/Portals/1/Files/BRFSS/2015%20Annual%20BRFSS%20Report.pdf>

Report Focus

This baseline report covers the process and implementation activities of the SIM initiative test grant in Iowa from pre-implementation (2015) through the first three quarters of the first implementation year (2016). The objective of the process and implementation evaluation is to describe the structure of the interventions/actions being utilized in the SIM initiative and the characteristics of the communities and settings which are impacted by the SIM. The key questions addressed in this report include:

- 1) *How are the SIM interventions being implemented around the state of Iowa? To what extent are each of the SIM interventions being implemented consistently and what is the level of diffusion?*
- 2) *What non-SIM factors or statewide programs are in place that could also impact the SIM-specific goals?*

Additional process evaluation questions and the core outcomes analyses will be discussed in future reports. Thus, this report is organized into three sections, a description of the governance, key stakeholders, and stakeholder engagement strategy for the Iowa SIM initiative, a report on the main SIM implementation activities during this study period, and a conclusion section summarizing key findings and discussing the next steps for evaluation.

Methods

The PPC state-level evaluation of Iowa's SIM includes both qualitative and quantitative methods incorporating multiple data sources and collection methods to capture information from many areas of the healthcare system (local, regional, and state-level; patient, provider, and stakeholder). The two-part evaluation will: 1) assess the process and implementation of the key SIM interventions and activities and, 2) assess the core SIM goals and/or aims (primary outcomes used to measure the success of the SIM). As noted previously, this report focuses on part 1, the description of the implementation activities in the first year and should be considered part of the baseline process assessment of the Iowa SIM.

Process and Implementation

A variety of methods were used to gather the information provided in this report. The PPC team reviewed documents and collected information from pertinent websites, participated in bi-weekly phone conferences with the state SIM team and CMMI, participated in monthly phone conferences with the state SIM team and the national evaluators, and conducted stakeholder interviews to understand how the SIM initiative was being implemented during this time period. The PPC subcontracted with Rural Health Solutions, a consulting company with national rural health development, research, and evaluation expertise, to conduct the portion of the evaluation concerning the C3 initiative.

Environmental Scan of SIM-related Initiatives

The PPC evaluation team uses a regular, systematic scan of data sources to document health initiatives in Iowa related to tobacco, obesity, and diabetes management or prevention in order to have a comprehensive understanding of efforts in the state independent of the SIM initiative. This is intended to contrast the actual implications of the SIM versus other health initiatives already underway. The search terms used in the general internet searches for these initiatives included "Iowa and obesity program," "Iowa and tobacco program," and "Iowa and diabetes program." Initiatives and programs found through the internet searches were restricted by dates, relevancy, and operation in C3 counties or C3 comparison counties. In addition to the semi-structured internet searches, other data sources were monitored for information and updates including periodic discussions with the state SIM team and review of SIM related websites, grant and funding sources, and periodic publications. These sources were reviewed at least quarterly with the data collection frame for this reporting period ending in September 2016.

The following specific sources were used to gather information for the environmental scan of SIM-related initiatives in the state of Iowa.

Websites

- Iowa Department of Public Health
- Iowa Department of Human Services
- Iowa Healthcare Collaborative
- Iowa Medicaid Enterprise
- Centers for Medicare & Medicaid Services State Innovation Models Initiative
- SIMplify (the Iowa SIM initiative website for the community partners)
- Amerigroup Iowa
- Amerihealth Caritas Iowa
- United Healthcare of Iowa

Periodic Publications

- SIMplify newsletter
- SWAN newsletter
- V2V newsletter (a newsletter specific to SIM VBP status)
- C3 proposals and quarterly reports
- Medicaid e-news
- Quarterly and monthly MCO reports
- County CHNA/HIP reports

Outside Funding Sources

- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Center for Medicare & Medicaid Innovation

Much of the data included in this report derives from this review of pertinent SIM information and is intended to provide a snapshot of SIM and non-SIM (but related) activities during the pre-implementation year (2015) and the early part of the first implementation year (2016).

Foundation of the Iowa SIM

The Iowa SIM initiative is based on a leadership and governance structure to provide direction to and encourage the participation and involvement of a wide variety of stakeholders across the state. This section describes the SIM governance, key stakeholders, and the strategies invoked to encourage the collaboration across these entities necessary to implement the SIM activities and achieve the SIM goals.

Governance

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

The Director of DHS is the recipient of the SIM grant and as such, DHS is accountable for the operations and execution of the SIM activities. IDPH partners with DHS to implement particular functions of the SIM grant. IDPH contracted with the Iowa Healthcare Collaborative (IHC) to provide technical assistance and quality improvement support services to one of the primary SIM interventional components, the Community Care Coalitions (C3 Communities). These three entities have the primary responsibilities for carrying out the majority of the SIM activities. Other entities contracted for specific grant functions include 3M (for VIS and VBP), Informatics Corporation of America (for SWAN technology assistance), Telligen (for grant management and administrative functions), and the Public Policy Center (to conduct the state level evaluation).

The leadership structure of the SIM includes the high-level leadership from a variety of SIM stakeholders including those entities primarily charged with implementing SIM activities (DHS, IME, IDPH, and IHC). In addition, leadership from Wellmark BCBS, the Department on Aging, and the State Hygienic Laboratory at the University of Iowa are represented as well as someone from the provider community, specifically, a mental healthcare provider. Taken together, this leadership structure represents key stakeholders within the payer, provider, and public health communities in Iowa and is charged with establishing the overall vision of the SIM and encouraging the partnerships both within and outside of their particular constituencies necessary for achieving the goals of the SIM.

Key Stakeholders

There are many stakeholders who are integral to the successful implementation of the SIM in Iowa. Partners in the SIM vision and implementation include payers, providers, communities, state governmental entities, and others. Table 1 provides a list of SIM stakeholders organized by sector.

Table 1. SIM Stakeholders

State Government	Payers	Providers	Communities	Contracted Entities
Iowa Department of Human Services (DHS)	MCO: Ameri-Health	Accountable Care Organizations (ACOs)	Social services agencies	Iowa Health-care Collaborative (IHC)
Iowa Department of Public Health (IDPH)	MCO: Amerigroup	Independent primary care providers	Local government	3M Analytics
Iowa Medicaid Enterprise (IME)	MCO: United Healthcare	Behavioral health-care providers	Healthcare consumers	Informatics Corporation of America (ICA)
Governor's Office	Wellmark	Hospitals	Local and county public health	Public Policy Center (PPC)
State Hygienic Laboratory			C3 community teams – care coordinators, providers, nurses, etc.	
Iowa Department on Aging				

Shaded cells indicate representation on the SIM leadership team

A primary responsibility of the SIM leadership is facilitating partnerships among these key stakeholder entities, particularly with private and public payers, regarding the incorporation of VBP agreements with their providers. Along with advising their constituencies to support SIM initiative needs, members of the SIM leadership adjust strategic direction when needed. For example, with the April 2016 introduction of MCOs to the state healthcare delivery landscape, representatives from each MCO were invited to a SIM Leadership meeting to introduce SIM concepts and begin VBP discussions. The strategic shift to engage the Medicaid MCOs illustrates how the SIM leadership identifies and interacts with key stakeholders to advance the goals of the SIM Initiative. More recent discussions have involved engaging Accountable Care Organizations (ACOs) in Iowa more directly, another indication of trying to adjust the SIM to the changing delivery system landscape in the state.

Stakeholder Engagement

Iowa SIM activities engage stakeholders at all levels of implementation, while incorporating feedback from stakeholders into operative processes. Because there are multiple stakeholders in the SIM initiative, a variety of stakeholder engagement methods were employed. These methods ranged from broad-based remotely accessible communication, such as email, websites, newsletters, and webinars, to customized one-on-one technical assistance. Table 2 summarizes the main SIM stakeholder engagement strategies. Additional detail about these strategies are in [Appendix B](#).

Table 2. Stakeholder Engagement Strategies

Activities	Lead Entity	Stakeholders	Objective
Convene Leadership Team	DHS	DHS, IME, IDPH, Wellmark, MCOs, Governor's office	Provide governance, monitor and ensure quality of SIM activities, plan next steps
Conduct Public Forums	IME, IDPH	Provider Associations, Members and member advocates, ACOs, MCOs, other Federal, State, & Local government stakeholders	Provide regular opportunities for two-way communication between SIM representatives and the public
Maintain SIM website ¹	IME	General public	Update SIM activities, vision, and goals, information about public forums, meeting agendas and minutes, SIM presentations and reports, SIM guiding principles, statewide strategies, and links to SIM partner websites.
Convene Short Term Integration Workgroups	IME	Groups developed by recommendation from SIM leadership	Establish a method of integration into VBP quality measures for special populations: Long term care, Behavioral Health, Children & Youth with Special Healthcare Needs, Dual eligibles, Dental
Operate a SIM feedback E-mail account	IME	All public stakeholders	Provide an outlet for communication between SIM stakeholders and the SIM team
ACO/Delivery System Meetings	IME	ACOs, IHC, MCOs	Support the healthcare delivery system's ability to analyze data, improve care, and track measures
Value Based Purchasing meetings	IME	MCOs	Provide a venue for the delivery system entities to discuss SIM goals, timelines, data requirements, and potential barriers to progress
VIS User Group Conference	3M	All payers using VIS	Collect feedback from payers about the VIS measurement system, share results, update entities about upcoming changes
SIM Technical Assistance	IHC	C3 Communities; other areas of the healthcare delivery system	Provide education and training about topics related to the SIM activities and goals (more detail can be found in the CBPI section below)

Process Evaluation of Implementation Activities

The primary implementation strategies used by the SIM to address the aims of improving population health, transforming healthcare delivery, and promoting sustainability center on five main activities that relate to the primary drivers (plan to improve population health, care coordination, community based performance improvement, and value based purchasing). These include the establishment of strategic plans for population health improvement (PHI), community care coalitions (C3s) to promote care coordination at the community level, the deployment of a statewide alert network (SWAN) to promote coordinated care at the level of the healthcare delivery system, promote community-based performance improvement (CBPI) to help communities transform how healthcare is delivered, and institute value based purchasing (VBP) as a method of payment reform.

Table 3 provides a snapshot of these five activities, the primary drivers related to the activity, the goals or outcomes intended to be impacted by the activity, and the population to be affected by the activity.

Table 3. SIM activities and associated primary drivers and goals

SIM Activity	Primary Driver(s)	Target Population	Goals or Outcomes Affected by Activity
PHI	<ul style="list-style-type: none"> Plan to Improve Population Health Care Coordination 	General population (statewide)	<ul style="list-style-type: none"> Tobacco Cessation Reduce Obesity Improve Diabetes Promote Care Coordination
C3s	<ul style="list-style-type: none"> Care Coordination Plan to Improve Population Health Community-Based Performance Improvement 	At-risk residents of selected C3 communities	<ul style="list-style-type: none"> Tobacco Cessation Reduce Obesity Improve Diabetes Management Address Social Determinants of Health Promote Care Coordination
SWAN	<ul style="list-style-type: none"> Care Coordination 	Patients of providers in a VBP arrangement	<ul style="list-style-type: none"> Promote Care Coordination Reduce rate of preventable hospital readmissions Reduce rate of preventable emergency department visits
CBPI & TA	<ul style="list-style-type: none"> Community-Based Performance Improvement 	C3s, healthcare & social service providers	<ul style="list-style-type: none"> Promote Care Coordination Promote healthcare delivery system transformation Promote stakeholder participation in SIM activities
VBP	<ul style="list-style-type: none"> Value based Purchasing 	Medicaid, Medicare, and Wellmark beneficiaries	<ul style="list-style-type: none"> Increase participation in VBP Promote use of quality measures (Value Index Score) Reduce rate of preventable hospital readmissions Reduce rate of preventable emergency department visits

The rest of this section provides a description of each activity, the intended implementation steps or approach, and the status of implementation during this reporting period.

Population Health Improvement (PHI)

The Iowa SIM population health improvement plan focused on designing and building upon two of its public health-based programs and by targeting its activities on the core SIM goals/objectives of addressing diabetes, obesity, tobacco use, and secondarily, social determinants of health, healthcare

associated infections, medication safety, and obstetrics. The first action built upon a public health planning process that has been in place in Iowa for over 20 years. For each of Iowa's 99 counties, local boards of health have been conducting Community Health Needs Assessments and Health Improvement Planning (CHNA/HIP)³ activities. The SIM initiative proposed to use the CHNA/HIPs for priority setting and to understand how the individual county plans, particularly those that addressed the SIM focal areas and objectives, could be summarized and used to develop a Statewide Health Improvement Plan (SHIP) called Healthy Iowans.

Early in 2016, CHNA/HIPs from all 99 counties in Iowa were submitted to IDPH. Throughout the spring and summer of 2016, CHNAs were analyzed by IDPH staff to summarize the most critical health and social service needs identified by communities across Iowa. IDPH is currently conducting a similar analysis of the HIPs. Table 4 presents the top ten CHNA needs identified in Iowa from this analysis. The highlighted rows indicate the areas that coincide with goals targeted by the SIM initiative.

Table 4. Top 10 CHNA Priorities, 2016

Rank	Issues Identified as Priorities	# of Counties Identifying the Issue
1	Obesity, Nutrition, & Physical Activity	86
2	Mental Health, Illness, & Suicide	69
3	Access to Mental Health Services	68
4	Immunizations	60
5	Alcohol & Binge Drinking	55
6	Tobacco/Nicotine Use	52
7	SDH: Transportation	49
8	SDH: Access to outlets for physical activity; food access	45
9	Access to Oral/Dental Health Services	42
10	Diabetes	42

In concordance with the summarization of the CHNA/HIPs into the Healthy Iowans Plan, the second component of the PHI activities includes the development of Statewide Strategy Plans to address each of the SIM objectives (tobacco, obesity, diabetes, care coordination, social determinants of health, healthcare associated infections, medication safety, and obstetrics). These statewide strategies were developed by multi-stakeholder, multi-disciplinary committees with representatives from across the variety of healthcare settings, community-based services, payers, governmental agencies, and other entities that make up the healthcare continuum. Committee members meet three to four times annually to develop statewide strategies and meet approximately twice a year to update the plans. Each statewide strategy includes an overarching mission and vision statement, specific goals and objectives, and targeted tactics that address primary prevention, detection, management/treatment, and use of data for each of the topic areas. The tactics defined in each Statewide Strategy Plans are intended to guide health initiatives throughout the state, including those proposed and implemented by the SIM C3 communities (see below).

Over the course of 2015 – September 2016, seven [Statewide Strategy Plans](#) have been developed, approved, and published to the IDPH website.⁴ Table 5 provides the plan topics and timeline of development and approval.

3 Iowa Department of Public Health. CHNA & HIP. Community Health Needs webpage at <http://idph.iowa.gov/chnahip/community-health-needs>

4 Iowa Department of Public Health. State Innovation Model: Statewide Strategy Plans. Accessed November 1, 2016 from <http://idph.iowa.gov/SIM>

Table 5. Timeline of Statewide Strategy Plan Development

Statewide Strategy Plan Topic	Approved
Healthcare Acquired Infections	July 2015
Medication Effectiveness & Safety	July 2015
Obstetrics Care	July 2015
Diabetes	July 2015
Care Coordination	June 1, 2016
Obesity	June 29, 2016
Tobacco	July 8, 2016
Social Determinants of Health	Under Development
Person & Family Engagement	Under Development
Falls Prevention	Under Development

Most of the SIM work done regarding PHI in 2015 and during 2016 was developmental and preparatory for the coming years' activities. In future years, the summaries of CHNA/HIPs will be used to help guide the direction of population health goals and the Statewide Strategies will be used as tools for TA activities and education as well as to help advise C3 communities and track their activities as they relate to SIM goals.

Community Care Coalitions (C3s)

SIM-funded Community Care Coalitions (C3s) are designed to transform healthcare delivery by promoting care coordination across the traditional divide between medical, public health, and social service delivery systems. C3s are community-based coalitions of health and social service stakeholders who collaborate to promote the coordination of their population's care across the variety of care settings and systems.

The SIM C3 initiative is modeled on a program administered by the IDPH and the Iowa Primary Care Association (IPCA) from 2013 – 2015 called the Iowa Community Care Coordination Initiative. Using funds appropriated by the Iowa Legislature, two communities in 2013-14 and seven more in 2014-2015 were awarded grants to develop and implement regionally-based networks aimed at promoting care coordination. The main intent of that grant program was to provide funding for care coordination teams (whether through public health departments or hospital-based programs) to help primary care providers connect vulnerable populations to resources in the community that could be used to address their particular barriers to health improvement, which included both biomedical and social determinants of health. From this initiative, four findings were pertinent for the development of the SIM C3 initiative: 1) Community Care Initiatives require *dedicated staff* to focus on project management, communication, and building and maintaining the partnerships and relationships with regional stakeholders, 2) *process improvement* should be built into project implementation plans, 3) *data sharing* should be worked into the planning early on, and 4) open and regular *communication* with community partners is essential.

In November 2015, IDPH issued a Request for Proposal (RFP) soliciting applications from organizations for SIM-funding to carry out C3 care coordination initiatives and to promote integration between public health and the traditional healthcare delivery system. C3 initiatives were defined as locally-based coalitions of stakeholders promoting the coordination of health and social services across care settings and systems. Eligible applicants included nonprofit organizations, governmental agencies, and educational institutions in Iowa and stakeholders could include hospitals, primary care providers, other healthcare providers, public health and community action organizations, and social service providers. SIM-funded C3 initiatives were required to include interventions designed to address the primary SIM objectives of tobacco use, obesity, and diabetes and an action plan describing how the initiative would address social determinants of health (SDHs). In addition, C3 initiatives were encouraged to include interventions regarding secondary SIM objectives such as medication safety, patient and family engagement in care, healthcare acquired infections, and obstetrics.

Funding was available for both developmental and implementation C3 initiatives. Developmental

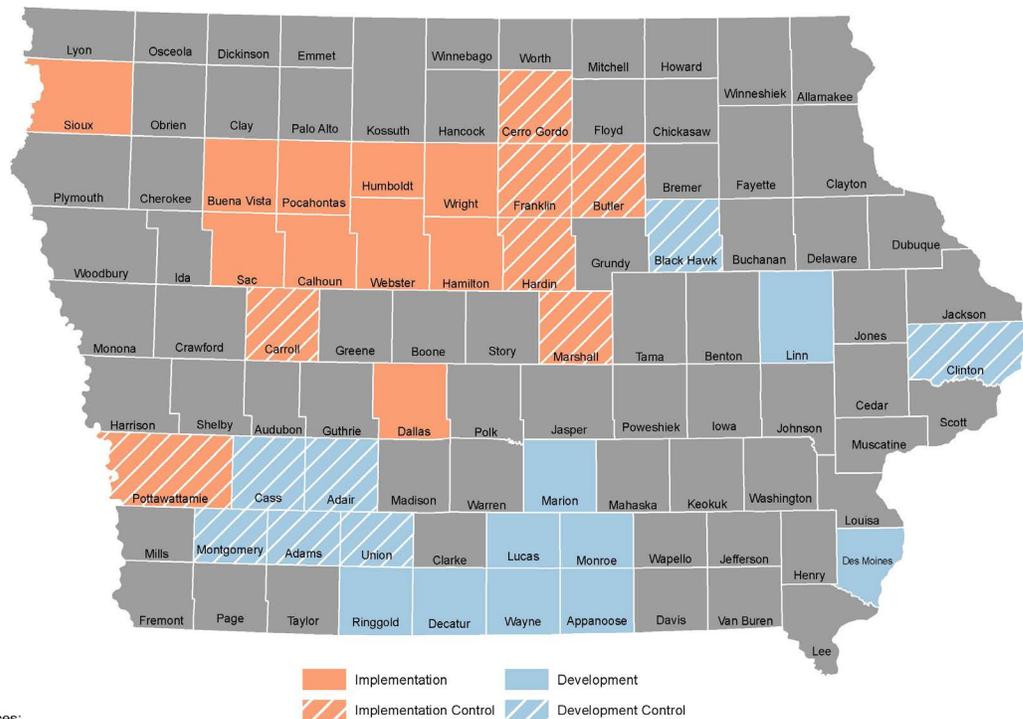
sites included organizations in the early stages of infrastructure development (establishing partnerships, organizing stakeholder teams, understanding local needs, designing interventions, etc.) to carry out advanced care coordination activities. Implementation sites were organizations with established care coordination networks either implementing or ready to implement SIM-specific care coordination activities and interventions. C3 initiatives were responsible for using the local public health CHNA/HIPs to identify local needs and utilizing IDPH Statewide Strategy Plans when carrying out their interventions. In addition, C3 applicants were required to establish a Steering Committee made up of community members, providers, and community partners who were representative of the stakeholders relevant to the initiatives proposed. Applications in response to the SIM C3 RFP were initially due on December 23, 2015 with a notice of intent to award to be issued on January 20, 2016. In December 2015, the due date was postponed to February 1, 2016 and the notice of intent to award changed to February 19, 2016. The project period start date was March 7, 2016.

IDPH, through the SIM, announced its intent to award C3 initiative funding to six applicants. The developmental grantees included three organizations over ten counties (Great River Medical Center – Des Moines County, Linn County Board of Health – Linn County, Marion County Public Health Department – Marion, Lucas, Monroe, Ringgold, Decatur, Wayne, Clarke, and Appanoose Counties). The implementation grantees included three organizations over ten counties (Community Health Partners of Sioux County – Sioux County, Dallas County Public Health Nursing Services – Dallas County, Webster County Health Department – Webster, Hamilton, Humboldt, Wright, Pocahontas, Calhoun, Sac, and Buena Vista Counties). During the summer of 2016, stakeholders from Clarke County decided to remove themselves from the Marion County Public Health Department initiative.

SIM funded C3 communities began their initiatives on March 7, 2016. A summary of the initiatives proposed by each of the communities can be found in [Appendix C](#). To get a sense of what other, non-C3 counties in the state were doing with regard to the main SIM objectives, the evaluation team chose a set of comparison counties using the following criteria: similarity to the C3 counties with respect to overall population size, percentage of rural residences, percentage non-white (specifically African American and Hispanic), median household income, and percentage of people with diabetes, adults who smoked, and adults with obesity based on the 2015 County Health Rankings from the Robert Wood Johnson Foundation.⁵ The following map provides the counties with C3 communities funded by the SIM and the comparison counties chosen by the PPC evaluation team. The solid orange counties are C3 Implementation communities and the orange hash-marked counties are the comparison counties for C3 Implementation sites. The solid blue counties are C3 Development communities with the blue hash-marked counties as their comparison.

⁵ County Health Rankings and Roadmaps. A Robert Wood Johnson Foundation program. Accessed August 1, 2016 at <http://www.countyhealthrankings.org/our-approach>

State Innovation Model Community Care Coalition Sites and Controls



Data sources:
<https://idph.iowa.gov/Portals/1/userfiles/38/SIM%20C3%20Service%20Areas.pdf>

Corresponding colors indicate matched counties.

Table 6 provides a description of some key county-level characteristics for four groups: C3 counties combined, comparison counties combined, the other non-C3 and non-comparison counties combined, and the state as whole. The data comes from the 2015 County Health Rankings & Roadmaps.⁶

Table 6. Key Characteristics of C3, C3 Comparison, and Other Counties in Iowa

Characteristic	C3 Counties (n=19)	Comparison Counties (n=14)	Other Counties (n=66)	Entire State (n=99)
Mean Population	30,043	33,560	31,057	31,216
% Rural	61%	54%	63%	61%
% Aged 65+	19%	19%	18%	19%
% African American	1.4%	1.5%	1.1%	1.2%
% Hispanic	4.8%	4.8%	4.1%	4.3%
Median Household Income	\$49,648	\$48,154	\$51,736	\$50,829
% Diabetic	10%	10%	10%	10%
% Adult Smokers	18%	19%	18%	18%
% Adult Obesity	31%	32%	31%	31%

With the exception of rurality, where the comparison counties have a somewhat lower percentage of rural residences, the groups are similar to each other and to the state as a whole.

The main population health end goals to be affected by the SIM, specifically by the PHI and C3 initiatives, involve the areas of tobacco cessation, obesity, and diabetes. To assess how the C3 and comparison communities addressed tobacco cessation, obesity, and diabetes, the evaluation team

⁶ County Health Rankings and Roadmaps. A Robert Wood Johnson Foundation program. Accessed August 1, 2016 at <http://www.countyhealthrankings.org/our-approach>

reviewed the C3 proposals, the CHNA/HIPs for each county, and conducted internet searches with particular parameters (see methods section) to find out what types of activities (SIM and not directly related to SIM) were being conducted specific to the SIM goal areas. Statewide Strategies for each of the goal areas were used as a guide for categorizing the initiatives.

Both SIM and non-SIM initiatives were categorized into one of four categories of action included in the Statewide Strategies for tobacco, obesity and diabetes (primary prevention, detection, management/treatment, and use of data. Some initiatives did not fit into the four Statewide Strategy actions. These initiatives were generally related to infrastructure and workforce training goals needed to carry out tobacco cessation, obesity, or diabetes programming. Table 7 provides a summary of the number and types of initiatives found related to diabetes, obesity, and tobacco within C3 and comparison counties.

Table 7. Diabetes, Obesity, and Tobacco Initiatives in C3 and Comparison Counties

Category of Initiative	# Diabetes Initiatives		# Obesity Initiatives		# Tobacco Initiatives	
	C3	Comparison	C3	Comparison	C3	Comparison
Primary Prevention Strategy	40	3	105	50	30	7
Detection Strategy	37	10	20	4	39	0
Management/Treatment Strategy	55	26	30	5	9	4
Using Data	11	0	44	0	33	0
Other	10	0	14	0	8	0
Total	153	39	213	59	119	11

Diabetes

Using the data collection methods detailed in the methodology section, 192 initiatives related to diabetes were identified in C3 and C3 comparison counties. Of the 192 initiatives across C3 and comparison counties, the most common were management/treatment strategies (n=81), with similar numbers of detection (n=47) and primary prevention (n=43) strategies evident. Some initiatives fit into the statewide strategy categories in a general sense, while some fit specific tactics within the approaches. For example, Management and Treatment tactic 4.3-B states: *Support increased access and use evidence-based, endorsed diabetes self-management education and training curriculum.* The incorporation of this tactic is exemplified by the CDC certified diabetes education programs in the state, five in C3 counties, and two in comparison counties.

Obesity

Along with initiatives explicitly targeting obesity, initiatives focusing on healthy foods access and physical activity were included under the broad category of obesity programs. Across C3 and comparison counties, 272 initiatives related to obesity. The majority (n=155) were considered primary prevention strategies. An example of an initiative specifically supporting primary prevention is Iowa Choice Harvest. Iowa Choice Harvest is a company in Marshall County (a C3 comparison county), providing healthy, locally grown food to grocery stores, restaurants, and institutions. This program aligns directly with Tactic 1.2-A: *To increase availability of fruits and vegetables in public service venues and private sector businesses (grocery stores, convenience stores, restaurants, worksites, etc.).* Of note, the second highest category for obesity related initiatives was the use of data (n=37); though all 37 were found in C3 communities.

Tobacco

Finally, around 130 initiatives related to tobacco cessation were identified in C3 and C3 comparison counties. Relatively few of these tobacco related initiatives (n=11) were found in C3 comparison counties. Initiatives fell nearly equally into primary prevention (n=37), detection (n=39), or using data (n=33) categories. One example of a detection strategy was in the C3 proposal developed by

the Community Health Partners of Sioux County which included training providers to use Ask, Advise, and Refer, an evidence based screening program recommended in Tactic 2.1-A in the Tobacco Statewide Strategy. Of note, few initiatives (n=13) involved management/treatment strategies.

Across all three population health goals (diabetes, obesity, and tobacco), it is important to note that the communities that were chosen to be a part of the C3 program were already engaged in initiatives to address these issues, prior to the SIM funding. Around 45% (n=69) of the 153 diabetes initiatives, 83 of the 213 (39%) obesity initiatives, and 20 of the 119 (17%) tobacco initiatives in C3 counties were not directly related to their SIM-funded proposals. The addition of SIM funding seemed to provide a boost to the intensity of ongoing efforts to address diabetes, obesity, and tobacco use in C3 communities.

Baseline Status of the C3s

Early Stages of Implementation

In September 2016, the evaluation team conducted site visits and interviews with all six C3 teams to obtain a baseline understanding of their initiatives and progress since their kick-off in March. While the C3s reported a range of site-specific accomplishments and shortcomings, several common themes emerged from the interviews. Table 8 summarizes these common themes from the site visit interviews.

Table 8. Summary of baseline interviews with C3 communities

Strengths	
Progress	<ul style="list-style-type: none"> • All C3s are ahead of project plans • Innovative initiatives are being planned, developed, and carried out with regard to tobacco, diabetes, obesity, care coordination, and social determinants of health (SDH) • Implementation C3s are leveraging other resources to address SDH along with tobacco, diabetes, and obesity
Partnerships	<ul style="list-style-type: none"> • C3s appreciated the support from IHC and IDPH • Community buy-in and engagement has increased • C3s are committed to the SIM vision set forth in the original RFP and believe they have buy-in from their communities/regions to continue moving forward • Development C3s are building community infrastructure
Deliverables	<ul style="list-style-type: none"> • Rural and urban models are emerging for future replication and development
Needs	
Responsiveness	<ul style="list-style-type: none"> • C3s reported that they made requests for TA but most often have not gotten a response
Coordination	<ul style="list-style-type: none"> • C3s are not confident that those managing the SIM C3 initiative really understand the work of the current C3s. As an example, one of the developmental sites was asked to report the number of patients being served. Developmental sites by design use their first year to plan programs and develop infrastructure and are not yet implementing activities with their constituents. • C3s expressed frustration with the lack of coordination between the SIM lead organizations. An example of this is the duplicate reporting requested by IHC and IDPH (monthly vs. quarterly but same/similar data).
Collaboration	<ul style="list-style-type: none"> • C3s reported limited to no sharing across the C3s; however, they would like to do this and believe it would be beneficial to share best practices

Applicability	<ul style="list-style-type: none"> • C3s reported that the Learning Community Events were not particularly useful to them because they are at a high level (conceptual and academic) and they need more programmatic (how-to) detail. • C3s reported challenges inviting community partners to the Learning Community Events because many of the event topics do not apply to the work/role of their community partners.
Assurance	<ul style="list-style-type: none"> • C3s expressed considerable concern about what they are hearing in terms of potential upcoming changes to the C3s including: <ul style="list-style-type: none"> ◦ Changing from a focus on addressing SDH and the need for healthy behaviors to a purely clinical/hospital/system-based approach, ◦ Changes that could alienate community partners, ◦ Changes that could duplicate activities and efforts already underway through ACOs, APMs, and MIPS

In general, the C3 sites have successfully incorporated the SIM population health goals (tobacco, obesity, and diabetes) into their site activities and local partnerships. The C3 sites report positive responses from partners in clinical settings and from community-based service providers, who are committed to working toward SIM goals. However, some sites reported hesitation in including local collaborators in SIM sponsored TA activities, citing concerns that the material is not necessarily relevant to their context. The C3 sites provided insight about the difficulties encountered, along with concrete feedback to overcome setbacks and have expressed concern about how upcoming changes to the SIM will affect their communities and the progress they have made toward SIM goals. [Appendix D](#) provides the interview script questions and additional detail from the C3 site visit interviews.

Care Coordination

In the 2016 SIM Driver Diagram, care coordination is a primary driver and the C3 initiative is one of the main SIM interventions designed to promote it. Care coordination is the means to the end goal of population health improvement. During the initial site visits, we asked the lead staff for each C3 initiative to self-rate their progress with some of the tactics advocated in the Care Coordination Statewide Strategy to get a sense of where the C3 communities are with regard to care coordination activities. Sites could rate their status on each tactic as *“Not Applicable and/or Not Intending to Implement,” “No Activity,” “Planning Underway,” “Developing,” “Implementation Initiated/Underway,”* or *“Completed and/or Fully Operational.”* For each of the tactics under the care coordination objectives assessed, progress was ranked from 0-5:

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

A baseline assessment of the status of each objective was determined by a score calculated for each site by summing the status rankings and dividing by the number of tactics. Table 9 provides the baseline scores for developmental sites and implementation sites.

Table 9. Baseline C3 Self-Assessment of Care Coordination Activities

Objective (# Tactics)	Dev1	Dev2	Dev3	Dev C3s Combined	Imp1	Imp2	Imp3	Imp C3s Combined
1.1 Advance patient centered care practices (7)	2.9	2.9	3.4	3.0	4.1	3.9	2.6	3.5
1.2 Facilitate the impactful delivery of healthcare services (5)	2.0	2.8	2.6	2.5	3.8	4.0	3.4	3.7
1.3 Establish coordinated connections to needed community-based services (3)	2.0	3.3	3.7	3.0	3.7	4.0	3.7	3.8
2.1 Develop multi-discipline patient-centered care teams (6)	2.1	1.6	1.7	1.8	2.3	3.3	1.3	2.3
2.2 Use of HIT to facilitate cross-communication and documentation (4)	2.5	3.5	3.0	3.0	2.0	3.5	1.5	2.3
2.3 Establish standardized processes and protocols for collaborative care delivery (3)	2.0	3.0	2.3	2.4	4.3	3.7	1.7	3.0
2.4 Enhance collaboration among healthcare providers, community-based services, and the payer community (3)	1.3	2.0	2.0	1.8	2.3	3.7	1.0	2.3
3.1 Align community-based services for each patient/service recipient to ensure greatest impact (3)	3.3	4.0	3.3	3.6	4.0	4.0	4.0	4.0
3.2 Connect clinical services with community-based services (4)	2.5	4.0	3.3	3.3	3.8	4.0	4.0	3.9
4.1 Promote and enhance the use of HIT to identify, track, and monitor population health (3)	2.7	3.3	2.0	2.7	2.3	4.0	2.3	2.9

With the exception of a couple of the objectives, the developmental C3 communities rate themselves in the planning or developing (mean score of 2-3) stages of implementing these care coordination tactics. The implementation C3 communities rate themselves in the developing or implementing (mean score of 3-4) stages of care coordination strategies. For three of the objectives, the implementation communities are still rating themselves mostly in the planning stage (mean score around 2). Largely, these results are to be expected given the type of C3 community (developmental or implementation). Each C3 community will be asked to assess their progress annually to better understand how care coordination tactics evolve over the course of the C3 initiative.

Statewide Alert Notification System (SWAN)

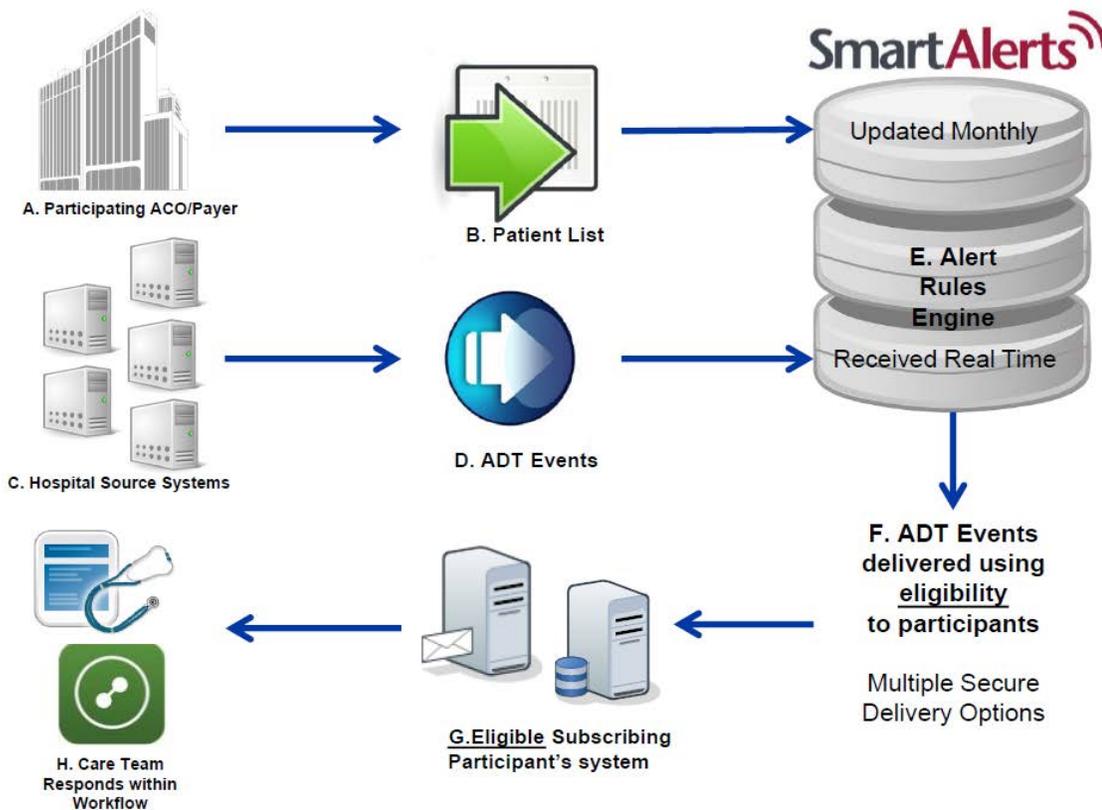
The SWAN is a part of a health information technology (HIT) infrastructure investment through the SIM to promote better care coordination within the healthcare delivery system. The SWAN is a software technology hub that uses ADT (Admission, Discharge, and Transfer) files from participating hospitals and providers to formulate alerts to care teams when one of their patients has a hospital admission or an emergency department (ED) visit outside of their network. Alerts are intended to be

a resource for providers and care teams to use in providing better follow-up care following a hospital event (admission or ED visit) with the ultimate objective of preventing unnecessary return visits or admissions. The SWAN activities are intended to help transform the healthcare delivery system by improving the quality of care coordination activities and, as a result, impacting health and healthcare utilization by reducing the rates of preventable readmissions and preventable ED visits.

The first provider population to receive SWAN alerts were the five Medicaid Accountable Care Organizations (ACOs) in Iowa. These include Broadlawns Medical Center (BMC), Iowa Health + (IH), University of Iowa Health Alliance (UIHA), Unity Point Health Partners (UPHP), and Mercy ACO (Mercy). Medicaid members who are patients of providers in a VBP arrangement within these ACOs are intended to benefit from SWAN alerts during the initial phase of implementation. The SIM initiative’s main intention for the SWAN is to populate the engine with ADTs from all hospitals in Iowa, send alerts to all five Medicaid ACOs, and encourage them to fully utilize the alerts for care coordination. A goal for sustainability of SIM care coordination efforts would be to expand the SWAN activities to other payers (i.e., Medicare and Wellmark).

For the SWAN to have an impact on the stated goals of the SIM initiative, its implementation will need to include two important components. First, the SWAN system needs to become fully functional across the state and second, it needs to be used by providers for care coordination. To build SWAN functionality, SIM staff needs to connect all hospitals (more than 100) in Iowa to the Statewide Smart Alert engine (the HIT infrastructure used to generate SWAN alerts) so that hospitals can send their ADT records to this statewide portal. The goal is to have all hospitals connected by July 31, 2018. While sharing ADT files within organizations is relatively common, they have not historically been shared between organizations at a statewide level. Once ADT files are transferred to the Smart Alert engine, patient lists from IME (and potentially other payers) are used to cross reference Medicaid patients with ADT events in order to route SWAN alerts to the providers who signed up to use the SWAN system. The following figure provides a graphical representation of the SWAN system process.

Statewide Alert Notifications (SWAN)



Throughout 2015 and into 2016, SIM staff worked with the Informatics Corporation of America (ICA) and SWAN-specific stakeholders such as administrators from the Medicaid ACOs to build SWAN functionality (A – F in the Figure) among Medicaid providers associated with the five Medicaid ACOs. Table 10 provides a summary of the growth of the SWAN during this reporting period.

Table 10. Timeline of Implementation of SWAN

Timing	SWAN Event	# Hospitals sending ADTs to SWAN engine	ACOs Receiving SWAN Alerts
December 2015	SWAN is launched and active	15	BMC IH +
April 2016	Additional hospitals connected and 1 additional ACO receiving alerts	21	BMC IH + UPHP
May 2016	Another additional ACO receiving alerts	21	BMC IH + UPHP UIHA
August 2016	1) All five ACOs receiving alerts; 2) SIM personnel from IDPH and SWAN vendor begin TA with ACOs on how to use SWAN	24	BMC IH+ UPHP UIHA Mercy
September 2016	SWAN alerts are halted due to issues with eligibility files	25	No alerts being sent to any ACOs

Note – While outside the scope of this report, it is of note that the SWAN became active again in December 2016.

The second piece of successful SWAN implementation involves ensuring that providers use the SWAN as a tool for care coordination (G – H in the Figure). To this end, in 2016, SIM staff at IDPH in partnership with ICA (the vendor who built and maintains the SWAN system) began developing a program of technical assistance for the five ACOs. Beginning in May 2016, SIM staff began scheduling meetings with the stakeholders of the ACOs interested in learning more about the best practices for incorporating SWAN alerts into their workflow processes. As of August 2016, three of the five ACOs had expressed interest in learning more about how to best manage and use the SWAN alerts to improve care coordination activities. As part of our evaluation activities in 2017, we will be interviewing administrators and healthcare providers affiliated with these five ACOs to assess their awareness and use of the SWAN system.

Community-Based Performance Improvement (CBPI)

Community-based performance improvement (CBPI), as a SIM intervention, is a multi-faceted methodology used to help support its community-level implementation activities. The main goal of CBPI is to facilitate healthcare delivery transformation at both the system and community level. The CBPI activities should affect all SIM goals as it incorporates all of the other SIM activities (PHI, C3s, SWAN, and VBP) into its methodologic approach. The Iowa Healthcare Collaborative (IHC) has primary responsibility for establishing and facilitating CBPI, with the C3 communities being the main focus of CBPI activities in this reporting time period. Yet, other stakeholders may also be impacted by CBPI activities.

In essence, CBPI methods include providing technical assistance (TA) and quality improvement (QI) strategies to C3 sites so that they are better prepared to implement SIM initiatives and contribute to attaining the SIM goals.

The stated goals of the CBPI TA and QI initiatives include:

- 1) Engaging leadership and receiving leadership commitment
- 2) Developing and implementing QI strategies
- 3) Conducting rapid-cycle evaluation of performance data for stakeholders

Most healthcare transformation initiatives rely on 1) advanced communication and data sharing platforms and 2) the use of health information technology (HIT). The IHC CBPI initiative uses both of

these methods to provide TA and QI to C3 communities. The TA and QI SIM activities are discussed individually below but it is important to note that, while discussed separately, there is overlap between TA and QI activities.

Technical Assistance Activities

The IHC TA activities included a wide variety of opportunities, strategies, and venues to provide education and training to, along with information sharing among C3 communities and other interested stakeholders. Table 11 provides a summary of the TA menu of activities implemented over this reporting period.

Table 11. Summary of the TA Activities Menu

Activity	Intent/Description	Timeline Implemented	Venue/Stakeholders
SIMply Newsletter	A way to update stakeholders on SIM activities, share relevant resources, and promote upcoming events.	Began in March 2016; Monthly dissemination	Online/email distribution – C3 and others
SIMply Website	A website developed as a venue for the C3 communities to access information and resources, share files, and participate in discussion threads.	Began in April 2016	Online – C3 and others
SIMply FORUM	An interactive real-time online consultation exchange by led by content experts on matters pertinent to SIM goals.	First one held June 2016	Online – C3 specific
Webinars	Designed as “Lunch and Learn” webinars of about 45 minutes in duration covering topics related to the SIM.	June 2016 Early July 2016 Late July 2016 August 2016	Online – C3 specific
Learning Community Events	Day-long conferences designed to provide SIM-specific education and training to stakeholders	Held 3 times/year March 2016 July 2016 November 2016	In person – C3 and others
Regional Workshops	Regional workshops provide personalized TA for C3s to work through issues that are specific to their context of their site and the local health systems	1 Workshop agenda – 3 regional locations in September & October 2016	In person – C3 specific
Site Visits	Site visits to C3 communities were conducted to introduce the SIM, provide education and training, and incorporate feedback from C3s into planning for future events.	Q1 – Initial visit Q2 – 9 visits Q3 – 13 visits	In person – C3 specific
Phone Conferences	Phone calls intended as a two-way exchange of information between IHC and C3 staff, for status updates, questions, and in-depth conversation on timely topics or concerns	Began in Q1 of Year 2 and have occurred monthly	Phone – C3 specific

SIMply Newsletter

The SIMply newsletter was launched in March 2016 as a way to keep C3 stakeholders informed about the SIM. Stakeholders access the newsletter as a recipient on a mailing list or by visiting the SIM website. The newsletter informs readers of upcoming events and webinars organized by the Iowa SIM team and the national SIM team. Along with promoting SIM sponsored events, the SIMply newsletter shares learning opportunities related to SIM goals, presented by SIM leaders and other organizations not directly affiliated with the SIM such as the Iowa Falls Prevention Coalition,

the Iowa Rural Health Association, the Iowa Public Health Association, and the University of Iowa Department of Internal Medicine. The current issue and past issues of the SIMplify newsletter can be found [here](#).

SIMplify Website

The [SIMplify website](#), a web-based communication platform, was launched in April 2016 and facilitates communication between SIM staff and C3 members. As of September 30, 2016, the SIMplify website had 98 members, with representatives from C3 sites, IHC, IDPH, and IME. Members of the SIMplify website have the option to subscribe to discussion e-mails or a daily digest to receive e-mails about activity happening on the site.

Some of the main features of the SIMplify website are the resource library and discussion board. The resource library stores resources shared by members, and is organized by topic. While all users have the ability to add to the portal's resource library, during this developmental period, IHC staff members were the primary contributors, adding 48 of the 54 documents posted through August 2016. The resource library covers topics related to SIM drivers, including care coordination, tobacco use, obesity, and diabetes.

Along with ongoing communication about SIM activities, the discussion board hosts topical discussions. Starting in August 2016, two-week topic cycles were introduced to inform participants and encourage discussion among the C3 partners. Since the topic cycles began later in this reporting period, their use as a tool for engagement and discussion may expand as users become more familiarized with the routine.

SIMplify FORUM

The SIMplify Forums are designed to be an interactive real-time online consultation exchange between topic experts and C3 stakeholders. The first SIMplify FORUM was held in June 2016, and featured a panel discussion of a scenario involving diabetes management for a client with a behavioral health diagnosis. Members of the panel met in a videoconference, which was available in a live simulcast to registered SIM stakeholders. The forum included perspectives from experts in diverse domains of diabetes management and treatment, specifically, a physician, dietician, social worker, and pharmacist. Members of the panel discussed the application of concepts including integrating community services, care coordination, and patient-centered case management. An audio recording of the 90 minute discussion was posted to the SIMplify website.

Webinars

SIM-specific webinars are available on the SIMplify website. Designed as "Lunch and Learn" webinars of about 45 minutes in duration, the webinars cover topics related to the SIM goals and are intended to provide a less time intensive way to disseminate SIM-related educational material to C3 partners. After the real-time content concludes, the webinars are posted on the SIMplify website for reference.

SIM Learning Community Events

SIM Learning Community events were designed to be day-long in-person conferences to provide education and training for healthcare providers, payers, care coordination teams, hospitals, ACOs, MCOs, and C3s in their respective roles in the SIM Initiative. The conferences feature speakers, panels, and networking breaks. During this evaluation period, IHC organized two statewide conferences, which were held in Altoona, Iowa on March 8 and July 12, 2016. Another conference was scheduled to be held in November 2016.

The March 8 Learning Community conference had 210 registrants, with representation from all six C3s, providers, SIM staff, the SIM Leadership team, all five Medicaid ACOs, all three MCOs, and contracted vendors. The content of this conference included an introduction to the SIM and its primary components and goals. Along with broad-based background content, providers and experts talked specifically about using data to drive quality improvement and utilizing community resources to address social determinants of health. There was also an opportunity for C3s to share experiences

when stakeholders from the Linn County C3 development site discussed their experiences related to care coordination and coalition building.

The July 12 Learning Community conference had 224 registrants, with representation from all six C3s, providers, SIM staff, the SIM Leadership team, all five Medicaid ACOs, all three MCOs, and contracted vendors. The content concentrated on the concept of alignment. The conference featured experts from Idaho and Nebraska sharing insights from their own statewide healthcare transformation efforts. Other topics included understanding PCMH models, payment reform, how to utilize data tools such as ChimeMaps and GIS –mapping software, and a discussion about multi-sector collaboration models and applications.

Regional workshops

Regional workshops were designed to be held in a setting local to the C3 communities and to provide an outlet for C3 stakeholders to work through issues specific to their communities and the local health systems. Regional workshops were held in September and October 2016 at three sites, including Storm Lake, Ames, and Coralville. An IHC staff member who specializes in process improvement conducted the fall 2016 regional workshops. Participants from C3 sites had the opportunity to learn about the tools, organizational culture, and methods needed to implement and sustain QI processes within their coalitions.

Site Visits and Phone Conferences

IHC staff conducted several on-site visits to the C3 communities and held monthly phone conference calls with the leadership of the C3 coalitions. The intention of these visits and calls was to maintain a consistent contact and presence with the C3 communities to be able to educate, answer questions, and provide and receive feedback about progress toward SIM goals.

A more detailed timeline of these activities, including topics covered and attendance can be found in [Appendix E](#).

Quality Improvement Activities

Along with and often as a part of TA activities, IHC also utilized QI activities as part of CBPI. QI activities included implementing rapid-cycle performance improvement (RCPI) methods and designating QI advisors for each C3 community to assist them with developing QI initiatives and implementing RCPI methods. RCPI is the use of data to drive change within a community setting. Central to RCPI is the establishment of a plan, do, study, act (PDSA) cycle based on the data received by each community. QI advisors then facilitate the formation of and partner with teams composed of C3 project leaders and staff who are responsible for carrying out the PDSA processes within RCPI. In this role, QI advisors work in a TA capacity as they educate, train, and work with the C3 communities to collect and analyze data and implement performance improvement strategies.

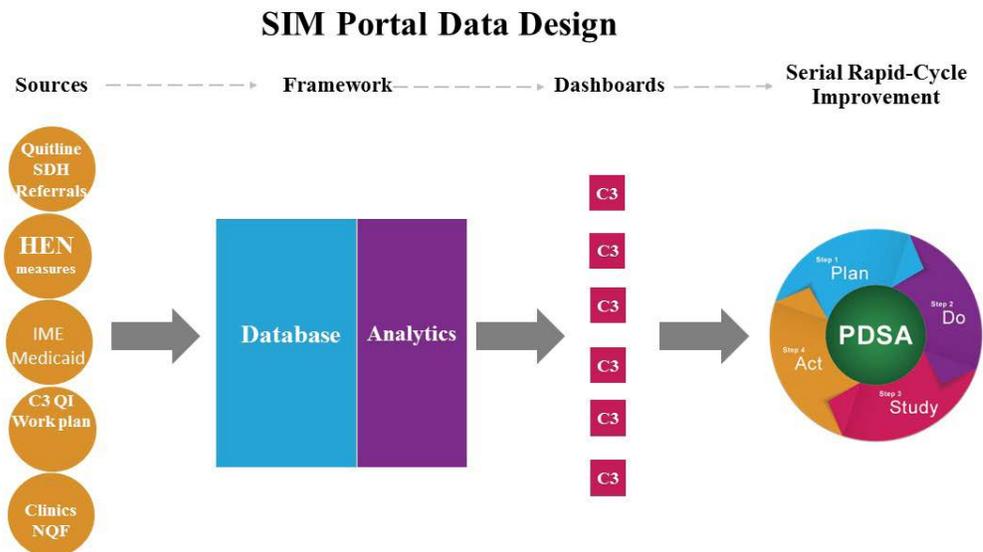
Several of the data tools that were introduced or were in development during this reporting period were designed to provide a backbone to the QI initiatives. The three data tools in particular were ChimeMaps, GIS mapping, and an electronic data portal (IHC-SIM Data Portal).

ChimeMaps are a data application used by hospitals to assimilate patient and public information for service line and market analysis, intervention planning, and community health needs evaluation. IHC envisioned broadening the scope of the ChimeMaps to include information that could be used to promote population health. To that end, in the second quarter of Year 2, IHC staff worked to promote ChimeMaps as a way to facilitate partnerships between the C3 projects and their local hospitals to share population health demographic data for the purpose of identifying high risk populations for enhanced care coordination. This work is ongoing and in the third quarter of 2016, 17 hospitals had partnered with C3 communities to use ChimeMap technology to capture data and promote the SIM objectives of care coordination to improve population health.

GIS mapping services were under development in the second quarter of Year 2 and became available in the third quarter for C3 communities to start using. GIS mapping is an online tool that can be used by the C3s to aid them in planning and delivering coordinated care services. For example, one of the

first maps displayed Medicaid admissions to hospitals located in areas near C3 communities. This work is ongoing with training webcasts and instructional YouTube videos planned. The intention is for C3 communities to take advantage of this technology during the coming months.

From the start of the SIM project, there was an intention to design and build a secure, web-accessible reporting database to collect C3 project-specific metrics from each of the communities. These metrics would be used in RCPI data reports to be shared between the C3 sites and the IHC. The purpose of this database was to use data to conduct serial rapid-cycle improvement through the use of PDSA methods. During the first quarter of the SIM, IHC began building this reporting database (to be referred to as the IHC-SIM Data Portal) which was modeled after its Hospital Engagement Network (HEN) Reporting Database. In the second quarter of Year 2, there was a re-evaluation of the IHC-SIM Data Portal and a decision was made to rebuild it to include statewide SIM-specific measures. In addition, during this time period, IHC worked to secure the necessary data use agreements with the C3s, met with the C3 communities to determine the best process measures for the development of C3-specific QI reports, and began holding meetings with the local hospitals and designated clinics in C3 communities to discuss the collection of patient-specific measures. The IHC-SIM Data Portal was rebuilt and became functional in the third quarter of Year 2. Each C3 project has access to a dashboard through which it can share and access data, including SIM-specific National Quality Forum (NQF) measures from hospitals and clinics in C3 counties, C3-specific data for tobacco Quitline and SDH client referrals, C3-specific QI process measures, and potentially preventable admissions data for Medicaid patients in each of the C3 counties. The following figure provides a graphical representation of the IHC-SIM Data Portal Design.



PDSA image source: <http://improvementmethodology.govt.nz/getting-started/understanding-model-improvement>

During Year 1 and most of Year 2, data collection design and methods for capture and use were being developed, built, and refined. By the third quarter of Year 2, data collection was beginning to become active and technology was being used to inform the performance and QI initiatives for the C3 communities. TA activities have included a focus on educating and training the C3 sites on the use of these technologies. The expectation is that this endeavor will grow and continue to be promoted in the coming grant years.

Value based Purchasing (VBP)

VBP is broadly defined as linking healthcare provider payment and incentives to improved quality of care and performance. This payment methodology is intended to hold healthcare providers accountable for both the cost and quality of care they provide. VBP programs can take on many forms but all attempt to encourage reductions in inappropriate care and identify and reward the best-performing providers. A primary driver of change in Iowa's SIM was to encourage an increase in the use of VBP within the three major payers for healthcare, namely Medicaid, Medicare, and

Wellmark. To do this, over the course of Year 1 and Year 2 of the SIM award years, SIM teams worked to increase both the understanding of and ability to participate in VBP contracts for providers. As a SIM goal, establishment of VBP is measured by an increase in the number of provider contracts in a VBP arrangement and number of lives covered under VBP contracts.

While the ultimate goal is to encourage VBP participation by all payers in Iowa, the initial focus of the VBP initiative was Medicaid. In 2014, the IME started using a quality measurement tool called the Value Index Score (VIS), a Treo Solutions product,⁷ to measure and track providers' quality outcomes. Around the same time, IME began to implement an ACO model for the Medicaid population. By 2015, there were five Medicaid ACOs in operation. Thus, the original initiative to promote VBP focused on the use of VIS measures and VBP contracting within the five Medicaid ACOs.

Also during the pre-implementation period (2015), SIM staff and leadership worked with Wellmark to encourage their efforts in VBP. Since 2012, Wellmark has had active ACO programs and has used the VIS quality measurement tool within its VBP programming. As part of the SIM initiative, Wellmark and Medicaid VIS tools were aligned so that the VIS could be used as the standard quality measurement tool for the SIM VBP efforts. In addition, SIM staff has worked with Wellmark to ensure that the Medicaid ACOs and Wellmark ACOs have similar intent with regard to SIM goals and VBP.

To get a sense of a baseline rate of VBP uptake in Iowa, by the end of the SIM pre-implementation year (2015), approximately 11% of Medicaid beneficiaries were receiving care under a VBP arrangement. And, around 45% of Medicaid providers and 53% of Wellmark providers were participating in a VBP program.

Original plans, timelines, and goals regarding the statewide adoption of VBP were disrupted by significant changes to the healthcare delivery landscape. Beginning in 2016, Iowa Medicaid implemented comprehensive managed care for almost all of its beneficiaries. Now known as Iowa HealthLink, the Iowa Medicaid program transferred coverage and payment for almost all Medicaid beneficiaries to three managed care organizations (MCOs). As a result of this major shift in the management of Medicaid in the state, the bulk of 2016 was devoted to working with partners at the MCOs to implement VBP programs within their organizations. IME developed definitions and criteria for determining eligible VBP models as a guideline for integrating VBP contracts and targets into the MCO contracts. The following guidance and criteria were developed to inform MCOs about VBP.⁸

7 Value Index Score (VIS) Overview. Treo Solutions. Iowa Department of Human Services. Accessed November 1, 2016 at <https://dhs.iowa.gov/sites/default/files/ProductBriefValueIndexScore.pdf>

8 Value based Payment (VBP) Models Definition and Qualifying Criteria for Determining Eligible Models. Iowa Department of Human Services. Accessed November 1, 2016 at <http://dhs.iowa.gov/ime/about/initiatives/newSIMhome/VBP>

VBP Operational Guidance for MCOs: The VBP models implemented by MCOs shall include but are not limited to risk sharing including both shared savings and shared costs between the MCO and the participating provider organizations, and bonus payments to providers for improved quality on a population basis. Both the bonus payment for improved quality and any risk sharing shall be evaluated using a Total Cost of Care (TCOC) methodology and the state’s approved set of risk adjusted quality measures called Value Index Score (VIS). A TCOC calculation at a minimum includes a comprehensive set of services approved by the state that spans across the continuum of care, including inpatient, outpatient, pharmacy, mental health, and Long Term Care Supports and Services (LTSS).

Examples of Qualifying VBP models:

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

Examples of Non-Qualifying VBP models:

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

Efforts to engage, inform, and update the various VBP stakeholders (Medicaid ACOs, MCOs, and Wellmark) about the SIM and, in particular the aspects of VBP programs, have included educational meetings and training sessions, invitations to SIM learning events, outreach by the SIM leadership, a monthly newsletter devoted to VBP (and SWAN) updates, and monthly phone calls. Table 12 summarizes these efforts during this reporting period.

Table 12. Timeline of Efforts to Promote VBP

Engagement Activity	Topics	Dates
Education & Training Meetings	Overview of SIM VIS Dashboard & HRA Review MCO presentation to SIM Leadership VIS Dashboard MCO view preview Learning Community Event Wellmark presentation to SIM Leadership	November 2015 March 2016 April 2016 May 2016 July 2016 August 2016
Monthly Phone Calls	Dashboard/VIS Updates SWAN Update Other SIM Updates Open Discussion	January – September 2016
VBP Partner Update Newsletters	Each provides: VIS score summaries SWAN updates Other SIM news	2014 – October, November, December 2015 – March, April, June, July, August, October, November, December 2016 – February, April, May

Evaluation Next Steps

The PPC state-level evaluation team will continue to monitor the progress and implementation of the SIM initiative in Iowa using the methods described in this report. The implementation evaluation will also include analyzing results from a statewide survey of Iowa residents, conducting interviews with the key stakeholders for each of the SIM initiatives, and conducting interviews with people who had experience with C3 care coordination activities. However, there are significant changes being proposed to the Iowa SIM initiative that will likely also require significant changes to the evaluation plan, including the process evaluation.

Appendices

Appendix A. SIM Metrics Reported to CMMI (Pre-Implementation Year 2015)

The following are definitions for the categories and metrics described in the goals/outcomes table. This table will be updated yearly throughout the SIM evaluation period based on the annual reports provided to CMMI.

Provider Organizations are healthcare related organizations which could be categorized as:

- Hospital – Organizations that provide inpatient medical care and other related services for surgery, acute medical conditions, or injuries.
- Ambulatory & Independent/Group Practice – Orgs that provide outpatient services, including community health centers, independent and group practices, cancer treatment centers, dialysis centers.
- Long Term Care – Orgs that provide long term, post-acute care and rehabilitative services including nursing homes.
- Home and Community Based Services – Orgs that provide opportunities for individuals to receive services in their own home or community.

Tax Identification Numbers are used to identify provider organizations.

Providers are staff employed at/represented by organizations participating in SIM which could be categorized as:

- Licensed Clinicians – Such as MDs, DOs.
- Other Licensed Professionals – Such as Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialists (CNS), Doctor of Dental Medicine (DMD), Doctor of Pharmacy (PharmD).
- Allied Health Professionals – Such as social workers, physical therapists, dental hygienists, care coordinators, community health workers, and medical interpreters.
- Beneficiaries/members/enrollees are individuals who receive any healthcare related services by the organizations participating in SIM.

Four Categories of Metrics included in the following table:

Model Participation Metrics - intended to capture data on the participation of providers in SIM as well as the number of beneficiaries impacted.

Payer Participation Metrics – specific to payer participation in value based purchasing and/or alternative payment models supported by SIM.

Model Performance Metrics –intended to capture data on quality, cost, utilization, and population health.

State Healthcare Landscape & Delivery System Reform – intended to capture data on providers and beneficiaries impacted by APMs in the state REGARDLESS OF SIM FUNDING.

SIM Metrics Reported to CMMI

Type	Metric Title	Definition	2015 Pre-Implementation	2016 Performance Year 1	2017 Performance Year 2	2018 Performance Year 3
Model Participation	Beneficiaries Impacted by SIM (Medicaid VBP only)	Total # of beneficiaries receiving care through each VBP and or APM supported by SIM / Total # of beneficiaries targeted for inclusion in VBP and or APM supported by SIM	64,599/592,711 (11%)			
Model Participation	Providers Participating in SIM (Medicaid VBP only – total Medicaid PCPs)	Total # providers participating in each VBP and or APM supported by SIM / Total # providers targeted for inclusion in each	2,740/6,136 (45%)			
Model Participation	Wellmark Providers Participating in VBP	Total # of PCPs participating in a VBP model / Total # of Iowa Wellmark PCPs	1,993/3,746 (53%)			
Model Participation	Provider Organizations Participating in SIM (Medicaid VBP)	Count of total # of provider orgs participating in VBP and or APM supported by SIM	40			
Model Participation	Wellmark Provider Organizations Participating in VBP	Count of total # of provider organizations with a VBP contract with Wellmark	0			
Model Participation	Population Impacted by SIM	Total # of Medicaid beneficiaries receiving care through any VBP and or APM supported by SIM / Total population of Iowa	64,599 / 3,100,000 (2%)			
Model Participation	Providers Participating in SIM	Total # of Medicaid providers participating in VBP or APM models supported by SIM / Total # of providers in Iowa	2,470 / 6,136 (40%)			
Model Participation	Provider Orgs Participating in SIM	Total # of Medicaid provider orgs (with PCPs) participating in any VBP or APM models supported by SIM / Total # of PCP provider orgs in Iowa	40 / 327 (12%)			
Model Participation	Provider Orgs Participating in SIM C3s	Total # of provider orgs participating in C3 / Total # of provider orgs in the C3 Community (those counties identified as a C3 service area)	54 / 116 (47%)			
Model Participation	Providers Participating in SWAN	Count of total # of Alerts generated through SWAN	3,222			
Model Participation	Stakeholder Participation	Count of total # of people who attend a Learning Community Event	410			
Payer Participation	Medicaid Cat 1 Payments – FFS with no link of payment to quality	Beneficiary Count % of Payments to Providers	4,726,687 70%			

Type	Metric Title	Definition	2015 Pre-Implementation	2016 Performance Year 1	2017 Performance Year 2	2018 Performance Year 3
Payer Participation	Medicaid Cat 2 Payments – FFS with payment linked to quality	Beneficiary Count % of Payments to Providers	2,048,343 30%			
Payer Participation	Medicaid Cat 3 – Alternative Payment Models	Beneficiary Count % of Payments to Providers	0 0%			
Payer Participation	Medicaid Cat 4 – Population-based Payment (PACE)	Beneficiary Count % of Payments to Providers	2,825 0.2%			
Payer Participation	Wellmark Cat 1 Payments – FFS with no link of payment to quality	Beneficiary Count % of Payments to Providers	1,186,573 68%			
Payer Participation	Wellmark Cat 2 Payments – FFS with payment linked to quality	Beneficiary Count % of Payments to Providers	0 0%			
Payer Participation	Wellmark Cat 3 – Alternative Payment Models (ACOs)	Beneficiary Count % of Payments to Providers	494,471 32%			
Payer Participation	Wellmark Cat 4 – Population-based Payment	Beneficiary Count % of Payments to Providers	0 0%			
Model Performance	HEDIS Ambulatory Care Emergency Dept Visits	HEDIS definition	367,903/611,078 (60%)			
Model Performance	Plan All-Cause Readmissions	NQF Measure #1768	1,946/17,206 (11%)			
Model Performance	Total Cost of Care	NQF Measure #1604 [risk-adjusted PMPM Index]	420.93			
Model Performance	PopHealth: Tobacco Use Screening & Cessation Intervention	NQF #0028: See definition	Not provided			
Model Performance	PopHealth: Body Mass Index (BMI) Screening & Follow-up	NQF #0421: see definition	Not provided			
Model Performance	Potentially Preventable Readmissions	3M Grouper definition – see metrics definition	3,569/56,876 (6%)			
Model Performance	Potentially Preventable ED Visits	3M Grouper definition – see metrics document	255,422/359,012 (71%)			

Type	Metric Title	Definition	2015 Pre-Implementation	2016 Performance Year 1	2017 Performance Year 2	2018 Performance Year 3
Model Performance	PopHealth: Tobacco Use Quitline	# of calls, faxes, and web-based services conducted by Quitline Iowa / Number of Iowans over age 12	13,016/2,599,411 (1%)			
Model Performance	PopHealth: HbA1c Management for Diabetes	NQF #0059: # of patients whose most recent HbA1c level is > 9.0% (during measurement period) / Patients 18-75 with diabetes with a visit during the measurement period	Not provided			
Model Performance	Weight Assessment and Counseling Children & Adolescents	NQF #0024: see definition	Not provided			
Model Performance	Adverse Drug Events	# of acute care adverse drug events that cause harm / # of acute care discharges	Not provided			
State Landscape	Population impacted by VBP & APM (all payer benes)	Total # of benes receiving care through any VBP or APM model / Total state population	559,070/3,100,000 (18%)			
State Landscape	Providers participating in VBP & APM (all payers)	Total # of providers participating in any VBP or APM model / Total # of providers in the state	2,740/6,139 (45%)			

Appendix B. Stakeholder Engagement Addendum

Leadership Team Meetings

The SIM Leadership team was initially scheduled to meet three times per year. However, meetings were convened as needed when issues arose during implementation that needed to be addressed. For example, with the advent of MACRA and its effect on the VBP activities of the SIM, the leadership team shifted course and scheduled additional meetings to address this directional shift.

SIM Public Forum

SIM Public Forums were established to provide regular opportunities for two-way communication between SIM representatives and the public through three public arenas: 1) Iowa Medicaid Clinical Advisory Committee, 2) Patient-Centered Health Advisory Council and 3) Medical Assistance Advisory Council. The following table provides meeting dates and settings for these public forums.

Public Forum	Forum Dates
Iowa Medicaid Clinical Advisory Committee	April 17, 2015 July 17, 2015 October 16, 2015 January 15, 2016 April 15, 2016 July 15, 2016
Patient-Centered Health Advisory Council	August 12, 2015 November 18, 2015 May 20, 2016
Medical Assistance Advisory Council	May 14, 2015 May 28, 2015 August 31, 2015

Through public forums, the SIM team reports milestone metrics and disseminates updates regarding SIM activities. Additionally, public stakeholders and those directly impacted by SIM initiatives have an outlet to provide feedback. The SIM team has established a process for responding to public comments, which includes recording feedback and reporting any recommendations about current or upcoming SIM activities to the SIM Leadership Team.

SIM Website

The [SIM website](#) is housed on the Iowa DHS website and maintained by the IME Office of Healthcare Transformation. Along with continuous updates of SIM activities, vision, and goals, the SIM website contains information about public forums, meeting agendas and minutes, SIM presentations and reports, SIM guiding principles, statewide strategies, and links to SIM partner websites.

The SIM website is used to familiarize stakeholders with SIM initiatives and promote adoption. For example, press releases and success stories from providers using SWAN to coordinate care are posted on the SIM website.

Short Term Integration Workgroups

The short term integration workgroups are responsible for establishing methods for integrating VBP to specific populations, including long term care, behavioral health, children and youth with special healthcare needs (CYSHN), and dual eligible Medicaid-Medicare beneficiaries. Along with adapting VBP to particular settings and populations, the workgroups are responsible for integrating social determinants of health (SDH) into the VBP programming. Meetings and conference calls facilitated by the IME SIM staff - by invitation only September 2015-December 2016.

Operation of SIM feedback e-mail account

The IME Office of Healthcare Transformation manages the SIM feedback e-mail account. The establishment of an e-mail account dedicated to the SIM provides an outlet for communication between public stakeholders and the SIM team.

Delivery System Meetings and Correspondence

Partnerships between the IME, Medicaid ACOs, and Medicaid MCOs are critical to improving healthcare delivery, lowering the cost of care, and advancing population health. The IME is responsible for ensuring ACOs and MCOs are capable of analyzing data to improve care and measure progress within Medicaid programs. Medicaid ACOs and MCOs are responsible for implementing best practices and using data analysis in decisions concerning resource allocation and process improvement. To sustain these partnerships, IME staff held monthly phone conferences and semi-annual meetings with each of the five Medicaid ACOs each month during this evaluation period. With the introduction of Medicaid Modernization in the state, Medicaid MCOs were included in meetings beginning in January 2016. In order for the SIM to operate, ACOs and MCOs need to have the capacity to fully participate in VBP and the SWAN. During these meetings, IME collected feedback about shortcomings in data or HIT readiness that created barriers for ACOs and MCOs in their progress towards SIM goals.

IME distributes timely information to each ACO and MCO via an eCommunication newsletter, which contains updates for the 1) VIS dashboard, 2) SWAN, and 3) SIM. Routine meetings and correspondence with these partners allows the IME to share updates concerning progress toward SIM goals, including the data sharing process, timelines for meeting benchmarks, and implementation of VBP.

Medicaid ACO updates based on monthly communication with IME are available publicly on the [SIM website](#). Between February 2015 and November 2015, the updates were posted to the website with the title "ACO Partner Updates". Beginning in December 2015 through April 2016, ACO meeting updates were posted with the title "VBP updates." Since May 2016 to the present, the monthly update is titled V2V (Volume to Value).

VIS User Group Conference

SIM contracts an external vendor, 3M, to meet annually with VIS users to collect feedback about the delivery and measurement of VIS. The VIS uses claims data to measure the quality and efficiency of care delivered. For these user group conferences, 3M included representatives from all MCO and ACO payers. These meetings were to be conducted by 3M in the summer or fall of each grant year.

Community Health Partners of Sioux County



Project Director:	Kim Westerholm, Community Health Partners of Sioux County
Project Director Contact:	kim.westerholm@siouxcountychp.org; 712-737-2971
C3 Type:	Implementation
Service Area:	Sioux County
C3 Funding Received:	\$179,268

C3 Steering Committee

The Sioux County C3 Steering Committee is comprised of individuals from each of the 4 hospitals in the county, community stakeholders and committed community members.

Planned Year 1 Activities

Community Health Partners of Sioux County will be implementing the following activities in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Increase the number of providers assessing patients for tobacco use at each visit through collaboration with the local Community Partnership, partnering with primary care providers, and conducting a provider survey.
- Link C3 participant referrals for tobacco users to cessation services, including referrals to classes, counseling, primary care providers, and fax referrals to QuitLine.
- Increase fax referrals to QuitLine by providing training and developing a referral process for all C3 care coordinators.
- Facilitate 2As and R training for providers and follow up to ensure implementation.
- Ensure assessment of BMI for all C3 participants, and lower participant BMI, increase physical activity through Complete Streets and Joint Use policies, and increase breastfeeding knowledge in providers.
- Increase participation in county diabetes prevention programs, hold diabetes screening events, and increase the number of C3 participants with an A1c value equal to or less than 7.0 through screenings and referrals to diabetes education, and self management.

Social determinants of health activities include:

- Educate providers on the Lemonade for Life tool to address Adverse Childhood Experiences in the service area.
- Promote utilization of health literacy based tools.
- Increase access to physical activity and recreation resources.
- Reduce stressed housing by collaborating with community leaders and the Community Health Needs Assessment task force to provide support to communities.
- Initiate the development of a county-wide intra-community transportation system through the use of a committee and administrative support.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/new-SIMhome>.



Dallas County Public Health Nursing Services



Project Director: Jennifer Walters, Dallas County Public Health Nursing Service

Project Director Contact: jennifer.walters@dallascountyiaowa.gov

C3 Type: Implementation

Service Area: Dallas County

C3 Funding Received: \$236,780

C3 Steering Committee

- 4RKIDS ECI
- American Diabetes Association
- American Lung Association
- AmeriGroup
- AmeriHealth Caritas Iowa
- Bluebird Integrative Health
- CareMore Care Ctr
- Citizens
- Crisis Intervention/Advocacy
- Dallas County Board of Health
- Dallas County Community Services
- Dallas County Conservation
- Dallas County EMS
- Dallas County Habitat for Humanity
- Dallas County Hospital
- Dallas County Public Health
- Dallas County Public Health
- Des Moines University
- Des Moines MPO
- Eat Greater Des Moines
- HIRTA
- HomeCare
- Hunger-Free Dallas County Coalition
- Iowa Chronic Care Consortium
- Iowa Clinic
- Iowa Community Health AmeriCorps Program
- Iowa Department of Public Health
- ISU Extension
- Juvenile Court Services
- Mercy
- Mid Iowa Health Foundation
- Municipalities
- New Opportunities
- Primary Health Care
- SAIL-DC (volunteer driver program)
- Sumpter Pharmacy & Wellness
- Telligen
- United Way of Central IA
- Unity Point Clinic
- Unity Point Health Des Moines
- Waukee United Methodist Church
- West Des Moines EMS
- YMCA Healthy Living Center

Planned Year 1 Activities

Steering Committee

- Promote coordination of care across systems through regular meetings, resource mapping, data sharing, and intervention planning
- Implement referral systems and provide care coordination to address diabetes, obesity, and tobacco
- Connect residents with resources, education, and social supports through utilization of the existing Health Navigation Program
- Collaborate with the C3 coalition to identify and implement other community-applied policies and strategies to support health

C3 Coalition

- Collaborate with the Transportation Advisory Group (TAG) and Supporting Active Independent Lives in Dallas Center (SAIL-DC) to improve transportation options – including hosting town halls, providing HIRTA ride vouchers to low-income residents, and piloting a volunteer driver program
- Collaborate with Hunger-Free Dallas County to increase access to healthy foods through continued implementation of a healthy corner store initiative in Perry, improving concession stand and pantry options, and increasing access to healthy foods in communities
- Increase physical activity through alignment with existing statewide programs, connecting residents to physical activity programs and resources, implementing a volunteer-led walking school bus, and educating municipal leaders on evidence-based strategies and policies
- Host community summits and training opportunities to increase community awareness around social connection, poverty, and cultural competence



April 2016

Great River Medical Center



Project Director: Sue Ferguson, Great River Medical Center

Project Director Contact: sferguson@grhs.net

C3 Type: Developmental

Service Area: Des Moines County

C3 Funding Received: \$152,759

C3 Steering Committee

The Great River Medical Center C3 Steering Committee is comprised of individuals from the hospital, stakeholders from public health and a variety of community resources, and committed community members.

Planned Year 1 Activities

Great River Medical Center will be implementing the following activities in year 1 to address the required target areas of tobacco, diabetes, and obesity, and other CHNA/HIP priorities of mental health, poverty, and violent crimes:

- Sub-committees will be developed to assess resources, identify needs, develop action plans and begin to implement action plan for each area to improve population health.

Social determinants of health activities include:

- Host workshops for providers to educate how social, economic, and environmental factors impact health. These workshops will be provided by the University of Iowa's Community & Behavioral Health Department.
- Educate C3 Steering Committee members on community resources available in the service area.
- Identify ways to improve collaboration to ensure community members have access to services and resources by reviewing evidence-based policies, systems, or environmental changes and creating and implementing an action plan.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/new-SIMhome>.



April 2016

Linn County Board of Health



C3 Awardee:	Linn County Board of Health
Project Director:	Cynthia (Cindy) Fiester, Linn County Public Health Department
Project Director Contact:	cindy.fiester@linncounty.org; 319-892-6081
C3 Type:	Developmental
Service Area:	Linn County
Blue Zones Communities:	Cedar Rapids and Marion
Linn County C3 Funding Received:	\$245,466

C3 Steering Committee

- Linn County Community Services
- United Way of East Central Iowa
- Linn County Public Health
- CarePro Health Services
- Heritage Area Agency on Aging
- UnityPoint Health, St. Luke's Hospital
- Abbe Center for Community Mental Health
- Mercy Medical Center
- Eastern Iowa Health Center (FQHC)
- Care Initiatives
- Community Health Free Clinic; His Hands Free Clinic
- Transportation Advisory Group & Horizons/ Neighborhood Transportation Services
- Four Oaks

Plans are underway to integrate with the Community Health Needs Assessment/ Health Improvement Plan steering committee. SIM Steering Committee members will be added to assure representation from the key SIM areas of tobacco, obesity, diabetes, and social determinants of health.

Planned Year 1 Activities

The Linn County Board of Health, in collaboration with the two local hospitals and a multitude of other community partners, completed an in-depth assessment of Linn County's community health needs in 2015. As a result, three strategic issues have been chosen for the 2016-2019 Community Health Improvement Plan: Health Promotion, Behavioral Health, and Social Determinants of Health. The Linn County SIM project will assist with addressing these community needs by:

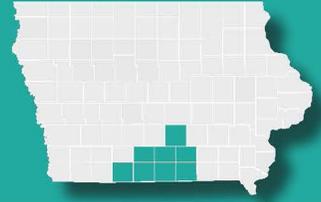
- Conducting comprehensive assessments to identify populations at risk of or engaged in tobacco use; or at a higher risk for developing obesity or diabetes.
- Compiling a database of stakeholders providing prevention, control or referral programs in the areas of diabetes, tobacco and obesity.
- Analyzing and modifying current referral practices for addressing social determinants of health.
- Updating the Community Health Profile to add increased focus on Access to Care and Social Determinants of Health.
- Identifying Community Care Coordination software to address social determinants of health in collaboration with community partners.
- Expanding an existing workgroup that focuses on diabetes and investigating opportunities to address medication safety in persons having diabetes.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/newSIMhome>.



April 2016

Marion County Public Health Department



Project Director:	Kim Dorn, Marion County Public Health Department
Project Director Contact:	kdorn@marionph.org; 641-828-2238
C3 Type:	Developmental
Service Area Counties:	Marion, Clarke, Lucas, Monroe, Ringgold, Decatur, Wayne, and Appanoose
C3 Funding Received:	\$285,983

C3 Steering Committee

- Ginny Krichau, Knoxville Hospital and Clinics
- Jill Sage, Knoxville Hospital and Clinics
- Ilene Johnson, SIEDA Community Action
- Vondale Tonelli, Domestic Violence and Abuse, DODDS
- Cheryl Garland, Integrated Counseling Solutions
- Stephanie Gehlhaar, Tenco
- Shelly Bickel, Decatur County Public Health
- Angie Mitchell, Knoxville Schools, School Nurse
- Karna Alexander, Community Member
- River Hills FQHC
- xlst, Behavioral Health
- Kendra Fries, Hy-Vee Dietician
- Milestones Area on Aging
- Angela Nelson, CROSS Mental Health Region

Marion County Public Health intends to add additional members to the C3 Steering Committee, including the Health Coach and Ambulance Director from Wayne County Hospital, an ARNP, and representatives from Monroe County Public Health, SCICAP, Mercy ACO, HIRTA Transportation, and Delta Dental Foundation.

Planned Year 1 Activities

Marion County Public Health Department will be working to strengthen existing partnerships and build new relationships with a variety of providers throughout the first year. The following activities will be implemented in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Engage partners throughout the eight-county service area in the coalition through partner agreements, quick wins, and workgroups.
- Develop and promote a region-wide standardized screening and referral process for tobacco, diabetes, and obesity. Evidence-based training and resources will be provided to all C3 Partners on care coordination and population health initiatives. TAV software will also be utilized to share data and ensure consistent communication.
- Work with school district nutrition directors and physical education directors, the University of Iowa Obesity Research and education Initiative, Mercy and UnityPoint ACOs, and local pharmacies to build and strengthen the coalition and referral processes.

Social determinants of health activities include:

- Ensure C3 Partners utilize the TAVHealth software for all community care coordination referrals.
- Develop and promote a region-wide standardized screening and referral process for Social Determinants of Health.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/newSIMhome>.



April 2016

Webster County Health Department



Project Director: Kari Prescott, Webster County Health Department

Project Director Contact: kprescott@webstercountyia.org; 515-573-4107

C3 Type: Implementation

Service Area Counties: Buena Vista, Calhoun, Hamilton, Humboldt, Pocahontas, Sac, Webster, and Wright

C3 Funding Received: \$216,500

C3 Steering Committee

- Aaron McHone, Berryhill Mental Health Center
- Kelli Wallace, UnityPoint Family Medicine
- Pam Halverson, ACO UnityPoint
- Kari Prescott, Webster County Health Department
- Jane Condon, Calhoun County Public Health
- Diane Ferguson, Pocahontas County Public Health
- Michelle Hankins, Humboldt County Public Health
- Shelby Kroona, Hamilton County Public Health
- Tiffani Toliver, Wright County Public Health
- Rhyan Wing, Community Representative
- Jennifer Wuebker, Webster County Health Department
- Jackie Duffy, Sac County Public Health
- Pam Bouge, Buena Vista County Public Health
- Kathy Nicholls, Wright County Public Health
- Sherri Richardson, Pocahontas County Public Health
- Renae Kruckenberg, Fort Dodge Community Health Center

Planned Year 1 Activities

Webster County Health Department will be working with seven other county health departments, local health systems, community resources, and the Accountable Care Organization to implement the Community Care Coordination Initiative. The following activities will be implemented in year 1 to address the required target areas of tobacco, diabetes, and obesity:

- Standardize wellness lab panels to identify the presence of diabetes, provide diabetic education to diabetic clients, and develop diabetic action plans for diabetic clients.
- Promote awareness of QuitLine to community partners, and increase smoke-free and tobacco-free policies in the community.
- Obtain BMI scores of clients and develop an outreach strategy for clients. Education will be provided to clients with a BMI of 30 or more. Develop resource inventories for healthy eating and physical activity and distribute to C3 navigators, health coaches, and care coordinators.

Social determinants of health activities include:

- Assess clients for needs through a basic assessment and psycho-social assessment
- Refer clients for appropriate and available services both from medical and behavioral health appointments as well as from assessment results. Analyze gaps on a quarterly basis.
- Increase the rate of referral follow-ups through patient engagement, motivational interviewing, transportation assistance, and financial assistance. Analyze gaps on a quarterly basis.

Other CHNA/HIP priorities include:

- Coordinate care for asthmatic children and children with complex diagnoses through primary care providers, schools, daycare, and families.
- Complete high-risk assessment on WIC children and connect to community resources.
- Conduct high-risk assessments on incarcerated persons with multiple chronic conditions as well as adults with multiple chronic conditions, and persons with a mental health condition.

For more information on the State Innovation Model in Iowa, visit <http://dhs.iowa.gov/ime/about/initiatives/newSIMhome>.



April 2016

Appendix D. Details from Baseline Interviews with C3 Communities

The summary below is derived from the qualitative interviews with C3 personnel conducted in September 2016. The interview question template is included for reference. To protect the confidentiality of the C3 sites and personnel who participated, we grouped the comments into the following categories: 1) Overview of the C3s and Initiatives in Progress, 2) Successes, 3) Challenges, 4) Needs, 5) Concerns, and 6) Next Steps.

Baseline Interview for all C3 Sites – Interview Script
<ol style="list-style-type: none">1. Provide an overview of the C3. In particular, who are the key partners, how is it organized, and describe any changes that have occurred since submitting the initial proposal.2. What community, health system, structural, and process related changes are occurring because of C3 activities?3. Describe activities that are underway and/or being developed to address tobacco cessation, diabetes, and obesity. Do you have any plans for changing this in the upcoming grant year? Is there anything your team needs to be supported in this work? Do you have any recommendations for other teams that are and/or will be working to address these challenges?4. Have you been using information technology to facilitate cross communication and/or documentation with the C3? Describe.5. What have been your greatest successes and challenges thus far in the grant period? Have you made any adjustments to project plans because of these successes or challenges?6. What is your vision/planned changes to the C3 for the coming grant period?7. Over the past several months your C3 has participated in various workshops and/or technical assistance through the SIM/IA Healthcare Collaborative. What has been helpful, not helpful? What additional support would be helpful to your C3?
Overview of C3s and Initiatives in Progress
<ul style="list-style-type: none">• Had a stagnated period with difficulty getting community members on board.• Focusing on developing relationships and working with the community, as well as tapping into community partners' resources and connections.• View the C3 as "support agents" for each of the communities involved.• SDH is built into the steering committee activities vs. having a separate sub-committee for each.• They are building on and developing the C3 based on findings from the CHNA. Past CHNAs sat on shelves. Current one developed in coordination with LPH and other partners.• Hired 2 staff to manage and operate C3.• Pre-diabetes program is established. First class is full. Will be starting a physician referral component where MDs will screen patients for pre-diabetes and refer them into the program. Because the YMCA and LPH are C3 partners, they didn't start their own pre-diabetes program but instead are engaged in this community-wide program. The program: 1) education community about pre-diabetes; 2) How to address; 3) know the local services to address; 4) local level collaboration (MDs, YMCA, LPH); 5) Use NDPP through LPH as the community program; 6) LPH offers a 12-week course).• Meetings have been held with about 20 people representing 15 community organizations.• Reflected on the work of Healthy [neighboring county initiative] and what they have accomplished with limited outside investment.• Local organization received a Community Partners of Health grant to implement tobacco cessation activities (beyond current Quitline).• Initially planned to have steering committee and work groups develop project plans but these groups want to be directed and guided based on C3 requirements.• Planning and development have focused on SDH related activities• Plan was to train local teams to do care coordination but all of the hospitals and clinics are already doing some form of clinical care navigation and they believe they are doing it well. Internally, this approach is working, it's the SDH portion that is getting missed.• Each county is developing based on current status, needs, and resources.• [County] LPH was already using TAV. They now have 3 data sharing agreements in place: 2 hospitals and 1 AAA. 3 agreements are in process with hospitals and school.• Hospitals have asked to be paid to participate. Subcontracts are in place, up to \$10k each, and are billed on a time/patient basis.

- Initially serving 40-50 patients but now serving 200-300/month.
- Paper referral forms are adapted versions from [name removed] County and what they developed through the Safety Net. The forms are standardized and used by those not in TAV. Those using paper forms complete them, fax to [County] LPH and then they enter the data into TAV.
- [Name removed] County was initially a part of the C3 but they have backed out.
- Work groups: Tobacco, diabetes/obesity, and BH.
- There is an adversarial dynamic that exists between hospitals [in C3 area] and [one of the participating clinic entities].
- Spending time looking at data sharing technology options for the community. Challenging because of the types of organizations involved, in particular, large, urban, competing hospitals/systems.
- Three vendors have shared their technology. The coalition has decided to pursue TAV health.
- United Way had funds to purchase a new data sharing system for community care coordination. Their project is on hold until the C3 can make some decisions.
- Intent is to have several local programs go-live with the C3 using the same system (e.g., iSmile, ACES, First Five, an FQHC).
- Need additional buy-in from community partners, in particular, they are looking for the return on investment that results from community care coordination.
- C3 initiative has been presented to local groups. Community areas of interest have been identified beyond what was originally noted, (e.g., homelessness).
- They are being strategic in development and the partners involved because they don't want to lose partnerships because they are brought into the project prematurely. Examples of this are transportation and pharmacy. Instead, they are establishing the project foundation, bringing partners on-board, adding more to the foundation, adding additional partners, etc.
- They have been told they should have a C3 steering committee and a coalition. Too many of the people that would serve on both groups so they only have one. Committees will be established as needed.
- Although the CHNA was completed additional data are needed to help support the C3.
- The referral system assessment tool was used and adapted and has been really helpful.
- This initiative has been developing over the past six years through various funding and other supports, including prior state safety net, care coordination grants, and now SIM funding.
- Steering Committee has more clinical representation. They hold monthly meetings, to discuss and plan referral process, connecting, health navigation, and accessing and using data. This group's engagement has increased. Shifted from physician involvement in planning to nurses.
- Health systems were asked, "What would be helpful to know about your patient population?" Focus was on C3 core areas and included Unity Point, Primary Healthcare Inc., Mercy, and Iowa Clinic. All patients with [C3] County zip codes were included (some [C3] Co zip codes also fall into [neighboring] County). May 2015 – May 2016 was the study period.
- Initiative also hosts a community committee that includes Steering Committee members (invited); however, those attending usually work in the area(s) being discussed at the meeting (e.g., diabetes).
- Initiative activities complement CHNA HIP.
- DCPH has started several SDH initiatives over the years. All of these are funded through other sources but all support the intended outcomes of the SIM C3 (diabetes and BMI – food and exercise programs and transportation). C3 Steering and Community Committee members provide input:
 - Food: Hunger Free [C3] County - convening all of the area food pantries for planning and program development, mobile pantry, and a backpack program.
 - Food: Healthy Corner Store – Partnership with Iowa Extension. Signage and training on how to store food, moving health food items closer to the counter.
 - Food: Double Up Food Bucks – Anyone in the SNAP or EBT programs can double their fresh produce purchase up to \$10.
 - Food: Online ordering system and volunteers deliver food.
 - Food: Community garden with 500 lbs. of food donated.
 - Exercise: Walking School Bus – 3-year initiative funded by Wellmark and using an AmeriCorp and local groups, 40 kids, walk to school on a longer route (1 mi), Friday mornings.
- Diabetes classes and tobacco prevention program
- Care coordination

- Clinic partners continue to refer patients using fax.
- Track referring person and organization because staff turnover occur regularly.
- Use 'Salesforce' for their data tracking system.
- They continue to build on and develop project developed as part of the community care coordination collaborative from the past 3 years.
- Continue to have a strong relationship with [a local health system], including on-going participation in the weekly EDDC (ER high use) meetings where they discuss patients that are over-using the ER.
- They continue to have access to the [local health system] EHR (Epic) where they can look at last encounters, vaccinations/immunizations, screenings, and ER visits of patients.
- [Local behavioral health provider] is bringing primary care into their mental health clinic.
- Patient volume for the C3 has increased.
- All of [Name removed] County PH services have moved to CHAMPS. They are working with [a local health system] to provide access to CHAMPS as well. [Four additional counties] also use CHAMPS.
- Have established a central referral point at [Name Removed] Co PH for C3 patients. All calls go to [Name Removed] Co PH and fax was moved to [Name Removed] Co PH workstation.
- [Two] counties continue to fax patient activities to [County]. All counties [in C3 area] can access EPIC Care Link. 40% of counties are fully in EPIC and access patient data there.
- [Name Removed] County has become more engaged.
- [Name Removed] County C3 participated in an EDDC meeting to learn about it.
- They are working with local organizations to further integrate and leverage funding, activities, to create a more seamless system that serves more people, better, with better outcomes.
- There are 32 measures in the [local ACO]. Everyone is working on these measures together as common goals.
- They have worked hard at including those that support the mission of the C3s. For those that do not, they have been let go.
- Steering Committee meetings are held every quarter. However, C3 staff are a part of meetings across the county and region and are active in the ACO.
- [A local health system] has their own home health agency (along with LPH agencies). [Name Removed] Co PH met with them, discussed who the "ideal patient" is for each organization and agreed there is enough work for everyone. Prior to this meeting [Name Removed] Co PH had 85 home care patients. Since then they have had around 125.
- They have noted that nurse practitioners are more likely to refer patients to the C3. Additionally, there are differences between what/type of patients nurse practitioners and physicians refer.
- Care coordinators (CC) are imbedded into the healthcare system.
- 6 total with 2 at the PH office and 4 in the field (hospitals and clinics)
- 1 CC is bilingual, focus tends to be on SDH
- Have a paper care coordination documentation system.
- Still working on the flow
- Decided to remain paper so the process is not dictated by the software
- First referral occurred May 2016.
- 4 of the hospitals involved.
- 3 different EHRs
- They have developed a network relationship with local hospitals over the past 8 years. All of the hospital administrators serve on the CHP board of directors. This has allowed them to build trust and identify issues they can work on together without being competitive. They have learned that clinics and hospitals operate differently.
- An FQHC is part of the initiative, including on the steering committee, but there has been some friction because the FQHC added an internal CC and they do not refer based on the C3.
- Established a diabetes prevention program.
- Used national diabetes prevention program as template.
- Targeted at those with pre-diabetes and/or high risk scores.
- Met with a diabetes coordinator at 3 hospitals to create the training.
- 27 people attended first meeting

- 2 diabetes coordinators wrote for grants to enhance the program.
- Obesity activities (not funded by SIM)
- 5210 Program that was started in Maine and [Name removed] County has been implementing for 3 years.
- Monitoring BMI of school kids (grades K, 3, 5) as part of a surveillance program conducted by school nurses. There is no "screening" so there is no follow-up.
- They have been seeing patients as part of the C3 for 1 quarter.

Successes

- Pre-diabetes program.
- Working with and leveraging the resource of regional planning commissions/committees (e.g., [Regional] Planning Committee).
- Two public health professionals are managing the C3 and they are able to bring this perspective into the health system.
- [Local Hospital] is developing an internal care management system.
- Article was published in the local paper talking about the initiative and the project manager.
- Great working relationships with staff who are "boots on the ground".
- Building on relationships already established through local coalitions, non-profits, clinics and hospitals. Best hospital relationship is with [Name removed].
- Focusing on social determinants of health
- Project alignment with United Way Spark 5 project.
- Partnerships with the United Way.
- Community buy-in.
- Have a training program where clinical staff can shadow [Health Navigators] as they meet with patients outside of the clinical setting.
- Participated in a Health Leads training that was directed at improving the screening process to better address SDH.
- Care Coordinators are spending more time with patients so patients can learn about the healthcare system and how to more independently navigate it and they are teaching patients new care skills.
- Shifted from focusing on physician involvement and buy-in to nurse involvement and buy-in which has increased overall clinical involvement and support.
- Weekly ED meetings to discuss and plan for meeting the needs of high utilizers.
- AM huddles are conducted by lead staff.
- Moving from a paper and fax care coordination process to a paperless process.
- Multi-county C3 development.
- Data sharing: EHR (by C3) and care coordination (by healthcare providers/system).
- Creating a county-wide, integrated social-health delivery system.
- Putting technology in the hands of front-line workers.
- Have process improvement built into the initiative and its development.
- Using staff's credentials to their fullest.
- Established a diabetes prevention program.
- Increasing referrals to diabetes prevention program.
- Tracking patient stories.

Challenges

- Keeping community partners engaged and moving forward, in particular if there is a shift in C3 goals and objectives.
- Many of those working in the health system are still in silos. Trying to move out of this, in particular in addressing readmissions but movement is slow.

- Hospital inter-agency meetings are too big and allow work to remain in silos.
- Competitiveness of area hospitals (e.g., [Name Removed] Hospital participated initially but has backed out).
- Organization leaders/decision makers don't trust one another.
- Local hospitals and health systems seem to be unwilling to share aggregated patient data related to core SIM areas (e.g., tobacco use, diabetes, and obesity).
- Duplicative reporting to IDPH and IHC.
- IDPH and IHC requests that are derailing/taking a lot of time away from project development.
- SIM pressure to implement even though they are a developmental grantee.
- In ability to use SIM funding for data sharing technology.
- Requests are made to the IHC and IDPH but there is no response/TA provided.
- Engagement by LPH departments given several have limited staff. In addition, some LPH don't collect data.
- Some local organizations (including LPH) don't have a clear understanding of their mission and roles.
- The further south a person is from [City], the more limited the LPH resources.
- LPH's engagement is limited by staff time and resources. Even if the C3 pays for staff time, it is not enough to maintain the needed staff at each site.
- [2 Local Clinics] are not engaged in the initiative.
- Engaging Casey's Convenience Stores in discussions about healthier food options.
- Changing the paradigm to one where there is no competition regarding patients and they are not "owned" but are rather served towards achieving health, wellness, and better outcomes.
- Apparent changing direction of the SIM and the C3s.
- Duplicated efforts and lack of coordination by IDPH and IHC which results in more busy work for C3s.
- ACO focuses mainly on Medicare. They are working as a community to get beyond this population.
- Cannot get buy-in from CAHs because their reimbursement is not based on health outcomes. Note there is a difference in CEO buy-in if the CEO lives in the CAH community (vs. commuting).
- Duplicative reporting to IDPH and IHC.
- Requests are made to the IHC and IDPH but there is no response/TA provided.
- Closing the loop on the referral process and data collection.
- Being able to concisely describe the SIM and the work of the C3.
- Lack of electronic software for data tracking.

Needs

- Opportunities to network with implementation grantees, focusing specifically on the work underway by a developmental grantee.
- Listing of care coordination vendors being used nationally.
- Tools to address/respond to the media.
- Targeted TA that is identified by asking them what their needs are.
- Don't have and haven't identified an e-data tracking system for the community. Exploring this, including TAV and HelpSteps.
- Developing relationships and trust with decision makers that operate in a competitive environment.
- Creating incentives/buy-in with rural partners (e.g. CAHs)
- Figuring out a unified approach to meet patient needs when there is overlap of patients getting served across counties.
- Clarification on how MACRA and MIPS affects CAHs, RHCs, and FQHCs.
- Literature review focusing on care coordination return on investment.
- Methodology for care coordination software decision making.
- Establishing a community model in an urban setting with competing, large hospitals.
- SIM evaluation overview, in particular that related to the C3s.
- Access to local level patient data that can come from state level sources instead of having to rely on local hospitals and health systems.

- Communication, sharing and best practices from and between the other C3 initiatives.
- Sample data sharing agreements and patient release of information forms.
- Discussion and planning around working with Casey's Convenient Stores to have a statewide strategy to offer healthier food options at a competitive price.
- Creating a huddle format that allows partners to meet efficiently and regularly to connect on and plan for addressing patient needs.
- Transitioning to a fully electronic care coordination system.
- Linking care coordination with pharmacy.
- They have data from IHC and IDPH but need to TA on how to use it.
- Strengthen internal programs and processes.
- Documentation and studies on what other C3s and care coordination communities are doing related to telehealth and oral health.
- Physician advisory committee (maybe statewide group) that identifies needs, proposes system changes, and supports these efforts.
- HIPAA compliance contracting expertise.
- Care coordination to be imbedded in the reimbursement model.
- Statewide reimbursement advisory council that can reconfigure the reimbursement model and methodology.
- Closing the loop in the referral process.
- Methodology for care coordination software needs assessment, decision making, and selection.
- Regional workshop on informatics

Concerns

- Violent crime and behavioral health are big concerns for local partners. They are concerned that state changes to the C3 will limit what the community is able to address and force their work to fit into a prescribed box of services/target areas.
- Possible shift in the C3 approach to focus more on hospitals and clinics vs. community. Not helpful given that federal programs are already hospital-centric.
- Large local inter-agency meetings just get re-purposed for other needs without having the right community partners on board and without having a targeted purpose/goals.
- Fear of losing buy-in from community members, "so many things that get started never go anywhere".
- New C3 RFP will involve reinventing what has already been started.
- Developing something that cannot be sustained.
- Frustration with IDPH and IHC not being on the same page: "How can they lead it when they don't get it?"
- Lack of follow-through by IDPH and IHC.
- Local partners have reached out to IDPH and IHC with questions/concerns but these partners have not been redirected back to [County] LPH.
- Community partners that will disengage because of competition, too many state-directed changes to the C3, and/or fear that the initiative is just short-term.
- Resistance to data sharing by local hospitals and health systems.
- IHC C3 training to date has had limited benefit and takes a lot of time. Many of the C3 team members have more expertise than those providing the training.
- They were told by IDPH and IHC that they needed to create and implement a release of information form for patient participating in care coordination through the C3. That form was to indicate that patients would allow the C3 to release all unique patient data to any partner, including IHC and IDPH. They believe this was a requirement that was coming from the UofIA as part of the SIM-C3 evaluation.
- Changing direction of the SIM which could have a negative impact on local relationships and care coordination.
- Data reporting to IHC and IDPH is not consistent. Why not have the same reporting to both?
- SIM learning workshops are too clinically focused and clinic teams are not going to participate.
- SIM learning workshops are not helpful. It would be worthwhile to share between the C3s and learn more from one another.

- IHC C3 training to date has had limited benefit and takes a lot of time. Many of the C3 team members find no value in participating in sessions.
- Claims data collected at state level will not show the care coordination work being done at the local/community level.
- Lack of long term funding/a model where care coordination is built into reimbursement.
- Funding can flow to hospitals/healthcare providers, however, there needs to be a mechanism for these funds to flow into communities for care coordination and services.
- Tools and resources developed for the C3s should be done with C3 input.
- "There is always a new initiative and this is just one more thing."

Next Steps

- Creating a website for the C3 and its activities.
- On-going relationship/partnership building.
- Shift focus to coordinating care as a community vs. as individual organizations/providers.
- Updating the community services directory.
- On-going identification of champions within the C3 to help drive program development and community buy-in/change.
- Educating the community.
- Looking at ways to incorporate BH. Looking at TAV and an opportunity to put together a demonstration.
- Waiting to see what is in the RFP.
- Project alignment with United Way Spark 5 project. This will serve as the pilot for rolling out community care coordination.
- Identifying strategies that address their need to operate in a community with large, competing, urban hospitals.
- CHNA identified community gaps and duplication in services. This information is being used to drive community level planning and some of the C3 activities. It has also gotten the C3 Coalition on board.
- Educating community partners about the programs and services that already exist (e.g., diabetes services)
- Wishing to work with state and other partners to establish a statewide nutrition strategy with Casey's Convenience Stores. There is a model for healthy convenience stores and often Casey's is the only food source in rural areas.
- Monthly newsletter.
- Incorporate patient huddles or another approach to further engage clinical and other community staff.
- Developed a patient SDH screening tool and they need to test it in the clinic setting with the intent of implementing across their service area.
- Share use conversations with local organizations, as well as establishing safe routes and making sidewalk improvements.
- Trying to shift from a focus on trails to a walkable community.
- October 25 Bridge Out of Poverty workshop.
- Having conversations to identify patients with chronic conditions and risks of SDH.
- Creating/adding to partnerships, including jails, schools, and colleges. [Local BH provider] already has a contract in 37 schools so they are trying to build on this with children's health.
- They are going to be an iSmile Silver site so oral health will be a new area of health that will be added.
- Plans to include telehealth.
- Possibly include additional questions as part of the evaluation surveys.
- Holding an event in November that will include Tom Evans. Event will include board of supervisors, hospital leaders, clinic leaders, and hospital boards.

Appendix E. Detailed Timeline of TA Activities

The technical assistance provided by IHC are categorized into eight general topic areas, including

- Introduction to and/or status updates on the overall SIM project
- Using Data for Quality/Performance Improvement
- Social Determinants of Health (SDH)
- Population Health (diabetes, tobacco, obesity, etc.)
- Healthcare Delivery System Transformation
- Care Coordination (PCMHs, ACOs, etc.)
- Payment Reform (VBP, MACRA, APMs, etc.)
- C3 Specific (shared experiences, best practices, etc.)

The following table provides a timeline of TA activities over the course of this reporting period.

	Activity (Title)	Topic Area(s)	Attendance
Quarter 1	TA Site Visits	Introductory Visits	Visits to all 6 C3 sites
March 2016			
	Phone conference (Connect Call)	Introductory Call	IHC staff and C3 Leaders
	SIMplify Newsletter Volume 1: March 2, 2016	<ul style="list-style-type: none"> • Introduction to the overall SIM project • Using Data for Quality /Performance Improvement 	
	SIM Learning Community March 8, 2016 (Altoona, IA)	<ul style="list-style-type: none"> • Introduction to the overall SIM project • Using Data for Quality /Performance Improvement • Social Determinants of Health • C3 Shared Experiences 	<ul style="list-style-type: none"> • 210 registrants, including representatives from the following key stakeholders: • All six C3 sites • Providers • SIM staff • SIM Leadership • All five Medicaid ACOs • All three MCOs • Contracted vendors
	Webinar : SIM C3 Welcome March 23, 2016	<ul style="list-style-type: none"> • Introduction to and status updates on the overall SIM project • Population Health • C3 specific topics 	
April 2016			
	Phone Conference (Connect Call)	Per requested need	IHC staff and C3 leaders
	SIMplify Newsletter Volume 2: April 6, 2016	<ul style="list-style-type: none"> • Status Updates on the overall SIM project • Healthcare Delivery System Transformation 	
Quarter 2	TA Site Visits	<ul style="list-style-type: none"> • Using Data for Quality Improvement/Performance Improvement • Care Coordination • Healthcare Delivery System Transformation • Payment Reform • Status Updates on the overall SIM project 	<ul style="list-style-type: none"> • IHC made 9 sites visits to C3 sites during this quarter

May 2016			
	Phone conference (Connect Call)	Per requested need	IHC staff and C3 leaders
	SIMplify Newsletter Volume 3: May 4, 2016	<ul style="list-style-type: none"> • Payment Reform • Care Coordination • Social Determinants of Health • Healthcare Delivery System Transformation 	<ul style="list-style-type: none"> • 430 subscribers
June 2016			
	Phone conference (Connect Call)	Per requested need	IHC staff and C3 leaders
	SIMplify Newsletter Volume 4: June 1, 2016	<ul style="list-style-type: none"> • Status Updates on the overall SIM project • Population Health • Healthcare Delivery System Transformation • Care Coordination • Social Determinants of Health 	
	Webinar : Post initial site visit June 6, 2016	<ul style="list-style-type: none"> • C3 specific • Using Data for Quality Improvement/Performance Improvement 	
	SIMplify FORUM: Diabetes & Behavioral Health June 30, 2016	<ul style="list-style-type: none"> • Population Health (Diabetes) • Care Coordination 	<ul style="list-style-type: none"> • 100 participants • 7 post-event downloads from SIMplify website
July 2016			
	Phone conference (Connect Call)	Per requested need	IHC staff and C3 Leaders
	SIMplify Newsletter Volume 5: July 6, 2016	<ul style="list-style-type: none"> • Status Updates on the overall SIM project • Care Coordination 	<ul style="list-style-type: none"> • 445 subscribers
	SIM Learning Community July 12, 2016 (Altoona, Iowa)	<ul style="list-style-type: none"> • C3 Specific • Using Data for Quality Improvement/Performance Improvement • Healthcare Delivery System Transformation • Care Coordination • Payment Reform 	<ul style="list-style-type: none"> • 248 Attendees, including representatives from the following key stakeholder groups: • All six C3 sites • Providers • SIM staff • SIM Leadership team • All five Medicaid ACOs • All three MCOs • Contracted vendors
	Webinar: Data July 29, 2016	<ul style="list-style-type: none"> • Using Data for Quality Improvement/Performance Improvement 	<ul style="list-style-type: none"> • 35 participants, including attendees from each C3 site and state SIM partners • 11 post-event downloads from SIMplify website

Quarter 3	TA Site Visits	<ul style="list-style-type: none"> • C3 specific needs • Using Data for Quality/Performance Improvement • Care Coordination • Payment Reform • Healthcare Delivery System Transformation • Social Determinants of Health (PCA) 	<ul style="list-style-type: none"> • At least 13 site visits completed during the start of the third quarter
August 2016			
	Phone conference (Connect Call)	Per requested need	IHC staff and C3 Leaders
	SIMplify Website 2 Week Topic Cycle: Introduction August 2, 2016	<ul style="list-style-type: none"> • Introduction to and status updates on the overall SIM project 	
	SIMplify Newsletter Volume 6: August 3, 2016	<ul style="list-style-type: none"> • Population Health • Healthcare Delivery System Transformation • Care Coordination 	
	Webinar Quality Improvement 101 August 10, 2016	<ul style="list-style-type: none"> • Using Data for Quality/Performance Improvement 	
	SIMplify Website 2 Week Topic Cycle: Pro- vider Engagement August 17, 2016	<ul style="list-style-type: none"> • Healthcare Delivery System Transformation 	
	SIMplify Website 2 Week Topic Cycle: Statewide Strategies August 31, 2016	<ul style="list-style-type: none"> • Population Health • Care Coordination 	
September 2016			
	Phone conference (Connect Call)	Per requested need	IHC staff and C3 Leaders
	SIMplify Newsletter Volume 7 September 7, 2016	<ul style="list-style-type: none"> • Population Health • Using Data for Quality Improvement/Performance Improvement 	<ul style="list-style-type: none"> • 445 subscribers
	SIMplify Website 2 Week Topic Cycle: MACRA September 14, 2016	<ul style="list-style-type: none"> • Payment Reform 	
	Regional Workshop QI Execution & Integra- tion September 22, 2016 (Storm Lake, IA)	<ul style="list-style-type: none"> • C3 Specific • Using Data for Quality/Performance Improvement 	<ul style="list-style-type: none"> • Sioux County and Webster County C3 Partners
	SIMplify Website 2 Week Topic Cycle: PCMH September 26, 2016	<ul style="list-style-type: none"> • Care Coordination 	
	Regional Workshop QI Execution & Integra- tion September 29, 2016 (Ames, IA)	<ul style="list-style-type: none"> • C3 Specific • Using Data for Quality/Performance Improvement 	<ul style="list-style-type: none"> • Dallas County and Marion County C3 Partners