

# MINUTES

## Prevention and Chronic Care Management Advisory Council

Tuesday, December 16, 2008

10:00 am – 12:00 pm

Conference Call

### Members Present

Bill Appelgate  
Mary Audia  
Steve Flood  
Della Guzman  
Terri Henkels  
Tom Kline  
Kathryn Kvederis  
Noreen O'Shae  
Patty Quinlisk  
Peter Reiter  
Rev. Dr. Mary E. Robinson  
Donald Skinner  
John Swegle  
David Swieskowski  
Debra Waldron  
Jenny Weber

### Members Absent

Jose Aguilar  
Krista Barnes  
Melanie Hicklin  
Rahul Parsa  
Suzan Simmons  
Steve Stephenson  
Jacqueline Stoken

### Others Present

Beth Jones  
Jill Myers Geadelmann  
Angie Doyle-Scar  
Abby McGill  
Tom Newton  
Julie McMahon  
John Hedgecoth  
Sara Schlievert  
Lance Roberts  
James Donoghue  
Morgan Salinas  
Nicole Schultz  
Leah McWilliams  
Linda Goeldner

\* **Prevention & Chronic Care Management Advisory Council Website (handouts found here):**  
[http://www.idph.state.ia.us/hcr\\_committees/prevention\\_chronic\\_care\\_mgmt.asp](http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp)

Topic	Discussion
Introductions <i>Ground Rules</i>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"><li>• The meeting was called to order at 10:00.</li><li>• Attendance was taken for council members.</li><li>• Others that listened in are asked to email Abby (<a href="mailto:AMcGill@idph.state.ia.us">AMcGill@idph.state.ia.us</a>) to let her know in order for attendance to be accurate on the minutes.</li><li>• The ground rules were discussed. They are available on the website.</li><li>• The attendance policy was highlighted saying that if a committee member is unable to attend a meeting, an alternate may be allowed to sit in the committee members place. If the committee member uses an alternate or misses two consecutive meetings, the IDPH director will designate a new council member.</li><li>• The weather policy was also highlighted saying that we will make every effort to determine if a meeting will be cancelled due to weather 24 hours in advance. If unable to make a meeting due to weather, and absence will not be counted against you.</li><li>• Send any comments you have about the ground rules to Abby.</li><li>• We will vote at the next meeting to finalize the ground rules.</li></ul>

## Wagner's Chronic Care Model

*Dave Swieskowski*

- See PowerPoint "Chronic Care Model"
- Started using the model in October 2002 with the Institute for Healthcare Improvement Collaborative. It changed the way they did things in Mercy clinics. They have used that model ever since.
- The Acute Episodic Care Model leaves gaps and focuses on treating illnesses rather than preventing them.
- A new model was created with a goal of changing from reacting to an illness to proactively preserving health. This was called the Chronic Care Model.
- The essence of good chronic illness care is the productive interactions that occur between the practice team.
- The key component to this model is the empowerment of the patient and the family. The patient needs to understand the disease process, and realize his/her role as the daily self manager.
- Another key component is that the practice team needs to be prepared and proactive. At the time of the visit, the team needs to have the information on a patient at hand.
- Domains for improvement include resources and policies, self-management support, health care organization, delivery system design, decision support, and clinical information systems. These six components all interact with each other. .
- Clinical information systems are the first step. Having a disease registry is the single most important step to improve chronic care.
- Electronic health records do not work as well as disease registry. They are more expensive, hard to implement, and produce less productivity.
- Decisions support includes deciding what the best care is and what can you do to make sure it happens every single time a patient comes in. Guidelines and standing orders support this goal. Standing orders are things that get done automatically for every patient.
- Delivery system redesign includes who is on the team and how do they interact with patients. These include health coaches, planned care, and new ways of communication. Health coaches are knowledgeable about every disease rather than just one.
- Self-management support acknowledges the patients central role in their care. It helps patients become the experts in the management of their disease. Patients manage their disease 99% of the time. Assessment, goal setting, action planning, problem-solving, and follow up are very important aspects. The patient will be called in 1-2 weeks to see how they are doing. We must meet the patients where they are, rather than what works for the provider.
- Community resources that help patients manage their disease include diabetes educators, school nurses, grocery stores, State Dept. of Elder Affairs, and ADA. Providers need to connect their patients to these resources.
- The Chronic Care Model has patient on left side and team on the right side.
- Noreen O'Shea made a comment that it would be nice if a state wide registry was free and available to everyone. One of Swieskowski's

	<p>dreams would be to have a free state wide disease registry. Many physicians do not have a good way to collect data.</p>
<p>Other Health Care Reform Councils</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• The Medical Home System Advisory Council had their first meeting in November and will have their second meeting over conference call on December 17<sup>th</sup>. So far they have done mostly educational learning on the overview of medical homes. At their second meeting they will be learning about dental homes and the North Carolina model of medical homes. The North Carolina model started by implementing medical homes to children in Medicaid. Their council will submit a brief report in January. There is not a specific due date for their report so they are setting a timeline of their own.</li> <li>• The Clinicians Advisory Panel will meet this Thursday, December 18<sup>th</sup>. This is a group of nine practicing physicians whose role is to provide information on evidence based practices to both the Medical Home System Advisory Council and the Prevention and Chronic Care Management Advisory Council.</li> <li>• The Rebalancing Healthcare in the Heartland conference was held on December 4<sup>th</sup> in Des Moines. It was hosted by the University of Iowa. Policy overview was given on what has been going on in Iowa. Bill Applegate presented for this council. When the materials are available from that conference, we will be posting a link on the website.</li> </ul>
<p>Iowa Healthcare Collaborative <i>Iowa Health Status Report</i></p>	<p><i>Lance Roberts</i></p> <ul style="list-style-type: none"> <li>• See PowerPoint “Iowa Healthcare Collaborative”</li> <li>• The Iowa Healthcare Collaborative is a non profit partnership focused on public reporting efforts related to prevention and chronic care management.</li> <li>• Many people are evidence based when it come to prevention and chronic care data and practices. Data is being collected through CMS records collected by hospitals. Most of these are outcome measures.</li> <li>• There are 94 quality measures that can be used as “screens” for adverse quality/safety outcomes. They are using those as screens in Iowa. These quality measures are aligned in four different domains: patient safety indicators, inpatient quality indicators, pediatric quality indicators, and prevention quality indicators. Not much is being reported in the prevention quality indicators group.</li> <li>• On the charts included in the PowerPoint, everywhere you see a star means that Iowa was better than national average.</li> <li>• The plan for 2009 includes expanding ambulatory care voluntary reporting measure sets, exploring opportunities to measure Readmission Rates, and promoting statewide goal of Healthcare Workers Influenza Immunization. They want to have 95% of workers immunized by 2010.</li> <li>• The 2008 Iowa Report can be found at - <a href="http://www.ihconline.org/iowareport/iowareport.cfm">http://www.ihconline.org/iowareport/iowareport.cfm</a></li> </ul>

<p>Health Risk Assessments Overview</p>	<p><i>Bill Appelgate</i></p> <ul style="list-style-type: none"> <li>• See PowerPoint “Health Risk Assessments”</li> <li>• We need to empower individuals to self manage their disease and reclaim responsibility for their own healthcare.</li> <li>• Good health risk assessments aren’t done without lab panels and biometric screenings.</li> <li>• Individual benefits from health risk assessments identify personal health status and health risks based on lifestyles. They also measure readiness to change for key lifestyle behaviors.</li> <li>• Provider benefits include a summary of an individual’s lifestyle risks, lab results, personal medical history, chronic conditions, health status, preventative screening, family history, and readiness to change.</li> <li>• Population management benefits provide aggregate data reports that identify population health risks, status and time-over-time comparisons. Individuals are also stratified into risk groups for programs and interventions.</li> <li>• Providers are able to see how many patients were good on blood pressure, cholesterol, and then they can look at those that have challenges. It gives a good picture of population data.</li> <li>• Some quality health risk assessment features include ease of use/time, web-based security, lab integration, provider report, chronic disease risk, and value to cost competitiveness.</li> <li>• Health risk assessments as a pivotal tool promote identification of risk prior to evidence required for diagnosis or chronic conditions.</li> <li>• Health risk assessment companion strategies include provider engagement, coaching, wellness programs, and prevention programs.</li> <li>• Providers don’t use health risk assessments as much as they should because they do not have much experience with them and do not get reimbursed for them.</li> <li>• Key findings are that high-risk health status equals high medical costs; a change in cost follows a change in risk. It is important to allocate resources to maintain low risk behaviors.</li> </ul>
<p>Medicaid and Health Risk Assessments</p>	<p><i>Tom Kline</i></p> <ul style="list-style-type: none"> <li>• See PowerPoint “Medicaid and Health Risk Assessments”</li> <li>• Began back in 2005 with HF 841. The Iowa Care Program was created. It is available to Iowans that are between Medicaid eligibility and 250 percent of poverty.</li> <li>• IOWACARE Expansion Population made this available to all Medicaid eligible individuals. It was to be culturally specific.</li> <li>• Health risk assessments needed to be web based and provided access to the health status and recommendations to improve their health.</li> <li>• Any provider that was eligible to provide to Medicaid eligible population was allowed to provide a comprehensive medical exam.</li> <li>• The personal health improvement plan included reviewing and evaluating the health risk assessments and giving the member a prescription for health improvement.</li> <li>• Things that needed to be revised to the health risk assessment:</li> </ul>

	<ul style="list-style-type: none"> <li>○ Develop a billable code</li> <li>○ Develop an assistance fee for completion</li> <li>● Expected outcomes included Medicaid as a Smart Health Plan, health status of Medicaid population, allocation of resources, focused quality improvement programs, healthier Medicaid population.</li> </ul>
<p>Follow and Next Steps</p> <p><i>Other State Examples and Work Session Reschedule Next Meeting Date</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>● If you have questions or want to have a follow up discussion about any topics from today’s meeting, let Abby or Beth know and we can add it to the next meeting’s agenda.</li> <li>● An environmental scan was done looking at prevention and chronic care best practices. The 14 recommendations were grouped and incorporated into the environmental scan. The presentation will be posted on the website.</li> <li>● A conference call before the next meeting is an option to discuss the results of this environmental scan.</li> <li>● The report for this council is due July 1s 2009.</li> <li>● We will keep the Feb 6<sup>th</sup> meeting date and try to get more work done before then.</li> <li>● If you have agenda items to add to the February 6<sup>th</sup> date email Beth or Abby.</li> </ul>
<p>The next meeting of the Prevention and Chronic Care Management Advisory Council will be held February 6, 2009 from 10am – 3pm at the Urbandale Public Library.</p>	

The purpose of the Prevention and Chronic Care Management Advisory Council is to advise and assist the Iowa Department of Public Health to develop a state initiative for prevention and chronic care management as outlined in HF 2539.