

MINUTES

Prevention and Chronic Care Management Advisory Council

Friday, April 24, 2008

10:00 am – 3:00 pm

Urbandale Public Library, Room B

Members Present

Jose Aguilar
 Bill Appelgate
 Mary Audia
 Krista Barnes
 Steve Flood
 Trula Foughty
 Della Guzman
 Tom Kline
 Terri Henkels
 Noreen O'Shea
 Peter Reiter
 Donald Skinner
 Jacqueline Stoken
 John Swegle
 Debra Waldron

Members Absent

Melanie Hicklin
 Kathryn Kvederis
 Rahul Parsa
 Patty Quinlisk
 Rev. Dr. Mary E. Robinson
 Suzan Simmons
 Steve Stephenson
 David Swieskowski
 Jenny Webber

Others Present

Jill Myers Gadelmann
 Abby McGill
 Beth Jones
 Angie Doyle-Scar
 Maureen Myshock
 Becky Groff
 John Hedgecoth
 Daniel Garrett
 Matt Fitzgerald
 Leah McWilliams
 Andy Penziner
 Gary Christensen
 Sandy Nelson
 Carlyn Crowe
 Kay Corriere
 Brima Rogers
 Kala Shipley

* **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	<ul style="list-style-type: none"> Jill Myers Gadelmann introduced Becky Groff, who will be facilitating this meeting due to a family emergency for Jane Schadle. Introductions were given along with one thing they have learned so far.
Other Health Reform Councils <ul style="list-style-type: none"> <i>Medical Home</i> <i>E-Health</i> 	<p><i>Beth Jones; John Hedgecoth</i></p> <ul style="list-style-type: none"> The Medical Home System Advisory Council finished their first progress report. It can be found at their website under the last section "Required Reports": http://www.idph.state.ia.us/hcr_committees/medical_home.asp The Council met on April 3rd and spent a large portion of the meeting working in their workgroups. The workgroups are: 1) definition and certification, 2) reimbursement strategies, 3) education/learning collaborative. A Leadership Group was also recently formed to oversee the work of the workgroups. This leadership group includes the 3 chairs of the workgroups along with Beth and Tom Evans, who is the chair of the entire Council. The Iowa Health Care Collaborative health the first Medical Home Learning Community on April 1st. The next two are June 17th and September 9th. The focus is on NCOA Certification. Over 150 people showed up to this 1st session. The site for the next 2 sessions will be moving.

- The Spring Colloquium was on April 17th in Iowa City. The focus of this colloquium was on “Medical Homes & Role of Public Health”.
- September 18th All day, Marriott Hotel in Coralville, Iowa. The College of Public Health Hansen Award Lecture to be presented by Dr. Stephen Shortell from University of California at Berkeley. This is presented by the Forkenbrock Series on Public Health and is part of a conference on strategies to connect patients to care. The focus of this event is on Medical Homes. The Council will be having a meeting in the afternoon on this date.
- We still have not heard anything on the CMS demo project. It is going to be mid to late summer. There is a lot of conversation that Iowa is not a good candidate because they are limiting it to more of an urban perspective. Abby will send that to you.
- The Nebraska based center for Rural Health Care is holding health forums around the state. Maybe we can partner with them to focus on rural sites for a Medical Home demo.
- The Medical Home Council is waiting for PCCM recommendations. The reimbursement workgroup was discussing if we were able to put together a pilot, how we would measure “medical homeness”. They would want to make sure any practice would have access to a disease registry.
- The Council will submit another progress report update before fall and they will build on what the PCCM Council has recommended in this report.

- The eHealth Advisory Council met on March 13 and received reports from each of the seven workgroups that have been formed. They also have a report due July 1st. The report is going to include a framework for a statewide HIE (Health Information Exchange) system.
- The groups have proceeded to action items around specific tasks that would be undertaken as part of any planning grant for which Iowa would apply. It is anticipated federal guidance will be forthcoming within a few weeks and that work can then begin on the grant application itself. In preparation for the anticipated federal grant process, IDPH has formed a grant writing team. This grant would be from the stimulus package and be for around approximately 5-10 million dollars. The guidance may not be released until fall.
- The council has begun implementation of a grant with pilot projects that will begin sometime next spring. This is Important for the PCCM Council because the eHealth Council is at a point when input from other councils is very important.
 - **What records are we going to exchange, and why?**
 - **Should we recommend a registry? Why?**
 - **What would it do?**
 - **How does it help people in their practice?**
 - **What does a patient need to know and see and how often do they need to know and see it?**
- If we were to say we are doing this HIC in order to facilitate, we would end up with a stronger grant proposal. 30-60 days provide that info to Abby. Concept 5 and 10 relate most to this councils work.

<p>Adults vs. Children - <i>Distinguish focus for each</i></p>	<p><i>Council Discussion</i></p> <ul style="list-style-type: none"> • Needs to be universal and include ALL residents of Iowa. This shows that we have an invested interested in our citizens. • Andy Penziner mentioned that we should think about health equity, along with health disparity. Health disparity is a data-related concept and it is time to move to health equity. Success in moving to health equity shows investment in human capita. • Steve Flood agrees that the recommendations need to include ALL residents and their families. He is not convinced that we need to be taking money from citizens to fund illegal aliens. A significant portion of the population of Iowa believes this also. For us to make that decision for this population is worth a discussion. Peter Reiter responded by mentioning the public health argument. Without access to care, children do not get their immunizations and harm the entire population. We need to think about the best interested of the population of Iowa. We need to take care of everybody. • Jose Aguilar agrees. It is a reality that we have these people here. There are two solutions- one being deportation and the other is to give them legal status. Neither of these are going to happen therefore we need to take care of them to prevent disease.
<p>Leveraging a New Understanding to Eliminate Trend</p>	<p><i>Steve Flood</i></p> <ul style="list-style-type: none"> • See PowerPoint Presentation "Leveraging a New Understanding to Eliminate Trend" • Slowing the "production" and "destruction" from disease is the only sustainable way to flatten the <u>trajectory</u> of health care. This can be done by reducing the number of claims through improved health outcomes. • The slide "Slowing Disease Production- A New Understanding" is the most important slide. A small percentage of claimants drive the majority of paid claims each plan year. Intervention Challenge: Who is going to be in the "red" next, and how do you keep them from getting there? We need to keep new people from going into red. Half the green is healthy the other half is ticking time bombs. If you can identify people before they have that event, you can save so much money. HRA's are self-reported, and many people just lie. There is no way to track where or not they are telling the truth. We need to tie the claims and their biometric data together. • Waist circumference is the best predictor of future claims. • The slide called "The True Cost of Voluntary Screening" shows how an employer would measure if they are winning. It shows the amount of money they are saving if they "did not screen" claims dollars. • People are going to start measuring absenteeism. • How do you mandate participation? Financial incentives, HIPA compliance. If you want health care, you need to go through annual screenings. On one side, it is saying you are making people take screenings, but on the other, you aren't because they do not need to accept health care if they don't want. Jose Aguilar asked can they get any benefit if they move down the scale. They aren't giving money to get better. Their model is to just TRY. If you have three or more risk factors, you must go thought intervention. If they went through intervention and failed, then they must go to a physician and have a

	<p>discussion. Most of these people have never been to a physician. Next step is specific testing.</p> <ul style="list-style-type: none"> • Peter Reiter thinks this is great. Making positive incentives and selling it as creating a culture, “in order for you to receive health care and get the lowest premium, you must go through these screenings.” It is a prevention model and self-driven wellness model. Steve Flood also agrees and asked why we are letting people who are unwilling to try to make health improvements take money from other employees who are. • Andy Penziner commented on this by stating that the wellness movement hasn’t really caught on yet. There are some major social issues in the country and there are a lot of people living in circumstances that health is not their main priority- i.e. violence, poverty, and no early childhood care for their kids. Steve Flood responded to this by saying the reason why wellness fails is because it is structure poorly. The group Andy is talking about is the greatest opportunity for us to make changes. For example, mandate that if you want to go to Broadlawn, you <u>must</u> get these screenings. They uninsured are without health <u>insurance</u>, but not without health <u>care</u>. It is an ultimatum.
<p>Council Work Session</p> <p>-Identification of Key Recommendations</p>	<p><u>RECOMMENDATIONS</u></p> <p>Overarching Recommendations:</p> <ul style="list-style-type: none"> • Utilize Wagner’s Chronic Care Model and Medical Home Model as the umbrella for all concepts. • Active participation from individuals to take responsibility for their health status and well-being. <p><u>Concept 1:</u> Independent multi-stakeholder oversight group for the management of the process.</p> <ul style="list-style-type: none"> • Use existing organization chosen by competitive process *Non-governmental oversight • Create independent commission that would oversee prevention and chronic care management. <p><u>Concept 2:</u> Unify existing prevention and chronic care management initiatives and programs. Identify champions of the two disciplines chronic care and prevention within first year of initiative.</p> <ul style="list-style-type: none"> • Champions = individuals, groups, organizations etc. <p><u>Concept 3:</u> Add COPD to priorities.</p> <p><u>Concept 4:</u> HRA biometric funding.</p> <ul style="list-style-type: none"> • Utilize health risk assessments with biometrics as required universal standard for measuring impact and value for all prevention screening outside the medical establishment to include pre and post health risk assessments.

- Develop programs and payment mechanisms for statewide health using biometrics and health risk assessment tools.
- Identify the elements of a comprehensive health risk assessment tool.

Standardization of data collection for prevention and chronic care management.

Concept 5:

Health Literacy

- Focus on health literacy and methods of patient education and self management

Integrate health coaches, health literacy, payment mechanisms and information technology.

Patient access to EHR. Patient access to personal health data via portal (home comp. office kiosks, USB memory stick, web based) (also in concept 12)

- Recommend to eHealth Council to give highest priority to patient portal system. (also in 10)

Community resources (in concept 5, 6, 9)

- Fund and develop community resources for patient self-education and include where to access care
- Develop multiple sources of information through web, 211, regional Health care centers charged with disseminating.
- Identify ideas of various means to education public on owning their own health.

Concept 6:

Community resources (in concept 5, 6, 9)

- Fund and develop community resources for patient self-education and include where to access care
- Identify ideas of various means to education public on owning their own health.

Patient self-management

Develop simple, usable, clinical management protocols.

Centralized Iowa based website for evidence based tools for provider education and chronic care management.

- Mandate chronic and preventive care curricula in all health professional schools and CEU venues. (also under 14)

Concept 7:

Support development of practice based registry with state reporting of selected diagnosis

- Disease registries are an integral part of a chronic disease

management. Benchmarks should be based on widely accepted national and state guidelines. They need to periodically be reviewed.

- Adopt high level measures and benchmarks that are validated.
- Registry needs to be free, with no penalties for reporting, support also free. (also under 10)

Concept 8:

Develop new and innovated payment methodologies to align reimbursements and create financial incentive and rewards for health care professionals for preventive and chronic disease management and treatment.

Concept 9:

Maintain advisory groups with wide representation and public reporting (sustainability)

Community resources (in concept 5, 6, 9)

- Fund and develop community resources for patient self-education and include where to access care
- Develop multiple sources of information through web, 211, regional Health care centers charged with disseminating.
- Identify ideas of various means to education public on owning their own health.

Concept 10:

Patient access to electronic health records. (also in 5)

Recommend to eHealth council to give highest priority to patient portal system (also in 5)

Use existing state HIT/HIE initiative to support provider based efforts (6)

- Registry needs to be free, with no penalties for reporting, support also free. (also under 10)

Concept 11:

Develop evaluation process to study cost and effectiveness of prevention and chronic care management

Concept 12:

Patient access to electronic health records. (also in concept 5)

- Patient access to personal health data via portal (home comp. office kiosk, USB memory stick, web based) (also in concept 5)

Develop a multi-venue marketing campaign focusing on a population density in rural and urban areas

Concept 13:

Provider names should be publicized for utilizing registry

Outcomes data may show unfair disadvantage for providers with

	<p>dispirit populations All Iowa providers should be included in aggregate data (individual success stories) Identify/publicize best practices. (not to be used for report cards)</p> <p>Concept 14: Develop meaningful curricula for health care professionals and patient prevention and chronic disease management.</p> <ul style="list-style-type: none"> • Mandate chronic and preventive care curricula in all health professional schools and CEU venues. (also under 6)
Council Discussion	<p>Population management- Who is your patient and who is not your patient? What measures you use over what period of time, how you judge success? This is a concern and needs to be worked out fair and studied very carefully before that is recommended. There are a lot of places where information may not be very valid. Choosing based on claims data is a problem because it is a bit out of date. It talks about the performance of the provider and doesn't have anything about how engaged the patient is. It needs to be looked at a more global scale and needs to be treated with the right amount of expect. Peter Reiter mentioned the effects of reporting by name. Performance is likely to be poorer and provides a disincentive to provide care to a lower population of patients. Therefore, we need to be clear on the intent.</p>
Closure Conversation	<p>Could have had the draft report prior to the council meeting to prepare better.</p> <p>Lt. Gov. challenge starting 1st couple weeks in June. Nation, want Iowa to compete with other states. This is different than the governor's council for physical fitness.</p>
Next steps/Closing Comments -Volunteer roles & volunteer identification	<ul style="list-style-type: none"> • May 15 conf call instead of May 8th. • Council Assignment: Read through Medical Home Progress Report #1. . It can be found at their website under the last section "Required Reports": http://www.idph.state.ia.us/hcr_committees/medical_home.asp • The updated draft report will be sent out Friday, May 1st. Reply to all to bounce ideas off each other.
<p>The next meeting of the Prevention and Chronic Care Management Advisory Council will be held Friday, May 15, 2009 from 10am – 12pm via conference call.</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.