

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

**Members Present**

Cindy Baddeloo  
 Roy Bardole  
 Libby Coyte  
 Ryan Hopkins  
 Leah J. McWilliams  
 Catherine Simmons

**Members Absent**

Carol Alexander  
 Kyle Carlson  
 Shelly Chandler  
 Michele Devlin  
 Brian Farrell  
 Wendy Gray  
 Steve Johnson  
 Brian Kaskie  
 Susan Lutz  
 Laura Malone  
 Daniel Otto

**Others Present**

Michelle Holst, Iowa Department of Public Health  
 Doreen Chamberlin, Iowa Department of Public Health  
 Sarah Dixon Gale, Iowa Primary Care Association  
 Sandy Nelson, Iowa Medical Society  
 Patty Funaro, Legislative Services Agency  
 John Hale, Iowa CareGivers Association

<b>Topic</b>	<b>Topic/Notes</b>
<b>Introductions</b>	Library policy regarding food was discussed.
<p><b><u>Public Health Accountable Care Strategies (Public Health Perspective of Community Partnership with ACO)</u></b></p> <p>Kari Prescott,          Director,          Webster          County          Health          Department</p>	<p>Slides for this presentation are posted on the Meetings section of the Council’s webpage here: <a href="http://www.idph.state.ia.us/HLTC_Advisory_Council/Meetings.aspx">http://www.idph.state.ia.us/HLTC_Advisory_Council/Meetings.aspx</a>.</p> <p>Barn Door Philosophy – with change, there can be resistance from top or bottom, but it can be helpful if both, the top and bottom parts of the door are open.</p> <p>The Accountable Care Organization (ACO) in Fort Dodge consists of Trinity Regional Medical Center-Iowa Health System, Trimark Physicians Group, Berry Hill Center for Mental Health and Iowa Health Home Care. This ACO opens so many doors to resources shared by each of the 4 major players. Service area consists of 8 major counties, see slide. Public Health Director played a role in explaining to partners what public health does. Locally, the Board of Health is separate from the Board of Supervisors. Their budget has to cover expenses. Public health was able to help the ACO to fill the gaps with things like tobacco cessation, etc. Public health connected the county public health agencies to come into a public health “coalition”. This enabled them to analyze services, identify barriers, and find solutions.</p> <p>Triple Aim Goals (see slide) provided a focus for the agencies and a common ground. Identified fragmented services and conducted an analysis. Identified what they did well and what they needed. They developed county matrix of services.</p> <p>Slide on services provided. There were issues to work out along the way. For example, there were contracts for services like Maternal and Child Health for 9 counties, but the ACO includes 6 counties. Going down the list they shared services with varying numbers of counties but not necessarily all. Border/county contract issues were sometimes a barrier.</p>

	<p>Had to look at ways to cross these barriers. One piece was establishing the fiscal agent for services in various counties. An additional issue has been the grant cycles for various services.</p> <p>Next steps were to attend board meetings and communicate with every service and county. Local Public Health provides information and referral for members of the ACO. Performance measures have been a big challenge. Data is fragmented and it can be problematic to collect data. Need to develop systems to communicate within the ACO for patient follow up. Benchmarks include flu vaccines, immunizations, etc., that are needed by the ACO. There is a pediatric pilot project that is working well and want to get that out into the other communities.</p> <p>Council members asked about staffing for services in each of the counties. They develop contracts for services across counties that are in the ACO but not in this Local Public Health agency's service area. Council members asked about performance measures and assuring quality. They track the performance measures that are governed by their grant and others as they are able. Council members asked how the relationship works with the other 7 counties. Kari and key people go to the other Board of Health meetings to connect with other counties and sign them up into the process as they best fit. They had to identify ways to combine services and make agreements to provide services through contract negotiations and staffing arrangements. The majority of public health agencies are governed by the Board of Health and the Boards of Supervisors control the budget. Some are through their local hospital.</p> <p>Council members asked about how it has worked with home health and public health. She reported it has worked well. Described systems and navigator roles. They keep people from falling through the gaps through cooperation and collaboration.</p> <p>Council members asked where the high intensity services patients that receive high-cost services are going to go. Usually, these patients are on Medicaid and need a high volume of services. Council members asked where will the intense medical help that is needed for the subset of patients with high needs be provided. It was noted that the ACO includes the entire population.</p> <p>The trinity ACO is its own organization now and has a not for profit 501c3 status. Women Infants and Children (WIC) referrals have doubled as a result of the relationship. Dental care is coordinated through the I-Smile coordinator.</p> <p>Have they noticed a need for a different type of health worker to support and develop the ACO? They meet their staffing needs through existing staff and continuing education/training. They tap into existing staffs' competencies and skill sets and provide education and training to build on those.</p>
<p><a href="#">Safety Net Overview &amp; Community Care Team Models</a></p> <p>Sarah Dixon Gale, Iowa Primary Care Association</p>	<p>Slides for this presentation are posted on the Meetings section of the Council's webpage here: <a href="http://www.idph.state.ia.us/HLTC_Advisory_Council/Meetings.aspx">http://www.idph.state.ia.us/HLTC_Advisory_Council/Meetings.aspx</a>.</p> <p>Provided an overview of the slides. Described 3 initiatives. Of most interest to this group is the Community Care Team Models.</p> <p>Brief overview of components of the Safety Net Network, funding, initiatives and outcomes.</p> <p>Other initiatives due to the safety net umbrella status. The Commonwealth Fund study project including sub committees. Community Transformation Grant (CTG) funding helps to</p>

	<p>connect primary care and public health at the local level. They are a part of the Health Benefits Exchange (HBE) outreach efforts.</p> <p>Discussed Social Determinants of Health Concept and how it informs this project. Discussed issue of physicians seeing very complex patients and need for new models to prevent burn out. Follow the Triple Aim concept from the Institute for Healthcare Improvement (IHI). Provided an overview on North Carolina Vision. This includes a very sophisticated data collection system. They have a health informatics center. Community Care of North Carolina (CCNC) provides a statewide medical home concept. They have 14 primary care regional networks covering 100 counties. They have care managers that help manage care across the network. Council members asked about patient load for care managers. This can vary widely depending on how a care management program is set up.</p> <p>Payment is made on Per Member Per Month (PMPM) basis. Each of their networks are set up as a 501c3 non-profit. They started with management of care for patients with asthma but noted if they had to do it all over again they might start with pharmacy management because of the huge cost savings they experienced. They created a home grown informatics center because Medicaid didn't provide everything they wanted. They built it with care management in mind. It functions similar to a data warehouse.</p> <p>The North Carolina project is an example of a community utility model.</p>
Public Comment	<p>Discussion was raised about the direct care workforce (DCW). Provided statistics about the size of this workforce in Iowa (currently estimated at 73,000 and expected to grow to 88,000 in 5 years). Presented questions about how this workforce fits into the work of this council. To what extent is direct care a part of this agenda? Are any groups focused on the DCW? State and national has no plan on how to grow and meet this demand. Turnover and retention also an issue. So, to what extent can or will this group address the DCW issue?</p> <p>Council has been communicating about the issue of record checks in long term care taking so long delaying their ability to start work. Council has had several interactions with DHS regarding the issue. They have started some pilot steps to streamline the process. While that is important it does little to address the tremendous demand for DCWs and a person's desire to get into the profession.</p> <p>Concerned to see that fundamental issues are addressed to get people into this workforce such as better pay, respect, etc. Want to encourage a look at this group and member participation and if they aren't coming we need to identify new members that will participate and address the big issues of DCW. DCWs a critical part of the health care team and need to be addressed in workforce discussions. Discussion over the challenges of the job and getting people into it. Solutions known, but will/ability to do something about it is not there. Expressed opinion that part of the role of this group should be to create awareness of the problem/visibility. Referenced the work of the Direct Care Worker Advisory Council and their recommendations.</p> <p>Council members would like more information about the Direct Care Worker Advisory Council roles and mission. Council members would like further discussion to find where this topic/issue should land.</p>