

# MINUTES

## Prevention and Chronic Care Management Advisory Council

Friday, April 30<sup>th</sup>, 2010  
10:00 am – 3:00 pm  
Urbandale Public Library

Members Present

Bill Applegate  
Ana Coppola  
Eileen Daley  
Steve Flood  
Trula Foughty  
Terri Henkels  
Melanie Hicklin  
Tom Kline  
Teresa Nece  
Noreen O'Shea  
Peter Reiter  
Sue Simmons  
Kim Stewart  
John Stites  
Jacqueline Stoken  
John Swegle  
Debra Waldron

Members Absent

Jose Aguilar  
Krista Barnes  
Della Guzman  
Karen Loihl  
Patty Quinlisk  
Mary Robinson  
Don Skinner  
Steve Stephenson  
David Swieskowski  
Jenny Weber

Others Present

Angie Doyle-Scar  
Jill Myers Gadelmann  
Kala Shipley  
Abby McGill  
Jenny Schulte  
Paul Pietzsch  
Linda Goeldner  
Deb Kazmerzak  
Kay Corriere  
Deborah Helsen  
Daniel Garrett  
Marshall Tuetken  
Nicole Schultz  
Laurene Hendricks  
Anne Kinzel

\* **Medical Home System Advisory Council Website (Agenda/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	<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.               <ul style="list-style-type: none"> <li>○ Five new members have joined the Council                   <ul style="list-style-type: none"> <li>▪ Ana Coppola, MPH– Community Advocate</li> <li>▪ Kim Stewart – YMCA of Central Iowa</li> <li>▪ Eileen Daley, BSN, MHP – Iowa Public Health Association</li> <li>▪ Teresa A. Nece, MS, RD, LD, SNS – Iowa Dietetic Association</li> <li>▪ John Stites, DC, DACBR- Iowa Chiropractic Association</li> </ul> </li> </ul> </li> </ul>
Updates <i>Angie Doyle Scar</i>	<ul style="list-style-type: none"> <li>• Ed Wagner will be receiving the University of Iowa's Public Policy Center Forkenbrock Series and the College of Public Health's Hansen Award. A conference will be held on October 27th to present Ed Wagner with this award. Ed Wagner developed the <a href="#">Chronic Care Model</a>, which is the leading framework for improving care for chronic diseases. The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. The PCCM Council staff is assisting in the coordination of this event.</li> <li>• The disease registry issue brief draft was provided as a handout and is available online <a href="#">here</a>. This is now a combined issue brief with the PCCM</li> </ul>

	<p>Council, Medical Home System Advisory Council, and eHealth Advisory Council. Please send Abby (<a href="mailto:amcgill@idph.state.ia.us">amcgill@idph.state.ia.us</a>) any comments or edits you have to this draft.</p> <ul style="list-style-type: none"> <li>• The next issue brief will be on "Prevention".</li> </ul>
<p>Legislative Health Care Coverage Commission Update &amp; Federal Reform Overview</p> <p><i>Anne Kinzel</i></p>	<ul style="list-style-type: none"> <li>• <a href="#">SF 2356</a> has been signed by the Governor which includes three of the Commission's recommendations. The Commission completed their progress report to the General Assembly which summarizes the Commission's activities from September through December 2009. The report with their recommendations can be found <a href="#">here</a>.</li> <li>• Iowa, being an early exchange state, is a very positive thing. There are only three functioning exchanges in the country right now.</li> <li>• The three sections of SF 2356 are:       <ol style="list-style-type: none"> <li>1. <u>IowaCare Expansion</u>- Provides healthcare to uninsured adults below 200 percent Federal Poverty Level. This is the only part of the bill that has funding- 24 million dollar expansion. 8 million of this is state matched. The other 24 million is divided in half- 8 million going to the University of Iowa hospitals, and the other 8 million going to primary care networks, focusing on community health centers. The community health centers will follow a medical home certification process.           <ul style="list-style-type: none"> <li>• Dr. Reiter asked that if the primary care transition to the FQHC's would be outpatient care only. Yes, it will just be outpatient primary care.</li> <li>• Steve Flood commented that data shows 50% increase in Medicaid enrollment federally, in Iowa it will be around 25%. How will we financially absorb this increase in Medicaid enrollment? Will services be removed or taxes be raised? Tom Kline responded that IowaCare has additional subsidies. Also, a major goal of the IowaCare Expansion is to develop a medical home plan to help manage the patients, which should be cost-saving. Additionally, once patients initially enroll in IowaCare, their costs are higher, but after awhile the costs go down because they are better able to manage their health.</li> <li>• Dr. Reiter expressed concern about lack of provider's, especially primary care. We need to provide incentives for students to enter primary care practice.</li> </ul> </li> <li>2. <u>Iowa Insurance Information Exchange</u>- an informational clearinghouse where Iowans can obtain information about health care coverage that is available in the state including comparison of benefits, premiums, and out-of-pocket costs. It will include links to the private sector and public sector.           <ul style="list-style-type: none"> <li>• The Legislative Health Care Coverage Commission staff has been meeting with Iowa's Insurance Commissioner Susan Voss. A new workgroup has been assigned to this.</li> </ul> </li> <li>3. <u>Diabetes Care Coordination Plan</u>- IDPH will develop a plan to coordinate care for individuals with diabetes who receive care through community health centers (CHC), rural health clinics, free clinics, and</li> </ol> </li> </ul>

	<p>other safety nets. The plan may include a diabetic registry, to provide drugs through the Iowa Prescription Drug Corporation and to collect data to assist providers in tracking the care of their patients with diabetes.</p> <ul style="list-style-type: none"> <li>• The CHCs participating in this will need to be certified medical homes. This Council should create a strong process for certifying medical homes, and should think about how it will apply to private insurance and others. There needs to be only one model in Iowa, and it should be linked with HIT and meaningful use as well.</li> </ul> <p>For more information about the Legislative Health Care Coverage Commission visit their website <a href="#">here</a>.</p> <ul style="list-style-type: none"> <li>• It is important that Iowa be proactive and not wait around for federal health care reform. The Commission wants Iowa to be prepared for the huge increase in Medicaid in 2014 to ensure that the rollout goes smoothly.</li> </ul>
<p>New Legislation and Subgroup Assignments</p> <p><i>Lynh Patterson</i> <i>Angie Doyle Scar</i></p>	<ul style="list-style-type: none"> <li>• At the last Council meeting on February 5<sup>th</sup>, it was decided that the Council will break into two subgroups- one representing chronic care management and the other representing prevention.</li> <li>• Two new pieces of legislation have been assigned to the PCCM Council. Each subgroup will be assigned one of these pieces: <ul style="list-style-type: none"> <li>• <u>Prevention Subgroup- HF 2144</u> charges the Council to submit recommendations by December 15, 2011 on strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities. <ul style="list-style-type: none"> <li>○ The intent of this is not for the subgroup to <i>collect</i> the data, it is to do a literature review and find out what data is mission and what resources we need in order to collect the data more efficiently. The policy report that is created should be high level and not too specific.</li> <li>○ Eileen Daley gave a suggestion that we look beyond the numbers and look at qualitative research as well.</li> </ul> </li> <li>• <u>Chronic Care Management Subgroup- SF 2356</u> charges IDPH (the PCCM Advisory Council) to develop a plan to coordinate care for individuals with diabetes who receive care through community health centers, rural health clinics, free clinics, and other safety nets. The plan may include a diabetic registry to provide drugs and to collect data to assist providers in tracking the care of their patients with diabetes. As a first step, focus groups with patients will be conducted through the Community Health Centers to determine the barriers that people with diabetes face.</li> </ul> </li> </ul>

Subgroup Report  
Out/Discussion

**Prevention Subgroup**

- The Prevention Subgroup determined three overall tasks to work on.
- 1. [HF 2144](#) legislation regarding the report on data collection of multicultural groups of racial and ethnic diversity in Iowa.
  - A first step will be to do an environmental scan and look at other states reports regarding this and setting a benchmark, and to determine how data is currently being collected in Iowa.
  - At the next meeting, Project EXPORT (<http://www.projectexport.org/>) from the University of Northern Iowa will come speak to the Council. The mission of Project EXPORT is" to establish the knowledge base necessary to reduce diabetes, depression and other related health disparities among low-income African Americans and Latinos". They will accomplish this mission by bringing new vitality to the field of health disparities research via in-depth community participation alongside academia. The resources and information they can provide to us will be valuable when developing recommendations for the report directed in HF 2144.
- 2. Lead the Council in the development of the "Prevention" issue brief.
  - Discussion took place on if this subgroup should be called the "Prevention Subgroup" or "Health Promotion Subgroup". It was decided that health promotion is a broader topic and prevention is a subset of that term.
  - Initial topics that were discussed to include in the issue brief:
    - Terminology distinguishing primary, secondary, and tertiary prevention. Also defining "Health" - "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."- WHO
  - Environmental Health- CDC has great resources for this.
  - Mental Health
  - Pediatrics and life course health development framework.
    - Dr. Waldron mentioned an article that states four core things that people need:
      - Breastfeeding
      - Never being exposed to tobacco
      - Having a caring adult (includes prenatally, assumes that they care about their baby, also don't expose their unborn child to harmful toxins)
      - Living in a safe environment/neighborhood.
  - Other resources/next steps:
    - Revisit the prevention priory list created in the initial report
      - 1. Obesity, 2. Cancer. 3. Coronary Artery Disease. 4. Diabetes, 5. Human Immunodeficiency Virus (HIV), 6. Lower Back Pain, 7. Neurological/Behavioral, 8. Chronic Obstructive Pulmonary Disease (COPD), 9. Hypertension, 10. Mental Illness, 11. Hyperlipidemia (High Blood Fats), 12. Arthritis, 13. Congestive Heart Failure (CHF), 14. Asthma

- Look at [Healthy People 2020](#), and what it means for Iowa's population.

3. Community Utility Concept- Partner with the Medical Home System Advisory Council in developing the "Community Utility" issue brief.

Overview of the Community Utility Concept

National data from 2006-2007 demonstrated that insufficient practice infrastructure exists to support widespread implementation of the Patient-Centered Medical Home (PCMH) model. Perhaps the greatest challenge to reform of the health care delivery system is that 32 percent of U.S. physicians practice solo or in two-person partnerships. Some of the physicians in these smaller practices are eager to implement change but lack the resources to do so.

The "Community Utility" concept is an effective method to address this lack of resources. The *medical home* 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, and is something that cannot be accomplished efficiently alone, such as electricity, water, and public transportation.

*Medical Home* community utility examples include:

- care coordination,
- health information technology,
- consumer (patient/family) health information and family support,
- interpretation and translation services,
- child care,
- after-hours access,
- specialty services (genetic counseling, mental health consultation, nutrition consultation, pharmacy review),
- patient education and coaching,
- transportation, and
- home visiting or other off-site care.

The community utility concept has a unique role to play in medical home development, especially among the safety net population and primary care practices that are smaller or located in rural areas. Many primary care practices in Iowa will be challenged to meet the requirements of serving as a PCMH without partnering with local community organizations. If these community utility resources can be connected with primary care delivery sites, many aspects of becoming a PCMH will be addressed.

The subgroup discussed the possibility of break up these three tasks. A SurveyMonkey will be sent out to determine if the majority of the subgroup wants to do this, and if so, what task they would like to work on. Conference calls will be used to advance the work of these tasks between full Council meetings.

### **Chronic Care Management Subgroup**

- The main focus of this subgroup is on the diabetes care coordination plan established in [SF 2356](#)
- They focused their discussion on initial brainstorming of how the plan should look and first steps.
  - Standards of care for diabetes will need to be decided upon- use an existing resource.
  - Laurene Hendricks (Iowa Dept. of Public Health's [Diabetes Prevention & Control Program](#) Coordinator) shared information and resources about Iowa's Program:
  - The plan should utilize community resources, target both type 1 and type 2 diabetes, empower self-management, and improve consistency in medication use.
    - Dr. Kline mentioned that health care reform is going to be more focused on whole person treatment and screening of patients. The [Iowa Healthy Links Program](#) is good because it doesn't focus on one disease; it helps you manage general chronic diseases.
  - This subgroup reviewed the chronic disease priorities established by the Council in the initial report:
    - 1. Diabetes, 2. Congestive Heart Failure, 3. Hypertension, 4. Mental Illness, 5. Hyperlipidemia (High Blood Fats), 6. Cancer, 7. Neurological/Behavioral, 8. Lower Back Pain, 9. Chronic Obstructive Pulmonary Disease (COPD), 10. Asthma, 11. Arthritis, 12. Coronary Artery Disease
- An in-depth discussion took place about diabetes education including the barriers patients face when receiving this education, what qualifies as diabetes education, and how it is offered. Dr. Applegate stated that the percent of Medicaid patients who accessed diabetes education is only around 5%. Dr. O'Shea mentioned that a major barrier is the cost and time commitment of becoming a certified diabetes educator. Further discussion took place on alternative ways to provide diabetes education, such as through grocery stores- HyVee is training their dietitians about diabetes information. Steve Flood emphasized the importance of diabetes education prevention *before* patients are diagnosed with it.
- As a first step, focus groups with diabetic patients will be conducted through Iowa's Community Health Centers to determine the perceived barriers that people with diabetes face.
- Dr. Eckstat from Mercy Clinics will be invited to the next PCCM Council meeting to discuss the role of free clinics in the chronic care model related to the diabetes care coordination plan.
- PCCM staff will be looking at other state's diabetes care coordination plans, specifically looking to find out available patient information and information on diabetes education information.
- Lastly, the subgroup began to explore other chronic diseases beyond diabetes that could incrementally be included.

Medicaid Discussion

Tom Kline

**Background**

- [SF 2356](#) includes a section about IowaCare Expansion (mentioned above). A handout (found [here](#)) is included that gives further background information and lays out the IowaCare Medical Home Model.
- IowaCare expands Medicaid to 200% of the FPL for adults who don't otherwise qualify for Medicaid. The coverage includes single adults and childless couples. The IowaCare program has a limited benefit package and a limited provider network (limited to 2 providers – Broadlawns Medical Center in Polk County and the UI Hospitals and Clinics in Iowa City), which provides service statewide. SF2356 expands the provider network under the current IowaCare program to include a regional primary care provider network, beginning with a phased in approach of FQHCs. The bill mandates the FQHC's selected by the DHS to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home.
- IowaCare currently serves around 35,000 Iowans, and grows around 1,000 each month. Medicaid is not able to implement a waiting list.
- They are going to start with 2 FQHC's in western Iowa, and use a phased in approach.

**Medical Home Certification**

An interim set of minimum standards have been developed for IowaCare that the FQHC's will be required to meet the first year:

Medical Home minimum standards

1. Access to care and information;
  - Accessibility-24 hours/day, physician on call
2. Care Management
  - Comprehensive physical exam, and Personal Treatment Plan on annual basis
  - Disease Management Program
  - Wellness/Disease Prevention Program
3. Health Information Technology (HIT);
  - Demonstrate evidence of acquisition, installation and adoption of an electronic health record (EHR) system
  - Established plan for meaningful use of health information exchange (HIE) in accordance with the Federal Register requirement
  - Registry Function/Immunization Registry
- The handout is a working document and feedback from this Council is encouraged. Council feedback:
  - It was clarified that outcome measures were intentionally left out to remove barriers from participation in the program.
  - Peer-to-peer and open access conference could alleviate primary care from UI. Telemedicine should also be considered to perform consults. Additional money could be available to do this- there is funding in Medicaid to be directed to the FQHC's for health information technology. South Dakota successfully utilizes telemedicine services.

	<ul style="list-style-type: none"> <li>○ Depression screenings are an important component to track in performance reporting. It was also suggested to change cervical cancer screening to “when necessary” opposed to “annually” because of new ACOG guidelines. Also, it was questioned whether a physical exam should be annually or at the initial enrollment. Adding “age and gender appropriate” physical exams would sufficiently fix it. Dr. Kline reminded the Council that the vast majority of patients in IowaCare have numerous chronic conditions.</li> </ul>
Networking Opportunity	<p>Council members are given the opportunity to share any programs or projects they are currently working on</p> <ul style="list-style-type: none"> <li>• Terri Henkels- She is working with a program in an elementary school called “Switch” to encourage kids and parents to increase physical activity and eat better. It is an obesity intervention and prevention program. They have had very positive feedback-the kids love it and it’s been very successful.</li> <li>• Trula Foughty- The Iowa Comprehensive Cardiovascular and Stroke Plan 2010-2014 is finalized and available <a href="#">here</a>. It is a statewide plan that provides a framework to reduce risk factors related to heart disease and stroke and to increase quality and years of healthy life for Iowans.</li> <li>• Eileen Daley- She is part of a Wellmark recipient grant for the “Matter of Balance” program. It is an evidence based wellness program for older adults focusing on fall prevention. It emphasizes eliminating the fear of falling, improving balance and increasing activity.</li> <li>• Bill Applegate mentioned an opportunity that Iowa should look into in the federal health care reform legislation. It is a pre-Medicare program for adults age 55-64 and money will be made available for states. This is a vulnerable age group — their health status is going down and their health risk status is going up. Dr. Applegate is working on a similar program in rural Iowa (age 52-63 age range). Participants get a health risk assessment in the beginning and have a health coach. The goal is to get a zero trend and not have the trend go up. Another program the Iowa Chronic Care Consortium is working on with the chronic care delivery network, which identifies individuals in the Medicaid population CVD, COPD, and high risk diabetes. Any one of the three qualifies for the program.</li> <li>• Noreen O’Shea- Siouxland CARES recently gave a survey on alcohol use and found a reversed trend of alcohol use in 10<sup>th</sup> &amp; 11<sup>th</sup> graders. Click <a href="#">here</a> for more information.</li> </ul>
<p>The next Prevention and Chronic Care Management Advisory Council meeting will be held <b>Thursday, June 24<sup>th</sup></b>, 2010 from 10am-3pm at the YMCA Healthy Living Center.</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.