

MINUTES

Prevention and Chronic Care Management Advisory Council

Friday, May 15, 2009
10:00 am – 12:00 pm
Conference Call

Prevention & Chronic Care Management Advisory Council Website:
http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp

The task for this call is to discuss each recommendation and develop more specific justification language/implementation steps.

Recommendation 1-

Give a name and identity to this group. Over what timeframe do we anticipate it lasting?

- The group decided that it will last as long as it has meaning and purpose. The Clinicians Advisory Panel will provide oversight. There will be things we recommend that will not be our responsibility to implement, for example maybe another council would take that on that recommendation.
- It was suggested that this group be called the Iowa Priorities Council for Prevention and Chronic Care. Assign priorities to those who have authority. It was also suggested to include the word "partnership" in the name and to make it have a "people feel" that the average person can relate to. Another suggestion was to leave the name of the council as it is.
- If we go back and look at the 14 recommendations in the legislation, # 7 says "The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks."
 - We should look broader and implement something in Iowa similar to other nations. There are guidelines to integrate a Prevention and Chronic Care Model, as well as disease management. We need to determine what our ideal would be. Make recommendations as if there is enough finance down the road. Don't get caught up on little detail. The legislation wants this to be bigger and broader. The legislatures charged us with making recommendations addressing the 14 focuses. We are going to need to develop stronger, action oriented, verb driven recommendations.

Recommendation 2-

- Create a higher level of health literacy for Iowans. This is what we don't have that we need. What does "health literacy" really mean? We need to define terms like this so that everyone is on the same page to communicate broadly.

- Create a glossary of terms as an appendix, and say what we want to say in the report.
- In the Healthy Communities program at IDPH, how is health literacy approached? It is about the impact of the environment on people's health, creating a relationship between education and health status, and building awareness.
- Basic understanding at the consumer level is what is needed. Do patients understand what is going into their charts? This falls well within the medical home concept of care coordinators or health coaches to provide that interpretation.
- Dr. Applegate mentioned that health risk assessments explain what the test given means and what the value is. For example, it would answer "What does high cholesterol mean and how does it relate to me?" It also gives suggestions on what the patient needs to do next and helps them make informed decisions.
- Personal health records discussion - The eHealth Council is discussing this and they want to make sure it is functional. They haven't gotten into what belongs in a personal health record. The Health Information Technology process will be moving prior to August 1st. John will take our dialog to the eHealth Council. We also need to share with them that we believe it is essential to have a disease registry function in electronic health records.

Recommendation 3-

- It was suggested to "identify and recommend consensus guidelines" about metrics. The state should adopt some that are targets. Iowa has none. Do not say "develop". We shouldn't reinvent the wheel in Iowa.

Recommendation 4-

- Focus area 13 implies a disease registry where the physician is reporting to the state. The council decided **not** to do this. They did not want to make the provider population vulnerable and at risk with provider reimbursement. There is no motivation for providers to utilize a state registry. There are conflict between payor goals, improvement goals, and performance goals. Programs that exist now have high goals for payment increments and there is not much focus on improvement goals.
- Have the state be the facilitating body to help to identify and make available practice registries for the care of patients. State supported registry, not a state registry. It provides a way for practices to manage their own patients and provide routine interventions.
- Community Health Center's are largely uninsured, underinsured and minorities. The Healthy Disparities Collaborative share their data to see which clinics have the best data, and then that clinic would share with others what they are doing to achieve the good data. It is all about "sharing sensibly and sharing shamelessly" with each other. Take the best of many practices to build the best health care in the community. There are groups that are already doing this such as IHC, Wellmark, and AAFP.

Recommendation 5-

- The legislatures that read the report will be looking for specific examples or existing models regarding payment incentives. CMS in the near future will be giving incentives to providers to use EHR's and penalize them for not using one.
- Everything laid out in Health Care Reform has a common element. Everything involves more care coordination. The payment for these will rely on or directed to mid-level providers. Make a broad recommendation that we need to give greater attention for prevention and chronic disease management through payment incentives. We want to have incentives from current health plans to be focused on prevention and/or disease management to the extent that they reduce costs and improve quality of health. Farm Bureau has a good set up with no co pays etc. but requires routine preventative screenings. We are not going to *develop* payment incentives.
- Primary care providers are being asked to expand their practice without further resources. Successful ways of providing practices with the resources necessary to improve care are to hire health coaches and recruit and retain primary care physicians. There is a great deal of prevention and chronic disease management that happens outside the provider offices that is tremendously under-funded. Request to add funding for community prevention efforts.

Recommendation 6-

- Include specific language to improve chronic care and education opportunities for health care professionals (CEU).
 - The Council doesn't want another requirement for CEU's. Provide more opportunities for CEU's and have them relate to prevention and disease management.
- * Closing comment from Dr. Applegate- We need to encourage individuals to take responsibility for their own health. Mary Robinson – we should encourage them to be more responsible WITH the tools to do so. Many people have not been informed or do not have access to the information. We are victimizing the victims. There are some other factors that are beyond the control of individual which impacts the decisions that they make about their health.