

Iowa Collaborative Safety Net Provider Network

Lessons Learned from Medical Home Development Projects

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Patient-Centered Medical Home Principles

The Iowa Collaborative Safety Net Provider Network (Network) supports the broad definition of a patient-centered medical home (PCMH) set forth by the American Academy of Pediatrics, among other professional health care groups, which encompasses seven main concepts – accessibility, continuity, compassionate care, cultural sensitivity, coordinated services, comprehensive services, and a family focus whenever possible. Specifically, a PCMH is accessible because patients are not limited to services because of cost, geographical location, culture, or language; the patient and provider(s) have a continuous relationship that is compassionate and sensitive to individual differences and cultural backgrounds; the services provided in a medical home are not merely comprehensive in that all services needed are provided in one or a couple locations, but that any provider can serve as an entry point for coordinated services across many providers and locations; and finally, a medical home is enhanced by meaningful partnership, whenever appropriate, with patient and family.

The State of Iowa, through House File 2539, defined a medical home using the same principles as discussed above, which were endorsed by the Medical Home System Advisory Council (MHSAC), one of Iowa's health care reform councils. The MHSAC is currently working on specific criteria and requirements to measure a PCMH, among other items. The Network feels it is important to share this broad definition of the medical home concept to set a context for the projects described below.

Connecting the Network's Medical Home Work to State Health Care Reform Initiatives

Currently, the medical home funding provided to the Network is the only monetary resource that is allocated to local communities in the state focused on medical home development. The Network-funded projects discussed below have provided insights about the challenges local providers face in working to become PCMHs. These insights and lessons learned have been shared with key lead staff who are working on health care reform in Iowa, particularly the MHSAC. As the discussion at the state and national level evolves around PCMH development, it is clear that many primary care providers will need to work with other local, community-based organizations, in order to improve the quality of care provided to patients.

Background on Network-Funded Medical Home Development Projects

In state fiscal year 2008, the Network was provided funding by the state for distribution to local boards of health and maternal/child health centers for the purpose of developing medical home projects within their communities. Funding for the original six projects continued in state fiscal year 2009 and four of the six communities received funding again in state fiscal year 2010. All of the annual awards made to the communities have ranged from \$20,000-35,000. A brief summary of each project follows. For the four projects funded all three years, key activities and outcomes from the first two quarters of SFY10 are highlighted.

Local Boards of Health Medical Home Development

- Calhoun County (Funded SFY08 – SFY10): Provides case management and coordination services at two private medical clinics and is working to expand to a third private clinic in the county. Calhoun County will be developing written policies and procedures to guide medical home development in the county and work on sustainability by aligning their work to local public health practices and the work of the maternal/child health agency in the area. During the first two quarters of FY10, the project provided services to 33 patients, including 218 encounters and 38 direct referrals.

- Dallas County (Funded SFY08 – SFY10): Conducted a medical home assessment of all medical providers in the county and is using best practices to work with health care providers on coordination of patient care and services such as addictions, aging, dental, medical, financial assistance, parenting, and mental health, among others. One of the project goals is to increase awareness of existing programs and services throughout the county using a comprehensive resource website developed in year two of the project. A Health Navigation Coordinator takes direct referrals from medical providers and works with patients to connect them to needed community resources. Dallas County has focused on outreach to the community about the new resource during the first two quarters of FY10. The website has received 5,635 page views during FY10 and over sixty referrals have been made. Dallas County follows up with each referring clinic regarding the outcomes of the coordination services provided to the patient.
- Polk County (Funded SFY08 – SFY09): Polk County Health Department (PCHD) partnered with Visiting Nurse Services and Health Access Partnership to assess patient and provider perspectives of medical homes. Polk County and its partners worked to create the conditions to allow relationships of mutual respect and trust to be established between consumers and providers. Interviews were conducted with medically homeless Polk County residents and the findings and stories were used to support the development of a consumer-led agenda for change. A parallel effort occurred to explore the challenges facing primary care providers as they seek to provide medical homes for individuals who lack insurance or whose insurance does not cover basic health care services. During the spring of 2009, the consumer leadership team and representatives of the health care provider community gathered to develop a common list of priorities that could be addressed to improve access to medical homes in Polk County.

Maternal and Child Health Centers Medical Home Development

- Dubuque Visiting Nurse Association (VNA) (Funded SFY08 – SFY10): Provides case management and screening services at Crescent Community Health Center and has a goal to expand these services to a number of private medical practices in the community. All services are provided to the pediatric population and their families and many of the services provided are focused on ensuring patients have access to necessary specialty care services not provided at local primary care clinics. The Dubuque VNA staff follows up on 'no show' appointments to the clinic and this project connects the 1st Five program with other case management and coordination services. Dubuque VNA served 129 patients during the first two quarters of FY10 and continued working on expansion of the program to other primary care providers in the community.
- Siouxland Community Health Center – Sioux City (Funded SFY08 – SFY10): One of the goals of the project is to increase provider and consumer awareness about the medical home concept and the Mission Health program available in the Sioux City area. Siouxland has developed a structured referral network and is coordinating and communicating with local health and social service agencies to increase access to affordable primary and specialty care services for underserved patients. A systematic process for referrals has also been established. Siouxland continues to enroll patients into the Mission Health program and assists patients in establishing a medical home. The Mission Health program is a partnership between Siouxland and the two local hospitals whereby patients at and under 200% of the federal poverty level and who are un- or underinsured are eligible to receive health care services on a sliding fee scale based on income. For patients inappropriately using the hospitals for care, a referral process has been developed to encourage the patient to access primary care services at Siouxland. During the first two quarters of FY10, Siouxland enrolled 1,542 new patients into the Mission Health program and provided \$502,534 in discounted care according to the sliding fee schedule within the program (this does not include discounted care provided by the two hospitals).
- Visiting Nurse Services – Des Moines (Funded SFY08 – SFY09): See description of the Polk County project above.

Lessons Learned from the Network-Funded Projects

Following are several success and challenges the projects have experienced based on an independent evaluation of the grantees conducted by Rural Health Solution as well as regular reporting from the grantees to the Network.

Successes

- Local public health agencies have successfully partnered with primary care providers to improve access to and the quality of care delivered to underserved Iowans.
- Helping to address unmet needs of patients identified by primary care clinics in the communities.
- Assisting primary care providers with 'difficult to serve' patients by providing follow up to 'no shows' as well as addressing other patient needs that could improve the overall health of the patient.
- Development of policies and procedures focused on care coordination and case management to underserved patients.
- Creation of referral networks that involve a variety of community-based organizations in the grantee communities.
- Significant outreach and education has been provided to primary care providers, community-based organizations, and consumers about the PCMH concept.

Challenges

- Sustainability of the initiatives is a challenge for all of the grantees.
- Some grantees have had difficulties expanding care coordination and case management services into all primary care clinics in their community.
- Not all primary care providers see the value of developing a PCMH approach to care using a community-based approach.

Overall Successes and Challenges

The Network feels a significant number of positive outcomes have resulted from the grants provided to the communities especially given the small amount of funding available. All of the grantees are focused on sustaining the initiatives they have implemented, but ongoing funding to support these community-based efforts remains a challenge. Nevertheless, all of the grantees in one way or another have begun to address the issue of patient-centered medical home development through the lens of a community utility model (see the next section).

Additionally, much potential exists for PCMH development at the community level to involve partnerships with already existing initiatives such as Community Empowerment, ABCDII, and 1st Five. While all of these initiatives are focused on improving access and care for children, they provide already existing avenues for better linking the health care community with the public health community, among other partners. These already existing community-level partnerships have the potential to transcend the pediatric population and improve health care services provided to individuals at all ages.

Medical Home Community Utility Development

Originally described by Dr. Ed Schor of The Commonwealth Fund, the 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 for something that cannot be accomplished efficiently alone, like the provision of electricity. Examples of the community utility model that apply to medical home are care management/care coordination, some aspects of health information technology, health education and prevention, and coordination of existing services in the community. The community utility concept has a

unique role to play in medical home development especially among the safety net population and for primary care practices that are smaller or located in rural areas.

In the case of medical home development, many primary care practices will be challenged to meet the requirements of serving as a PCMH without partnering with local community organizations. Case management, care coordination, and health education resources, for example, already likely exist within most counties in Iowa. If these resources can be connected with primary care delivery sites, some aspects of becoming a PCMH can be addressed.

To begin to address the community utility concept and how it can assist primary care providers in becoming PCMHs, the Network convened a workshop to provide information to safety net providers from across the state in June 2009. Workshop presentation topics included the following: Overview of the Medical Home Model and Its History; Community Utility Concept Description and Its Connection to Medical Home Development; Medical Home Attributes Most Amenable to a Community Utility Approach; Examples of Functioning Shared Community Utilities: Case Studies from North Carolina, Vermont, and Iowa; Medical Home/Community Development in Iowa; and, Community Development at the Local Level. Key partners that assisted in planning and sponsoring the event included: The University of Iowa Child Health Specialty Clinics, the Iowa Department of Public Health, the Iowa Healthcare Collaborative, Iowa Medicaid Enterprise, Wellmark Blue Cross Blue Shield, and The University of Iowa College of Public Health.

About the Network

Through a unique partnership created in 2005 by the Iowa Legislature, Iowa's health care safety net providers united to identify common unmet needs that can be addressed cooperatively. In the beginning, the Network was comprised of Community Health Centers, Free Clinics, and Rural Health Clinics, but has grown tremendously in the past few years to include Family Planning Agencies, Local Boards of Health, and Maternal/Child Health Centers. Access to pharmaceuticals, specialty care referrals, and health professionals recruitment were identified as the first three areas for collaboration. Promotion and development of the patient-centered medical home was added as an additional priority issue area in 2008.

Beyond the medical home project discussed above, the majority of the other funding that has been allocated to the Network through the Iowa Department of Public Health since 2005 is distributed back out to Iowa's safety net providers in a variety of ways. Direct provider awards are made to participating Free Clinics, Rural Health Clinics, and Family Planning Agencies. The Network also supports four specialty care grantees and a number of pharmacy-related programs that are administered by the Iowa Prescription Drug Corporation.

FY10 Outcomes (July – December 2009)

- Based on the FY10 Network appropriation and budget, 84% of the funding allocated will support direct services to safety net patients.
- Over 6,700 patients have received direct services from the Network's nine grantees (this does not include direct services provided to underserved patients through the provider awards to Rural Health Clinics, Family Planning Agencies, and Free Clinics).
- \$502,534 in discounted care has been provided by one grantee, Siouxland Community Health Center.
- Over \$635,500 in free care has been provided by three of the specialty care grantees, Linn County Project Access, Polk County Medical Society, and Primary Health Care, Inc.

The Iowa/Nebraska Primary Care Association coordinates and manages the Network. For more information about the Network, please visit www.iowasafetynet.com or call 515-244-9610.