

Minutes  
 Health & Long-Term Care Access Advisory Council  
 October 28, 2010  
 10:30 a.m. – 3:00 p.m.  
 Urbandale Public Library: Urbandale, Iowa

**Members Present**

Roy Bardole  
 Bobbretta Brewton  
 Libby Coyte  
 Brian Ferrell  
 Laura Malone  
 Leah McWilliams  
 Catherine Simmons

**Members Absent**

Cindy Baddeloo  
 Shelly Chandler  
 Michele Devlin  
 Wendy Gray  
 Ryan Hopkins  
 Steve Johnson  
 Brian Kaskie  
 Mark McMullen  
 Leah J. McWilliams  
 Daniel Otto  
 Jill Scott-Cawiezell  
 Julie Stauch  
 Roger Tracy

**Others Present**

Carol Alexander, The University of Iowa (rep for Roger Tracy)  
 Kelly Banning, Iowa Health Care Association (rep for Cindy Baddeloo)  
 Karith Humpal, Iowa Department of Public Health  
 Katie Reidy, Iowa Center on Health Disparities (rep for Michelle Devlin)  
 Jacqueline Ingabire, Iowa Center on Health Disparities (rep for Michelle Devlin)  
 Nicole Schultz, Iowa Pharmacy Association (rep for Mark McMullen)  
 Deborah (Heisen) Thompson, Legislative Services Agency  
 Sandy Nelson, Iowa Medical Society  
 Erin Drinnin, Iowa Department of Public Health  
 Kevin Wooddell, Iowa Department of Public Health  
 Michelle Holst, Iowa Department of Public Health  
 Doreen Chamberlin, Iowa Department of Public Health  
 Kate Payne, Iowa Department of Public Health  
 Andria Seip, Iowa Department of Public Health  
 Leslie Grefe, Iowa Department of Public Health  
 Sarah Cottingham, Iowa Foundation for Medical Care

\*Health and Long-Term Care Access Advisory Council Web site [http://www.idph.state.ia.us/hcr\\_committees/care\\_access.asp](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. Michelle provided an overview of today's agenda.
Iowa FLEX Program Overview  Kate Payne, IDPH Andria Seip, IDPH  Presentation available at <a href="http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20101028_flex.pdf">http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20101028_flex.pdf</a>	<p>Kate Payne and Andria Seip, Iowa Department of Public Health, presented an overview of the Medicare Rural Hospital Flexibility Program (FLEX program). The FLEX program was created by the Balanced Budget Act of 1997 and was modified twice: once in 1999 and once in 2003.</p> <p>Centers for Medicare and Medicaid Services (CMS) provide a cost based reimbursement to Critical Access Hospitals at a rate of 101 percent of reasonable cost for inpatient and outpatient services. States are eligible for grant funding through HRSA. States are eligible up to \$750,000 annually. Iowa received close to \$600,000 this year.</p> <p>The program provides funding for Critical Access Hospitals (CAH) and to the States to assist CAH's in grant specified areas. Requirements for designation of a CAH include; 1) more than 35 miles from another hospital, 'Necessary Provider' eligibility sunset in 2006; 2) no more than 25 inpatient beds; 3) average patient stay is less than 96 hrs; 4) must provide 24-hour emergency care; and 5) must develop networks with other hospitals, credentialing and patient referral &amp; transfer.</p> <p>There are 82 Critical Access Hospitals (CAHs) within Iowa. This ranks Iowa as second in the nation behind Kansas which has 83 CAHs. Followed by Minnesota with 79 CAHs.</p>

There are only a few states that are still converting CAHs. Texas is one.

FLEX provided over \$355,000 in grant funding to CAHs last year. Activities the hospitals participated in included health information technology, community meetings and assessments, training on implementation of LEAN, translation of documentation and information, and replacement of computer technology. FLEX also contracted with IFMC to provide Team STEEPS training with seven CAHs and Training Resources to facilitate the annual FLEX conference.

Partners with the FLEX program include:

- IFMC (Iowa Foundation For Medical Care)
  - QIO (Quality Improvement Organization)
  - HITREC (Health Information Technology Regional Extension Center)
- Iowa Healthcare Collaborative
- Iowa Hospital Association
- Iowa Department of Public Health
  - Includes: Family Health Services, Tobacco, Cardio Vascular and others

**Questions:**

What do you see as the top issues for CAHs in future years?

Implementing Electronic Health Records (EHR) and meeting Meaningful Use because of the cost burden for some of the hospitals.

How many CAHs are part of a larger network?

I do not have that information handy but we do have that information.

Are the smaller non-network CAH at a disadvantage with EHR and Meaningful Use?

Not really because there are many factors that are involved with EHR and Meaningful Use.

Is there a public policy gap that could be addressed by this council or recommended to policy makers?

Continuing programs like the health information technology programs at Des Moines Area Community College and Kirkwood Community College. Also, providing grants for training along with incentives for staying in rural communities.

Are there any issues with the 340B (discount prescription drug program) program and public policy?

We are currently learning the details of the program and what type of effect it will have.

What are the implications for other provider types, including skilled nursing facilities, nursing homes, mental health facilities, etc., have to meet Meaningful Use/EHR?

Yes, eventually all providers will be required to meet Meaningful Use/EHR to receive Medicare or Medicaid payments. This will be implemented by utilizing a phased-on approach. Different types of providers will have different criteria to meet Meaningful Use.

There is an infrastructure issue with EMS. We might want to have the EMS bureau chief present to the group.

What should we be thinking about regarding the available data and are the data everything we want it to be?

The Iowa Healthcare Collaborative's data committee discusses this issue. The data collected from participating hospitals are available on the website, <http://www.ihconline.org>. The committee looks at national standards/indicators and what indicators the National Quality Forum endorsed.

Kelly Piper is the person to contact regarding Medicaid Meaningful Use.

<p>Member sharing Information and Awareness</p> <p>Michelle Holst, IDPH</p>	<p>Members shared the following information.</p> <p>Advisory Council on the Iowa Physician Workforce, University of Iowa, conducted a relocation study and has been looking at retention. A sub-group of the council is focused specifically on retention and has discussed the possibility of a retention toolkit. We see these activities as a collaborative effort with different associations, societies, academies, and stakeholders. The council will meet again in January/February 2011.</p> <p>The Area Health Education Center grants were not funded. Efforts are being put into place to sustain activities until the next opportunity to obtain grant funds. This could potentially have implications for the strategic plan.</p> <p>Iowa was one of six states awarded a grant to develop a Personal and Home Care Aide State Training Program (PHCAST). This grant provides 3-years of funding, \$748,000/year, to pilot a program to implement the recommendations of the Direct Care Worker Advisory Council. The department will seek partnerships to participate in the pilot and there will be an application process to participate.</p> <p style="padding-left: 40px;">Why were the CNAs left off the grant and what was the rationale? This was due to the federal grant requirements and specifications.</p> <p style="padding-left: 40px;">There was another grant that included home health and certified nurse aides.</p> <p>Mary Mincer Hansen, RN, Ph.D., was <a href="#">appointed</a> to the <a href="#">National Health Care Workforce Commission</a>. The Patient Protection and Affordable Care Act gave the Comptroller General of the United States responsibility for appointing 15 members to the National Health Care Workforce Commission.</p> <p>2012 Strategic Plan component discussion</p> <ul style="list-style-type: none"> <li>• Barb Nervig is leading the efforts to complete the Certificate of Need plan.</li> <li>• Health Care Data Resources plan is being developed with Jim Goodrich.</li> <li>• Gloria Vermie is leading the efforts to complete the Rural Health plan.</li> <li>• The department received approval to move forward with codifying the Center for Health Workforce.</li> <li>• Agendas and dates have been arranged for meetings with other agencies with workforce overlap.</li> <li>• Louis Lex will be presenting on Community Health Needs Assessment and Health Improvement Plan (CHNA &amp; HIP) via webinar November 16, 2010. The time is yet to be determined but most likely will be held over the lunch hour. Additional information on CHNA &amp; HIP is available at <a href="http://www.idph.state.ia.us/chnahip/default.asp">http://www.idph.state.ia.us/chnahip/default.asp</a>. [Note: webinar was postponed.]</li> <li>• The next council meeting is scheduled for Wednesday, January 26, 2011, if drafts of the individual plans are available. If not, the meeting will be scheduled in February 2011. The draft Strategic Plan is scheduled to be complete in June or July 2011.</li> </ul> <p>Bobbretta Brewerton indicated that Primary Health Care received a grant that allowed them to remodel. Because of the remodel, Primary Health Care was able to double their number of patients/clients served. They also have capital improvement project for improvements of the eastside facility and the Marshalltown site received ARRA funding to relocate the dental clinic because of space constraints. The new access point grant will allow a facility in Story County.</p>
<p>e-Health Project Update</p> <p>Leslie Grefe, IDPH Karith Humpal, IDPH</p> <p>Presentation available at</p>	<p>Leslie Grefe and Karith Humpal presented an e-health update to the council. Leslie has been with e-Health since 2009. There are two primary aspects of e-health, electronic health records (HER) and state-wide health information exchange (HIE).</p> <p>Funding was available through ARRA at approximately \$8,375,000. Before the funding can be utilized a strategic and operational plan must be submitted and approved. The plan</p>

[http://www.idph.state.ia.us/hcr\\_committees/commo/pdf/care\\_access/20101028\\_ehealth.pdf](http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20101028_ehealth.pdf)

was finalized in May 2010 with ten major goals. The plan is pending approval and a second addendum was submitted October 8, 2010. e-Health has contracted with Hielix-Mednet to develop a business plan. The plan is required and due by March 2011.

A Notice of Intent was issued to ACS to develop the HIE infrastructure. We are currently in contract negotiations with ACS. A baseline environmental scans is being completed.

Trends in health care delivery and technology include EHR, HIE, health information technology workforce, medical home model, and distance care technologies. One of e-Health's main goals is to advance coordination of activities across state and federal government programs.

Providers, ambulatory care clinics, are different stages throughout Iowa in regards to EHRs. Fifty-two percent of providers are utilizing paper records, 46 percent are utilizing a type of EHR, and 2 percent are utilizing a computer based system.

Is there anyone looking at other providers like skilled nursing facilities?

The University of Iowa is conducting some baseline assessments for home health care, long-term care, radiology, laboratories, and pharmacies. At the next advisory meeting the researcher will present the basic findings.

Did you have a definition of an electronic health record?

There was a definition associated with the electronic health record questions within the assessment. There were additional/breakdown questions associated with the question regarding EHRs.

The HIE is basically a hub where information can be exchanged. It is not a repository to store data/information. Data moves across the exchange only if someone requested the data or if someone pushed the data through. There is a future option for a patient portal where individuals can access their information. There is an upward trend in the operational HIE in the last few years. From 2004 – 2010 HIE is up from 9 in 2004 to 73 in 2010 operating in the U.S.

Health Information Technology (HIT) workforce is the combination of health care with technology. HIT workforce is seeing double the projected growth of other workforce sectors.

Medical home has evolved within the state over the past few years. Medical home and e-Health can increase quality and care by reducing cost, utilize real time information to monitor and treat chronic conditions. Pilot projects for medical home have expanded across the state. When looking at the medical home trend, we will look to the recommendations of medical home advisory council.

Distance care technologies (telemedicine) in Iowa have grown from 14 users in 2004 to 66 users in 2010. However, there are still reimbursement issues with distance care technologies (telemedicine). The Midwest Rural Telemedicine Consortium, private sector through Mercy Health Network and Trinity Health Services, provide interactive services and specialty care in over 20 medical specialties.

IHA has reimbursement for telemedicine on the legislative agenda for this coming year's legislative session.

When developing the HIE has the HIPAA regulations offered any particular challenges?

The most recent HIPAA guidance classifies the HIE as a business associate of the provider organizations. At minimum, everything is qualified by HIPAA. But what is heard and seen in other states is that it is important to go further when talking about patient consent. We think from a HIE perspective that we need to go beyond HIPAA.

<p>Health Information Technology Regional Extension Center</p> <p>Sarah Cottington, Iowa Foundation for Medical Care</p> <p>Presentation available at <a href="http://www.idph.state.ia.us/hcr_committees/commo_n/pdf/care_access/20101028_ifmc.pdf">http://www.idph.state.ia.us/hcr_committees/commo_n/pdf/care_access/20101028_ifmc.pdf</a></p>	<p>Sarah Cottington, Iowa Foundation for Medical Care, Health Information Technology Regional Extension Center (HITREC) gave an overview of Meaningful Use. Sarah is a quality improvement advisor with the hospital team at the HITREC. They have been tasked to work directly with critical access hospitals and rural hospitals in Iowa.</p> <p>The American Recovery and Reinvestment Act (ARRA) contained the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act was established to improve health care quality safety and efficiency through the promotion of health information technology. Under HITECH, eligible health care professional and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology. Two regulations have been released which are meaningful use objectives and technical capability requirements for the certified EHR.</p> <p>The timeline for HITECH is; 2009 HITECH Policies; 2011 Stage 1 of meaningful use criteria; 2013 Stage 2 of meaningful use criteria; and 2015 Stage 3 of meaningful use criteria.</p> <p>Certified EHR technology required to achieve meaningful us standards and certification criteria was announced on July 13, 2010. A current list of certified EHRs is available under the temporary certification program <a href="http://onc-chpl.force.com/ehrcert">http://onc-chpl.force.com/ehrcert</a>.</p> <p>Medicare eligible providers are MD, DO, DDS, DDM, DPM, OD, and DC, Eligible hospital are acute care hospitals and critical access hospitals. Eligible providers could receive up to \$44,000 in incentive payments over five years. To receive the full amount eligible providers have until the 4<sup>th</sup> quarter 2012 to start the program.</p> <p>Medicaid eligible providers are physicians, nurse practitioners, certified nurse midwives, dentists, physician assistants working in a FQHC or rural health clinic that is also led by a PA. Eligible hospitals are acute care hospitals and critical access hospitals. Eligible providers could receive up to \$63,750 in incentive payments over six years. The requirement for incentive payments is adopt, implement and upgrade.</p> <p>Where do home care, skilled nursing, hospice, and such fall into this? Currently there are no incentive payments for those practice areas.</p> <p>Where does the incentive money come from? It was funded through the American Recovery and Reinvestment Act (ARRA).</p> <p>Medicaid incentives are based on patient volumes. A calculator is available to calculate your potential incentives. The Medicare and Medicaid EHR Incentive Payment Calculators are available on the <a href="http://www.iowahitrec.org">http://www.iowahitrec.org</a> website.</p> <p>Stage 1 of meaningful use includes meeting certain objectives, 80 percent of patients must have records in the certified EHR; eligible providers must report on 20 of 25 meaningful use objectives; and eligible hospitals must report on 19 of 24 objectives.</p> <p>What about penalties? Must demonstrate meaningful use by 2014 or penalties will begin in 2015. A one percent reduction in the Medicare physician fee schedule and if course isn't corrected, an additional one percent in 2016 and again in 2017. Enrollment for Medicare is estimated to begin January 1, 2011.</p> <p>Where can Iowa providers get help? Iowa providers can receive assistance through Iowa HITREC at Iowa Foundation for Medical Care. Services provided include technical assistance, vendor relationships, education, outreach, practice &amp; workflow redesign, health information exchange, privacy and security, along with additional resources. Beginning in 2011 services for "non-grant" providers will include technical assistance packages.</p> <p>There are 62 regional extension centers funded through The Office of the National</p>
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	<p>Coordinator for Health Information Technology (ONC). ONC is organizationally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS).</p> <p>How do you prioritize who needs help or services? When completed a priority matrix. Providers must sign a service agreement with IFMC. We are also in a recruitment stage and it is kind of first come first served.</p> <p style="padding-left: 40px;">They could hire an outside consultant but you would be hard pressed to find prices that are better than what the regional extension center is offering because it is so subsidized by the Federal Government at this time.</p> <p style="padding-left: 40px;">A benefit to providers for using the regional extension center is that when the health information exchange is rolled out they have been working closely with Medicaid and the extension center that we look to them to decide which system to bring on next. We want to make sure the providers using the extension center services are completing the full process. This is a plus for the providers because it will help them get on the health information exchange sooner.</p> <p style="padding-left: 40px;">Also, within the health information exchange patients can opt-out if they so choose.</p>
<p>Public Comment</p>	<p>Telehealth/distance care, in addition to reimbursement issues, Critical Access Hospitals continue to have issues with peer credentialing. Is IHA doing anything with that? We have been working with the American Hospital Association and have been some discrepancy between the joint commission, CMS and the credentialing telehealth providers. I think now where it stands is that hospitals will be able to accept all the initial material from the telehealth provider. They will still need to take it through their process/medical committees.</p> <p>The Board of Medicine is looking at regulations in the area of telehealth. The Board of Medicine has had a policy statement on telemedicine for years and there has been talk about revisiting it.</p>
<p>Facilitated Conversation “Critical Access hospitals/FLEX Program and Delivery Infrastructure” “eHealth and HIT REC Impacts on Delivery Infrastructure”  Michelle Holst, IDPH</p>	<p><b>Based on what you have heard today and the requirements within the strategic plan, what has stood out to you today?</b></p> <p>There are many different stages of this and much of the initial work is being done with providers and hospitals and heard some recognition for need for long-term care facilities and that is not there. Although, I don’t know if that is a state policy issue as it is a federal issue.</p> <p style="padding-left: 40px;">I’m pretty sure there are requirements for long-term care but am fuzzy on the timing of it. It sounds as if it is not as high a priority as acute care which it shouldn’t be. Nonetheless, it is something we shouldn’t forget.</p> <p style="padding-left: 40px;">The same is true for pharmacy. Pharmacy is a big component of e-prescribing and there are no incentives for pharmacies.</p> <p>There is a barrier in the reimbursement initiatives with the payments coming on the backend. This could be financially challenging for many providers and hospitals. It would be nice if there were some upfront incentives or funding.</p> <p>The use of the electronic records, We are aiming at a moving target for the population of Iowa. I cannot see anything that will stop the decrease in population in rural areas. The use of electronic records and distance care needs to be targeted to the rural population at some point in the future.</p>

Another piece of information that really struck me is the open health information technology jobs.

These are open mainly because there is a lack of skill or training for these positions. Thus, this could be a focus in our state that people do get these skills. There could be some type of training programs(s) for these types of positions.

IWD conducts their projections on the categories defined by the Department of Labor. This can create difficulties in predicting the types of jobs that will exist in the future that do not exist now. The categories used now may not be the same as the categories that will emerge.

Has there ever been an adjustment in the number of beds per provider/caregiver to meet the workforce we have?

The last adjustment in the number of beds came with the Critical Access Hospital program came into effect. Although, with medical home and how health care is going to be delivered, that is all starting to be looked at again.

Are we asking a team to take care of say 10 beds today where in the past we asked them to care for 5?

The nurse per patient data has gotten better the past 10 years. As far as fewer patients per nurse.

Do you know if once electronic health records are more commonplace, does that enable a nurse to care for more patients?

At this point in time, no. It still takes a huge amount of time for documentation regardless if it is paper or electronic.

**When you think about Iowa’s strategic plan and the Federal requirements and timeframes for electronic records, what do you think would be goals or strategies to put forward? Or, is most of this being addressed by the e-health initiative?**

Cross training between medical and technological. Education funding for the implementation of EHR.

Something we have to keep in mind is the funding of the whole thing. It is going to cost a whole lot of money in the short term and we can’t ignore that fact even if there is a reward coming years down the road. Some resources need to be diverted to training, hardware, software, and all these things is going to cause short term hardships.

Another issue is how quick the government wants to implement EHR and HIE. They never seem to meet the deadline that they set for themselves.

The early adopters of electronic records might have to replace their current system if it doesn’t meet the certification guidelines.

Part of the planning for Iowa e-Health is to develop a workforce plan and layout a way to tackle that situation. ONC is looking more towards the community colleges and universities to take the lead on the workforce programs. There have offered grant opportunities that community colleges have been able to apply for yet there has not necessarily been an opportunity that a state-wide entity would apply for. This has shifted Iowa e-Health’s thinking about how can we coordinate with community colleges and universities that receive the grant funds.

Something the workgroup is working on it to create a matrix to identify education/workforce competency. The next step would be discussing the matrix with other groups that could use the matrix as competency for their educational programs.

**What direction is this group taking is a question that Michelle has been asked a few times. People have commented that the discussion/topics have become overly broad.**

	<p><b>Do we want to do more targeted discussions on the remaining components of the strategic plan?</b></p> <p>Someone needs to look at the entire realm of the health care industry within Iowa and record the needs of the state. But this maybe outside the scope the legislature had for this group.</p> <p style="padding-left: 40px;">I don't think this is outside the scope. I think it is exactly what they told us to do.</p> <p style="padding-left: 40px;">The challenge is to look at it state-wide.</p> <p style="padding-left: 40px;">Does this begin to touch on/get into Healthy Iowans?</p> <p style="padding-left: 40px;">Need to look at alternative ways to provide services, etc. I believe there are untapped resources in the county health departments that if utilized, partnerships with facilities and providers, could make those things that didn't work before work a lot better.</p> <p>At some point in the future we are not going to be able to afford a critical health center in each county because the population base will not be able to support it.</p>
<p>Next Steps <i>Plans for future meetings</i></p> <p><i>Conclusions/directions from today</i></p> <p>Michelle Holst, IDPH</p> <p>Members</p>	<p>The Iowa Department of Public Health, Bureau of Health Care Access is hosting a recruitment and retention workshop in Des Moines on December 1, 2010.</p> <p>Presentations requested at future meetings:</p> <ul style="list-style-type: none"> <li>• Medical Home System Advisory Council update</li> <li>• Prevention and Chronic Care Management Advisory Council</li> <li>• Iowa Board of Medicine</li> <li>• CHNA-HIP – Louis Lex, IDPH</li> <li>• Personal Health Information\Records.</li> </ul> <p>A clinic organization in Virginia is giving all their patients a flash drive with their personal health information\recrods.</p> <ul style="list-style-type: none"> <li>• When the Rural Health Resources Plan (Rural Health Safety Plan) is ready to be reported, the RHPC Advisory Committee and the HLTCA Advisory Council could hold another joint session.</li> <li>• Have a presentation on Safety Net</li> </ul> <p>Future meetings formats could be online meetings/webinars and small workgroups to complete specific tasks/projects.</p>

**Next meeting:** Wednesday, January 26, 2011, 10:00 a.m. to 3:00 p.m.  
Location: Urbandale Public Library, Room A