

# MINUTES

## Medical Home System Advisory Council

**Friday, January 9, 2009**  
**10:00 am – 2:00 pm**  
**ChildServe, Training Center Room**

Members Present

Chris Atchison  
 Jen Badger  
 Melissa Bernhardt  
 Libby Coyte  
 Kevin de Regnier  
 Tom Evans  
 Carrie Fitzgerald  
 Naomi Guinn-Johnson  
 Jeffery Hoffmann  
 Petra Lamfers  
 Mary Larew  
 Tom Newton  
 Bob Osterhaus  
 Jane Reinhold  
 Bruce Steffen  
 Susan Voss  
 Nat Kongtahworn

Members Absent

David Carlyle  
 Berry Engebretsen  
 Ro Foege  
 Richard Haas  
 Don Klitgaard  
 Bret McFarlin  
 Jennifer Vermeer

Others Present

Beth Jones  
 Jill Myers Geadelmann  
 Abby McGill  
 Julie McMahon  
 Jane Borst  
 Tracy Rodgers  
 John Hedgecoth  
 Nicole Schultz  
 Angie Doyle-Scar  
 Mike Kanellis  
 Leah McWilliams  
 Dan Royer  
 Deborah Helsen  
 Bob Russell  
 Karla Fultz McHenry  
 Larry Carl  
 Daniel Garrett  
 Craig Logemann  
 Lindsey Gooding  
 Dennis Janssen

\* **Medical Home System Advisory Council Website (handouts found here):**  
[http://www.idph.state.ia.us/hcr\\_committees/medical\\_home.asp](http://www.idph.state.ia.us/hcr_committees/medical_home.asp)

Topic	Discussion
Introductions	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• The meeting was called to order at 10:00.</li> <li>• Council members and others present introduced themselves.</li> </ul>
Iowa Choice Advisory Council Report	<p><i>Carrie Fitzgerald</i></p> <ul style="list-style-type: none"> <li>• The Iowa Choice Health Care Coverage Advisory Council was established from House File 2539. The purpose of this council is to develop a comprehensive health care coverage plan.</li> <li>• This council first met on August 11<sup>th</sup> and have met seven time every two weeks at the state capitol building. They broke into small groups to address the larger issues in children’s coverage including benefit review, definition of “all kids”, coordination of the current programs, maximization of funding for hawk-i and Medicaid, and covering children who are not currently eligible for hawk-i and Medicaid.</li> <li>• On December 15<sup>th</sup>, they submitted their report to the legislature.</li> <li>• You can find this report with their recommendations at: <a href="http://insurealliowakids.org/">http://insurealliowakids.org/</a>. The list of council members is located in Appendix I.</li> <li>• A big issue in this report is that they recommended covering <u>all</u> children in Iowa, including illegal and undocumented children.</li> </ul>

	<ul style="list-style-type: none"> <li>• There is a small section in their report on covering all adults. This is a very challenging task and there is still a lot to learn and examine in Iowa about covering adults. Iowa will need support from the federal government to do this.</li> <li>• The last page of the report is an example from Illinois. Illinois example would truly cover ALL kids. It gives an example of how much families with different income levels would pay.</li> <li>• Chris Atchison asked about compensation of care coordination and ways to make policy changes to compensate for professionals who do care coordination. The 1<sup>st</sup> Five program is a good example of this, and there are many more out there. They could not capture them all with the limited amount of time allowed to do this.</li> </ul>
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<p>Certification of Medical Homes</p>	<p><i>Petra Lamfers</i></p> <ul style="list-style-type: none"> <li>• Several colleagues verbalized concern that in the Medical Home and CMS grant, that nurse practitioners are left out completely. Nurse practitioners need to be included in primary care physicians. They can provide primary care to all age groups. Iowa Code 655 Chapter 7 states that a nurse practitioner can practice independently.</li> <li>• Nurse practitioners have their own panel of patients that they have under them and they have their own Medicaid number.</li> <li>• Recommended that patients should not be forced to change primary care providers and nurse practitioners need to be included in the design and development of the Medical Home project.</li> <li>• Tom Evans wasn't aware that only certain providers/practices can become a certified medical home. He did not think it was a scope of practice issue and we want as many people to climb the ladder towards becoming a medical home as possible.</li> <li>• Libby Coyte stated that nurse practitioners are included and that the council needs to be careful about language. The language that was heard was aimed at practices including nurse practitioners. There are two groups in Iowa that need to be included in the demonstration project, but their payment systems are different. They are rural health clinics and community health centers. We need to make sure that these groups are involved. This is about advancing what state health policy already is. Also, this council should go ahead and make recommendations to change or make HF 2539 better.</li> <li>• Nurse practitioners are included into the language of HF 2539.</li> <li>• Tom Evans stated that it is important for us to remember that the destination is an engaged and effective primary care practice. Medical homes are a tool to get there. NCQA has a laundry list of items to reach a certain level of medical home to become reimbursed. This council has the power to change NCQA's ideas to fit for Iowa. There are two pieces to this 1) how do we define credibility, and 2) what are Wellmark and Medicaid going to be willing to pay for.</li> <li>• Chris Atchison said that EPSDT is a beneficial component within coverage. Evidence/reports of this will be found and shared with the council.</li> <li>• Jane Borst shared that there are studies out there and we need to find which ones are important to you. We can do the research to see what is already out there.</li> </ul>
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<p>Oral Health and the Medical Home</p>	<p><i>Jen Badger</i></p> <ul style="list-style-type: none"> <li>• The objectives of her presentation are to explain the role of an I-Smile coordinator, discuss activities carried out on the local level, discuss the dental home concept related to medical homes, and share an example of a success story from a dental home.</li> <li>• The information shared will expand on the information shared by Bob Russell at the last Medical Home Advisory meeting.</li> <li>• There are 24 I-Smile coordinators spread out throughout Iowa. The Iowa Dept. of Public Health website has a map where you can click on your county and it will show you your I-Smile coordinator.</li> <li>• The I-Smile coordinator has many responsibilities and they work with a variety of people.</li> <li>• Jen has recently been working with many dentists by visiting numerous offices in area and presenting a continuing education lunch and learn. She talked about how to do an age 1 dental exam and was able to survey them about the number of Medicaid patients and the ages of patients they see. There were only two offices that would see children under 1 year old, and only one of those saw Medicaid patients.</li> <li>• Her work with primary care providers included a series of ICN networks in their local training. Three clinics were represented and 11 providers. She provides a pocket guide and posters that reference how to apply a varnish.</li> <li>• I-Smile coordinators also have been working with MCH agency staff, boards of health, WIC staff, empowerment boards, school nurses, head/early head start, child care nurse consultants, public health agencies, and parents.</li> <li>• The key thing about a dental home in relation to medical homes is the partnership between families and providers. We need to empower families to be an active part in their child's oral health.</li> <li>• She shared a success story of how a team really works together to help a child receiver the proper oral care needed.</li> <li>• I-Smile Coordinators do the things for children that the parents do not.</li> </ul>
<p>Oral Health and the Medical Home</p>	<p><i>Michael Kanellis</i></p> <ul style="list-style-type: none"> <li>• He is from the University of Iowa College of Dentistry and has been in private practice for 13 years.</li> <li>• Healthcare Guaranteed is a book he recently read that he shared with the council.</li> <li>• The I-Smile coordinators are the glue that has been missing for a long time.</li> <li>• In regards to Iowa's Dental Home Legislation- if anybody can do it well, Iowa can. Iowa has some unique opportunity and strengths that other states do not. Some of these unique strengths include a highly educated population, low poverty level, high water fluoridation, and good distribution of dentists. Iowa is a rural state, not a remote state.</li> <li>• In 2008, 69 percent of dentists had a Medicaid claim. Medicaid only reimburses 41 percent of a bill.</li> <li>• Iowa has a good distribution of pediatric dentist accepting Medicaid patients. It is essential because they are the only group of providers with the training, ability and comfort to provide care to the children</li> </ul>

who have the most difficult time finding access to care.

- We have a state funded dental school, yet many graduates are not staying in Iowa. In summary, Iowa is relatively health state with a strong infrastructure for delivery dental care to its citizens.
- Medicaid has to be funded to adequate levels. There has been no serious effort to reimburse better. Less than 3% of what is spent on Medicaid is to dental.
- He suggested establishing a loan repayment plan for dentists willing to practice in shortage areas which will make it affordable for them to practice there.
- Two additional cost-effective ideas were given: 1) Establish program and licensure to allow expanded function dental assisting, and 2) have regular meetings of leadership of key organizations in Iowa to discuss access and other issues concerning the oral health of Iowans. Key organizations including Iowa Dental Association, Department of Public Health, College of Dentistry, Iowa Board of Dental Examiners, and Iowa Dental Hygienist Association.
- Cautionary notes include utilization vs. access, program evaluation, and populations left un-served.
- North Carolina took 17 children with early childhood caries, enrolled them into a protocol that had nutritional counseling, fluoride, and tooth brushing instructions. They are followed up on 3 months later and 15 out of 17 didn't change behaviors.
- There is a serious problem with uninsured adults going to emergency room for dental health issues. We need to make sure that the disease rate is going down and not the services going up.
- Chris Atchison asked how many pediatric dentists are there. Is this a direction we need to go? Are there enough dentists in the state? He doesn't know and thinks that pediatric dentists have a large capacity to see a large number of patients in a little time. There is a 2000 people to 1 dentist. It is more of a distribution issue.
- It is not the goal is to use the term dental home to be one person in a building. We need to have everyone working together with a dentist centered program.
- Bob Russell stated that I-Smile is not limited to Medicaid and they also focus on uninsured children. We need to put the resources together and make it more robust.
- Melissa Bernhardt shared that there is a capacity and dentists are willing to see theses kids. However, they need to pay their bills and cannot afford a 40 percent reimbursement rate for Medicaid patients.
- Tom Evans stated that most of these issues also apply to primary care practice. Two major issues were discussed. 1) The current medical home model of care delivery is inadequate. We provide inadequate access to care and are not using electronic health records. We need to fundamentally change how things are done. 2) What is the relationship between medical homes and dental homes? Dentistry is very different than primary care. If you see a patient in primary care. They are operating on different organ systems but are very similar. The University of Iowa hospitals and clinics have setup satellite clinics across the state.
- When we talk about medical homes and dental homes, there needs to be a connection. When children hit school age, dentists see them

	<p>more often than primary care. This advisory group needs to consciously build that relationship and integrate them.</p>
<p>Break/Pick up Lunch</p>	
<p>Role of Pharmacy in the Medical Home System</p>	<p><i>Craig Logemann</i></p> <ul style="list-style-type: none"> <li>• Bob Osterhaus introduced Dr. Logemann. Dr. Logemann is a clinical pharmacist University of Minnesota. He graduated from the University of Iowa College of Pharmacy.</li> <li>• Dr. Logemann works directly in the family physician office and will give examples of how pharmacists can be involved in a clinical setting. He works for Urbandale Family Physicians and West Des Moines Family Physicians.</li> <li>• Some clinical services provided by a clinical pharmacist are taking individual appointments for medication and disease management. They take on the role of “health coach” where they combine monitoring and education about diet and exercise education. Another service is to provide education to pharmacists and patients.</li> <li>• There are new guidelines for collaborative practice agreements. The types of medications that clinical pharmacists are able to adjust doses on were outlined.</li> <li>• Some future changes in the primary care environment are to switch from traditional visit payment schemes to “pay for performance”. Also to develop patient safety initiatives and a collaborative care model.</li> <li>• A handout was provided that depicted three different scenarios of pharmacist activity in a family medicine setting. Some of the benefits listed on this handout included minimized workload for the primary physician, additional monitoring of high-risk medication provided by clinic personnel, enhanced patient education, and coordinated care with specialists.</li> <li>• Mary Larew asked if the insurance company is billed independently. He bills under the referring doctor and has the physician cosign it.</li> <li>• Jeffery Hoffmann commented on cost savings for the insurance company and how lifestyle changes for the patient are measured. We need to get consumers to understand that they are the ones benefiting from these changes.</li> <li>• Bob Osterhaus mentioned that there is a number of studies on avoidance costs dealing with diabetes, obesity screenings. The pharmacists paid the workers. The medication program that they did for Medicaid in Iowa has very interesting statistics, the fewer emergency room visits from taking care of asthma patients. If you reduce a few of those in a year’s time it is cost effective to pay the pharmacist to spend time covering this. There are many things that pharmacists do to collaborate with other health care professionals in the medical home model.</li> <li>• Nat Kongtahworn said they are about to embark on a series of tests to assess the effects of several different types of models and these models are sensitive to the patient population.</li> <li>• Bob Osterhaus commented that North Carolina decided to have a clinical pharmacist in every clinic because they know that it will be</li> </ul>

	<p>cost beneficial to them.</p> <ul style="list-style-type: none"> <li>• Nat Kongtahworn spoke on the adherence to medication. We need to engage patients to continually refill their medications. What is being done to make sure they adhere to their prescription? He asks his patients how often they miss your medications. He has their refill history electronically and can see if they did not come in for a refill. There may be some aspects outside of the medical domain that can attribute to patients not refilling their medication. 1) Psychosocial issues/denial. We need to reinforce the importance of taking the medicine. 2) Cost issues.</li> </ul>
<p>Legislative Report Draft</p> <p><i>Provide feedback and group discussion</i></p>	<p><i>Beth Jones/Abby McGill</i></p> <ul style="list-style-type: none"> <li>• This report is a <b>draft</b> and will not be distributed to the public or posted online.</li> <li>• This copy has Bery Engebretsen's comments incorporated because he was not able to be here today and we wanted to make sure that you could see his thoughts.</li> <li>• The three major goals of this report are to provide background education to the legislature, provide them with an update of the work that this council has done so far, and to provide recommendations.</li> <li>• It is important to keep in mind that we are not going to get any money this year. There may be things that are cost neutral or we can ask for legislative support on. We need to state what needs to be done to move this system forward.</li> <li>• The council had a discussion about the draft report and they shared their input and comments.</li> </ul>
<p>Off to a Good Start Policy Recommendations</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• This is a reference document geared for children age 0-5.</li> <li>• Goal three is to increase the number of children with a medical home. We need to come up with two to three bullets of policy recommendations. These will then be expanded on in a one page document.</li> <li>• This will be sent out to you along with the revised draft report. Your input and comments are encouraged.</li> </ul>
<p>Next Steps</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• Send your comments about he draft report to either Beth or Abby. We will resend you the draft report with these comments incorporated. It sill will not look like the final document however.</li> <li>• The meeting was adjourned at 2:00.</li> </ul>
<p>The next meeting of the Medical Home System Advisory Council will be held February 20, 2009 from 10am-2pm at the Urbandale Public Library, Room A</p>	

The purpose of the Medical Home System Advisory Council is to advise and assist the Iowa Department of Public Health to develop a medical home system as outlined in HF 2539.