MINUTES
Prevention and Chronic Care Management Advisory Council
Friday, December 4th, 2009
10:00 am – 3:00 pm
West Des Moines Public Library

Members Present	Members Absent	Others Present
Bill Appelgate	Jose Aguilar	Angie Doyle-Scar
Mary Audia	Krista Barnes	Beth Jones
Della Guzman	Steve Flood	Jill Myers Geadelmann
Terri Henkels	Trula Foughty	Kala Shipley
Melanie Hicklin	Tom Kline	Abby McGill
Noreen O'Shea	Kathryn Kvederis	Kay Corriere
Patty Quinlisk	Rev. Dr. Mary E. Robinson	Michelle Holst
Peter Reiter	Steve Stephenson	Bobbi Bentz
Suzan Simmons	David Swieskowski	Maureen Myshock
Donald Skinner	Jenny Webber	Eric Nemmers
Jacqueline Stoken		Ashley Wolfe
John Swegle		Amy Huzefa
Debra Waldron		Sara Schivert
		Carlene Russell
		Lisa Sharp
		Linda Goldner
		Jennifer DeWall
		Jane Schadle
		David Carlyle
		Dan Baldi
		Sam Graham
		Michele Greiner
		Linda Hinton

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

Topic	Discussion
Welcome/Introductions	• Council members and others introduced themselves.
Other Health Reform Councils • *Medical Home* • *E-Health*	***Medical Home*** *CMS Demonstration Project* • Medicare will be joining Medicaid and private insurers in a new demonstration project to improve the way healthcare is delivered. The public and private payers will be based on a model of primary-care delivery that's currently being tested in Vermont. Under this model, private insurers work in cooperation with Medicaid to set uniform standards for advanced primary-care models (medical home). This demonstration marks the first time Medicare will participate as a full partner in these experiments, where the practice model would align compensation offered by all insurers to primary-care physicians. • The five overall goals of the demonstration are: 1. Reduction of unjustified variation in utilization and expenditure

2. Improvement in safety, timeliness, effectiveness, and efficiency
3. Increased patient participation in decision making
4. Increased access to evidence-based care in underserved areas
5. Contribute to 'bending the curve' in Medicare/Medicaid expenditures

- Guidance has not yet been released. There have been a few webinars, and the information given has been used to start determining what Iowa's pilot would look like.
- This is different than the initial guidance that came out from CMS. The first one was limited to a number of states, and this one is not. If Iowa doesn't get the first cycle, we can apply again. We need to have payors on board, but we would want practices and communities to lead the pilot. We can just look at payment; we are more interested in practice redesign.

Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant from CMS

- The goal the grant is to establish and evaluate a national quality system for children's health care which encompasses care provided through the Medicaid program and the Children's Health Insurance Program (CHIP). It will
  - experiment with and evaluate the use of new and existing measures of quality for children covered by Medicaid and CHIP;
  - promote the use of health information technology (HIT) for delivery of care for children covered by Medicaid and CHIP;
  - evaluate provider-based models to improve the delivery of Medicaid and CHIP children's health care services;
  - demonstrate the impact of the model electronic health record (EHR) format for children on improving pediatric health, and pediatric health care quality as well as reducing health care costs.
- Iowa Medicaid intends to apply for the grant, with IDPH taking the lead in writing it. Iowa's application is titled *Navigating the Neighborhood: Improving Child Health Quality.* The project will be organized around a medical neighborhood model of care. The medical neighborhood approach will take place in two targeted Iowa communities, one rural and one urban. The application is due January 8th.

Health and Long-Term Care Access Advisory Council

- In September, the Council submitted Recommending Strategic Plan Initiatives to be included in the Health and Long-Term Care Access Strategic Plan. It can be found here.
- Six goal areas were established:
  1. Assure access for all Iowans living in *rural areas.*

2. Assure access for all Iowans living in *urban underserved areas.*
3. Assure access for *people with disabilities.*
4. Assure access for *the elderly.*
5. Assure access for *ethnic and racial minorities.*
6. Assure access for *the uninsured and underinsured*.

Direct Care Worker Advisory Council

- This council is working on the regulation and certification of direct care workers. The group also develops recommendations on certification, education and training, standardization requirements for supervision, and functions for direct care workers.
- They have a report due January 15th.

Patient Autonomy in Health Care Decisions in Pilot Project Advisory Council (IPOLST)

- The Council met on November 6th for their one and only meeting. At this meeting, they came up with recommendations for their report that is due in January.

The recommendations are:

- **Educate and Outreach Recommendations:** IDPH shall assist the community pilot in the following education and outreach activities: 1) Continue education of pilot county providers and promote change in all involved facilities; 2) Develop a plan for statewide outreach and education about the pilot program; 3) Identify statewide stakeholders to increase their knowledge of the pilot program; and 4) Determine if additional stakeholders should be included in the pilot program.
- **Resources Recommendation:** Affiliate with organizations (including but not limited to local public health departments) to establish partnerships and enhance funding opportunities for replication of the IPOST pilot.
- **Research Recommendation**: Continue data analysis including pilot medical chart reviews. Expand analysis to include health care staff, patient, and family surveys. Analyze the need for extension into various health care settings (home/hospital/rural/urban) and continue the literature review and content analysis for current best practice.
- **Pilot Expansion Recommendation**: In support of the ultimate goal of statewide implementation of IPOST: we recommend a two year extension of the pilot project. This extension could include an expansion to a contiguous rural county that has a referral relationship with the pilot county. Additionally, in preparation for statewide implementation, assess the feasibility for future expansion to a community-based setting and a county with a state owned tertiary care hospital.
- **Continue Pilot Project Recommendation**: Continue the current pilot for another two years. Additionally, charge the pilot with assisting to provide outreach education statewide to achieve culture change. Collect data on the need for IPOST in all settings and do a needs assessment exploring regional and/or statewide future expansion. Identify sustainability issues including funding.

	Council Discussion • IPOST is a strong community effort that addresses an opportunity for the community and family. The document belongs to the patient. 1/3 of patients that filled out the form want all treatment possible. • Dr. Peter Reiter commented that this is an example of a document that provides piece of mind. It's a good planning document that forces families to work through different situations. • IPOST has become a national movement. The form is the same across all states and is widely used. • The Department of Aging has many similar resources. They are involved in a lot of the home and community-based home initiatives with those needing higher level of care in the homes. The web link www.lifelonglinks.org gives available services to keep them living in their homes. • John Swegle mentioned that Mason City has a fellowship with great internal information regarding the cause of death in hospitals. They did a study and have a wealth of information and data about this. • The PACE (Program of All-Inclusive Care for the Elderly) program was developed to address the needs of long-term care clients, providers, and payers. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. • Dr. Peter Reiter mentioned that he has an advanced directives conversation with his patients when they are admitted at the hospital. People often say they have a living will, but aren't really certain. Half of the time they say they don't want any extra care. • Bill Applegate commented on how this document could be incorporated in an electronic medical record. A patient many times sees more than one provider. What happens to the other providers that that person sees? The IPOST form needs to be a part of the medical record, but we are going to see medical records that are going to follow people. It is probably going to be web based to have 24-hour access. ***eHealth*** ***Governor's Council on Physical Fitness and Nutrition*** See November Check Up
Health Care Coverage Commission and Discussion *David Carlyle*	• The Commission met on December 2nd to formalize their recommendations. These recommendations will go into the report that will go to the legislature. For more information about the Legislative Health Care Coverage Commission and to view these recommendations, click here. • There are 14 voting members on the commission, and they broke into three workgroups. Each workgroup met at least four times, and came up with their recommendations that were shared at the Dec.

	2nd meeting. **Workgroup 1- Coverage of Adults** • **First Recommendation:** Expand the IowaCare program to create a regional delivery model that will provide access to primary care and hospital care in the least geographically burdensome manner, which is defined as providing all but tertiary level care as close as possible to an IowaCare member's home. • The IowaCare program has many barriers. It only offers services in Iowa City and Des Moines, and it can often take months to get into the Iowa City location. These services can be done locally. • **Second Recommendation:** Increase funding for technology capacities in DHS. In anticipation of federal health care reform, DHS needs to receive increased technology funding, including funding to provide for electronic eligibility determination and processing. The Department also needs to be aggressive in pursuing funding opportunities from the federal government to implement new technological approaches for determining Medicaid eligibility and enrollment mechanisms. • **Third Recommendation:** Iowa should pursue federal health care reform early opt-in opportunities. Iowa has a strong history of taking on a leadership role in health care access reform. If the federal government provides useful incentives for early adoption of measures that can increase access to affordable health care, the Workgroup recommends that Iowa move aggressively in pursuing these opportunities before 2014. • At the federal level, state policy makers were told that if you are an early adopter you might get a huge part of it paid for federally. • **Fourth Recommendation:** The workgroup supports the development of a statewide diabetic registry**.** In order to improve care of uninsured diabetic patients and begin the process leading to upcoming Medicaid expansion, the state should set up a diabetic registry with the assistance of Iowa's Community Health Centers and free medical clinics. In exchange for data and lab tests, the registry will provide a basic combination of medications, including anti-hypertensive's, cholesterol lowering agents, and diabetic medications. • The Iowa Prescription Drug Corporation would be utilized. In exchange for participating in the registry, the patients would get a 90-day supply of drugs. This frees up clinic time for refilling prescriptions. *Council Feedback* • Dr. Noreen O'Shea commented that at the community health center she works at, a major issue is that the patients do not want their names to be shared. You need to stress that the data is de-identified when it goes to the registry, especially if it is web based. • Terri Henkels works in a public health department where they enter data in a number of different systems. There are no financial resources to do the data entry. • Dr. Peter Reiter mentioned the advantage of having the medications available at a central community pharmacy that can be

	secondarily dispensed in bulk to off-site centers. • Dr. John Swegle commented that free medical clinics rely heavily on samples. You need to have a consistent supply of medication coming in that isn't outdated. Dr. Carlyle replied that the Iowa Prescription Drug Corporation's medicine all has to be up-to-date- they don't give out expired drugs. • Dr. Don Skinner expressed that the statewide registry needs to be accessible to everyone and it shouldn't just focus on diabetes. It needs to track all chronic diseases. That will allow for better research and population management, and will offer opportunities for portability across different sources of care. • Bill Applegate expressed that if we are going to have a registry in Iowa that it needs to be web-based and available to everyone. There also needs to be an incentive to use it, such as changing the payment structure. **Workgroup 2- Use/Creation of a State Pool** • This workgroup was tasked to review, analyze, recommend, and prioritize options to offer a program to provide coverage under a state health or medical group insurance plan to non-state public employees of counties, cities, schools, area education agencies, community colleges, nonprofit employers and small employers. **Workgroup 3- Administration of Health Care Reform in IA** • This workgroup was tasked to review, analyze, recommend, and prioritize options related to the administration of health care reform in Iowa and creation of an affordable, accessible, seamless health care coverage system for all Iowans.

Healthy Links Taskforce
 	
Kay Corriere
	• A five minute video was shown that gave an overview of chronic disease self-management programs.
	• The Iowa Healthy Links Chronic Disease Self-Management Program (CDSMP) is a workshop given two and a half hours, once a week, for six weeks, in a community setting, such as senior centers, churches, libraries and hospitals. Workshops are conducted by two trained leaders, one or both of whom have health conditions themselves or have a family member that does.
	• Participants learn:
	  • Techniques to deal with isolation, frustration, fatigue, pain
	  • Suitable exercises for maintaining and improving strength, flexibility, and endurance
	  • Appropriate use of medications
	  • How to communicate your feelings effectively with family, friends, and health professionals
	  • Healthy eating and nutrition tips.
	  • How to evaluate new treatments
	• The program, administered by the Iowa Department of Aging and funded by grants from Administration on Aging, the National Council on Aging/Atlantic Philanthropies, Iowa Department of Public Health, and The Wellmark Foundation, gives them the skills to help coordinate and manage their chronic condition, as well as to help them keep active in their lives. For more information visit

	http://www.iowahealthylinks.org/ • Q-- Is there evidence of success? • A – It was developed by Stanford's School of Medicine. Data shows that participants in this type of self-management program show significant improvement in health and behavior changes. Cost savings are also significant. Every dollar invested in such program can cut health care costs by approximately four dollars. These improvements are shown to last as long as 3 years. • Dr. Peter Reiter commented that if people were more aware of the availability of this program, it could help make it more widespread. The program is not that expensive to adminster; it is about getting people to the training.
Mental Health Panel Dr. Dan Baldi Dr. Sam Graham Dr. Michele Greiner Linda Hinton	• Mental Health Panel members introduced themselves: - Dr. Dan Baldi- *Iowa Pain Institute- Pain Management Specialist* - Dr. Sam Graham- *Iowa Psychological Association/Iowa Pain Institute* - Dr. Michele Greiner- *Iowa Psychological Association* - Linda Hinton- *Iowa State Association of Counties* • Dr. Greiner mentioned the importance of the integration of primary care and behavioral health. Sixty percent of visits to primary care are stress related or mental health related. Studies have shown that integration and care coordination can be a cost savings. • Three out of 5 persons with mental illness die because of a preventable illness. It is very difficult to communicate with people with mental illness. • The Iowa Coalition on Mental Health & Aging exists to expand and improve mental health care for older Iowans so that they can live, learn, recreate, engage in meaningful activities and access appropriate services in the communities of their choice. For more information visit http://www.public-health.uiowa.edu/icmha/ • Care coordination is a major part of the patient-centered medical home model. It ultimately one way to prevention and to treat the chronic diseases. • Telehealth was discussed. It is an innovated way of care that is a great model for many patients. Oklahoma jumped from a grade D to a B by using telehealth from the National Alliance on Mental Illnesses "Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness". To view the entire report, click here. • Dr. Graham is a psychologist best known for treating people with chronic pain disorders. He gave an overview of chronic health issues. • Those with chronic pain have significant behavioral factors on the onset and interfere with the effects of the disease. He sees patients with co-occurring diabetes, pain, and depression. It is very complex to treat these patients. There is not enough time in the office to talk with them about the behavior changes they need to make to manage their disease. • A third of depressed patients will develop chronic pain, and 1/3 of

	chronic pain patients will develop depression. • It is critical to manage depression, and to do this in a chronic pain population seems impossible. The more we can get the system to work together and have closer contacts the more cost savings we will show. • Dr. Baldi shared that more and more people are reporting back pain. We know more about pain today than we ever have. Recent technology is causing people to lose coping skills and mechanisms. • Linda Hinton has been involved in the policy piece of what happens in mental health services for 20 years now. She represents the Iowa State Association of Counties. Counties provide funding for adults with mental health issues and developmental disabilities. Counties are providing mental health services based on a mandate to provide institutional services. They also provide services to people with chronic mental health conditions. Some of the acute services are paid for, but the system is based on a financial need. They support mental health parity legislation. It's the right thing to do and most people come to their programs because they don't have insurance. If insurance companies offered mental health coverage, we would have a better health care system. • Iowa is an underserved state. We are 3rd from bottom in terms of psychologists per capita. The rural/urban balance is another issue. People sometimes have to travel four hours to see a psychologist. • Terri Henkels mentioned that TeenScreen found very high percentage of at risk kids. • Those in the jail system get mental health services while they are incarcerated. When they are released, they don't have insurance that continues cover the mental health services that are needed.
Issue Brief *Chronic Disease Management*	• Issue brief needs to include data and information specific to pediatrics. NICHQ Children's Health Care Quality has good data. • A second draft will be sent to the Council for further feedback.
Group input	• Dr. Don Skinner asked what will our deliverable be as a Council? What do we want to do next? • This will be the first agenda item at the February 5th meeting. • We need to determine ideas/recommendations that cost no money to present to the legislature. • The Council discussed looking into different disease registry tools, as well as determining consensus guidelines that would be used. www.guidelines.gov was referenced. A workgroup will be set up to do this. • The Vermont Blueprint should be reviewed by council members. It is on the website. It can also be found here: http://www.healthvermont.gov/blueprint.aspx • Google Groups/ other listserves will begin to be used for this Council.
The next meeting of the Prevention and Chronic Care Management Advisory Council will be held **Friday, February 5th, 2010** from 10:00 am – 3:00 pm at the Urbandale Public Library.	