MINUTES
Prevention and Chronic Care Management Advisory Council
Friday, March 6, 2008
10:00 am – 3:00 pm
Urbandale Public Library, Room A

Members Present	Members Absent	Others Present
Bill Appelgate	Jose Aguilar	Jane Schadle
Mary Audia	Krista Barnes	Jill Myers Geadelmann
Steve Flood	Kathryn Kvederis	Angie Doyle-Scar
Della Guzman	Rahul Parsa	Maureen Myshock
Tom Kline	Suzan Simmons	John Hedgecoth
Terri Henkels	Steve Stephenson	Sara Schlievert
Melanie Hicklin	Jenny Webber	Abby McGill
Noreen O'Shae		Leah McWilliams
Patty Quinlisk		Nicole Schultz
Peter Reiter		Ann Ungerman
Rev. Dr. Mary E. Robinson		Shirley Roberts
Donald Skinner		Kate Heineman
Jacqueline Stoken		Kelly O'Kiefe
John Swegle		Heidi Goodman
David Swieskowski		Kay Corriere
Debra Waldron		Carlene Russell
		Matt Fitzgerald
		Kristen Klimus

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

Topic	Discussion
Welcome/ Introductions	*Jane Schadle* • The meeting was called to order at 10:00 • Introductions were given along with something good that has happened to you since the last meeting
Other Health Care Reform Councils	*Medical Home* • The Medical Home System Advisory Council last met on February 20th. • They finalized their Progress Report #1 and Abby will send it out to and post it on their website early next week. • They formed three workgroups: 1. Definition/Certification 2. Reimbursement Strategies 3. Education/Learning Collaborative • These workgroups will meet monthly most likely via conference call and the entire council will start meeting quarterly. *eHealth Advisory Council* (see handout) • Last met on February 20 and formed seven workgroups: 1. Continuity of Care and Interoperable EHR

	2. Provider Adoption of EHR 3. Patient ID 4. HIE Infrastructure and Networks 5. Safeguard Privacy and Security 6. Finance and Sustainability 7. IT Workforce and Education
Identification of Key Diseases that Iowa Needs to Address in a PCCM Plan	*Jane Schadle/Council Discussion* • From the last meeting on February 6th, the Council prioritized that the top 5 policy changes or new policies that could be recommended that would make changes in population are: 1. Focus on community for wellness- worksites, school systems etc. 2. Prevention is important 3. Disease registry 4. Efforts need to be measurable- show outcomes 5. Cost effectiveness efficacy <u>Discussion Question:</u> **To identify those chronic diseases important for us to begin our first work, what criteria should we use?** • Cost of the disease (Medicare, Medicaid, the individual). There is a great cost for certain diseases such as congestive heart failure with Medicare. Public costs can create an economic burden. • Evidence-based intervention • Survey of current initiatives. Therefore, we can build upon something that is already in existence and not start from scratch. • Lives lost. Mortality burden. • Prevalence data of top 10 chronic diseases from CDC. We need to focus on the diseases that affect the most people. • Process and outcome quality measures. • Burden of disease on patient and how the disease affects their quality of life. One challenge of chronic disease surveys is that they are self-reported and the patient says they are very healthy. It isn't because they are untruthful; it is because some diseases are asymptomatic on a day-to-day basis. • Diseases that relate to multiple chronic diseases developing. • Hospitalization discharge data. We need to prioritize where we can spend the least money and get the highest/best results. • Patient accountability for self-inflected diseases (Type II diabetes, obesity etc.) The Council had a discussion regarding this topic: o Many people are ticking time bombs and do not know it. There are no consequences for eating unhealthy foods. It is no different than smoking. Anybody that started smoking within the last 20 years cannot legitimately say that they didn't know that it is bad for them. Nowadays, it is the same way with eating unhealthy foods. There is no question that people need to have access to education regarding eating right. After the access, some people still chose make unhealthful decisions. There are many community issues that we need to look at as well. Are we going to take out McDonalds in the world to prevent obesity? Wagner's Chronic Care Model demonstrates an active and informed patient that is taking care of themselves. The Medicaid program is an opt-in program, but

there are no consequences for unhealthy behavior. Culture differences and variations play a huge role. Tobacco is a good example of this and we have made huge progress in last 3 years of moving it to be more socially unacceptable. With chronic diseases it is not going to be one easy answer or change, it is going to be a combination.

- Transtheoretical/Stages of Change Model:
  - Precontemplation
  - Contemplation
  - Preparation
  - Action
  - Maintenance
- The Iowa Chronic Care Consortium believes that they need to encourage and engage people to reclaim responsibility for their own health. Some people have many issues that are bigger than we can imagine. Whatever we do, we need to realize that there is going to be a lot of variation (commercial health plan population is going to be different than Medicaid populations). People need help realizing how their behaviors affect a chronic condition. 80 percent of chronic conditions are an effect of behaviors.
- Cost-Benefit
- Socio-ecological Model:

- Recognize special interests
- Diseases that are not recognized as chronic conditions (i.e. cancer).
  - Noreen O'Shea discussed the need to address the elephants and sacred cows. We need to recognize that there is always going to be special interests. For example, leaving out congestive heart disease because then provider would not get paid. We are spending a lot of money on very short outcomes. Some end of life decision making might be a part of our strategy and part of chronic disease management. The last year of life is often the most expensive.
- Look at existing data (i.e. congestive heart failure/immunizations)
  - There is going to be persistent tension between states. Some states are thinking about having a sugar tax. Alabama is thinking of taxing obesity.
  - What's happening now is we are developing chronic disease in childhood; this never happened in the past. Parents are setting bad examples for their kids (i.e. poor food choices, inactivity) Kids grow up with their parents who are setting bad examples. Seeing hypertension in an 8 year old is an astounding thing. Think of what their health care costs will be when they are 50 years old.

Prioritization of PCCM Activity based on work done at Feb. 6th Meeting	*Council Participation* **What chronic diseases need to be included in an Iowa Prevention and Chronic Disease Management plan?** • Diabetes, asthma, congestive heart failure, COPD, lower back pain, mental illness, coronary artery disease, hyperlipidema, chronic liver disease, hypertension, rheumatic diseases, arthritis, HIV, neurological/behavior, cancer, chronic pain syndrome, osteoporosis, inflammatory bowl disease (GERD), obesity • According to legislation the term "chronic condition" means "an established clinical condition that is expected to last a year or more and that requires ongoing clinical management." As an Advisory Council, we can develop a different definition for our work if needed. For example, the CDC states that "chronic diseases are noncommunicable illnesses that are prolonged in duration, do not resolve spontaneously, and are rarely cured completely." • The Council voted on if they wanted obesity included on this list. All but one member (Mary Robinson) wanted it off. She justified this by saying that obesity is a risk factor, not a disease. Money spent on treatment of cancer is going to improve longevity and quality of life. • The Council wanted to create two separate priority lists: one for prevention and one for chronic disease management **Priorities- Chronic Disease Management** 1. Diabetes (29) 2. Congestive Heart Failure (13) 3. Hypertension (13) 4. Mental Illness (8) 5. Hyerlipidemia (4) 6. Cancer (3) 7. Neurological/Behavioral (3) 8. Lower Back Pain (3) 9. COPD (2) 10. Asthma (2) 11. Arthritis (1) 12. Coronary Artery Disease (1) **Priorities- Prevention** 1. Obesity (30) 2. Cancer (12) 3. Coronary Artery Disease (6) 4. Diabetes (4) 5. HIV (4) 6. Lower Back Pain (3) 7. Neurological/Behavioral (3) 8. COPD (3) 9. Hypertension (2) 10. Mental Illness (2) 11. Hyperlipidema (1) 12. Arthritis (1) 13. CHF (1) 14. Asthma (1)

Disease Registries	*John Hedgecoth* • See handout "Chronic Disease Registries". This gives a basic overview on existing disease registries and how we might apply a registry to Iowa. • A disease registry is a special database that contains information about people diagnosed with a specific type of disease. • Procedure registries collect data about specific medical procedures, such as mammography or coronary artery bypass graft surgery. • For immunization history, Iowa uses the Immunization Registry Information System (IRIS). More information about IRIS can be found here: http://www.idph.state.ia.us/adper/iris.asp • Brief Report: "The Prevalence and Use of Chronic Disease Registries in Physician Organizations: A National Survey". Link to the report: http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1490197&blobtype=pdf • Is a disease registry the goal, or are we interested in making it part of a care spectrum? How are disease registries going to relate to EMR? If we start working with this registry system, can there be a one stop shop or are we going to create two separate systems? It presumes a certain level of technological capacity. • Peter Reiter said that they have an EMR. It does not have a registry option, but the technology people do not understand that. IRIS is a good example of integration because it is taking a considerable amount of work to cooperate between the state and their system. The technical portion took a year and a half to put in place. In a physician's office, IRIS is not designed to do what they need because they are not able get the performance reports that they need. • Indiana's chronic disease registry uses a top down model. If we were in Indiana and wanted to add depression to the list of diseases, we would have to work with the legislators to do that. Is that how we want Iowa's registry to work? Discussion Question: **Given the impact of chronic diseases on our population and the prevalence of our priority chronic diseases, can we justify a recommendation to develop a disease registry?** - **Will a registry improve the quality of health care services?** - **Will a registry decrease disease prevalence or incidence?** • State registries has some significant issues attached with it such as listing peoples names (effects employability, insurance coverage, and asthma patients cannot participate in physical activity at school and are having higher insurance rates). Public records are public records, they would not be anonymous. • Don Skinner wants to see registries used in physicians offices. They can report the data to the state in order for them to get the information needed, but would never have the names. It is important to have disease registries available to physicians because data shows that they see much better results. They have 82% of their patient's blood pressure under control as a result of disease registries. • The state needs some sort of identifier because some patients have physicians reporting on the same patient multiple times. It is very rare

	nowadays for a patient with a complex disease to only be seeing one single doctor. • Noreen O'Shea commented that a disease registry is not the same as a cancer registry. The goal of a disease registry is to manage a patient better. She would like a disease registry that housed in the office where the care is given. Some current barriers with disease registries are cost and they are not user friendly. • A conscientious physician WILL make improvement changes if poor data comes back from a disease registry. The disease registries need to be free, accessible, and not mandatory. The registry is a way to organize population health; it isn't an individual thing. • Bill Applegate stated that if we are going to make change, there needs to be pull strategies rather than push strategies. A registry is a good business accelerator and outcome accelerator. • It takes a good 3 to 5 years to become good at managing a registry. But this is good because there will be payment reform and outcome focus. It will help Iowa's capacity to be ready for payment reform and to prepare for EMR. You should learn to use a registry first, and then learn how to use an EMR. • One advantage of a centralized registry is that health care continues to be fragment, and there are many different care groups that may see patients with one diagnosis (i.e. diabetes). It may facilitate that data and care. • There will be a high percent of patients on this in the Medicaid population. You could build this into a state plan with substantial reimbursement from the federal government. • Tom Kline discussed the Iowa Chronic Care Consortium's registry and care management. The registry came from claims data. They had an internal software package that they used, but it did not have the ability to extract the data. The technology piece of how information is exchanged is a huge part of this. • Medicaid has a registry that many do not take advantage of. • The Electronic Health Information Advisory Council formed seven workgroups and one is the adoption of HER. So we can assume that this is being taken care of, but we need to give some input. • Mary Robinson's number one concern with disease registries is protecting people's privacy and having it not impact their life in a negative way. • Peter Reiter stated that disease registries are extremely valuable and that they need to be part of every medical home. The council agreed with his statement.

Council Work Session - *Revisit 14 recommendation areas*	*Council Workgroups* **What action criteria must we include for future implementation planning?** <u>Action Areas:</u> • A spokespersons who is a role model and would inspire people • Social Marketing with a variety of media outlets (ex. facebook, radio, TV) • Evidence-based Intervention. • Measurable and evaluated. They are closely related. If it is evaluated, it has been measured, and if it is measurable, it can be evaluated. • Education • Replicable • Valuable populations as a priority • Affordable now and cost effective in the long run • Feedback mechanism: Real-time reporting back to providers • Physician decision making "autonomy" for "outliers. With a statewide disease registry, many people do not fit into the heard. How are you going to deal with these outliers? Whatever the Council recommends, it should protect the anatomy of physicians. Noreen O'Shea disagrees and thinks that we need to deal with the majority of people overall. If you are doing registries at the practice level, physicians can take care of these outliers. The system needs flexibility and goals need to be realistic. * Agenda item - We didn't distinguish between adults vs. children. Make a recommendation that there needs to be specific focuses for each. **Go back to groups and look at focus issues. Apply values to those actions and come up with steps to implement that particular action.** **<u>Group 1- Identifying/Engaging Professionals</u>** • Focus area 2 (coordinating care among health care professionals) o Chronic disease management system creation, which includes case management, vest practices, community resources, and availability to multiple providers. Criteria to be included: measurable, evidence-based, cost effective, affordable, and educational tools for both the provider and the patient. • Focus area 8 (align reimbursement/financial incentives) o Outcome based incentives for patients include an evaluation component that works and that people like. It also needs to be cost effective/affordable, flexible for provider and patient, and give technical assistance. The priority would be given to those with the highest risk and the most difficult to treat. • Focus area 14 (collaborate with licensing boards) o Improve chronic care management and prevention by decreasing barriers created by the licensing boards and professional societies to learn about and implement changes. A good example is granting CME for practice based learning and implementation of care management systems. Some key components include education, spokesperson/professional champion(s), measurable (i.e. how many doctors, RNs, pharmacists do this?) and affordable. We could look into

inventive resources that will allow documentation and allow CEU credits.

Group 2- Health Care Technology/Disease Registry

- Focus area 4 (identify eligible patients for PCCM services)
  - Use a disease registry. Consider those who are most vulnerable first (i.e. cancer, diabetes patients)
- Focus area 6 (education tools)
  - We need to look at the individual's interest by coordinating the information available through different venues. We need to coordinate medical information, specific societies/providers, and the state system.
- Focus area 7 (outcome measures/benchmarks)
  - Should be national and state accepted. Provide flexibility to address patient outliers in providing care to those who use the "traditional medial model of care". (i.e. Patients who have chronic pain and workman's compensation insurance refuses to give them reimbursement for it).
- Focus area 10 (align chronic care information systems)
  - The information system must be affordable.

Group 3- Increasing patient education/community resources

- Focus area 5 (increase communication between patients and providers)
  - Get additional funding for community screenings. Have these screenings be targeted and measurable, such as blood pressure, BMI, spinal screenings.
  - HRA's need to be affordable and cost-effective. Need to look into grants, funding, IT analysis, staff, and centralized measurement, and it public health nursing.
  - Electronic patient portal- are they measurable and any technical issues/affordable. Deferred to by individual physician groups.
  - Health coaches- cost issues. Continue access to IHC training program. Integrate health coaches into clinical practice. Development of the medical home with payment reform.
- Focus area 9 (involvement to sustain initiative)
  - Community resource calendar- adapt existing models and best practices.
  - Enhancing doctor/patient partnership by making sure that there is an increasing emphasis in training that is part of the continuing education curriculum. Having a centralized disease registry may allow access to information that will improve patient sharing because you will have the whole picture. Health literacy is also very important to improve the dialog between the patient and the provider.
  - Increase existing programs such as the Live Healthy Iowa program and programs that focus on patient self management of chronic conditions. Look for stimulus dollars, grants, partnerships, and public/private dollars to try to make this work.
  - Involvement to sustain this initiative will require payment reform and enhancement of primary care within the state.
- Focus area 12 (marketing campaign)
  - Community Education should be multimodal and sustained. It is difficult to measure and evaluate. Community marketing can also be very expensive.
  - We should market existing programs such as Live Healthy Iowa, chronic

	disease self management programs, and health literacy programs.
	
	<u>Group 4- Evaluation</u>
	• Focus area 1 (organizational structure)
	  o Suggest an actual entity to oversee this. Reaching out to the provider community is very important.
	• Focus area 11 (resources for collecting data/evaluating economic and social impact)
	  o Utilize systems and organizations already in place for benchmarking.
	• Focus area 13 (determine percent participating and success)
	  o Measure around clinical value. Use smaller component analysis for venerable populations. Component analysis- when you set up the intervention, define the risks and use retrospective integrators.

Funding Opportunities	*Jane Schadle* • The stimulus package has $600 million for wellness and prevention. Current rumors have plans to push $100 million of that to CDC for the states for infrastructure development in healthy communities to address chronic disease and wellness and prevention. <u>Contemplation Question (will be continued next meeting):</u> **To most effectively address the health needs of Iowans in prevention and wellness to diminish chronic disease, what should the IDPH do with the opportunity the stimulus package offers us?** • Address disparities • Support already existing state initiatives (i.e. prenatal programs, childhood/adult immunization programs). There is however separate funding that will be used for childhood immunization. They would like to see free flu shots for children at schools. The problem with children is that you need parental consent. Most likely though, they will consent because it will be free and convenient. • Terri Hicklin agrees with the school immunizations. Polk County added two more school districts this year. It takes a lot of resources but it is very effective. • Debra Waldron would like to see postnatal development for parental support. • Childhood obesity • Incorporating wellness in schools (i.e. flu vaccine, HRA, etc.). The school has the kids for a large portion of the day and this can be a huge influence. The teachers are also going to have to be leaders and role models. We should be partners with the educators because they might not have the health expertise. • Patty Quinlisk mentioned fruits and vegetables in schools. They found that introducing fruits and vegetables to children changed the whole eating habits of the family and it had a huge impact. • Peter Reiter talked about funding so that breakfast can be offered to kids that are hungry in the morning. Some families do not have enough money for that. The cheapest foods are not always the healthiest foods. Kids do not learn well if they are hungry and can not concentrate as well. Some schools even have a summer breakfast program. Some schools send a backpack home with kids on the weekends to provide them with three meals.

	• Mary Audia mentioned back problems resulting from heavy backpacks and improper carrying of backpacks. There could be educational programs on backpacks or even burn books onto a CD to reduce the weight. • Over 20 percent of the population in Iowa is age 60 or older, so we can't forget about them. Think about a chronic disease self-management program for them. • Mary Robinson recently attended an Advisory Committee for Allen Hospitals. Listened to a sobering presentation regarding mental health issues. They talked about mental health clinics that are closing, and there are still people who need to be treated. There is nowhere to put them, so they are forced to be discharged. This is a good place to look for Iowa. We ranked in bottom 10 percentile. We need to look at what we are doing with mental health within our communities because we are doing a disservice regarding this. • Overall, the Council really wants the money to be focused on children to help their future. It was in agreement that schools and children are two good places to do interventions. A wellness program for the school population would most likely also spread to the families.

Planning/Timeline for next 3 months- *Closing Comments*	*Jane Schadle*
	• Our report will be a standard report of our deliberations, their outcomes, and our conversations and recommendations. We will identify our priorities, explain our rationalizations and lay out our work process.
	
	<u>Outline of Report:</u>
	• Cover
	• Abstract
	• Introduction
	• The Report
	  o The process used
	  o The work product
	  o The recommendations with narrative and justification
	  o Measures of success
	• Closing
	• Attachments
	  o Member List
	  o Legislative language reference
	
	• We will ask some of you to review and edit- if some of you are good at this, let Abby know. We have IDPH review, but would like some of the Council members to be involved in the process.
	• A conference call will be scheduled to discuss further the opportunities for action offered by the funding opportunity.

The next meeting of the Prevention and Chronic Care Management Advisory Council will be held April 24, 2009 from 10am – 3pm at the Urbandale Public Library, Room B	

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.