

December 8, 2011

**Attending:****Committee members:**

Maureen Reeves Horsley  
Mike Rosmann  
Roy Bardole  
Kelly Donham  
Rep. Curtis Hanson  
Angela Halfwassen  
Kathy Nicholls  
Dr. Laine Dvorak

**Presenters:**

Tracy Rodgers  
Brad Buck  
Brian Donaldson  
Jon Michael Rosmann  
Carmily Stone  
Randy Lane  
Libby Coyte

**Others:**

Kate Payne  
Katie Jerkins  
Jane Schadle  
Gloria Vermie  
Jay Iverson

Meeting started at 9:45 with Katie Jerkins providing meeting logistics. The quorum has not been achieved so formal vote on the minutes was postponed – review of minutes provided as part of the packet review. Clarification on the letter that was drafted – it has not been sent as yet as some changes are suggested and Carmily Stone will address this issue with the committee this afternoon.

**ACTION:** Tabled approval of the minutes until one more member arrives to achieve the quorum.

**ACTION:** Correct spelling of Kathy Nicholls' name in the minutes.

**Presentation**

**Jon Michael Rosmann 515-327-5405 [jon.rosmann@iowapdc.org](mailto:jon.rosmann@iowapdc.org)** – Iowa Prescription Corporation –  
**Program Overview**

Presentation materials are attached; reviewing four programs that provide greater pharmaceutical access primarily for uninsured and poorer citizens in primarily rural areas. The source is from recycled medications through dispensing pharmacies and long term care facilities. Recipients have to be a resident of Iowa and not covered by pharmaceutical insurance programs. This program covers medications and durable medical equipment.

**Drug Donation Repository**

Medications are donated by long term care facilities and other sources and are sorted, and recycled by providing the meds via a computerized order process. They have served 20,000+ individuals with total value of about \$3+ million. Over 140 medical facilities are participating in the program. There is a large increase in demand and the program is attempting to gear up. Meds are dispensed through any medical facility where there is someone who can dispense drugs. One case study was a patient who needed a 10 day IV antibiotic via hospital stay and the outpatient medication was available through the repository allowing the individual to go home the next day and continue medical treatment at home.

### **Iowa Medication Voucher Program**

IMVP covers five disease- states providing medications directly to individuals through a voucher program. With a prescription and a voucher a participating pharmacy (135 participating Iowa pharmacies) an individual can get medications. This program is working with Iowa prison system right now – particularly with those prisoners who have diagnosed mental illness. Maintaining medication after discharge cuts recidivism and helps the prisoner maintain medication treatment for their chronic mental illness. The question is if the program can help individuals maintain medication coverage and decrease their risk of re-offending. The new plan will provide 90-day coverage for Dept. of Justice formulary medications upon release from prison and will also provide meds for any of the five disease states as well. 7000+ vouchers utilized so far for 697,000+ units of medication.

### **Prescription Discount Card**

This provides a card for discounts when people do not have insurance. Provides discounts through Med One discount systems out of Dubuque. On average saves about \$41.50 per prescription.

### **340B Pharmacy Initiative**

Expanded to include CAH and RHC and this is slowly being implemented in Iowa. This program is just getting started. Many folks who have Medicare Part D are part of the donut hole and participate in the program.

When you do a Google search and ask for drug donation programs – this is the first item that comes up.

Funding for this program comes from a couple of IDPH programs and a contract with Iowa Primary Care Association.

ACTION: One way we could support this program is to create a one page flyer to hand out on our Legislative Day – February 9<sup>th</sup>. This should also be sent to the members of the Health and Human Services Committee. Maureen moves that we invite Jon to our Legislative Breakfast to answer questions about his program. Second by Ron Schaffer but motion was tabled due to quorum – group decided to move forward and invite Jon without a vote—since the vote was not strictly necessary for the invite.

## **Presentation**

### **Community Paramedic – Gloria Vermie – Brad Buck (Cedar Falls) -- Brian Donaldson (Sumner)**

This concept exists solely to serve the needs of the community. A number of projects are underway across the country. It helps reduce the transportation of people who really don't need to be transported. The projects have evaluated community issues, monitored issues and implemented projects to address community issues. Case studies exist for asthma or diabetes treatment issues. Frequent callers for help or people frequently admitted to hospitals for stabilization are able to get follow up visits which can provide preventive services to decrease the number of transports.

There is a training component (curriculum) for these EMS – but there is no certification or improved pay for these trained EMS. EMS for the future – a 1996—report introduced the concept of community EMS – providing being out in community, provide some prevention services, provide some basic support or treatment. The community health role was emphasized; with EMS providing a broader community

service than just EMS and transport. This concept partners EMS with public health and health providers in community to fill service gaps and identify issues for intervention. Right now the majority of EMS staffs are volunteers and this community EMS would provide small and rural communities with a higher level of service. Some of the envisioned services include blood draws, 12 lead EKGs, follow up visits, fall prevention, medication review, basic wound care post hospitalization, etc. Some safety and wellness initiatives can be identified for the community. The training for EMS is a didactic training with a family practice. In phase I we focus on health of personnel. In phase II (2013) we will focus on youth and do car seat inspections for safety. For children doing safety training and encouraging helmet use and fitting helmets for kids in a safety clinic. The phase IV is blood pressure screening, blood glucose screening, depression screening, and balance and gait screenings. Home safety inspections and identify nutritional status and make proper referrals to meet the individual needs.

Community coordination between hospitals and care facilities, between public health and other health providers, among a community set of providers. This program links the health care and public services in the community. Coordination with public health and public health offices in home care services – where the county public health services are not available or not as frequently available as needed.

This concept does not change the current practice, or change the current EMS scope of practice. This does not increase the level of care, but does provide the care in an alternative way. The outcome of this model may decrease the incidence of readmissions, decreased cost of treatment at higher cost sites, builds on injury and illness prevention. Currently no funding is available for this service.



A discussion ensued of advanced EMS role in farms and in the field because of the type of life threatening circumstances that can be encountered in the field.

This is not meant to be a cookie cutter approach and will be different in each community.

### **Presentation**

**Tracey Rodgers** –Fluoridation – Dr. Russell and Randy Lane are IDPH staff working on Fluoridation issues: IDPH is getting sporadic information about communities that have stopped fluoridation – the handout is a listing of the known communities that have stopped fluoridating. The handout is also posted on the Committee meeting site on the website for your use to email to others and your stakeholder groups. IPHA is providing a webinar next Friday the 16<sup>th</sup> about community fluoridation. Anyone is able to go on their website and register for the webinar. That link is in the handout.

I-SMILE™ – dental home initiatives. Dentists are seeing twice as many kids as when I-SMILE™ began. Our coordinators are working to pair dentists with the children who need the services. We have a lot of work to do with children under age 3. We are also working with physicians to provide screening for these children.

I SMILE – coordinators are doing needs assessments for each county in the state to identify what counties need to do to address dental issues. Coordinators are undergoing a public health education program to build their knowledge of public health and its systems. IRHA has requested an oral health webinar and we will be doing one for them in February. We are also engaged with issues related to dentists’ recruitment into rural Iowa.

### LEGISLATIVE Priorities

The priorities submitted last year were part of the packets and reviewed.

#### Discussion items for development into legislative priorities.

- Maintain funding for : I SMILE funding, Local Public Health, PRIME CARRE and Iowa prescription drug program
- Fluoride issue – support fluoridation of public water systems
- E health issues
- Restore line item funding for Iowa’s Center for Agricultural Safety

#### ICASH Issues

- Annual meeting in DSM this year focused on mental health issues – with stress of natural disasters as a result of climate change which puts stress on our farming community
- MRSA issues are getting a lot of research. The livestock strain does not have the invasive factors that the MRSA that is part of our hospitals. We are researching respirators and bio-filters that remove MRSA by capturing the particulate matter and the bio then breaks them down.
- Cleaning up hog sites with power washers kicks up endotoxins 40-50,000 times normal that causes asthma
- What rural or farm hazards do you identify for this time of year? 1) Vehicles both on farm and on the rural roads as heavier trucks are traveling rapidly along rural highway, 2) exposure to gases as cold weather closes up buildings and ventilation is decreased, 3) slips and falls with weather related slippery conditions, 4) bins of course though those are down with the dry fall.

### Presentation

#### Libby Coyte- Rural Health Clinics in Iowa 2011

What is a rural health clinic?  
Description of Iowa RHCs  
Opportunities for the future

#### RHC Service act – PL 95-210

- Cost based reimbursement to qualified clinics for services provided by PA and NP
- Rural locations and shortage designation
- Independent RHC and provider based RHC
- 78.07 is Independent clinic visit cap – provider based RHC has no cap (reasonable and allowable costs)



## RHC in Iowa

- 141 RHC in Iowa – fewer in southern part of the state.
- In 58 of 99 counties
- 75% provider based (expertise and payment)
- [www://iarhc.org](http://www://iarhc.org)
- Iowa Governor Designations of shortage areas – some areas have lost designations due to rapid growth and loss of manpower shortage designations
- Safety Net Provider Group – Grants to RHC (\$1500)
  - 23% uninsured; Medicare 31%; 587,874 visits in 2010
  - 40-50 percent is Medicaid or uninsured in most RHC

## Challenges for RHC

- Payment caps for independents has not kept up with expenses
- Bill to increase cap – in congress sponsored by Senator Harkin
- Rules to decertify RHC passed – to decertify those who no longer qualify – did not pass
- Redefinition of HPSA and MUA
- Barriers for access to care – limitations of license
  - Orders for home health services
  - No hospice care
  - Not paid under work comp rules
  - Electronic health funding
  - Signing death certificates, return to work forms, DOT forms
  - Order respiratory care
- Health Care Reform
  - Not included in early health care reforms
  - Medicaid chronic care home health program (not inclusive of PA)



## Opportunities

- Need to expand available pool
- Collaborate with local providers

## Mission and Vision

### Members

- Myrna Erb Gundel has retired and so we have one position vacant to be filled by gubernatorial appointment – represents IHA
- New member representing Critical Access Hospitals – New
- Rep from farm organizations

We need to update mission and vision statements and will revisit those in an email process.

Ideas for presentations – a document in your packet will allow you to list ideas and give them to Katie.

Coordination of services in rural communities – no longer have health commissions – who is responsible for that? A study is warranted.

## Presentation

**Carmily Stone and Randy Lane** – water quality/fluoridation

Our goal is to provide technical assistance and outreach to lowans and to local boards of health.

Fluoride in Iowa is funded under the block grant but that funding is redirected after June 30, 2012.

CDC funding helped develop the bureau originally to provide TA to communities in development of local water fluoridation systems.

Iowa is on private well or a public (community) water system – defined as year around service for permanent populations that they serve. A rural citizen is anyone living in a town with a population of 10,000 or less.

DNR – resources and environmental services bureau regulate public water systems. They get monthly operation reports as mandated by the safe drinking water act. Fluoridation is not a safe water issue but is one covered by the state. DNR water fluoride is seen as contamination level when over .5 mg/liter. DNR knows who is fluoridating water supplies and assigns monitoring to those communities.

A city gets an operating permit and they have to check water sample daily and test natural water levels periodically – have to do organic level of contaminant and fluoride is included in that (if good then do sampling every 9 years).

**HISTORY:** In 1962 national standards for water are developed. 1951 first cities added fluoride. Funding for fluoridation provided to communities up until 1995. 232 systems in the state are adding, and monitoring fluoride. In January 2011 CDC, EPA and HHS changed fluoride recommendations for water systems. Now recommend 0.7 – which changed how communities are treating their water. Some were close to that level naturally and some had equipment which would allow them to adjust down to that level.



### Issues:

- Equipment costs are hi and old equipment is wearing out
- New recommendation levels have made communities make decisions about it
- There has been lots of public messaging about the dangers to health
- Customers/citizens are not told of fluoride levels

Water systems are very complex and the public systems are regulated by the Safe Water Act – many of these systems buy water to serve their citizens.

## Presentation

**Keith Mueller – reports – rural health care system of the future**

RUPRI is a 20 year old land grant institute based program (Iowa, Nebraska, Missouri).



The Center is a virtual institute and activities include a wide range of subjects --health, government, etc. Dr. Mueller directs the RUPRI center for healthcare and analysis. The RUPRI rural health panel has been operating to inform national health care policy. How does

<http://www.rupri.org>

legislation impact the health care delivery system? How does it improve that system? This document will be used in development of comments regarding health reform legislation. Much of our work is in dialog with legislators and federal staff. This was the basis for specific discussions with the federal staffers and legislators. This has generated a great deal of interest among the policy makers.

How can we use this to affect change? We begin with the concept that the heart of our system is the local health care providers and the strength of our system of care is based on the strength of that local health care team. One of the models being tried here in Iowa uses health care workers who are not NP, PA or currently licensed workers. We may not want to invest in the health care in the same way as we always have – we may not want full service hospitals in every place? When those old facilities come up for replacement then that is the time for a community to consider options.

There may be a place for another care model like the Montana or Alaska frontier model. We are looking at that concept right now.

We have a situation where our clients wait some time to be seen and yet we may also have specialists flying in to see clients locally. There are programs where an individual can get a broad scan with a CT scan, lab work, etc. A screening program for prevention of more serious acute episodes might be acute in nature.

How do we create a system of care free of the advocacies that affect the outcomes?

If we hold the values as that of what people locally need then we are freed from some of the advocacy. Then we assume a projected increased demand but that assumes that unserved populations would seek health care if access was improved. With respect to health providers, we project based upon a health care system set up like it is now – that may not be relevant. The future medical care may not be the same model as what we do now. We may not need 150,000 new physicians to direct medical care – but new models don't assume that a physician directed medical care is the way to provide adequate local services.

Electronic health records seems to have a time cost as physicians can see fewer patients in the beginning. How does this fit with a more efficient health care system? The intent of electronic record was to make more efficient the documenting in the office. The office electronic record allows cares to happen outside the physician involvement and the office functions and routine matters don't necessarily fall to the physician as part of the office team.

Meeting adjourned at 3 pm.