MINUTES

Medical Home/Prevention and Chronic Care Management Advisory Council

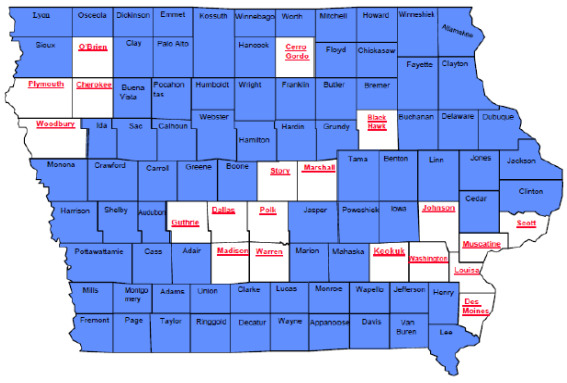
YMCA Healthy Living Center
Wednesday, December 5th, 2012
9:30 am – 3:00 pm

Members Present	Members Absent	Others Present
Chris Atchison	Kevin de Regnier	Angie Doyle Scar
Melissa Bernhardt	Tom Evans	Abby McGill
Charles Bruner	Steve Flood	Marni Bussell
David Carlyle	Ro Foege	Sarah Dixon Gale
Marsha Collins	Don Klitgaard	Peggy Stecklein
Anna Coppola	Debra Waldron	Tracey Rodgers
Chris Espersen		Janice Jensen
Michelle Greiner		Sarah Dixon Gale
Jeffery Hoffmann		Denise Wheeler
Petra Lamfers		Sheri Vohs
Mary Larew		Judith Collins
Linda Meyers		Laurene Hendricks
Teresa Nece (Kala Shipley)		William Applegate
Tom Newton		Jacqueline Stoken
Patty Quinlisk		Daniel Garrett
Trina Radske-Suchan		Leah McWilliams
Peter Reiter		Dennis Tibben
Bill Stumpf		Janelle Nielson
John Swegle		Doreen Chamberlin
Kurt Wood		Joe Sample

Meeting Materials

- Agenda
- Health Homes for Iowa Medicaid Members and SIM- PPT
- Health Navigation PPT
- Primary Health Care- Becoming a Medical Home- PPT
- Safety Net Network and Community Utility PPT
- Community Utility Issue Brief
- CTG Health Provider Toolkit- PPT
- Diabetes Clinical Subcommittee Final Recommendations
- Diabetes Numbers at a Glance NDEP
- Iowa Algorithm for Prediabetes and Type 2 Diabetes
- Iowa Diabetes Action Plan
- Iowa Diabetes Care Flowsheet
- Iowa Diabetes Issue Brief
- Accountable Care Strategies- Report from The Commonwealth Fund

Topic	Discussion
Welcome/ Introduction	Council members and others present introduced themselves.

<u>Health Care Transformation Focus</u>
 	
• **Health Home**
• **Iowa Medicaid-State Innovation Model**
Marni Bussell
 	
PowerPoint:
Health Homes for Iowa Medicaid Members and SIM-PPT
	<u>Health Homes</u>
	• Section 2703 of the Affordable Care Act gives states the option to submit a State Plan Amendment (SPA) depicting a health home model of care. There is a drawdown of funding a 90/10 Federal match rate for eight quarters for specific health home services. States are required to consult with SAMSHA to ensure integration of mental and behavioral health services.
	• Individuals eligible for the program include those diagnosed with at least one serious and persistent mental health condition, has at least two chronic conditions or has one chronic condition and is at risk for a second chronic condition from the following list of categories:
	  • Mental Health Condition
	  • Substance Use Disorder
	  • Asthma
	  • Diabetes
	  • Heart Disease
	  • Obesity (overweight, as evidenced by a BMI over 25 or 85 percentile for children)
	  • Hypertension
	• Note that dual eligible's for Medicaid and Medicare are eligible to participate.
	• The Primary Care SPA was effective on July 1st, 2012, with a drawdown of 90/10 Federal match rate for eight quarters.
	• As of December 1st, 2012, there are 17 health home entities enrolled covering 54 different clinic locations in 20 counties with 492 individual practitioners.
	• Also as of December 1st, there are over 1900 members assigned to Health Homes. Below is a breakdown of the percentage of enrollees in each of the four tiers:
	  ○ Tier 1 (1-3 chronic conditions)- 46%
	  ○ Tier 2 (4-6 chronic conditions)- 40%
	  ○ Tier 3 (7-9 chronic conditions)- 12%
	  ○ Tier 4 (10+ chronic conditions)- 2%
	• Almost half of the current enrollees are dual eligible.
	• Payment is directed to only practices that commit to providing:
	  ○ Comprehensive care management
	  ○ Care coordination
	  ○ Health promotion
	  ○ Comprehensive transitional care
	  ○ Individual and family support services
	  ○ Referral to community and social support services
	• The link to the Health Home Map (below) can be found here: Iowa Medicaid Health Home Map. Counties in white currently have medical homes. Click on the county to see a current list of the health homes.
	
	 

- The IME Health Home Website can be found here: http://www.ime.state.ia.us/providers/healthhome.html. This website includes a number of links on how to enroll as a health home provider and other tools:

How to Enroll as a Health Home Provider:

- Provider Application
- Health Home Provider Agreement
- TransforMED PCMH Self Assessment
- Individual Practitioners and Health Home Locations

Health Home Tools for Providers:

- Health Home Provider Standards
- Patient Tier Assessment Instruction Form
- At-Risk Guidance for Providers
- Health Home IMPA Access Request Form
- IMPA (Tool to enroll members into your Health Home)
- PMPM Fee Schedule

- A second SPA is currently being developed which is a "specialized" Health Home focusing on Medicaid members with serious or consistent mental illness for adult and children. IME is currently working with CMS and receiving technical assistance. Their target effective date for this second SPA is April 2013. The key details of this second SPA are likely to include:
  - Specialized provider requirements due to special population needs
  - Administered through the Iowa Plan
  - Additional payment tiers above the current 4 tiers due to high need of the population
  - Patient/Family Centered, peer support, and team approach.
- At the February 20th meeting, we will invite Magellan to present about the second SPA and also discuss the shortage of children's mental health specialists in Iowa.
- Dr. Carlyle commented about the Primary Care SPA and how it will take time to unfold. McFarland Clinic's Epic system cannot bill more than four diagnoses in one charge. There are some payment and billing issues that will take time to work through.
- Dr. Reiter responded that it would be nice if there were some way to submit a list of diagnosis periodically- for example once a year and then Medicaid keeps track of what tier they are in. There needs to be an electronic solution and it would be ideal if you could submit the tier level as the diagnosis.
- IME stated that down the road in 3-4 years, there will be a new MMIS system to submit those diagnosis codes without submitting the claim.
- A barrier that was mentioned is that when going through the provider standards, there is an assumption by the provider that those standards are all being measured line-by-line and that the provider will be held accountable. This is not true and IME understands that there are limitations in the health care system- such as dental shortages in some areas of Iowa.
- Another barriers that was mentioned is establishing a model of care for all of the six Health Home Services. Practices will need to determine their case load. Practices should research what the ideal is, and then build a business model based on that dollar amount. Practices should not implement a model that will put them out of business.

Financial Alignment Model for Dual Eligibles (Medicare-Medicaid Members)

- There are two options to integrate care for duals:
  1. Capitated- three way contract between MCO, CMS, and State
  2. Managed Fee-For-Service- Memorandum of Understanding between CMS and State with the ability to Share Savings.
- Iowa has proposed a managed fee-for-services to CMS. Iowa must meet quality standards and conditions, and also must commit to a three year demonstration project.
- CMS conversations have led to the following shifts from the original plan:
  - It is now likely to start in early 2014
  - Focus on Health Home as the chief strategy
  - Likely require a benchmark volume of dual eligible members enrolled to start

	State Innovation Model Initiative
	• Iowa submitted an application on September 24th, 2012 on behalf of the Governor's office.
	• The award date is December 4th
	• The CMS Innovation Center plans to award up to $50 million to up to 25 states
	• There is a potential round two for design awardees in Spring of 2013.
	• The SIM design is looking at a broad vision of Health System Transformation including multipayer, high quality, value based, etc.
	• There is a six month design phase to produce:
	  ○ Detailed State Health Care Innovation Plan
	  ○ Stakeholder engagement process
	  ○ Testing model for implementation
	• Iowa's strategies involve IME adopting the Wellmark ACO model which is already used by many Iowa Healthcare systems. It includes Medicare and a significant percentage of the population is managed under the same ACO model. Iowa will also address the Medicaid Long-Term Care population and will also include the Healthiest State Initiative in the design.
	• Iowa requested 1.4 million dollars and will use a vendor to perform analytics, a technical assistance vendor to help in Medicaid Administrative work, and will use Milliman to perform actuary activities.
	• IME will be creating an Advisory Group with broad representation for this initiative.
	• The PCCM/MH Advisory Council agreed that they would like to be involved in the stakeholder piece.

Health Care Transformation Focus • **Primary Health Care's Experience in Becoming a Medical Home/Health Home** *Chris Espersen* *PowerPoint:* Primary Health Care- Becoming a Medical Home- PPT	• Primary Health Care was recently awarded Level 3 NCQA certification. • Chris Espersen described the process of becoming a certified medical home/health home. She started off by describing the structure of Primary Health Care. • Primary Health Care is made up of four medical clinics- three in Des Moines and one in Marshalltown. They provide services in pediatrics, OB/GYN, internal medicine, family practice, HIV, dental, mental health, supportive services, and pharmacy. They see around 25,000 patients. • Out of these 25,000 patients, ¼ are homeless, 51% are uninsured, and half are minority. She explained that it is important to the community that the FQHC's see these patients, because otherwise they would likely end up utilizing the emergency room. • They are in the process of implementing electronic health records and are moving forward with ACO's. • The process of becoming certified through NCQA was described. There are numerous reporting requirements in order to ensure that they are doing operating appropriately, and many audits take place. They divided the tasks among senior leaders with oversight and clinic directors. • A pilot is being done with four Community Health Centers in Iowa about outcomes and measures. It includes a survey about what is happening in the clinics, such as reminders about medications and asking about stress levels. One thing that came from the pilots was the inclusion of learning disability- being unable to read, on the charts. They also learned that a barrier in managing patients that they see is their perceived health status. Often, the patient has low levels of health and a high hospitalization rate, yet they rate their overall health as good. • The process of becoming a Health Home through the IME SPA was discussed, including challenges and solutions. Their philosophy is active patient consent and understanding most important part of the process. • The major barriers that were described include filling out the PTAT, which is the method in which patients are enrolled, patients being enrolled elsewhere, patients changing insurance status, and billing issues. A helpful solution is to start enrolling small, and only to their most regular patients in the beginning. • The outcomes they have experienced include a dramatic increase in process measures including foot screening, labs being done, and hospitalization follow-up.

	• They have some movement in clinical outcomes, increased job satisfaction of Nurse Care Managers, relief of care teams, and increased joy and empowerment of their patients • Patient success stories were then described and are included in the PowerPoint presentation. • A question was asked about the 25 percent of their patients that are homeless- how do they stay in touch with them? She responded that they have clinics in the homeless shelters and they have case managers who know where the homeless live in areas in the community to reach out to them.

Community Care Coordination Focus
 	
• **Community Utility**
• **Iowa Collaborative Safety Net Network**
Sarah Dixon Gale
 	
Handout:
Safety Net Network and Community Utility PPT
 	
Community Utility Issue Brief
	• The Safety Net Network awards funding to Free Clinics, Rural Health Clinics, and Federally Qualified Health Centers (FQHCs). They also other initiatives, one of which is a Medical Home Development Initiative for Local Boards of Health and Maternal and Child Health clinics. This year, Community Transformation Grant funding enhanced this initiative.
	• Some key outcomes from this year were that 87.8% of funding allocated supported direct services to safety net patients from across the state. They provided funding to 115 clinics or grantees. 10,600 patients received direct services from the 10 grantees and over $3.1 million in free care were provided by four grantees.
	• Safety Net patient demographics include 12% belonging to racial minority, 17% identify as being Hispanic/Latino, and women utilize the Network far higher than men.
	• In 2011, the top five ICD9 codes include:
	  ○ Community Health Centers- 1) Diabetes, 2) Hypertension, 3) Routine Infant/child health check, 4) Depressive disorder, and 5) hyperlipidemia
	  ○ Rural Health Clinics- 1) Hypertension, 2) Diabetes, 3) Acute Upper Respiratory, 4) hyperlipidemia, and 5) Allergic rhinitis
	  ○ Family Planning Agencies- 1) OB global visit, 2) Comprehensive preventive medicine exam, 3) Comprehensive preventive services (18-39 years), 4) Contraceptive pill, and 5) gynecologic exam
	• The Commonwealth Fund project was discussed. One of the three subcommittees is on dental health.
	  ○ Activity #1- current state of access to oral health services in Iowa: inventory reports, policy briefs.
	  ○ Activity #2- public dental delivery system capacity assessment.
	  ○ Activity #3- private dental delivery system capacity assessment for Medicaid patients.
	  ○ Activity #4- collaboration with key stakeholders.
	• There will be a survey to private dentists about the Medicaid program and recommendations will be developed.
	• Peter Damiano will share these results with the PCCM/MH Advisory Council at the June 26th Council meeting.
	• The National Academy for State Health Policy (NASHP) has selected Iowa as one of seven states chosen competitively to participate in an initiative that seeks advance partnerships to improve access to care for vulnerable populations. The University of Iowa Public Policy Center joins the Iowa Primary Care Association and the Iowa Medicaid Enterprise (IME) in the Medicaid-Safety Net Learning Collaborative. This is part of NASHP's ongoing work to provide information and technical assistance to states to help them improve their Medicaid programs.
	• NASHP Activities- collection and reconciliation of various sources of data for Rural Health Clinics and electronic medical record adoption, including the Iowa Association of Rural Health Clinics, Safety Net Network, and Telligen.
	• Community Utility was discussed and highlights from North Carolina's model were described. North Carolina's vision included building a delivery system where:
	  ○ Physicians and providers are the champions
	  ○ Primary care is the foundation
	  ○ Patients with choric illnesses are the target
	  ○ Physicians and other health care providers are engaged
	  ○ Local collaboration and support is in place

	○ Meaningful data is available and used to enhance quality which results in cost reductions ○ Performance expectations are clear and aligned ○ Performance is tracked and constructive feedback is provided ○ Processes are in place to drive on-going improvement • North Carolina started out with seed money to create 9 pilot projects and used their Medicaid data. Their geography is very similar to Iowa's in that they have 100 counties, many of which are rural. • North Carolina's recommendation is to look at pharmacy management first, as it is a low-hanging fruit. • The key opportunities in Iowa to develop from include: ○ Iowa's 2703 SPA Health Home Program ○ Patient-Centered Medical Home Recognition efforts ○ Medicaid Subcommittee ○ NASHP Technical Assistance ○ MH/PCCM Advisory Council discussions ○ ACO Development ○ State Innovation Model Application to CMS • NASHP will be providing an onsite visit to Iowa within the next 4 months to offer technical assistance about the North Carolina Model.
Community Care Coordination Focus **Diabetes Care Coordination Plan** *Angie Doyle Scar* *Abby McGill* *Handouts:* • Diabetes Clinical Subcommittee Final Recommendations • Diabetes Numbers at a Glance NDEP • Iowa Algorithm for Prediabetes and Type 2 Diabetes • Iowa Diabetes Action Plan • Iowa Diabetes Care Flowsheet	• The Council was charged by SF 2356 to develop a plan to coordinate care for individuals with diabetes who receive care through safety net providers. • As a first step, the Iowa Primary Care Association (Iowa PCA) conducted focus groups in the FQHC to determine the barriers that people with diabetes face. Iowa PCA produced a report for the Council summarizing the results of the focus groups. The main conclusions from the focus groups are that: ○ patients want more information about diabetes in a way other than written material ○ patients wanted their family members to be more engaged in the management of their diabetes ○ patients felt that their diabetes was triggered by stress • An environmental scan was done on what other states are doing with diabetes care plans and New York has an excellent website that many of these documents were modeled off of New York's website can be accessed here: http://fulldiabetescare.org/ • PCCM Staff have been meeting with members of the Iowa Collaborative Safety Net Provider Network, including the free clinics, community health centers, family planning clinics, and rural health clinics to discuss this legislative charge and continue collaboration for the diabetes care coordination plan. • The Council has finalized an Iowa Diabetes Issue Brief which will include initial recommendations concerning issues that have quickly become high priority while working on the diabetes care plan. The recommendations are: 1. Coordinate with existing programs to ensure that test-strips are made available for underinsured and uninsured people with diabetes in Iowa. 2. Ensure that certified diabetes education is available statewide and that outreach is conducted to patients to ensure awareness of this critical service. 3. Ensure the utilization of educational tools, resources, and programs to promote the engagement of people with diabetes and self-management of both obesity and its complications, including diabetes and metabolic syndrome. • Additionally, a Diabetes Clinical Subcommittee was created to provide input and make clinical recommendations for the diabetes care coordination plan. The Subcommittee has finalized 11 recommendations and a number of Iowa specific documents to be used in the clinic to manage and prevent diabetes, including a Diabetes Care Flowsheet, Diabetes Patient Action Plan, and an Algorithm for Prediabetes and Type 2 Diabetes. • The Iowa Prescription Drug Corporation is now offering test strips at a reduced cost through the Iowa Prescription Drug Donation Program.

	• A comment was made that ADA's guidelines have changed slightly in October. • Discussion took place about barriers to access diabetes education. Diabetes education programs are required to go through accreditation if they want to be reimbursed. It was suggested that Iowa looks at creative alternatives to formal diabetes education, such as online training with basic education materials and videos. • Staff will research to see if ADA already has online diabetes education materials. Resources that were suggested to look at include ADA, American Academy of Family Physicians, American College of Physicians, and Medlineplus.gov. • The overall goal for Iowa is to have the diabetes tools that were created, along with credible education materials, all in one place on a website. • Trina Radske-Suchan, from the YMCA of Central Iowa, commented that while education is extremely important, we need to start getting our patients to act by following a nutrition and exercise plan. The YMCA Healthy Living Center in Clive is a model facility, where other states in the U.S. are coming to visit it to learn how to model it. This facility is the next step for medically-guided exercise programming and physician integration within the exercise program. The Healthy Living Center has a partnership with Mercy that is evidence-based. She described that there are many YMCA's in communities across Iowa, and if patients are not able to afford it, the YMCA has a financial plan and offers scholarships to help. She emphasized that they YMCA has great programs for children also. • The Council thought it would be helpful if Trina gave a full presentation about what the YMCA has to offer at the next meeting.
Patient & Family Engagement Focus **Health Navigation** *Peggy Stecklein* *PowerPoint:* Health Navigation PPT	• Peggy Stecklein is with the Dallas County Public Health department and she described their Health Navigation program. • As background, Dallas County Public Health received medical home grant through the Safety Network. In 2009, they developed an online resource directory. The goal of this directory is that "Residents of Dallas County will have access to available resources in the county through one point-of-contact, with emphasis on timely referrals, fewer steps to receipt of care, efficiency, increased options and improved outcomes." • Health navigation can assist with screening for needs and can refer or assist the client in obtaining needed services and resources. It can help gain access to health insurance, medication, and other "non-medical" services which include social determinants of health-substance abuse, childcare, housing, mental health, and violence. • Health navigation is not emergency services, case manager/care coordinator/health coach, or discharge planner. However, the Health Navigator can assist in all of these services. • Provider, agency, or individual may refer to the health navigation (healthcare providers are given priority). The providers complete a short form and fax the referral. The Health Navigator contacts the client within 3 days; they screen for additional information and needs; and they refer and assist the client in obtaining resources. If the client is referred by provider, the Health Navigator will follow-up with that provider. • Health navigation is client-focused with active engagement, a focus on the client's current needs, information and support to make decisions, giving them choice and empowerment. • The mode and location of assistance is up to the client. The Health Navigator meets them wherever they are comfortable. • Lessons learned include the range of skills and knowledge needed for Health Navigation, the utilization of Health Navigation by providers (they were getting fewer referrals from providers than expected), and data tracking. • A resolution was to put together a team with a social worker, health navigator, and a nurse. The nurse is the liaison with the medical providers. • The Health Navigation program is averaging 46 clients per month with 3.7 contacts per client. Their referral sources were 23% healthcare providers, 26% community partners, and 51% self/family. The primary presenting issue for clients is access to care (68% of referrals) with the barrier being 45% income. • A question was asked about the type of information that is being shared back to the primary care provider. This information includes barriers, series of notes, contacts,

	contacted on date, and at the end is the resolution (for example- provided vouchers from IPDC from this pharmacy for this amount of time) • It was mentioned that this is a great model that public health could explore. It fits into the ACO concept as well.
Community Transformation Grant Health Care Provider Toolkit *Kala Shipley* *PowerPoint:* CTG Health Provider Toolkit-PPT	• Community Transformation Grant toolkits were described and provided. • The overall CTG Goal in Iowa is- "Improved statewide awareness for clinical prevention screenings and healthy lifestyle behaviors through consistent messaging in public health, primary health care, business, and community settings; and to create community-based strategies for systems and environmental changes in a 26 county subgroup to improve access for healthy opportunities. • A number of billboards and posters were developed that were aimed to empower people through "I Messaging". For example- I will protect my heart. • The toolkits include 25 brochures, 1 provider poster, 1 consumer poster, 100 magnets, 10 jelly bracelets, and an instructional letter.
Networking Opportunity	• The Health Benefit Exchange was discussed and it has been decided that Iowa will have a partnership model, with the long-term goal of having a state-based exchange. • Discussion also took place around Medicaid expansion. Dr. Carlyle made a suggested that the PCCM/MH Advisory Council make a recommendation to expand Medicaid. Bill Stumpf seconded this motion, and then a vote took place. All council members were in favor. • Two reports have recently been finalized by IDPH. The first is an Iowa Health Benefit Exchange Consumer Outreach and Education Report, which will be sent to the Council. • The second report is a legislative charge from Senate File 2336. The legislation charges us to "No later than December 15, 2012, the department of public health, in collaboration with the department of education and other interested parties, shall develop guidelines for the management of chronic conditions that affect children to be made available to public schools and accredited nonpublic schools throughout the state." This report has been finalized and will be sent to the Council. • Dr. Bernhardt stated that next year's Iowa Missions of Mercy dental event will be held Friday, October 18th and Saturday, October 19th in Des Moines at the Varied Industries Building. • The February 20th Council meeting will be focused on ACO's and will have a discussion about oral health in the medical home. • The report Accountable Care Strategies from the Commonwealth Fund is an excellent resource that describes the need for the patient-centered medical home within an ACO.
The next meeting of the Medical Home and Prevention and Chronic Care Management Advisory Council will be held **Wednesday, February 20th, 9:30 – 3:00 at YMCA Healthy Living Center**	

2013 Meeting Schedule

- **Wednesday, February 20, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, June 26th, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, August 21st, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Friday, November 1st, 2013- Location TBD**