

Minutes  
 Health and Long-term Care Access Advisory Council  
 April 26, 2011  
 10:00 a.m. – 3:00 p.m.  
 West Des Moines Learning Resource Center

**Members Present**

Roy Bardole  
 Libby Coyte  
 Brian Farrell  
  
 Ryan Hopkins  
 Laura Malone  
 Catherine Simmons

**Members Absent**

Carol Alexander  
 Cindy Baddeloo  
 Bobbretta Brewton  
  
 Shelly Chandler  
 Michele Devlin  
 Wendy Gray  
  
 Steve Johnson  
 Brian Kaskie  
 Susan Lutz  
 Leah J. McWilliams  
 Daniel Otto  
 Jill Scott-Cawiezell  
 Julie Stauch

**Others Present**

Michelle Holst, Iowa Department of Public Health  
 Kevin Wooddell, Iowa Department of Public Health  
 Doreen Chamberlin, Iowa Department of Public Health  
 Sandy Nelson, Iowa Medical Society  
 Michele Greiner, Iowa Psychological Association  
 Angie Doyle-Scar, Iowa Department of Public Health  
 Abby McGill, Iowa Department of Public Health

\*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.
Prevention and Chronic Care Management Advisory Council  Angie Doyle-Scar, Iowa Department of Public Health  Presentation available at <a href="http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20110426_chronic_care_presentation.pdf">http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20110426_chronic_care_presentation.pdf</a>	<p>Angie Doyle-Scar presented an overview of the <a href="#">Prevention and Chronic Care Management Advisory Council (PCCM)</a> and their activities. The council was created with legislation in 2008 (HF 2539) – Iowa Code <a href="#">§135.161</a>. The PCCM works closely with the Medical Home Advisory Council.</p> <p>The initial legislative charge of PCCM was to recommend strategies to improve health promotion, prevention, and chronic care management; identify two chronic disease priorities for the state of Iowa; and submit recommendations to legislature July 1, 2009. The initial recommendations of the council are:</p> <ul style="list-style-type: none"> <li>• Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management.</li> <li>• Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses.</li> <li>• Identify and recommend consensus guidelines for use in chronic care management beginning with those that address the state's chronic disease and prevention priorities.</li> <li>• Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices.</li> <li>• Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination.</li> <li>• Improve the health workforce and their skills in prevention and chronic disease management.</li> </ul> <p>The <a href="#">First Report to the Director and State Board of Health</a> is available on the PCCM webpage. Since the release of the initial report, a seventh recommendation has been</p>

	<p>added which is: <i>Create a societal commitment to health through implementing policies to remove barriers that prevent Iowans from leading healthy lives. Empower and expect Iowans to take personal responsibility for being as healthy as genetically possible and improving their own health, as well as the health of those around them.</i></p> <p>The council also developed prevention priorities and chronic disease priorities. Prevention priorities include obesity, cancer, coronary artery disease, diabetes, hypertension, and mental illness. The chronic disease priorities parallel the prevention priorities and include cancer, congestive heart failure, diabetes, hypertension, and mental illness.</p> <p>Immediate activities following the report include hiring full-time staff, review of membership, add new members, and creation of two subgroups – 1.chronic disease, 2. Prevention.</p> <p>After the initial report the council wanted to start implementing their recommendations. One way the council decided they could move implementation along was to create issue briefs that would educate policy makers about the issues. The first issue brief created was on chronic disease which outlines the cost of chronic diseases, where it is headed and why we need to get a handle on it. The next issue briefs were on creation of a disease registry and the third on prevention. Future issue briefs will include social determinants, care coordination, and community utility. All the issue briefs are available on the PCCM webpage.</p> <p>Two new legislation charges from last legislative session are:</p> <ul style="list-style-type: none"> <li>• HF 2144 - the council shall recommend, no later than December 15, 2011, strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities.</li> <li>• SF 2356 - The department of public health shall work with all appropriate entities to develop a plan for coordination of care for individuals with diabetes who receive care through community health centers, rural health clinics, free clinics, and other members of the Iowa collaborative safety net provider network.</li> </ul> <p>Additional activities of the council include engaging partners through numerous presentations; Edward Wagner Event with University of Iowa; Healthy Links Advisory Committee; medical home/multi-payer initial discussions; Healthy Polk 2020 &amp; Healthy Iowa 2020; ACA grant applications; CHOP CHOP; COPD/Asthma/Safety Net Collaborative/ Cancer Consortium/ Iowans Fit for Life; and the health benefits exchange project.</p> <p><b>Questions:</b> How is the disease registry different from a diabetes registry or stroke registry? The council would like to have a registry available for free or low-cost to all clinics in Iowa. The information would be de-identified and transferred to a state registry for use in population based care at the state level. So, the registries would be for population health on both, a clinic level and a statewide level.</p>
<p>Medical Home System Advisory Council</p> <p>Abby McGill, Iowa Department of Public Health</p>	<p>Abby McGill presented an overview of the <a href="#">Medical Home System Advisory Council</a> and their activities. The council was created with legislation in 2008 (HF 2539) – Iowa Code <a href="#">§135.159</a>.</p> <p>The council developed <a href="#">recommendations</a> for the Iowa General assembly in March 2009. The council recommended to build, spread, and sustain the Patient-centered Medical Home model (PCMH) to benefit all Iowans. Initial recommendation include:</p>

Presentation available at [http://www.idph.state.ia.us/hcr\\_committees/commo/pdf/care\\_access/20110426\\_medical\\_home\\_presentation.pdf](http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20110426_medical_home_presentation.pdf)

- Continue to develop and sustain the Iowa Medical Home System Advisory Council to promote the PCMH concept as a standard of care for all Iowans.
- Encourage and support the identification and implementation of a multi-payer reimbursement model that supports the PCMH.
- Support the current efforts to implement and expand the PCMH through existing infrastructures that educate providers and demonstrate best practices.
- Support health reform initiatives that address health care workforce needs, health care information technology, prevention, and chronic care management.

Iowa's medical home definition: A team approach to providing health care

- primary care setting
- partnership among patient, provider, other health care professionals, and the patient's family when appropriate
- utilizes medical and non-medical services needed by the patient and family
- centralized, comprehensive record of all health-related services to promote continuity of care
- includes the following characteristics: a personal provider; a provider-directed medical practice; whole person orientation; coordination and integration of care; quality and safety; enhanced access to health care; and payment.

The PCMH system will strive to:

- reduce disparities in health care access, service delivery, and health status
- improve quality of health care and lower health care costs

The council created four workgroups (certification, education, reimbursement, and policy) to address and further develop the recommendations. Each workgroup has a chairperson that forms the leadership team along with the council chairperson. The leadership team meets regularly via conference call.

There are currently two medical home pilots in progress across Iowa. The first pilot is the 0-5 patient-centered medical home pilot. The goal of the pilot is to gain an understanding of the requirements needed to create a patient-centered medical home for children age 0-5. Visiting Nurse Services of Iowa (VNS) partnering with Iowa Health Physicians Walnut Creek Pediatrics was chosen to provide access to the community resources. Initially this was a six-month pilot from March 1 to September 30 but additional funds were secured to extend the pilot an additional year. During the first six months the project served 458 children at Walnut Creek Pediatrics. They provided additional screening and care coordination services to 19 percent of their 2,400 patients during well child check-up who normally would not have such services. The measures used to evaluate this pilot are TransforMED survey, screening tools, care coordination encounters, family care plans, and family satisfaction surveys.

The second pilot is the IowaCare medical home pilot. This pilot was established under SF 2356 in 2010. The two goals of the pilot are to phase in Federally Qualified Health Centers as primary care providers and to comply with certification requirements of a medical home. The first phase of the pilot assigned 2,500 members of IowaCare to a medical home. At the medical home, members received routine care, preventative services, and disease management at four different clinics (Siouxland Community Health Center in Sioux City, Peoples Community Health Clinic in Waterloo, Broadlawns Medical Center in Des Moines, and University Hospitals and Clinics in Iowa City).

#### Questions:

What is the definition of medical home/

[Iowa's official definition of medical home](#) was voted on and approved by the council. Each state usually has their definition of medical home.

The standards for medical home are established by [National Committee for Quality Assurance \(NCQA\)](#).

Does the NCQA approve each state's definition of medical home?

	<p>No, they do not approve each state’s definition. They approve the nine different standards that are submitted to assure they are qualified medical homes.</p> <p>Iowa is currently in the rule-making process to adopt the NCQA standards for medical home. Therefore, clinics seeking to become state-certified in Iowa would need to meet NCQA standards.</p> <p>The IowaCare medical home coverage map concerns me because if you look at the population and the age of the population there is a big C in Iowa. This really leaves out the declining population and elderly population of Iowa.</p> <p>This is the initial rollout and Medicaid is expanding across Iowa. The goal is to add additional sites and coverage across Iowa.</p> <p>Medicaid planned on having most of the state covered by this time. However, the enrollment numbers were approximately twice as high as they expected. This is why they haven’t expanded as they anticipated. There is also a cap on the number of enrollees in IowaCare. The FQHCs involved in the project experienced challenges with scheduling all of the new patients, and noticed that the new patients required longer visits.</p> <p>I would suggest it might be a very productive exercise to identify the school districts and the percent of free-and-reduced meals which will pin point the Medicaid population that aren’t even using that program. Sometimes it is really telling how the poverty pockets in the state show up but only show up in only the free-and-reduced meals in the school systems.</p> <p><b><i>What are the important points from these two councils/efforts that could be included in our 2012 strategic plan?</i></b></p> <ul style="list-style-type: none"> <li>• A workforce that meets demand,</li> <li>• effective/reliable transportation,</li> <li>• clinic location, mental health,</li> <li>• medical records,</li> <li>• electronic medical records,</li> <li>• acceptance of medical home concept,</li> <li>• expectations of patients,</li> <li>• capacity and number of facilities,</li> <li>• technology/e-health/telemedicine (located within facilities),</li> <li>• oversight, quality assurance, accreditation,</li> <li>• training of new professionals,</li> <li>• community utility, enhanced care coordination,</li> <li>• scope of practice,</li> <li>• the concept of patient-centered care.</li> </ul>
<p>Review of Overall Charge and Priorities</p> <p>Michelle Holst, Iowa Department of Public Health</p> <p>Iowa Code <a href="#">§135.163</a> and Iowa Code <a href="#">§135.164</a></p>	<p>Michelle Holst presented a review of the overall charge and priorities of the advisory council.</p> <p>In February 2009, the council approved a mission and vision.</p> <p>The mission of the council is: <i>“The council will assist the Iowa Department of Public Health to develop, update and monitor a strategic plan for implementation of health care delivery infrastructure and health care workforce resources and inform and advise the department and policymakers regarding issues relevant to health care access for</i></p>

Presentation available at [http://www.idph.state.ia.us/hcr\\_committees/committee/pdf/care\\_access/20110426\\_priorities.pdf](http://www.idph.state.ia.us/hcr_committees/committee/pdf/care_access/20110426_priorities.pdf)

*Iowans.*”

The legislation/code indicates the strategic plan for health care delivery infrastructure and health care workforce resources shall describe the existing system; describe & provide rationale for the desired health care system; provide an action plan for implementation; and provide methods to evaluate the system. All of the requirements of the plan can be found in Iowa Code [§135.164](#) or the highlights are available in Michelle’s presentation.

The logic model included in the strategic plan outlined components to include in the 2010, 2012, and 2014 strategic plans. The components to include in the 2012 plan are:

1. system assessment & objectives component
2. health care facilities & services plan
3. health care data resources plan
4. assessment of emerging trends in HC delivery & technology
5. rural health care resources plan
6. health care workforce resources plan (continue, revisit)

The vision of the council, for the first Phase of the process was: “*Assure a diverse, sustainable, and well-qualified workforce that provides access to quality health care for all Iowans.*” This was appropriate at the time due to the focus on workforce.

In Iowa Code [§135.164](#), several sentences in subsection 2, also set forth a list of “guiding principles” for the strategic plan. The council also added “guiding principles” in addition to those in statute:

- *Addressing underserved populations and resources*
- *Assuring affordable health care*
- *Assuring optimal coordination between primary and specialty care.*

The council’s report to IDPH contained six goal areas. The department’s initial strategic plan contained the following three recommendations, consistent with the first-phase focus on workforce:

1. Codify the Iowa Health Workforce Center as the state’s coordination point to address health workforce concerns in Iowa.
2. Target and fund loan repayment and other recruitment and retention efforts to attract and retain health and long-term care professionals to underserved areas and underserved populations.
3. Support educational institutions, including Area Health Education Centers.

The first recommendation was amended out of the department’s omnibus bill this session in a House Subcommittee. The second recommendation, there have not been many programs funded. The third recommendation may move forward with an appropriations bill (SF 58) that would appropriate funding towards AHECs.

**Questions:**

What is more workforce intensive the preventative care of the chronic problems or the acute care if the preventative care isn’t dealt with?

On the surface it appears like the primary care and prevention will be more intense. But is that because it is more intense or because more people coverage and are accessing care.

Is there an advocacy part in our charge?

The “charge” as it was set forth in statute doesn’t mention advocacy as a requirement on the part of council members. Council members may choose to advocate for strategic plan goals and objectives, but it is not a statutory “charge”.

	<p>What was the concern with the Iowa Health Workforce Center? Michelle Holst did not know for sure why the language was removed.</p>
<p>Facilitated Conversation To Incorporate today's Information</p> <p>Facilitated Conversation Results/Feedback from Questionnaire</p> <p>Michelle Holst, IDPH</p>	<p>The council reviewed the list of prior presentations that were presented to the council. Iowa e-Health's and the e-Health assessment; Iowa Care; Direct Care Worker Advisory Council; Rural Health and Primary Care Advisory Council; Certificate of Need; Iowa Workforce Development's ARRA workforce planning grant (not funded); Iowa FLEX program; Iowa Office of Health IT.</p> <p><b>Questionnaire</b></p> <p>Michelle Holst asked council members to spend time reviewing the questionnaire distributed to the council.</p> <p><i>Member Comment:</i> We should think about the recommendations that were put forward and that nothing really became of them. There was a lot of time and energy put forward by the department and staff. It was like – putting out a policy that sounds good and looks good but doing nothing about it.</p> <p>There have been some major changes in the policy making landscape and administration since the council and department developed the recommendations. There is a need to reeducate about health and long-term care access issues and workforce issues and determine policy directions.</p> <p>After council members reviewed the questionnaire, brainstorming discussion generated the following responses. Further work will be completed to gather additional responses from absent council members. <i>The following does NOT represent finalized consensus:</i></p> <ol style="list-style-type: none"> <li>1. Membership on this council – correct constituencies? Changes needed? <ul style="list-style-type: none"> <li>• Council membership not specified in Iowa Code</li> <li>• Meetings more project based in smaller groups. <ul style="list-style-type: none"> <li>○ Bring members in, based on their expertise, on a project-based basis. This has worked well on the Medical Home System Advisory Council and the Prevention and Chronic Care Management Advisory Council.</li> <li>○ Use flexible membership and expand constituencies represented as needed, depending on the item of focus.</li> <li>○ Potentially add allied health/support staff functions as representatives</li> <li>○ Planning, solutions, goals, recommendations</li> <li>○ Have specific/defined projects that address areas the legislature agrees are problems.</li> </ul> </li> <li>• Health professions – understand impact of changes to the system specific to their expertise. <ul style="list-style-type: none"> <li>○ General practitioner (MD/DO)</li> <li>○ Specialists on a project basis, depending on the issue</li> </ul> </li> <li>• Conduct meetings via webinars?</li> </ul> </li> <li>2. Provide top 3 to 5 public policy items you think should appear as goals in the 2012 Strategic Plan. <ul style="list-style-type: none"> <li>• Electronic medical/health records</li> <li>• Telemedicine</li> <li>• Promote real-time exchange of patient health information</li> <li>• Establish a plan to improve workforce in three areas: mental health, dentistry, rural and urban primary care</li> </ul> </li> </ol>

- Realistic understanding of statewide workforce – what the needs are projected forward (not today’s snapshot)
- Support health literacy initiatives for patients and caregivers (so they can gain access, know where to go, how to get to services) help individuals understand health insurance. Patients need to be informed and educated and need to understand their chronic disease and care plan
- Providing the right care at the right place in the right setting  
Making sure we have the right resources, that people understand the resources available to them, the hospital isn’t necessarily the first place to turn would help with costs
- Establish a way to work with health benefit exchange so patients know how to navigate it needs to be more than just state-level how does it intersect with local boards of health and local communities so there is better dissemination of information.
- Increase use of pilot testing and best practices prevention/registries (HITREC as example) increase information dissemination about good practice to communities
- Evaluate policies and processes and develop cost-benefit analysis. If a policy or process does not improve quality of care, why do it? Reduce/eliminate non-value-based regulations.

3. What is in the way of these items being achieved?

- Policymakers being so far removed from the user level that they lack the basic understanding of how it works or is delivered. This can result in policies that are not cost effective or user practical because of bad decisions or information during policy development.
- Difficulty involving front-line expertise in policy-development constituents not empowered/informed about how to inform policy makers
  - This is a barrier we can help with through written material, education, etc
- Communications – getting the real message through
  - Advocates to policymakers
  - Health care professionals to patients
    - Inconsistent delivery of materials or the right materials
    - Failure to identify and engage the right people in communication
- Individuals’ motivation to comply with health recommendations
- Societal barriers
  - Healthy food choices can be more expensive (e.g. 4 boxes of mac & cheese for \$2.00 same servings of broccoli \$40.00)
  - Wellness plans/programs – insurance will pay for treating health problems, but will not pay health club memberships (prevention)
- Mental health/stress management treatment stigma leads to less healthy coping mechanisms (alcohol, overeating, etc.)
- Definition of “right care/right setting” is not agreed-upon

4. How would you advocate – what tools would you need?

- Educating legislators by providing written material, face-to-face meetings, or other means.
- Each member knows their area of specialty and can communicate that to the appropriate people.
- An advocacy plan for the council overall. Create a consistent message for this council. What is that message?
- Need a good set of talking points backed up by facts
- Stories to illustrate the points and/or successes
  - Even better if constituents tells the story to policymakers
- How do we communicate with/to the general public and the media (consider a broader audience)

**Next meeting:** To Be Announced