MINUTES

Prevention and Chronic Care Management Advisory Council

Thursday, January 20th, 2011

10:00 am – 3:00 pm

YMCA Healthy Living Center

Members Present	Members Absent	Others Present
Bill Appelgate	Jose Aguilar	Angie Doyle-Scar
Krista Barnes	Eileen Daley	Abby McGill
Marsha Collins	Melanie Hicklin	Jill Myers Geadelmann
Ana Coppola	Karen Loihl	Sara Schlievert
Steve Flood	Teresa Nece	Laurene Hendricks
Della Guzman	Suzan Simmons	Sarah Dixon Gale
Terri Henkels	Steve Stephenson	Mark Grey
Jason Kessler	David Swieskowski	Michele Devlin
Janelle Nielsen	Jenny Weber	Anne Kinzel
Noreen O'Shea		Heth Bronson
Patty Quinlisk		Carlene Russell
Peter Reiter		Kay Corriere
Kim Stewart		
John Stites		
Jacqueline Stoken		
John Swegle		
Debra Waldron		

*** Prevention & Chronic Care Management Advisory Council Website (handouts found here):**
http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp

Handouts:

- Agenda
- Iowa Legislative Health Care Coverage Commission
- Health Benefits Exchanges - An Overview
- Health Benefits Exchanges - Consumer Overview
- Health Benefits Exchanges - Understanding Iowa Exchanges
- Health Benefits Exchanges - Key Implementation Decisions and Activities
- Health Benefits Exchanges - Medicaid Expansion Under the ACA
- Healthy Iowans - Fact Sheet
- Healthy Iowans - Letter to Council
- Real Iowans Research Initiative
- Iowa Center on Health Disparities Presentation

Topic	Discussion
Welcome	• Council members and others present introduced themselves.

Legislative Health Care Coverage Commission
Anne Kinzel
	• The Legislative Health Care Coverage Commission (Commission) has finalized their **2010 Health Commission Recommendations for Presentation to the 2011 General Assembly.**
	• Throughout 2010, the Commission held three official meeting, with numerous workgroup meetings during the year. The Commission will be terminated at the end of the month.
	• Of the 18 new recommendations, a few were highlighted and discussed:
	• Recommendations 1 and 2 relate to the status of high risk pool plan. The existing high risk pool sets the premium at 150 percent and the federal pool sets it at 100 percent. In the federal pool, however, they need to be uninsured for six months. The Commission recommended lowering the premium rate below 150 percent.
	  ○ As of last week 103 Iowans have joined the high risk pool.
	• Many of the recommendations focus on what DHS needs to accomplish before 2014. For example, they would not be able to meet the technology demands to accommodate the additional Medicaid enrollees. The state needs to invest in new technology to add the 30,000 - 40,000 additional enrollees.
	• Recommendation 7- DHS should investigate how the inclusion of behavioral health benefits in a PPACA benchmark plan would impact the delivery and financing of behavioral health services in Iowa.
	• Recommendation 10 relates to PCCM. It maximizes cost containment in health care. Having this data will improve the way we deliver and make decisions about health care in Iowa. It would also improve the health care quality in Iowa
	• Recommendation 11 relates to the Iowa Insurance Information Exchange. This will be a great vehicle to move into the purchasing exchange in 2014.
	• The Commission was united in recommending that Iowa should pursue the Health Benefits Exchange. If Iowa does not do this, the federal government will do it for us.
	• Recommendation 16 is from the Wellness Workgroup:
	  ○ To reach the long term goal of making Iowa one of the healthiest states in the nation with sustainable healthcare costs, the following concrete first steps should be pursued in 2011:
	  1. Instituting an outcomes-based wellness program for the State of Iowa.
	  2. Making use of tax credits to realize a healthier Iowa by:
	  a. Promoting the maximum possible use of the PPACA worksite wellness credits.
	  b. Creating state-based health and wellness tax credits for businesses that do not qualify for federal credits, using the Small Business Qualified Wellness Tax Credit plan (HF 2536) as a model.
	  3. Directing DPH and the Iowa Insurance Division to work together to develop best practices that will allow the incorporation and promotion of worksite wellness programs in Iowa employer-sponsored health insurance.
	  4. Determining how wellness measures can be incorporated into plans that will be sold in a 2014 Iowa Health Benefit Purchasing Exchange.
	  5. Developing a public (Medicaid) and private (insured) Iowa medical home model that incorporates health and wellness promotion.
	  6. Encouraging the Legislature to offer state employees a wellness program.
	• An Iowa Employer Benefits Study was conducted by David Lind, a well respected expert in Iowa on healthcare costs. The Lind report estimates that in Iowa, family coverage will rise significantly by 2020 and the cost for family coverage will range from $34, 337 - $44,895. His presentation can be found here.

	Four workgroups were created to focus on particular aspects of health care coverage. The workgroups include: • **Workgroup I- IowaCare Expansion, Medicaid Expansion Readiness, and High-Risk Pool** will focus on reviewing, analyzing, recommending, and prioritizing options to provide health care coverage to uninsured and underinsured adults. The Workgroup will concentrate on the expansion of the IowaCare program as specified in SF 2356; how to prepare the state for Medicaid expansion set to take place in 2014; and how to maximize the effectiveness of the existing (state) and new (federal) high risk pools in providing care to uninsurable individuals between 2010 and 2014. • **Workgroup II- Value-based Health Care** will focus on how to create opportunities for the most cost-effective use of health care resources throughout Iowa in both the publicly and privately purchased health care. • **Workgroup III- Insurance Information Exchange** will work with the Iowa Insurance Commissioner on the development of the new Insurance Information Exchange. • **Workgroup IV- Wellness** intends to take testimony from 20-30 organizations from both within and outside the state to discuss cutting edge cost-control efforts, including how to design incentives to change behavior for clients that will bend the curve on health care costs. The PCCM Advisory Council has been very involved in the work of the Legislative Health Care Coverage Commission. The PCCM Advisory Council Council's coordinator sat on Workgroup IV-Wellness and offered input in the development of their recommendations. The coordinator also presented to the other Commission workgroups on prevention and disease management initiatives. Additionally, the PCCM Advisory Council coordinator was available to Commission staff throughout 2010 to provide reports, issue briefs, and other information.
Iowa Center for Health Disparities – UNI *Dr. Michele Devlin* *Dr. Mark Grey*	• The Iowa Center on Health Disparities gave their expertise and advice on the current barriers in Iowa to collecting disparities data. Their presentation can be found here: Iowa Center on Health Disparities Presentation. • Some of the major barriers include, but are not limited to: o The unique demographics of Iowa (mostly aging whites, few minorities) o Small sample sizes that limit the validity of calculating incidence and prevalence rates o Potential violation of HIPPA/confidentiality regulations due to small sample sizes, especially by age, gender, disease o Bias towards quantitative research, particularly that collected through impersonal but more efficient methods such as telephone interviews, mailed surveys, and internet o Growing microplurality in state that leads to greater need for more complex and labor intensive methods to collect data in real time for mobile and hard-to-reach populations o Language and literacy barriers o Cultural Barriers –Religious differences –Gender differences –and many more o Transportation and geographical barriers o Legal status differences o Complexity of the term "diversity" – culture, race, ethnicity • The primary strategies to overcome these barriers include: o Reorganization of health data disparities by race/ethnicity o Shift research funding from quantitative methods to qualitative methods (interviewing, focus groups) o Reconsider confidentiality regulations to allow access to data o Oversample some minority populations to allow for larger sample sizes. o As health information questions by race and ethnicity. o May need to make judgement calls on value of data collected through less rigorous means vs. not having any data at all

	○ Increase training and knowledge of data staff on diversity by language and culture ○ Work together with minority and immigrant populations as partners in gathering information Iowa has the perfect demographic storm: - Aging white population - Out-migration of young population- colleges etc. - Urbanization - Lower birth rates among white residents - Higher birth rates among white residents - Higher birth rates among newcomers - In-migration of young Latinos - In-migration of several new and diverse populations Key concepts • Rapid ethnic diversification ○ Growing number of Iowa communities becoming more apparent. • Microplurality- the growing number of smaller ethnically and linguistically distinct groups • The anglo inversion vs. majority-minority- everyone is now a minority, which means nobody is a minority. • The Hispanic population in Iowa is younger than Iowa's total population. The median age difference between Hispanics and whites is 23.2 years. • The Asian population, on the other hand, is older than Iowa's total population. • Des Moines has the second largest Sudanese percentage in the United States. • Employers are shying away from hiring Latinos for fear of their immigration status. ICE has been doing soft raids on them, and they are very active in doing this. The employers are now hiring *legal* immigrants. That is why there is a smaller influx. - The legal immigrants are coming to Iowa because they are being employed/recruited by agricultural and meatpacking plants. They are either refugees or they're American citizens, or part of American territories (pacific islanders). • Iowa now has frontier counties of less than 1 person per square mile. • Iowa is in the process of becoming urbanized.
Discussion Items	**<u>Next Issue Briefs:</u>** - Social Determinants of Health - Community Utility Council feedback on the issue briefs will be done electronically. - The Council was commended that electronic feedback on issue briefs and reports have had a high level of engagement and involvement. **<u>PCCM Annual Report Draft</u>** The report gives an overview of everything that the PCCM Advisory Council has accomplished. When compiled, it was realized that we really have done a great deal of excellent work. This will be sent to the Council electronically for feedback. **<u>Healthy Iowans</u>** - The PCCM Advisory Council is assisting in submitting recommendations to potentially be included in Healthy Iowans. Healthy Iowans is Iowa's 5 year health assessment and health improvement plan. It focuses attention on Iowa's critical issues/needs and provides a blueprint for addressing them. Healthy Iowans will link with other planning efforts, including county health improvement plans. - To develop Healthy Iowans, numerous partners are engaged in health planning through health- related advisory committees, community-based planning, and other initiatives. The Healthy Iowans Steering Committee will use recommendations from these sources in developing Iowa's health assessment and health improvement plan.

	- The PCCM Advisory Council is to come up with three recommendations to submit to Healthy Iowans. Abby will send out a SurveyMonkey to determine which of the Council's recommendations should be included, and if we should come up with any new ones. **Health Benefits Exchange** - IDPH was awarded a one-year grant to plan for the Health Benefits Exchange (HBE). An Interagency Workgroup has been formed with IDPH, Iowa Medicaid Enterprise, Iowa Insurance Division, and the Iowa Department of Revenue to begin the initial planning. - Background of Insurance Exchanges- Beginning in 2014, tens of millions of Americans will have access to health coverage through newly established Exchanges in each State. Individuals and small businesses can use the Exchanges to purchase affordable health insurance from a choice of products offered by qualified health plans. Exchanges will ensure that participating health plans meet certain standards and facilitate competition and choices by rating health plans' quality. Individuals and families purchasing health insurance through Exchanges may qualify for premium tax credits and reduced cost-sharing if their household income is between 133 percent and 400 percent of the Federal poverty level. The Exchanges will coordinate eligibility and enrollment with State Medicaid and Children's Health Insurance Programs to ensure all Americans have affordable health coverage. - The Interagency Workgroup held a series of regional meetings and focus groups were held across Iowa to ensure considerable stakeholder involvement throughout the planning of the HBE. Joel Ario, Director of the U.S. Health and Human Services Center of Health Insurance Exchange, attended the first of five regional meetings in Des Moines on December 13th. They gained consumer buy-in and created transparency. Community stakeholder groups were given a chance to voice concerns and solicit ideas and expectations from what Iowans want out of an HBE. Information that was collected included such items as what benefits should be incorporated in the benefits packages, how should information be delivered and what tools should be available to access services. The information gathered from the meetings will be shared with stakeholders and policymakers as part of the planning process. A Stakeholder Advisory Council will also be formed to lead this effort. - Video presentations from the regional meetings can be viewed here. Educational whitepapers were created by the Interagency Workgroup: • HBE Overview • HBE Consumer Overview • HBE Whitepaper- Key Decisions and Activities Table • HBE Whitepaper- Difference Between Exchanges • HBE Whitepaper- Medicaid Expansion Under the ACA **Legislative Discussion** - The PCCM Advisory Council will continue with their current work, and fulfill the two legislative charges assigned. Chronic disease will still remain a priority in the overall state budget. It is becoming more recognized that we spend 3 out of every 4 dollars treating people with chronic conditions.
Update- ACA's Health Homes for Enrollees with Chronic Conditions *Dr. Kessler*	• Under the Federal Patient Protection and Affordable Care Act, there is an option that Iowa is looking into to get a state match through a State Plan Amendment. It is Title XIX of the Social Security Act- "State Option to Provide Health Homes for Enrollees with Chronic Conditions". This starts January 1st, 2011 and is for implementing health homes for people with chronic conditions. There is a 90% match for medical home payments in the first 2 years. After that, it goes back to the normal reimbursement rate of 65%. The language mentions that payment mythologies can be tiered and are not limited to per member per month. • The language defines that chronic conditions shall include but are not limited to: o A mental health condition o Substance use disorder o Asthma

	○ Diabetes ○ Heart disease ○ Being overweight, as evidenced by having a BMI over 25. • The services to be provided by the health home are: ○ Comprehensive care management ○ Care coordination and health promotion ○ Comprehensive transitional care, including appropriate follow-up from inpatient to other settings ○ Patient and family support ○ Referral to community and socials support services ○ Use of health information technology to link services, as feasible and appropriate. • DHS is moving forward with this opportunity. It will be similar to IowaCare expansion's medical home model. More emphasis will be placed on outcome measures. Wellmark already has robust measures for tracking outcome measures called CoQ Program.
Subgroups	***Prevention Subgroup*** • Lengthy discussion took place regarding the Center for Health Disparities presentation. Overall, the subgroup has a better grasp on this legislative charge and feels that they have a good direction of what the final report will look like. • Heth Bronson is doing his Capstone project from Des Moines University on this legislative charge. He will be gathering data from a variety of sources to do an environmental scan of the current disparities data being collected in Iowa. • The subgroup then talked through some of these main data sources that are Iowa specific, including: ➢ Iowa Youth Survey ○ In the fall of 1999, 2002, 2005 and 2008, students in the 6th, 8th, and 11th grades across the state of Iowa answered questions about their attitudes and experiences regarding alcohol and other drug use and violence, and their perceptions of their peer, family, school, and neighborhood/community environments. The survey reports list responses to every question on the survey, providing total percentages and breakdowns by grade and gender. ➢ Iowa Behavioral Risk Factor Surveillance System (BRFSS) ○ This is the largest, continuously conducted, telephone survey in the world. It is conducted by states under the guidance of CDC. The survey is designed to identify and monitor risk factors for chronic diseases and other leading causes of death. ➢ The Iowa Child and Family Household Health Survey (IHHS) ○ IHHS is a comprehensive, statewide effort to evaluate the health status, access to health care and social environment of children of children and families in Iowa. It is a population-based statewide household telephone survey. The primary goals of the IHHS are to: 1. assess the health and well-being of children and families in Iowa 2. assess a set of early childhood issues 3. evaluate the health insurance coverage of children in Iowa and features of the uninsured 4. assess the health and well-being of racial and ethnic minority children in Iowa. ➢ Iowa Cancer Registry ○ The Iowa Cancer Registry (ICR) is a population-based cancer registry that has served the State of Iowa since 1973. ➢ Iowa Barriers to Prenatal Care Project ○ The purpose of this project is to obtain brief, accurate information about women delivering babies in Iowa hospitals. Specifically, the project seeks to learn if women had problems getting prenatal or delivery care during their pregnancy. Other information is included which may be pertinent to health planners or those concerned with the systematic development of health care services. • The subgroup discussed the definition/meaning of "Disparities", and if there are disparities

	regarding chronic diseases within certain groups. • The new Census data will be a great source to use for projections. This data will be important for us to know the health issues that people had, but also to what would happen to their children etc. • The subgroup discussed the chronic disease that should be focused on in the report. - The Center for Health Disparities will guide us in determining this list. We don't want to duplicate research if they have already determined the key chronic diseases to focus on. - Dr. Waldron reminded the subgroup that a few children's health diseases should be included (ADAD, pre-term birth). - The subgroup then brainstormed for the Social Determinants of Health Issue Brief. A draft of this issue brief will be provided before the next Council meeting. Recommendations for the issue brief will be discussed at next subgroup meeting. The Life Course Health Development Model will be a main focus of this issue brief. ***Chronic Care Management Subgroup*** • The subgroup discussed three overall issues: o There is a large barrier for managing diabetes- access to needed materials including needles and test strips is not possible for many diabetics. They are extremely costly. The Iowa Prescription Drug Corporation is one avenue we are looking into to offer test strips to patients receiving care through safety nets. Access to regular testing is a vital piece of diabetes management. Diabetes education also a major piece. ▪ The New York Diabetes Campaign website is a great resource: http://www.nysdiabetescampaign.org/about. The New York State Health Foundation launched a five-year, $35 million campaign in March 2008 to reverse the diabetes epidemic in the State. The campaign will work to improve clinical care and patient outcomes, mobilize communities, and promote policy. o Discussion took place around the large effect that mental health has on prevention and chronic care management. Mental health care is getting worse in Iowa. o Heart failure was another topic of discussion. In the last year, hospital core measures have worsened across Iowa, as well as hospital readmissions. o The subgroup will also be creating a diabetes issue brief with recommendations.
Networking Opportunity	• The Department of Aging mentioned that the Stanford University's Chronic Disease Self Management Program- "Better Choices, Better Health" is now in 70 counties in Iowa. o The "Matter of Balance" program, which addresses falling in older adults, is now in 69 counties in Iowa. The Iowa Department on Aging website gives information on where the workshops are.
The next meeting of the Prevention and Chronic Care Management Advisory Council will be **Friday, March 25th, 10:00 – 3:00 location TBD.**	

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.