PREVENTION AND CHRONIC CARE MANAGEMENT ADVISORY COUNCIL

MEDICAL HOME SYSTEM ADVISORY COUNCIL

IOWA DEPTARTMENT OF PUBLIC HEALTH

ISSUE BRIEF

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Community Utility Concept

What is the "Community Utility" Concept?

A community utility is a service offered in a community and is linked to patients through a patient-centered medical home (PCMH). The community utility addresses the needs of a patient beyond the medical encounter. A PCMH is a medical office or clinic where a team of health professionals work together to provide a new, expanded type of care to patients. Having a PCMH feels like having an old style family doctor, but with a team of professionals, using modern knowledge and technology, to provide the best possible care. The team coordinates care with specialists and links patients to community utility resources.

The *medical home* community utility concept follows the same logic as a *public* utility. It is a service that is provided to the community that everyone contributes to and everyone benefits from, and is something that cannot be accomplished efficiently or effectively alone, similar to electricity, water, and public transportation. A community utility is located in a central setting where there are navigators and experts on the available resources in a community. It is important to understand that medical home community utilities vary greatly, and every community in Iowa will have different resources available. A community utility enables a fulsome PCMH that might be established through an Accountable Care Organization (organized groups of physicians, hospitals or other providers jointly provide care and share accountability for the cost and quality of care for a population of patients).

The Issue

National data from 2006-2007 demonstrated that insufficient practice infrastructure exists to support widespread implementation of the PCMH model. Perhaps the greatest challenge to reform of the health care delivery system is that 32 percent of U.S. physicians practice solo or in two-person partnerships. Efforts to address their patients' needs beyond medical care can be fragmented and lacking. Some of the physicians in these smaller practices are eager to implement change but lack the resources to do so. The community utility concept is an effective method to address this lack of resources.

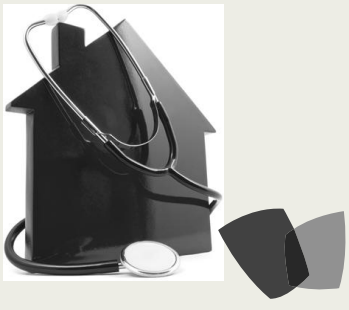
Examples of components of medical home community utilities are listed in the box to the right.

***Medical Home* community utility components:**

- care coordination
- health information technology
- consumer (patient/family) health information and family support
- interpretation and translation services
- child care
- after-hours access
- specialty services (genetic counseling, mental health consultation, nutrition consultation, pharmacy review)
- patient education and coaching
- transportation
- home visiting or other off-site care
- newborn screening

Community Utility Role in the Medical Home

The community utility concept has a unique role to play in PMCH development, especially among the safety net population (to make sure people don't fall through the cracks) and primary care practices that are smaller or located in rural areas. Many primary care practices in Iowa will be challenged to meet the requirements of serving as a patient-centered medical home without partnering with local community organizations. If the medical home community utility components (listed in the box above) can be connected with primary care delivery sites, many aspects of becoming a PCMH will be addressed.



Accountable Care Organizations

The current U.S. health care system uses a fee-for-service reimbursement model, which research has demonstrated to incentivize providers to perform more procedures and provide additional services. Additionally, different providers who see the same patient lack the information or resources to coordinate care, resulting in duplicative or conflicting treatment. Accountable care organizations (ACOs) are a solution to overcoming these challenges in providing high-quality and cost effective care, as well as community utility resources.

ACOs represent a health care model where organized groups of physicians, hospitals or other providers jointly provide care and share accountability for the cost and quality of care for a population of patients. As the model is generally unfolding across the nation, payers contract with ACOs to care for a defined group of patients, using financial incentives to encourage ACOs to produce improved health outcomes and reduce overuse of medical care. Because ACO members will share in the savings that results from their cooperation and coordination, they can theoretically act as a reform tool by incentivizing more efficient and effective care. This would help to combat the current fee-for-service incentives of overutilization of health care services.

ACOs are a potential strategy to overcoming the challenges that small or rural practice has in providing high-quality and cost effective care, as well as community utility resources.

Payment Reform

The current U.S. healthcare system does not recognize the care coordination services provided by primary care providers to specialists and community utilities. This payment structure weakens the relationship between patients and provider, and prevents practices from transforming in a way to enhance system in which care is delivered. Providing care coordination is a component of optimal care and is an important driver in the need for broad healthcare reform. Examples of current payment policies that adversely affect the ability of primary care providers to coordinate their patients' care and work in partnership with community utilities to achieve the best outcomes include:

- Payment system rewards physicians for increasing volume of visits and procedures.
- Payment structure does not provide incentives for physicians to coordinate care.
- No mechanism for providers to share in the savings that provider-guided care coordination activities generate.

Payment reform is needed to adequately reimburse primary care providers to provide patient–focused, coordinated care and to acquire the health information technology necessary to provide such care. Payment reforms will support providers in delivering this type of care through the **patient-centered medical home**, which includes accessible, continuous, comprehensive, and coordinated care.

Local Boards of Health

Local Boards of Health (LBOH) are a vital community utility for providing strong leadership in the promotion of physical, behavioral, environmental, social, and economic conditions that improve health and well-being; prevent illness, disease, injury, and premature death; and eliminate health disparities.

Ten national standards exist for LBOH to embrace as a means of working with their state health departments, communities, and governing bodies to develop a more robust governmental public health capacity, and as a means of holding themselves accountable to the public they serve. The ten standards are:

1. Monitor health status and understand health issues facing the communities.
2. Protect people from health problems and health hazards.
3. Give people information they need to make healthy choices.
4. Engage the community to identify and solve health problems.
5. Develop public health policies and plans.
6. Enforce public health laws and regulations.
7. Help people receive health services.
8. Maintain a competent public health workforce.
9. Evaluate and improve programs and interventions.
10. Contribute to and apply the evidence base of public health. (NACCHO)

Community utility services offered by LBOH include:

- **developing resources and tools**
- **providing technical assistance, continuing education, and capacity building support through demonstration projects**
- **facilitating peer exchange of best practices and tools**
- **educating and promoting disease prevention issues, including chronic disease, HIV/STI, other infectious diseases, injury, adolescent health, reproductive health, immunization, tobacco, primary care, prevention strategies, and mental health**

Other State Community Utility Successes

VERMONT
Blueprint for Health
Smart choices. Powerful tools.

The Vermont Blueprint for Health is a vision, a plan and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools and support that Vermonters with chronic conditions need to manage their own health – and that doctors need to keep their patients healthy. The Blueprint is working to change health care to a system focused on preventing illness and complications, rather than reacting to health emergencies. The plan will help Vermonters to stay as healthy as possible, improving their quality of life, and minimizing the onset of preventable disease.

Solutions Developed

The major components of the Blueprint for sustainable and well-integrated care delivery and prevention are summarized below.

1. Financial Reform
   a. Payment to practices passed on NCQA-PCMH Standards (in addition to current payment)
   b. Shared costs for Community Care Teams
   c. Includes Medicaid & commercial payers
   d. Blueprint subsidizing Medicare portion
2. Community Care Teams (CCTs)
   a. Local multidisciplinary team
   b. Nurse coordinators, medical social workers, behavioral specialists, dieticians, and other health professionals
   c. Core resource providing care support for patients across participating practices for prevention, health maintenance, and chronic disease
   d. Guideline based on care coordination for individual patients
   e. Guideline based on population management
3. Community Activation and Prevention
   a. Public Health Prevention Specialist as part of CCT
   b. Integration of public health prevention and care delivery
   c. PHPS guides a systematic approach to community assessment, broad stakeholder engagement, consensus building, planning, and targeted intervention
4. Health Information Technology
   a. Web-based clinical tracking system (DocSite)
   b. DocSite produces visit planners and population reports
   c. Includes electronic prescribing
   d. EMRs updated to match program goals and clinical measures in DocSite
   e. Health information exchange network to transmit data between EMRs, hospital data sources, and DocSite
5. Multi-Dimensional Evaluation
   a. NCQA-PCMH score (process quality)
   b. Clinical process measures
   c. Health status measures
   d. Claims-based health care patterns and expenditures (multi-insurer database)
   e. Claims-based return on investment and financial impact modeling

Recent Progress

In 2010, the Blueprint made tremendous progress and maintained a strong focus on preparation for statewide expansion. Significant changes include:

- Enactment of legislation that mandates the statewide expansion of the Blueprint by requiring all major insurers to participate in this model. Evidence of this expansion requires a minimum of two primary care practices in each health service area becoming Advanced Primary Care Practices by July 2011. The Act requires the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread).
- The Blueprint's successful application for the CMS's Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration Project. In November 2010, Vermont was chosen as one of eight states to participate in this 3 year innovative Medicare program. The MAPCP will eventually include up to approximately 1,200 medical homes serving up to 1 million Medicare beneficiaries. Other participating states include: Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania and Rhode Island. The demonstration allows Medicare to come on board as a participating insurer with the Blueprint for Health – joining private insurers and Vermont Medicaid – to provide financial support for the ACPCs through this multi-insurer payment initiative, beginning in mid-2011.

Vermont Blueprint for Health website:
http://hcr.vermont.gov/blueprint_for_health

Community Care of North Carolina

The Community Care of North Carolina (CCNC) program is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients.

Key Components of CCNC

CCNC is an enhanced medical home model consisting of several key components:

- *Local non-profit community networks* that are comprised of physicians, hospitals, social service agencies, and county health departments provide and manage care.
- Within each network, each enrollee is linked to a primary care provider to serve as a *medical home* that provides acute and preventive care, manages chronic illnesses, coordinates specialty care, and provides 24/7 on-call assistance.
- *Case managers* are integral members of each network who work in concert with physicians to identify and manage care for high-cost, high-risk patients.
- The networks work with primary care providers and case managers to implement a wide array of *disease and care management* initiatives that include providing targeted education and care coordination, implementing best practice guidelines, and monitoring results.
- The program has built-in data monitoring and reporting to facilitate *continuous quality improvement* on a physician, network, and program-wide basis.

How has CCNC Impacted Costs and Care?

North Carolina has contracted for two external evaluations of the CCNC program:

- The Sheps Center evaluated CCNC's impact on asthma and diabetes. They estimated a $3.5 million dollar savings resulting from CCNC's asthma management program and a $2.1 million savings resulting from CCNC's diabetes management program.
- Mercer Human Resources Consulting Group (Mercer) found when comparing what the access model would have cost in SFY04, without any concerted efforts to control costs, the program saved approximately $60 million in SFY03, $124 million in SFY04, $231 million in SFY05 and SFY06, and $147 million in SFY07. Cost effectiveness analysis for SFY08 is complete and continues to show that CCNC is controlling costs for the NC Medicaid program. Mercer also analyzed the cost effectiveness of the coverage of select over-the-counter medications and other medications highlighted in the Prescription Advantage List. They reported an almost $1 M in savings achieved during the first two quarters of SFY05.

Community Care of North Carolina's website: http://www.communitycarenc.com/

Iowa Examples of Components of Community Utilities

Birth to Five Patient-Centered Medical Home Pilot

Overview

IDPH received funding to implement a medical home pilot project to develop a model for a community utility that will comprehensively serve children 0-5 to address their specific needs by providing a PCMH. A Title V Child Health agency in Iowa that operates 1st Five Healthy Mental Development implementation project (Visiting Nurse Services of Iowa) is partnering with a pediatric primary care practice (Walnut Creek Pediatrics) to provide care meeting medical home standards. Emphasis is placed on providing an enhanced level of care coordination both within the primary care setting and within the community utility.

Results (first six months of project)

- Project served 458 children at Walnut Creek Pediatrics
- Provided additional screening and care coordination services to 19% of their 2,400 patients during well child check-ups who would not normally have such services
  - Care coordination referrals were for medical issues, dental, mental health, vision, hearing, speech, autism, developmental referrals, and developmental activities.
- TransforMED Survey
  - Pre-Score: 225 of 341
  - Post-Score: 229 of 341 - Level 3-Good progress/continue improving

Measures

- TransforMED Medical Home Implementation Quotient survey score
- 1st Five Surveillance form for all children age 2 weeks to 5 years at well-child exams
  - Walnut Creek Pediatrics hired a RN Care Coordinator to do this surveillance
- Number of Screening Tools Used:
  - Edinburgh Postnatal Depression Scale- used to screen mothers of all infants seen for their first newborn weight check, 2 week check-up, and 2 month check-up
  - Ages and Stages Questionnaire- used to screen children for developmental delays at well-child exams at 9 months, 18 months, and 24 months of age
  - Modified Checklist for Autism in Toddlers- used to screen children for autism at well-child exams at 18 months and 24 months of age.
- Care Coordination Encounters
- Number of Family Care Plans used
- Number of Family Satisfaction Surveys

Iowa Examples of Components of Community Utilities (cont.)

Local Board of Health Medical Home Development- Dallas County

Dallas County Health Department (DCHD) received $24,839 of funding from the Iowa Collaborative Safety Net Provider Network in FY08, FY09, and FY10. DCHD has implemented a Health Navigation program for healthcare providers and community agency staff to refer patients/clients to the Health Navigation Coordinator for screening and referral to additional needed resources. The Health Navigation Coordinator can provide additional assistance to the individual in "navigating" the system and will report back to healthcare providers on the outcome of the referral. The program has helped local clinicians, ministers, social service agencies, and other organizations understand the value of having a shared community utility available in the county.

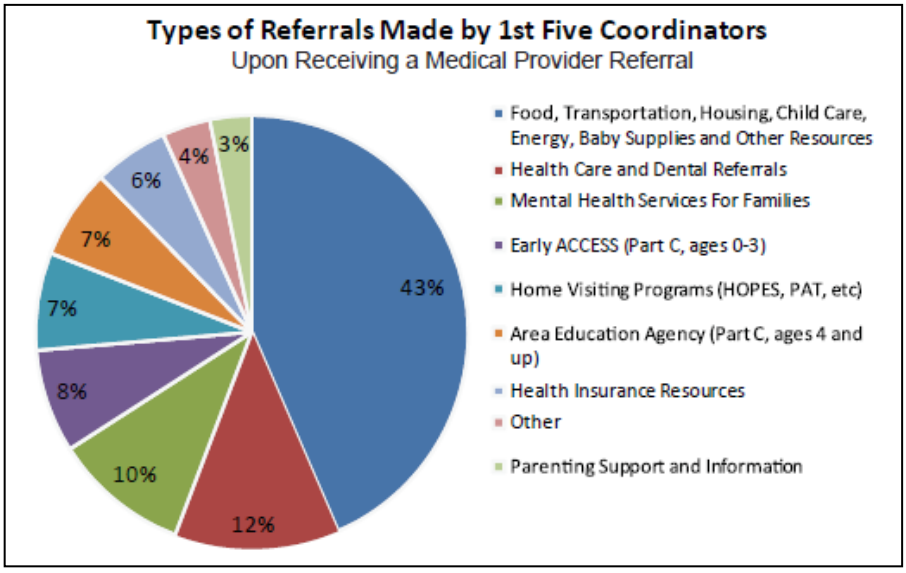
A shared community utility known as the Dallas County Resource Directory is continually updated and maintained to provide easy access to resources for medical care, parenting, mental health, addictions, housing and more. There are currently 95 health care providers in the county participating in the program and served 80 patients resulting in 220 referrals during the quarter. Additionally, procedures for Spanish interpretation services for uninsured / underinsured women receiving prenatal care have been established and actual services are expected to begin during the second quarter.

1st Five Healthy Mental Development Initiative

The 1st Five Healthy Mental Development Initiative builds partnerships between physician practices and public service providers to enhance high-quality well-child care. 1st Five assists primary care providers to deliver coordinated, comprehensive and family-centered care based on the patient-centered medical home model. The 1st Five coordinator essentially leads and promotes the program in targeted communities to physician practices, families and community service providers.

Referrals (Community Utility)

When a medical provider discovers a concern, the provider makes a referral to a 1st Five coordinator. Shortly after receiving the referral, the coordinator contacts the family to discuss available community resources that will meet the family's needs. Often other issues come to light during these discussions and additional referrals are made. For every one medical provider referral to 1st Five, 2-3 additional referrals are identifi ed when the care coordinator contacts the family. The coordinator works extensively with families to assure follow-up and access to services. The coordinator then provides feedback to the referring provider on the status of the referral. Overall improved patient care results from this comprehensive, family-centered model.



I-Smile ™ Dental Home Initiative

The I-Smile™ Dental Home Initiative was created in response to legislation requiring Medicaid-enrolled children age 12 and younger to have a dental home. I- Smile™ approaches the **dental home** as a network of individualized care based on risk assessment. This includes oral health education, dental screenings, preventive services, diagnostic services, treatment, and emergency services to allow all children to have early and regular care and ensure optimal oral health.

I-Smile™ uses a team approach to manage oral disease, and focuses on primary prevention and care coordination, centered in Iowa's existing public health network. Dental hygienists serving as local coordinators are reducing barriers to care by building dental referral networks. They are also providing screenings and fluoride varnish applications in WIC clinics, Head Start centers, and other public health settings. In addition, coordinators serve as local advocates to increase oral health awareness and promote community water fluoridation. http://www.idph.state.ia.us/hpcdp/oral_health_ismile.asp

Iowa Collaborative Safety Net Provider Network

Almost 700,000 Iowans under age 65, approximately 27% of the total population, do not have health insurance (Families USA, March 2009). Thousands more have insurance that only covers catastrophic illnesses and accidents. For these individuals and families, there are limited options available for affordable health care.

Many of these Iowans turn to Iowa's safety net providers for affordable primary and preventive health care. Through a unique partnership created in 2005 by the Iowa Legislature, the Iowa Collaborative Safety Net Provider Network, Iowa's health care safety net providers have united to identify common unmet needs that can be addressed cooperatively.

The Iowa Primary Care Association coordinates and manages the Iowa Collaborative Safety Net Provider Network.

Iowa Department of Public Health

IDPH promotes the health of Iowans by providing resources for health care services through public and private collaborative efforts. They advocate for services that are family-centered, community-based, and culturally sensitive. Through these efforts, community utilities are empowered to develop local health care systems that meet present and future health needs. The following are a few community resources offered through IDPH:

- Center for Congenital & Inherited Disorders- initiates, conducts, and supervises genetic investigations and research in order to provide for the protection and promotion of the health of Iowans.
- Early ACCESS- partnership between families with young children, birth to age three, and providers to identify, coordinate and provide needed services/resources that will help the family assist their child to grow/develop.
- Early Hearing Detection & Intervention Program- ensures that all newborns and toddlers with hearing loss are identified as early as possible and provided with timely & appropriate audiological, educational, medical intervention and family support.
- Early Periodic, Screening, Diagnosis and Treatment (EPSDT) Care for Kids- assures that children in Medicaid ages birth through 20 years receive preventive health care services, including oral health care.
- Perinatal Depression- program that provides consultation and resources to healthcare providers who have questions about screening, diagnosis, treatment, or referral regarding perinatal mood and anxiety disorders.
- HOPES (Healthy Opportunities for Parents to Experience Success)- provides family support through home visiting for families that begin during pregnancy or at the birth of a child and can continue for up to 4 years of the child's age.
- Family Planning- contracts with family planning clinics to provide medical services, birth control methods, and education.
- The Office of Problem Gambling Treatment and Prevention- reduces the harm caused by problem gambling by funding a range of services for Iowans including outpatient counseling, housing services, financial counseling, and a state-wide help line. In addition, the program funds prevention and education services for schools, community groups, casino employees, etc.
- WIC (Women Infants, & Children)- supplemental nutrition program for babies, children under the age of 5, pregnant women, breastfeeding women, and women who have had a baby in the last 6 months. WIC helps families by providing healthy foods, nutrition education, and referrals to other health care agencies.
- Iowa *Care For Yourself* Breast and Cervical Cancer Early Detection Program- helps reduce deaths from these two diseases by offering regular screening tests and education on prevention.

Conclusion

A community utility can provide enhanced services to Iowans who lack the ability to access needed resources. These enhanced services are comprehensive and are targeted at all aspects of a person's life. They go beyond medical care and focus on the social determinants of health and the broader community, such as childcare, transportation, and access to food or clothing. By linking patients to these available community services, Iowans will live happier and healthier lives**.**

The Prevention and Chronic Care Management Advisory Council and the Medical Home System Advisory Council are eager to share this document with Iowa's stakeholders and policymakers in hope that the Councils can educate and assist in moving Iowa to become the healthiest state in the nation.

To find out more about the Councils or about upcoming meetings, please visit their websites below:

- **Prevention and Chronic Care Management Advisory Council- http://www.idph.state.ia.us/ChronicCare**
- **Medical Home System Advisory Council- http://www.idph.state.ia.us/MedicalHome**