

MINUTES

Medical Home System Advisory Council

Friday, February 18, 2011

9:30 am – 12:30 pm

Iowa Hospital Association

Members Present

Chris Atchison
 Melissa Bernhardt
 David Carlyle
 Bery Engebretsen
 Tom Evans
 Carrie Fitzgerald
 Petra Lamfers
 Mary Larew
 Linda Meyers
 Tom Newton
 Elayne Sexsmith
 Anne Tabor
 CoraLynn Trewet
 Jennifer Vermeer
 Kurt Wood

Members Absent

Libby Coyte
 Kevin de Regnier
 Ro Foege
 Rep. Wayne Ford
 Jeffery Hoffmann
 Don Klitgaard
 Jane Reinhold

Others Present

Beth Jones
 Angie Doyle-Scar
 Abby McGill
 Nicole Schultz
 Carlene Russell
 Jodi Tomlonovic
 Leah McWilliams
 Marni Bussell
 Lary Carl
 Kate Bergner
 Linda Goeldner
 Kay Corrier
 Kelly Schulte
 Gretchen Hagemen
 Mariannette Miller-Meeks
 Annie Wood-Long
 Monica-Lee Parker
 Jenny Schulte
 Dawn Gentch
 Keith Muller
 Marni Bussell
 Bob Russell

Topic	Discussion
Welcome	<ul style="list-style-type: none"> • Council members and others present introduced themselves.
IowaCare Expansion- <i>Jennifer Vermeer</i>	<ul style="list-style-type: none"> • The Council continues to collaborate with Medicaid in the development the IowaCare Medical Home Model , established in SF 2356. The expansion will phase in FQHCs to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. Initially, the FQHC's will be required to meet a set of medical home minimum standards. • On October 1st, FQHC's in Sioux City and Waterloo have begun IowaCare expansion rollout. <ul style="list-style-type: none"> • 23,000 IowaCare members have a medical home. • 37 Counties are now covered by a medical home. • 93,000 Iowans are being served through the IowaCare program. • IME is continuing with weekly steering committee meetings to address implementation concerns/policy issues. <ul style="list-style-type: none"> • Waterloo's medical home has absorbed 25,00 new patients since October 1st , and grown by almost 1000 in the past few months • Sioux City's medical home started out around 500 patients and has grown to around 1,000 patients (doubled). • A number of lessons learned were discussed and are included in the PowerPoint including: <ul style="list-style-type: none"> ○ Non-covered services ○ Information sharing between facilities ○ Capacity to serve enrolled members

- 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 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. Medical home is a key aspect of exchanges, as well as incorporating integrated care in exchanges.
 - 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

	<p>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.</p>
<p>Accountable Care Organizations in the Rural Environment- <i>Keith Muller</i></p>	<ul style="list-style-type: none"> • Dr. Muller has been tracking the developments of Accountable Care Organizations (ACO's) in the Affordable Care Act (ACA) with a rural focus. • ACOs change the landscape of how care is currently being delivered. It places and emphasis on value-based purchasing and quality reporting. An ACO national plan will be present in 2012. • Eligibility for ACO's could start with either physicians or hospitals, and requires 5,000 beneficiaries. Additionally, there needs to be a formal legal structure to receive and distribute funds. ACO's must have a process to promote evidence-based medicine, report on quality measures, coordinate care, and meet patient-centeredness criteria. • Studies show that savings within ACOs are continuous. • Assumptions regarding ACOs include the requirement of large multi-disciplinary practices in order for the model to work. This is false- one study published in May 2010 Health Affairs found 3.6% lower annual costs from group practices. An important question being asked right now is if there is minimum population requirements- one carrier at a time or for multiple carriers. • Three tiers exist for ACO's which result in a large amount of flexibility: <ul style="list-style-type: none"> ○ Tier 1: minimal financial risk but eligible to receive shared savings and bonuses for meeting quality benchmarks and reduces per beneficiary spending ○ Tier 2: eligible to receive greater proportion of savings if achieve spending rates below target, but also at risk for spending above target; partial capitation; report more comprehensive data ○ Tier 3: full capitation or extensive partial capitation and bundled payments; highest potential reward but with greatest risk • Performance measures of ACOs include care coordination, care effectiveness/population health, safety, patient-engagement, and overuse/efficiency. • Vermont did an ACO pilot project. The key findings from this pilot include: • ACO cannot exist in a vacuum- public health services is a strategy for getting out of that vacuum • Working design for pilot built on three major principles: <ul style="list-style-type: none"> ○ Local accountability for defined population ○ Payment reform based on shared savings ○ Performance measurement, including patient experience data, clinical process and outcome measures • Pilots need capabilities in five areas to get started: <ol style="list-style-type: none"> 1. Manage full continuum of care settings and services, beginning with PCMH 2. Be financially integrated with both commercial and public payers 3. HIT platform that connects providers in the ACO and allows for proactive patient management 4. Physician leadership, as well as commitment of hospital CEO 5. Have process improvement capabilities to change clinical and administrative processes • Resources: <ul style="list-style-type: none"> ○ Learning Network: https://xteam.brookings.edu/bdacoln/Pages/home.aspx ○ Access Learning Network through: http://www.brookings.edu/health.aspx • For further information: <ul style="list-style-type: none"> ○ The RUPRI Center for Rural Health Policy Analysis http://cph.uiowa.edu/rupri ○ The RUPRI Health Panel http://www.rupri.org • Tom Evans commented that ACO's are rapidly evolving and they will drive the PCMH concept forward. • David Carlyle responded that the problem with viewing the PCMH and ACO's side-by-side is that the PCMH puts a large focuses on care coordination, while ACO's put a large focus on shared savings. From a sustainability perspective, with shared savings the margin of savings gets narrower. A PCMH has a much more sustainable financial future for providers.

	<ul style="list-style-type: none"> • Dr. Muller replied that if a practice already is at the PCMH level, then maybe they would be ready for the ACO model. • Carrie Fitzgerald asked if an ACO would affect the patient in any way. She would like to see data on the patient experience.
<p>Birth to Five Patient-Centered Medical Home Pilot Project- <i>Annie Wood-Long Monica-Lee Parker Kelly Schulte Abby McGill</i></p>	<ul style="list-style-type: none"> • IDPH received state funds through an agreement with the Department of Management’s Office of Community Empowerment to implement a medical home pilot project. • This project seeks to develop a model for a community based utility that will comprehensively serve children 0-5 to address their specific needs by providing a patient centered medical home. • A Title V Child Health agency in Iowa that operates 1st Five Healthy Mental Development implementation project will partner with a (pediatric) primary care practice to provide care to children birth to five that meets the Joint Principles of a Patient Centered Medical Home. <ul style="list-style-type: none"> ○ Visiting Nurse Services of Iowa was chosen as to be this community utility working with Walnut Creek Pediatrics in Des Moines. • The overall goal of the project is to gain an understanding of the requirements needed to create a PCMH for children working with other community providers and resources • IDPH’s role in the project is to: <ul style="list-style-type: none"> ○ Provided technical assistance to VNS of Iowa and Walnut Creek Pediatrics ○ Educated on key aspects of the medical home concept ○ Convened meetings bringing together VNS of Iowa and Walnut Creek Pediatrics • The measures that were used in the project are: • TransformMED Medical Home Implementation Quotient (MHIQ) <ul style="list-style-type: none"> ○ A question was asked why this tool was used over the Medical Home Toolkit. MHIQ was used because it seemed to be the easiest tool to use for the practices. • Walnut Creek Pediatrics hired a RN Care Coordinator who tracked care coordination referrals and did screenings for well-child visits. Walnut Creek Pediatrics also added a number of additional screenings during this pilot including healthy eating/exercise and BMI. • 1st Five Surveillance form for all children age 2 weeks-5 years at well-child exams • Screening Tools: <ul style="list-style-type: none"> ○ Edinburgh Postnatal Depression Scale- used to screen mothers of all infants seen for their first newborn weight check, 2 week check-up, and 2 month check-up ○ Ages and Stages Questionnaire- used to screen children for developmental delays at well-child exams at 9 months, 18 months, and 24 months of age ○ Modified Checklist for Autism in Toddlers- used to screen children for autism at well-child exams at 18 months and 24 months of age. • Family Care Plan • Family Satisfaction Survey <p>Results</p> <ul style="list-style-type: none"> • Project served 458 children at Walnut Creek Pediatrics • Provided additional screening and care coordination services to 19% of their 2,400 patients during well child check-ups who would not normally have such services • TransformMED Survey <ul style="list-style-type: none"> ○ Pre- Score: 225 of 341 points. ○ <u>Post- Score: 229 of 341 points</u> ○ Level III: Good progress, continue improvement <p>Strengths</p> <ul style="list-style-type: none"> • TransformMED Survey allowed for identified areas in which practice improvements can be implemented and reassessed • Family Care Plan & Family Survey were effective in providing valuable information which can be used in enhancing the quality of care and practice management • VNS of Iowa is extremely knowledgeable about available community resources to families in the Des Moines area <ul style="list-style-type: none"> • Ideal organization to serve as the community utility • Can address a vast variety of needs that a referred family may have.

Limitations

- Lack of time- pilot began at the beginning of the six month time frame
 - preparation time was not available to:
 - educate on the patient-centered medical home components
 - Take and assess the TransforMED MHIQ initial survey
 - collect data regarding the results of referrals
 - develop the Family Care Plan & Family Survey
- Access to patient’s health information unavailable
 - Walnut Creek Pediatrics' nurse had to duplicate the care coordination encounters from the EMR to an Excel Spreadsheet
- Collaboration of other state initiatives was not strong throughout the project
 - 1st Five Healthy Mental Development Initiative
 - Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health)
 - Early Access

Recommendations

- Additional pediatric practices should take the TransforMED MHIQ Survey to identify improvement areas and get baseline score of where they fall in the medical home continuum.
- Community utility utilization protocols should be determined so that the practices know appropriate situations to refer a family to VNS of Iowa to serve as the community utility and link the family with the needed resources.
- Family Care Plan utilization protocols should be determined so practices know appropriate situations (i.e. multiple referrals, children with special health care needs) to use the Family Care Plan.
- Practices should utilize developmental screenings vs. developmental surveillance.
- The extended pilot year should expand beyond the current 1st Five screening of well-child visits by including 1st Five screening during sick child visits and screening of pregnant women.
- Collaborate with Iowa’s 1st Five Initiative, Project LAUNCH, and Early Access throughout the entire project by holding monthly meetings with project staff.
- Utilize a “release of information” that would allow the VNS of Iowa to work directly with families receiving social service referrals.
- Discussion took place about the community utility concept. This is a reach beyond the clinical referral and encompasses the social determinants of health.
 - Could you have a pediatric practice without utilizing a community utility? It would have to be a very large practice. The families need to be linked to community resources to improve the health of children in the home.

Dental Home Initiative- Inside I-Smile
Bob Russell

Background of I-Smile:

- In Iowa, a dental home means a network of individualized care based on risk assessment. This includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.
- I-Smile™ was created to ensure that Medicaid-enrolled children have a dental home. Multiple health care providers are part of the I-Smile™ dental home. Also, services are provided in locations or settings where at-risk families are found. This includes physicians’ offices during well-child exams, at WIC clinics, and in preschools. Dentists are relied upon for definitive diagnosis and restorative care as needed.
- At the heart of I-Smile™ are 24 dental hygienists, working as community-based I-Smile™ Coordinators within Title V child health agencies.
- The coordinators are responsible for:
 - building partnerships within communities;
 - linking with local boards of health;
 - providing education and training for health care providers about children’s oral health;
 - developing oral health protocols;
 - ensuring care coordination services and assisting with referrals to dentists; and
 - assuring completion of screenings, risk assessments, and gap-filling preventive services.

	<p>The Need:</p> <ul style="list-style-type: none"> • More Iowa children, age 0-12, are receiving dental care, and more work is needed to ensure that very young Iowa children receive care. <p>What's working:</p> <ul style="list-style-type: none"> • 639 children received fluoride varnish from medical practitioners in 2010 (up from 13 in 2005). Prevention is key- fluoride is an effective way to prevent decay. • School dental screening requirement is increasing the number of children who are ready to learn • I-Smile™ Coordinators are successful in building partnerships and local infrastructure <p>The Future:</p> <ul style="list-style-type: none"> • Public-private partnerships- Dentists are more likely to take patients from a referral from and I-Smile coordinator. Discussion took place on the lengths I-Smile coordinators go to to ensure children get into the dental office. • Link with primary health care (I-Smile™ risk assessment, dental diagnosis codes, electronic health records). Primary care Electronic Health Records should include dental. <ul style="list-style-type: none"> ○ Care coordination within the patient-centered medical home will help link the health systems. Oral health can no longer be ignored because oral health affects the overall health of a person. • Improvements to Medicaid • Workforce considerations • Public education and oral health promotion with a focus on prevention. • Outreach to dentists and physicians about the oral health needs of very young and at-risk children • More gap-filling services within public health to prevent disease <p>Comments</p> <ul style="list-style-type: none"> • Tom Newton commended Dr. Russell for building the I-Smile program to address children's oral health issues. This has allowed Iowa to rise to the top. Dr. Russell has been called to states around the country to talk about the success of the I-Smile program. Additionally, Iowa is the first and only state to have a dental only carve out for <i>hawk-i</i>. • Carrie Fitzgerald has talked to child health advocates around the country. Many other states have a Children's Oral Health Taskforce. She asked if Iowa has ever had that. <ul style="list-style-type: none"> ○ Iowa has had a Children's Oral Health Taskforce in the past, but there has been no focus to reestablish it. ○ Carlene Russell (Elder Affairs) mentioned that Iowa had a similar taskforce for older adults. • Dr. Bernhardt gave appreciation on behalf of dentists. If the I-Smile program didn't exist, it will be detrimental to the health of children in Iowa. She relies on the I-Smile coordinators to find the children and families in the communities that need support. When children come through an I-Smile coordinator, she will treat them. Funding is a huge issue and most dentists are much more likely to accept patients who are referred through an I-Smile coordinator.
<p>Other Discussion Items</p>	<p><i>Iowa Health Benefit Exchange</i></p> <ul style="list-style-type: none"> • The Health Benefit Exchange website with resources and meeting information can be found here: http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp • IDPH has been 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. • <u>Background of Insurance Exchanges-</u> 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 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](#)

Healthy Iowans

- The MHSAC 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 MHSAC worked with Iowa Title V program to submit a recommendation- "Increase number of children (birth - five) utilizing preventive health care services through a medical home and dental home"

MHSAC Progress Report #3

Feedback for the MHSAC Progress Report #3 will be done through an electronic survey. The report focuses on a number of recommendations formed around priority areas for 2011.

Medical Home Learning Community

The next Medical Home Learning Community will be held on Wednesday, March 30th, 2011 at the Ramada Tropics Resort & Conference Center. The following topics will be discussed:

- Moving to Accountable Care
- Lean in Medical Homes
- Medical Home and Health Reform
- HIT and Meaningful Use
- Care Coordination and Transitions
- Achieving Level 3 NCQA Recognition

To register online visit the IHC Web site at www.ihconline.org. For more information about this session contact Janelle Nielsen (nielsenj@ihconline.org) at (515) 283-9300.

The next meeting of the Medical Home System Advisory Council will be held
Friday, April 29th, 9:30 – 12:30 at the Urbandale Public Library.