Minutes
Health and Long-term Care Access Advisory Council
July 11, 2012
10:00 a.m. – 3:00 p.m.
Urbandale Public Library

Members Present	**Members Absent**	**Others Present**
	Carol Alexander	Michelle Holst, Iowa Department of Public Health (IDPH)
Libby Coyte	Cindy Baddeloo	George Zarakpege, IDPH
Ryan Hopkins	Kyle Carlson	Francisco Olalde, The University of Iowa (rep for Carol Alexander)
Susan Lutz	Shelly Chandler	Sandy Nelson, Iowa Medical Society
Catherine Simmons	Laura Malone	Mary Parks (Iowa Board of Nursing)
Roy Bardole	Michele Devlin	Michele Greiner, Iowa Psychological Association
	Brian Farrell	Angie Doyle Scar, IDPH, Medical Home/Prevention & Chronic Care Management Council
	Leah J. Mc Williams	Charles Bruner, Child & Family Policy Center
	Wendy Gray	Sarah Dixon Gale, Iowa Primary Care Association
	Steve Johnson	Phil Wise (rep for Kyle Carlson)
	Brian Kaskie	Doreen Chamberlin, IDPH
	Daniel Otto	

*Health and Long-Term Care Access Advisory Council Web site http://www.idph.state.ia.us/hcr_committees/care_access.asp

Topic	**Discussion**
Introductions and Welcome	The meeting started with a brief welcome and introductory comments from Michelle Holst followed by members and guests introducing themselves.
Progress on Action Steps & Timeline	Key items discussed included: Three policy directions in fulfillment of the council's Healthy Iowans goal; fact sheet development; and continuing to define 'infrastructure' which was started in the April meeting. Healthy Iowans Goal: By 2012, recommend three policy directions for expanding retention and recruitment of the health workforce. See page 12 here. The following items generated during June 13 conference call, related to current pressing issues in health workforce, were used to start the discussion: 1. The need to go to DHS for review and approval if there is a criminal record check "hit" and the time it takes to receive response. 2. Openings for certified nurse aides are hard to fill in some areas of the state (small towns with nursing home and community of only 1500 – trying to get students into the education programs due to lack of instructors for CNA 75-hour course) (also near state line, especially southern and western part of the state) (also counties with lower income level) (traveling 20-30 miles to work) (lack of overall workforce availability): a. Course to be a CNA b. DHS approval c. Finding affordable child care d. Don't have transportation e. Helps when facilities have a good relationship f. Eliminated 16 hour program to get them started right way; can't get the 16-hour program anymore has had a huge impact;

	meetings already happening to address this – community colleges quit doing it; allows to get quality on-the-job training while getting 75 hour course g. Either the class is full 75- hour or there are not enough people to make the class, so they cancel it 3. New RNs not able to find a job, but due to economy, experienced nurses not retiring. 4. Iowa second-lowest paid state for nurses 5. Need for care coordinators and health coaches – medical home and TXIX programs requiring these types of individuals. Not sure what training is needed and whether there are well-developed education programs. Would be nice to start seeing educational programs developed to address these newly developing professions. 6. Couple of programs that could be expanded for incentives to practice in underserved areas. Should be expanded, should that include ALL primary care providers – any professions that provide primary care level. 7. How are professionals educated in the correctional system to take care of the mentally ill. 8. More people interested in coming to Iowa than slots available for post-doctoral training in psychology. 9. Health Information Technology – not just data entry – affecting everyone – getting everyone trained. Production goes down when switching to EHR. Believe it will eventually affect all levels of health professionals, even direct care. Struggles with technological issues in communicating with various organizations and internally. 10. Switching inpatient to outpatient. What kind of training is needed for that and also in terms of chronic disease. Added the following issues: 11. Don't want to give the impression that there is an overabundance of qualified nurses in the metro areas. Children with high medical needs are staying in ICUs because there are not qualified nurses to care for them in their homes. Need high level skill sets to care for acutely ill patients at home. Need RNs with a specific skill set and in specific care settings. 12. Significant shortage of nurse educators (with masters and doctoral training). .
Community Utility	Charles Brunner gave a presentation about Community Utility. Please see the link to the presentation for content. A key point in the discussion was the role of a care coordinator who helps assure that information about care provided by a specialist is shared with the primary care provider. As payment structures are developed around outcomes (starting with Centers for Medicare and Medicaid Services (CMS), believe that the whole array of supports (such as tobacco cessation) will need to be provided. Believe that as Community Utilities are required (through funding such as grants) to assure the full-circle communication, the culture will start to change. Discussed making electronic medical records usable when information is provided back. Think this is an area of adjustment, too. Following all requirements for releases of information about a patient to other providers can be challenging. It is good to look at barriers and lessons learned so we can find a way to address them. Regulations overall can sometimes make it easier <u>not</u> to refer (i.e., regulations can create barriers to referrals). Can take lengthy amounts of time with family to determine what needs are and then several follow-up phone calls to arrange services. It can be difficult to find a way to finance this work under a fee-for-service system. Discussed possibility that agreements (memoranda of understanding, etc.)

	among providers in the community would be established to address regulations related to confidentiality and sharing of information. Don't think we know yet because these types of arrangements are still in development and issues are still being worked out. Discussed connection with workforce in terms of whether there is a need for a new type of professional. And, until this type of professional is established, how do we assure current employees have the training they need. This is why some are suggesting that local public health agencies are the appropriate entity. They are already experts on their communities. Medical Home requirements include a health coach. Where we will find them, especially in rural communities. This is a huge growth market and communities, including local boards of health, may not be aware that this is coming. We are working to determine the time it takes to perform care coordination tasks and what are the skills that are required. Vermont and North Carolina are already doing this, and we can look at these other states. Are we looking at developing core competencies of a care coordinator? County Health Nursing is one type that provides some of these services. Another type of professional mentioned was social workers in hospitals. Some professionals in the inpatient settings may be retooled to work in outpatient settings. Think it will take research to determine what it will take to provide care coordination and whether there is a per-member-per-month payment system that will support it. The focus right now with many programs is on the very chronically ill people. Want the "big bang for the buck" right up front. But, the prevention aspect isn't being addressed. Would like to see us be proactive rather than reactive. The group discussed challenges when needs are identified and there is difficulty connecting a patient to the services needed. There are so many barriers out there. Entities that are being recognized by accrediting agencies as medical homes are expected to provide the services to all patients.
Infrastructure Action Steps	The discussion on definition of infrastructure from the previous meeting had included the following: "What is "infrastructure"? Not physical structures. Not bricks and mortar. A definition would help us stay on focus. Does include: • Transportation system • Communication system Infrastructure: How the patient moves within the system from one care structure to another (clinic to hospital to long-term care, etc.) and everything that happens in between, not necessarily confined to providers and entities within a group of affiliated organizations. (How the entities within the health care system interact as the patient/client moves through the system regardless of the entities affiliations.)" It was suggested that a third bullet should be added under "Communication System" and the third bullet should read "Health care entities". There was discussion that while the group does not intend to address Certificate of Need, there is still need to include "Health care entities" or some degree of physical components of the system. The group discussed the possibility of incorporating the concept of community utility into the definition. There was a suggestion to list out current mechanisms that are available: First Five, Community Utility, Care Coordinators, Discharge Planners, Family Support Workers, Mobility Managers.
Public Comment	"Patient" is a limiting term. Suggestion was made on how to broaden the terms beside "patient" as "client" or "consumer" or "individual". The last sentence should not be limited to but should be included.

DHS Review/Approval Process – Workers with criminal records	Lori Lipscomb from the Iowa Department of Human Services provided some information on the process of record check evaluation. Presentation slides are available here. DHS completes approximately 7,600 evaluations per year. Average turnaround time has been reduced from 8 days from receipt of complete packet to 4 days. DHS is working on steps to assure that the form and requirements are clear to improve the number of packets that come in complete. Currently, approximately 40% are returned for incomplete information. Possibilities for changes to the form were discussed. Ms. Lipscomb expressed appreciation for the opportunity to discuss with the council. All parties agreed this was a helpful discussion and promising for continued improvements in timeframes.
Review of 2012 Strategic Action Plan Steps (Continued from earlier agenda item) and Workforce Action Steps	Discussed removing the item related to DHS review/approval upon criminal record check from consideration as one of the three policy directions for the Healthy Iowans goal because it is already being addressed. Considered possible policy directions from June 13 conference call: What are some potential policy directions? 1. Eliminate barriers to hiring. a. Reduce turnaround for approval on DHS Evaluation to 5 working days or less for all employees who have an offense on their criminal record. 2. Eliminate barriers to entry into education to CNA programs. a. Cancellation of classes due low enrollment b. Lack of 16-hour program c. Classes full 3. Development/assurance of educational programs to develop care coordinators and health coaches. 4. Increased support for existing incentive programs for recruitment and retention of all primary care professions (including nurse practitioners, physician assistants, and physicians). 5. Increased support for existing educational and post-graduate programs for all levels of mental health providers. Added the following to the discussion: 6. Assess what health professions education programs or enhancements are needed. a. High level skills for home care (nurses) b. Care coordinator/health coach role c. Health informatics d. Continuing education for primary care providers regarding supporting the medical home model 7. Fully utilize skill sets of all members of the interdisciplinary health care team, especially pharmacists for medication therapy management – key to reduction of costs Discussed updated draft of fact sheet. Summary of conversation from conference call held on June 26, 2012 included the following.

AHEC has data points that may be useful and provided general information during the call and followed-up with detailed information via e-mail.

Supplied via e-mail:

Nearly 250,000 people in Iowa are unable to access a primary care provider because of a shortage in their community (IowaPolitics.com 2010)

Healthcare if often one of the top two employers in a small town, making up 10-20% of the workforce (Rural and Remote Health)

Rural-trained students continue to practice in rural communities longer, with nearly 80% still doing so after 11 years (Academic Medicine)

Number of people on IowaCare – latest IowaCare enrollment 59,909 as May 31st. Can draw down data monthly, but it is generally best to look at previous month. As long as we put a date, it will be okay that it is a changing number. The data trends up by 400 – 1000 per month.

- Why would we use it on a workforce fact sheet? It is an actual hard fact number – reproducible and verifiable.
- Difficulty in translating enrollment into access – hurdles to access to care.
- IME does collect referral information from all medical homes on a quarterly basis – number of referrals made (specialty care), patients seen, patient no-show … may give some sense of the access issue.
- Health workforce shortages are one barrier, but also there are general barriers to access to care.
- Went over infrastructure definition and think maybe IowaCare could fit there.
- Discuss further as Fact Sheets become more robust – decide where this item fits best.

Waiver waiting lists, etc. – fits into infrastructure. On workforce side … waiting list and number of services out there … there would not be close to the workforce out there to meet the demand if funded to serve everyone on waiting lists. Technology increases, we are saving people and living longer – there are more people to serve.

CHNA HIP – can we get specifics from those plans? – could be some good metrics in those – for example, the counties that are HPSAs. Try to localize the data a little bit. State the number of HPSAs, but also line up HPSAs and CHNA HIP, maybe.

OSCEP (Office of Statewide Clinical Education Programs) is developing year-end numbers for 2011. The reported numbers reflect practicing health care providers as opposed to a list of licensed health care providers available from the respective boards. OSCEP can provide some trend data. They don't determine HPSAs.

OSCEP conducts an annual benchmark survey of medical practice opportunities.

	After the survey is completed, the data is used to publish the Iowa Medical Practice Opportunities Directories. The Iowa Medical Practice Opportunities Directories are available on the web here. The type of opportunities collected in the Iowa Medical Practice Opportunities Survey include: Family Medicine Emergency Medicine General Internal Medicine including hospitalist positions General Pediatrics Ob/Gyn General Surgery Psychiatry Nurse Practitioner Physician Assistant The numbers quoted below represent actively practicing professionals in Iowa, as of the date of the conference call (6/26/2012). These are not the same numbers that will be reported as OSCEP's year-end 2011 benchmark. • Physicians 5,560 … has grown steadily • PAs 717 • 1,503 dentists … very stable number over 13 years • ARNPs 1,456 • Pharmacists 2,818 Whatever data points are listed, carry the story through the rest of the fact sheet. Are residency programs a hot-button issue? Nationwide – number of residencies haven't increased as fast as medical schools are added. Foreign entities are literally buying residency slots. Is there discussion about how residency programs should be funded – whether by government or privately. Rotation sites. Residencies are funded through Medicare and Medicaid dollars – any growth must come from private support. Certain number of slots. Suggestions for "**Key Data**" (with revised phrasing as needed) 1. Healthcare is often one of the top two employers in a small town, making it key to economy 2. Nearly X# of Iowans are unable to access care due to a shortage of providers. 3. HPSAs number primary care, mental health and dental HPSAs 4. Helpful to include the OSCEP data on numbers of practicing professionals, especially for trending (usable information – for entities planning to add FTEs) 5. OSCEP annual survey of openings (Iowa Medical Practice Opportunities) 6. X number licensed RNs – check with BON 7. X number of direct care workers – Direct Care Initiative
Wrap-up and Public Comment	Discussed possibilities for how to determine what specifically can go on the fact sheets regarding what the legislature can do for the issues addressed by the Council. Addressed

	that the group felt something was really accomplished with the presentation provided by Lori Lipscomb. Felt this group provided concrete suggestions for improvement. Would like a very focused conversation next.

Next Meeting: Tuesday, September 11, 2012 10:00 AM – 3:00 PM Urbandale Public Library Meeting Room A