MINUTES
Prevention and Chronic Care Management Advisory Council
Friday, February 5, 2010
10:00 am – 3:00 pm
Urbandale Public Library

Members Present	Members Absent	Others Present
Jose Aguilar	Krista Barnes	Angie Doyle-Scar
Bill Appelgate	Trula Foughty	Beth Jones
Mary Audia	Della Guzman	Jill Myers Geadelmann
Steve Flood	Tom Kline	Kala Shipley
Terri Henkels	Steve Stephenson	Abby McGill
Melanie Hicklin	Jacqueline Stoken	Kay Corriere
Leah McWilliams	David Swieskowski	Sara Schivert
Noreen O'Shea		Jane Schadle
Patty Quinlisk		Deborah Helsen
Peter Reiter		Karla Fultz McHenry
Rev. Dr. Mary E. Robinson		Judy Collins
Suzan Simmons		Chris Freland
Donald Skinner		Anne Kinzel
John Swegle (representative present)		Daphne Pearson
Debra Waldron		Maureen Myshock
Jenny Webber		Daniel Garrett
		Carol Voss
		Kristin Horning
		Lisa Sharp
		Dennis Hayne

*** 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	• Council members and others introduced themselves.
Updates	**Issue Brief** • The Council provided and agreed upon a number of edits and rewording of the issue brief. The changes will be made and the brief will be sent back out by Friday, February 12th. Any final edits should be sent to us by the follow Friday, February 19th. • The Issue Brief will be sent out to legislatures and other interested parties. It will be posted online, as well as highlighted in the next "Check Up"- Iowa's Health Reform monthly newsletter. This distribution list includes a wide variety of stakeholders across Iowa. • One of the changes the Council discussed was removing "lifestyle related" language from the Type 2 diabetes data. A more suitable phrase is that Type 2 diabetes is caused by obesity and genetic predispositions. • An idea for a 7th recommendation was proposed and accepted. It will stem from the quote in the issue brief from the Robert Wood Johnson Foundation- "Good health requires a joint philosophy

	between personal responsibility and a societal commitment to remove the obstacles preventing too many Americans from leading healthy lives."
	
	<u>PCCM Staff Announcements</u>
	• PCCM staff has been involved in a variety of activities over the last few months. These activities include:
	  ○ Collaborating with the community health centers regarding the colorectal grant and diabetes grant and how their registry can support the efforts of the grants.
	  ▪ One of the action steps that were collaborated on in the diabetes grant is to determine Iowa's perception of diabetic barriers. The action step included a brief survey for diabetics in Iowa to fill out, and if completed, participants will receive a healthy prize, such as a free salad at the grocery store.
	  ○ The PCCM Report was shared with the Legislative Health Care Coverage Commission and Office of Multicultural Health Advisory Council.
	  ○ Staff have been attending the Medical Home System Advisory Council's Leadership conference calls to ensure we are integrating and collaborating.
	  ○ Additional Council members are currently being discussed and recruited.
	  ○ Later in the week, staff will be presenting on the councils activities to the Safety Net Collaboration and the Office of Multicultural Health's Advisory Council.
	  ○ Various pieces of legislation have been introduced concerning potential future activities for the council. Staff has been responding to these items upon request.

Legislative Update	• SSB 3092 or 3092 is regarding the Stroke Registry and gives Information on Alzheimer's.
	  ○ Patty Quinlisk commented that a registry is a feel good thing. A registry by itself has no purpose. As an Advisory Council, we need to say that the registry needs to have action.
	  ○ Peter Reiter mentioned that the diagnosis of stroke and Alzheimer's is not simple. There is a great variety of strokes, and the bill needs to make it very clear what the diagnosis is.
	  ○ Dr. Applegate added that many people have multiple chronic diseases, and many relate to one another. The registry should have the capacity to track this.
	• IDPH responded to the bill that the Council would like to see a comprehensive chronic disease registry.
	  ○ If the diabetes registry does go forward, this Council would like the opportunity to collaborate and make recommendations for diabetic treatment in Iowa. We would also like to assist in defining what the registry would look like and how it would work.

	• Mental health parity is something that is back on the agenda this legislative session.
	• The Government Reorganization Bill originally recommended eliminating the Medical Home System Advisory Council, and it was discussed that the PCCM and MH Councils would be combined. This recommendation has been removed from the bill's language.
	• The Ominous Bill includes an amendment from Representative Ford regarding disparities with minority groups in Iowa. The amendment will direct the PCCM Council to be involved with data collection regarding disparities and make recommendations to address disparities in Iowa.
	• Anne Kinzel, the coordinator of the Legislative Healthcare Coverage Commission, described the recommendation to expand the IowaCare Program. The recommendation is:
	  ○ Expand the IowaCare program to create a regional delivery model that will provide access to primary care and hospital care in the least geographically burdensome manner, which is defined as providing all but tertiary level care as close as possible to an IowaCare members home.
	  ○ The IowaCare program has many barriers. It only offers services in Iowa City and Des Moines, and it can often take months to get into the Iowa City location. These services can be done locally.
	• Dr. Applegate commented that expanding IowaCare is a huge issue that deals with menu, price, and access. If those are the only variables, we have no quality care in Medicaid. In commercial health plans across the nation, we get about 70 percent of women who get an annual Pap. In Medicaid nationally, around 50 percent of women get a Pap, and in Iowa's Medicaid population, only around 25 percent get one. We don't have any quality reviews.
	• Staff reported that the bill addresses improving quality of care by expanding care and by moving toward a medical home model.
	• Peter Reiter shared an experience he had with IowaCare. It is a very difficult program for the patient. He has had a diabetic patient that qualified for IowaCare, but she couldn't make it to Iowa City to get her pump.
	• Anne Kinzel added to the discussion that IowaCare is a limited benefit program, and it still is in this bill. Iowa City is the vehicle that Iowa has right now to extend medical care to an underserved population. The bill looks expand this option and addresses the limited pharmacy benefit.
	• Steve Flood commented that Iowa needs to be honest with its citizens and taxpayers. The cost proposed to expand IowaCare, isn't truly the cost. Every new person that is put into program is an additional tax to the working people of Iowa. This tax is hidden to the citizens and is not included in the IowaCare budget. He suggested having the state pay this, or at least inform the citizens that they will be paying for it.

	• Dr. Skinner commented that you can no longer assume access because there is pressure put on the providers by everybody. Access will become an issue, no matter what. There is costs that the University of Iowa is no longer able to afford. • Sarah Dixon commented that patients are seeking care whether they have coverage or not. If you increase access first, then maybe quality can be focused on. The Medical Home Council ties into this. Professionals other than providers are providing support to patients, such as health educators, health coaches etc. The Council had further discussion on quality of care issues in Iowa and other chronic health issues. • The dollar amount spent in Medicaid equal to 23 percent spent on the elderly population, 47 percent spent on the disabled, and 15 percent spent on children. • Peter Reiter mentioned that there is a new model of palliative care for people with advanced dementia. This model is appropriate for end-of-life problems. Medicaid patients to him look like everybody else, so the quality of care is the same. • Steve Flood stated that we need to stop the production of disease, because at the current rate, the United States will be bankrupted from the cost of managing chronic diseases. We need to focused more on keeping healthy the current people that do not have chronic conditions. • Beth Jones mentioned that around 50 years ago, Type 1 diabetes was the most common type. Think of how much our food has changed over 50 years, and how is a consumer supposed to know this. It would be interesting to do some research and see what is in our food today that wasn't 50 years ago. • As far as policy goes, smoking is simpler to take away than food. The Council should push this movement in Iowa. • There are many social factors that play into this as well. For example, as a society we have stopped cooking our meals, and opt to eat fast food or go out to restaurants where the portion sizes are out of control. • Dr. Audia brought up the cigarette tax, and said maybe would could propose having a French fry or sugar tax. • Steve Flood stated that nobody starts smoking not knowing that it's bad for you. The sooner we get that mentality, around the food that we eat, the better. • Patty Quinlisk added to this that in New York City, restaurants can no longer use certain ingredients. There is also a major education piece to it, for example listing calorie count on menus. One example is that Outback Steakhouse's blooming onion has approximately 5,000 calories. When people know t his information they will be less likely to consume as much of it. People know that they should not be eating that many calories, but they may not *know* that they are eating that much.
Medicaid Diabetes	<u>Presented by Kathy Kunath</u>

Telemedicine *Dr. Bill Applegate*	• The goal of the Iowa Medicaid Diabetes Tel-Assurance Program is to evaluate the effectiveness of telehealth strategies to improve the health of rural Iowans with diabetes**,** who are served by the Iowa Medicaid Program. • Project dates: September 1, 2009 through August 31, 2012 • Participant Enrollment Campaign: Beginning February 8, 2010 • Funding Agency: Health Resources Services Administration (HRSA) • Grant Management Agency: Office for the Advancement of Telehealth • This is an opportunity for IME to target high risk diabetes members and put them into established networks to continue to diver of telehealth. • There were around 150-175 grants submitted, and Iowa was one of six awards given. • The project will enroll 250 people with high risk diabetes (high cost healthcare utilization within the past year) who live in rural counties in Iowa and are members in the Iowa Medicaid Program. • The participation will be voluntary, and have no extra cost to the patients. • The enrollees will participate in a daily telehealth survey to identify early health concerns. This may be symptom-based, or trending in daily blood sugars. • Nurse care coordinators will monitor the daily surveys and contact members who are showing "variances". • The project will focus on self-management support and patient education, although the care coordinators will also refer patients to physicians when appropriate. • Dr. Mary Robinson asked if there was a cross cultural component. The participation selection is random, and they hope that the cross cultural mix will appear. • Dr. Peter Reiter mentioned automatic reporting and inclusion of care providers. He would like to see the data be given electronically to the providers and allow it to interface with EHR's.

Disease Registry Workgroup Update	<u>Noreen O'Shea- "Tracking Quality" PowerPoint</u>
	• Definition of a registry: A disease registry is a computerized database that contains information about people diagnosed with a specific type of disease.
	• Types of registries:
	  ○ Clinical-based registries collect data on patients and allow providers to proactively manage their patients. Ex. DocSite, DEMS i2iTracks
	  ○ Population-based registries collect data on people diagnosed with a specific type of disease and a set geographic area. Ex. IRIS
	• Benefits of a registry:
	  ○ Integral to the Chronic Care Model and Patient-Centered Medical Home
	  ○ Improves patient outcomes

	○ Accelerates positive changes for the patient/provider, and identifies areas for improvement ○ Supports pay-for-performance programs ○ Highlights health priorities for public planning and legislative discourse ○ Tracks access to care and health disparities for underserved populations ○ Determines "best practices" for dissemination of innovation ○ Dr. O'Shea then showed the Council example screenshots of her disease registry. **The Council agreed upon a robust registry that can track multiple chronic disease and prevention. • The major concerns and considerations to think about when implementing a disease registry are: ○ Cost (and who bears it) ○ Where its housed (central, regional, clinical) ○ How its supported (IT and data entry) ○ What to measure: process (are we doing the right things in the clinic), outcomes, cost, efficiency (taking less time? Time study), patient experience. ○ What clinical topics/disease states should be tracked ○ Who selects the measures- NCQA vs. PQRI ○ How high is the bar? Ex) Hb1C at a target of 7 ○ How it interacts with the EMR. They are separate and they need to be able to talk to each other. ○ Provisions for data exchange and continuity of care. ○ Privacy and security issues ○ Incentives/disincentives for use (data entry, no reimbursement) ○ Long-term viability/sustainability ○ What do we do with the information and how does it benefit Iowans <u>Dr. Skinner- Disease Registry Report Draft</u> Overall- • The registry should have uniform measures- either NCQA or PQRI. • Interfaces are extremely important. If it's not integrated, it's a cost issue. • We need a single, scalable robust system from the start. • It needs to be easy to use, relatively intuitive, free, and the data needs to be usable. Trying to measure too many things at once makes it complicated and problematic. • Simplicity, scalability, and affordability are very important considerations. • Dr. Applegate mentioned that consensus guidelines should be

	developed. There needs to be a well-defined process of developing this. Input from a variety of providers all over Iowa should be involved. It shouldn't just be primary care/internal care doctors, we need specialists such as cardiologists etc. • The Disease Registry Subgroup will continue to work on this report.
Iowans Fit for Life	<u>Dennis Haney (Program Coordinator for Iowans Fit for Life)- Handout- "Iowans Fit for Life Plan"</u> • Iowans Fit for Life is a CDC funded grant program that aims to improve the health of Iowans by reducing the risks and preventing disease related to inactivity and unhealthy eating behaviors. It focuses more on the solutions rather than the problems. • Their Partnership brings together key Iowans dedicated to promoting physical activity and nutrition to prevent obesity and other chronic diseases. The partnership targets all Iowans through six channels: o Community o Early Childhood o Education o Food Systems and Ag o Health Care o Older Iowans o Worksite Wellness • The State Plan is a working document that is referenced constantly. It is very focused on policy and environmental changes. o Goal 1: Increase healthy eating and physical activity opportunities by fostering supportive policies and environments. o Goal 2: Increase the percentage of Iowans at a healthy weight. o Goal 3: Increase the percent of Iowans who follow healthy eating patterns. o Goal 4: Increase the percentage of Iowans who participate in recommended amounts of physical activity. o Goal 5: Increase the percentage of Iowans who limit TV and/or screen time. Carol Voss- representing the Governor's Council on Physical Fitness and Nutrition • The Council is assisting with the Iowans Fit for Life State Plan • Three Opportunities for the Council are 1. Live Healthy Iowa Kids/Governors Challenge 2. HealthierUS School Challenge 3. Healthy Iowa Awards The PCCM Council's recommendation #2- Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses. This recommendation is where the Governor's Council fits in very well and would be a great area to collaborate.

Survey Monkey Results & Next Steps	Survey Results 1. Should the Council break into two groups – one representing Chronic Disease Management and the other representing Prevention with the two groups coming together as a larger group a few times a year? **Yes- 12 No- 4** **- The Council will break into two groups. Please email us which subgroup you would like to belong to.** **- The subgroups will meeting in the mornings of the Council meetings, and then we will come back as a full Council in the afternoon.** **- During lunch break, have a presentation that concerns both Prevention and Chronic Care Management.** **- Angie will continue to facilitate/coordinate the Council.** 2. Should the Council appoint a chairperson? **Yes- 13 No- 3** 3. Only answer the following question if you answered yes to both question one and two. Should we have separate chairs for both subgroups? **Yes- 10 No- 4** **- We will appoint one Chair, and one Co-Chair. Each representing different subgroups.** **- Email us your nominations, and we will take the results to Director Newton.** 4. Should the council continue to work on creating issue briefs for the purpose of educating policymakers and stakeholders about prevention and chronic care management issues? **Yes- 12 No- 3** **- Issue briefs allow us to provide education and advocacy. It is important for legislators to understand clearly the issues are they are discussing.** 5. If you answered yes, what two topics would you like to explore for the next issue briefs? **Disease Registries- 6** **What is Prevention? – 7** **Evidence-based, Population-based, Public Health PCCM Strategies- 7** **- The Council agreed that the next issue brief should be "Disease Registries" since we have already formed a Subgroup and have started a draft report.** 6. Would you like to continue to have presentations and panels on subjects that pertain to Prevention and Chronic Care management in Iowa to gather information and avoid duplication of efforts? **Yes- 12 No- 4**

	7. If you answered yes, what topics would you like to receive information about? **<u>Current Prevention Efforts- 6</u>** **<u>Health Coverage for PCCM Activities- 4</u>** **<u>Multicultural Awareness with PCCM Issues- 4</u>** **- Some of the presentations could be done through Webinars. If they are specific to one subgroup, still invite the entire Council to participate if interested.** 8. If you answered no to question six, would you like to have these presentations via conference call or webinar instead of during Council meetings? **<u>Yes- 2 No- 4</u>** 9. Do you want to continue getting information and updates via email or should IDPH create a listserve for members to access information? **<u>Email- 11 Listserve- 4</u>** <u>Other Suggestion:</u> The PCCM Council should utilize the Clinicians Advisory Panel. They could do some of the actual "work" and bring back to the Council."
The next meeting of the Prevention and Chronic Care Management Advisory Council will be held **Friday, April 30th, 10:00 – 3:00** at the Urbandale Public Library	

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.