

Minutes
 Health and Long-term Care Access Advisory Council
 April 23, 2012
 10:00 a.m. – 3:00 p.m.
 Urbandale Public Library

Members Present

Roy Bardole
 Libby Coyte
 Ryan Hopkins

 Laura Malone
 Leah J. McWilliams

Members Absent

Carol Alexander
 Cindy Baddeloo
 Kyle Carlson
 Shelly Chandler
 Michele Devlin
 Brian Farrell
 Wendy Gray
 Steve Johnson
 Brian Kaskie
 Susan Lutz
 Daniel Otto
 Catherine Simmons

Others Present

Michelle Holst, Iowa Department of Public Health
 Kevin Wooddell, Iowa Department of Public Health
 Francisco Olalde, The University of Iowa (rep for Carol Alexander)
 Sandy Nelson, Iowa Medical Society
 Patricia Freeland, Iowa Nurses Association

*Health and Long-Term Care Access Advisory Council Web site http://www.idph.state.ia.us/hcr_committees/care_access.asp

Topic	Discussion
Introductions and Welcome	Michelle Holst welcomed the attendees to the meeting. Members and guests introduced themselves.
Review of 2012 Strategic Plan Action Steps	The council walked through the next Action Steps in the Strategic Plan. Action steps are available in the Executive Summary document posted with April 2012 Meeting Materials . The council was invited to discuss Action Steps and did not recommend changes or additions. Work on the strategic plan will continue through online/teleconference collaboration which will be staggered to encourage everyone to attend.
Discussion of Statute in 135.163 and 135.164 Alignment with Strategic Direction and IDPH Mission	<p>The council continued discussion from the point where discussion left off at the last conference call, the item on the last page pertaining to a rural health resource plan. The council was reminded of the Rural & Agricultural Health & Safety Resource Plan available on the Iowa Department of Public Health website on the page specific to the Iowa State Office of Rural Health. The council has met jointly in the past with the Rural Health & Primary Care Advisory Committee. Gloria Vermie, director of the Iowa State Office of Rural Health, presented to the council regarding the RAHSRP and most recently provided an update on November 7, 2011.</p> <p>The council is reviewing the statute as a tool to assist in addressing council members' comments that a more narrow focus would assist with the council's work. After completing the review of the final three sections of the statute, the council reviewed notes from the conference calls for the benefit of those who were unable to attend the conference calls and also for the benefit of public members in attendance. Results and recommendations are available at here or by looking in the April 2012 Meeting Materials list at this URL: http://www.idph.state.ia.us/HLTC_Advisory_Council/Meetings.aspx.</p> <p>Discussion occurred regarding how to identify and track the uninsured population so that we would know the workforce needed to serve them. Iowa Medicaid Enterprise may be a</p>

	<p>resource.</p> <p>Come back to data discussion from the first part of 135.164 to determine how we move forward. Are we talking about workforce data? Infrastructure data? What infrastructure data? Is the expectation that the general public could be able to access and understand the data which raises the question, “Should the general public have access to the data?” Misinterpretation and misrepresentation of data was discussed. Should the system be about identifying gaps in existing data? Develop a data catalog for health workforce planning?</p> <p>Discussion: Compare disease prevalence and types of professionals geographically to determine if there are enough professionals in that geography to address that disease. Research on distance patients are willing to travel for various conditions. Ability to look at the patient mix.</p> <p>A strategy for further defining and re-naming this council could be to reorganize the language so that it is clear that various components are important to a quality health system, but that this council and strategic plan address only certain specific components because others are addressed by other existing entities, workgroups, councils and committees.</p>
<p>Subcommittees: Infrastructure & Workforce</p>	<p>“Issues no one is raising” Consider eliminating this (“Issues no one is raising”) as something separate from “Recruitment and retention” and “New types of professionals”.</p> <p>A. An education system to prepare adequate numbers of professionals in Iowa for these trends:</p> <ol style="list-style-type: none"> 1. <u>Care Coordinator for new patient centered medical home</u>. Do we use the Title XIX model? If you are going to access Medicaid chronic care program (patients with 2 to 8 chronic conditions) per member per month funding, you are going to have to have a care coordinator. Has anyone considered where are you going to find the workforce for these additional professionals? Or, how do you hire someone if you don't have enough business to support hiring someone full-time? <p>North Carolina and Vermont have used patient centered medical home longer. When you have a system in place, overall cost of care does go down. North Carolina has similar demographics to Iowa and also has many rural health clinics.</p> <ol style="list-style-type: none"> 2. <u>Electronic health records are taking more time, causing clinics to take fewer patients</u>. Have talked to 2 physicians in the past 6 months who have transitioned to EHRs and both said they are able to see 1/3 fewer patients. Personal experience in clinic, when first started EHR, cut patient time back by 1/2 and as it has evolved, now seeing 1/4 less than before EHR. Example, a prescription that used to require a signature now takes 8 to 10 steps. <ol style="list-style-type: none"> a. From the provider (doctor, nurse practitioner, physician assistant) perspective, it is taking more time b. From the administrative perspective, it makes it possible to see data about overall patient load

This seems like a huge emerging or current issue.

Will have some source of income now, though, for managing people with chronic conditions.

3. Certified health coaches with medical home to manage people with chronic conditions like diabetes, congestive heart failure, etc.
 4. Some communities are looking at a “community utility” which is an entity that helps direct people to available services. You will see this in rural counties. It would be nice to see if there could be some combining of community utility with care coordinator.
 - a. CMS Partnerships for Patients. Iowa Hospitals are participating. Ten goals. Nine of the goals are to reduce health care acquired conditions. The tenth is to reduce readmissions. Looking at coordinating among all the different pieces. Iowa Healthcare Collaborative is leading.
 5. Technology experts to assist small clinics when EHR goes down.
- B. Continual need to address shortage of primary care providers.
1. This council would support funding existing incentive programs, including not only public funding but also finding private sources of funding. The council would discuss the types of programs that are effective, for example, those requiring community matches.
 2. Studies show that medical students stay in states where they complete their residency. This council may consider support of programs which encourage placement of students in Iowa residency programs. This council may consider support of physician education programs that encourage primary care.
 3. This council would look at the funds put into an incentive program and the results that are generated by that program. This council would watch which programs result in true retention and make recommendations about what types of programs should receive more resources.
 4. This council would consider the incentives and disincentives to participate in loan repayment or other programs to recommend which types of incentives and disincentives are effective.
- C. Continual need to address shortage of mental health providers
1. Council would study innovative solutions and incentives to increase the number of mental health providers
 - a. Example: In the past, providers in other states willing to provide telemedicine services but were prohibited due to no license in Iowa.
 - b. Uncertainty related reimbursement for telemedicine
 - c. Recommending that payers accept new definitions of “mental health providers” per Iowa’s mental health redesign effort.
- D. Continual need to address shortage of oral health providers
1. Utilizing a type of mid-level or other providers to extend access
 - a. Dental screenings

	<p style="text-align: center;">b. Fluoride varnish</p> <p>Infrastructure:</p> <p>What is “infrastructure”. Not physical structures. Not bricks and mortar. A definition would help us stay on focus.</p> <p>Does include:</p> <ul style="list-style-type: none"> • Transportation system • Communication system <p><u>Infrastructure</u>: How the patient moves within the system from one care structure to another (clinic to hospital to long-term care, etc.) and everything that happens in between, not necessarily confined to providers and entities within a group of affiliated organizations. (How the entities within the health care system interact as the patient/client moves through the system regardless of the entities affiliations.)</p> <p>Interoperability of EHRs would be addressed by the Health Information Exchange</p> <p>In general, there is a lot of skepticism about ACO and whether it is going to do what it is supposed to do.</p>
<p>Wrap-up and Public Comment</p>	<p>Potential items for further discussion/information:</p> <ul style="list-style-type: none"> • Discussion about required components of an EHR and interoperability. Would be addressed by the eHealth group. • Discussion about technology used for monitoring patients in in-home (community based) long-term care. • Presenter on the community utility or other community based programs. • Presenter on Accountable Care Organizations.

Next meeting: July 11, 2012 from 10:00 AM to 3:00 PM at the Urbandale Public Library