

MINUTES
Medical Home System Advisory Council
Friday, June 26, 2009
10:00 am – 2:00 pm
Iowa Hospital Association

Members Present

Chris Atchison
 Melissa Bernhardt
 David Carlyle
 Libby Coyte
 Kevin de Regnier
 Berry Engebretsen
 Tom Evans
 Carrie Fitzgerald
 Ro Foege
 Richard Haas
 Don Klitgaard
 Nat Kongtahworn
 Petra Lamfers
 Tom Newton
 Bob Osterhaus
 Jane Reinhold
 Jennifer Vermeer
 Jerry Wickersham

Members Absent

Jen Badger
 Wayne Ford
 Naomi Guinn-Johnson
 Jeffery Hoffmann
 Mary Larew
 Bret McFarlin
 Bruce Steffen

Others Present

Beth Jones
 Tracy Rodgers
 Abby McGill
 Angie Doyle-Scar
 Jane Schadle
 Julie McMahon
 Leslie Grefe
 Dawn Gentsch
 Kyla Kiester
 Linda Goeldner
 Judith Collins
 Nicole Schultz
 Drew Roberts
 Eric Nemmers
 Larry Carl
 Deborah Helsen

* **Medical Home System Advisory Council Website (Agenda/handouts found here):**
http://www.idph.state.ia.us/hcr_committees/medical_home.asp

Topic	Discussion
Introductions	<p><i>Tom Evans</i></p> <ul style="list-style-type: none"> • The meeting was called to order at 10:00. • Introductions were given • Director Newton presented Bob Osterhaus with a Certificate of Appreciation for his time on the MHSAC and in the community. CoraLynn Trewet will now represent IPA.
Updates	<p><u>eHealth Advisory Council- Leslie Grefe</u></p> <p>This council has a report due to the legislature July 1st. Their council is aligned with what is going on in health IT at the federal level. The council's vision is for a healthier Iowa through the use and exchange of electronic health information to improve patient centered health care and population health.</p> <p>Their initiative will produce a public good that will:</p> <ul style="list-style-type: none"> • Improve quality of health care • Assure patient safety • Increase efficiency in health care delivery • Promote and protect the health of Iowans <p>Their report has six primary goals:</p> <ol style="list-style-type: none"> 1. Build awareness and trust of health IT

2. Promote statewide deployment and use of EHR's and HIE
3. Enable the electronic exchange of health information
4. Safeguard privacy and security of electronic health information
5. Build an appropriately-trained, skilled health IT workforce
6. Develop a framework for implementation and sustainability of health IT

Goal 3 is where they will need to see a lot of the stimulus dollars go because it is the big technology infrastructure piece. Different systems will need to talk to each other and exchange data. There is a lot of information and resources already out there, but it is a matter of pulling it all together and making sure everyone is on the same page.

Meaningful use is something that this Council is discussing heavily. MH needs to pay attention to this as well. IF you are truly transforming practices of how they do things, using EHR's, you are using meaningful use. ONC has published a draft matrix with five goal areas and specific objectives for 2011, 2013, and 2015. They are looking for feedback from providers and clinics to determine if the objectives for each year are feasible. What are we missing and what concerns do providers have? Go to

<http://healthit.hhs.gov/portal/server.pt> . There is a box on the top right hand side with the link. IDPH's eHealth Council will submit comments and if you have any to add please send to Abby and she will forward on.

The IRIS concern has been a topic of discussion in many of their workgroups. Objective 3.9 addresses this – “Assess barriers for connecting clinic and population health systems”. Three major systems have been identified to be sure they connect. They are IRIS, Disease Surveillance System, and Metabolic Screening. If there is any other systems that you would like to see connect, please let Leslie know and it will be looked into.

PCCM Report- Jane Schadle

This council has been meeting regularly since November. They are charged with looking at a very broad systems approach and identify priorities to address prevention and chronic care management.

The first report to the director and state board of health has been completed. It is due on July 1st. The report gives six main recommendations that are the foundations development and action steps. The recommendations are:

1. Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management.
2. Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses.
3. Identify and recommend consensus guidelines for the use in chronic care management beginning with those that address the state chronic disease and prevention priorities.
4. Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices.
5. Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination.
6. Improve the health workforce and their skills in prevention and chronic disease management.

The council was also charged with coming up with two main priorities for prevention and chronic care management. They decided that these needed to be looked at separately. Therefore there are two different priority lists. Number one for prevention is obesity and number one for chronic care management is diabetes.

The Health Care Reform Connections and Integration Team was formed at IDPH to integrate all of the council and determine overlapping issues. In July, there will be a new staff person hired for the PCCM Council. Jane Schadle, from Healthy Communities at IDPH, stepped in when there was a hiring freeze.

Iowa Legislative Session Wrap Up- Julie McMahon

Lynn Patterson, IDPH legislative liaison, has put together her summary of those bills passed during the session that have health implications.

http://www.idph.state.ia.us/adper/legislative_updates.asp

- **HF 811 – HHS Appropriations Bill**. Within that given the economic climate, it was a significant piece of the deliberations. There was a real recognition of the importance of health to Iowans. Wherever possible, there was an attempt to put appropriations in that area. It builds on the health care reform legislation that was passed in 2008 to continue the work of the councils. There was a lot of support because health reform is part of the future of Iowa, and there needs to be funding to progress from the planning phase to the implantation phase. .
- **HF 820- Federal Block Grant and Stimulus Funding Appropriations Bill**. (American Recovery and Reinvestment Act) At IDPH, there was a huge budget cut. 3 million dollars were allocated to IDPH; however it will not be there next fiscal year. The Public Health Modernization Act went through the first year. It will build public health infrastructure in Iowa.
- **SF 389- Omnibus Health Care**. This continues the work done in the previous two sessions related to health care reform. It continues the work of the councils, as well as further increases health care access to children, and then adults. It is a strong document that continues to move us along.

Medical Home Learning Community- Kyla Kiester

June 17th was the last MHLC session held at Des Moines University. The interest and engagement of the MHLC continues to grow, and a wide range of people attended. Overall, the goal is practice transformation, improving primary and patient-centered care, and addressing NCQA's standards. Dr. Joseph Scherger was the keynote speaker. Two panel discussions took place- one on patient tracking and registry functions, the other on test tracking and referral tracking. There was also a discussion on medical homes from a liability perspective. Overall the theme of the day was data and registries. The ability to manage data and patients is the first step to an effective medical home. The third MHLC session will be held on September 9th at Foxboro Conference Center in Johnston. Cost is \$60 and you need to register before September.

Tom Evans- When we started the MHLC, NCQA certification process was discussed at the first session. There has been an evolving focus that if your practice does not have a disease registry, you can't even start the process of transforming into a medical home. You need the core information on the

population you are managing, and we need to all keep moving this concept forward. The second MHLC session was more focused on what a patient-centered medical home actually looks like. There was a progressive discussion around a community model, and it was concluded that it could be either one. Linking resources and getting the job done is more important than having all the pieces together in one box.

Bery Engebretsen commented about community utility.- Practices may not be able to produce all these MH functions on their own, but at the community level they could. We are really talking about transforming primary care. The different approaches, languages, and funding streams are all aiming for the same thing. We should try not to get too hung up on terminology, but it is important.

Don Klitgaard noted that every practice that went through TransforMed had a different path and situation they were in. He emphasized that you can have all the medical home concepts available in a practice, but functionally, the practice needs to be able to offer those services to their patients. Communication with community resources is a key part of this. The medical home is a highly functional part of primary care. In some communities, there may be no community utilities for people to access. We need a resource at the practice level to refer the patients to by merging between medical system and public health system. The Public Health Modernization Act is trying to develop a resource for practices to have as the medical home model is developed.

David Carlyle brought up that reimbursement will be the main thing in the end. With health care reform, what things are going to be paid for and what they are worth will be a huge discussion. Bery Engebretsen commented that the big challenge is when people not in primary care look at what we are talking about. Ro Foege added to this that when communicating about medical home, you need to look at the audience. Consumer vs. legislator vs. specialist vs. public health professional. What do they think of when the term "medical home" is used?

Tom Evans – Overall, specialists treat broken/sick patients, public health focuses on wellness and keeping people healthy. Primary care is defined as both of these. The medical home is moving the primary care world into a proactive approach for caring for patients. The problem for primary care is that we need to transform it to medical home, but our reimbursement system continues to pay for sick care.

National Reform - Carrie Fitzgerald

See handout "Side-by-Side Comparison of Major Health Care Reform Proposals"

http://www.idph.state.ia.us/hcr_committees/common/pdf/medical_home/090626_reform_comparison.pdf

The Senate Finance Committee still needs to release their bill. The HELP Committee has quite a bit on prevention and wellness. (Page 7 last paragraph – "Require plans participating in the Gateway to provide incentives to providers to better coordinate care, reduce hospital readmissions and implement wellness and health promotion activities")

If you would like additional information on national health policy development, the resources Carrie Fitzgerald referenced were both the CFPC Blog and the Kaiser Daily Health Policy Morning Edition. Here are the links to both resources: <http://www.kaiserhealthnews.org/> and <http://cfpciowahealth.wordpress.com/> The blog also includes information on upcoming town hall meetings being hosted by Iowa's congressional delegation.

Concord Coalition- Tom Evans

The Concord Coalition is a nationwide, non-partisan, grassroots organization advocating generationally responsible fiscal policy. They choose six states and examined what was unique about each one. Iowa was chosen because of our high-quality and low cost for health care. Tom has been working with University of Iowa College of Public Health to develop a whitepaper. There have been two meetings so far, mostly discussing Iowa's statistics/environment and an introduction to the Concord Coalition. There have been discussions about payors and purchasers. He is proud to report that they have endorsed a series of concepts that are strong medical home concepts throughout the entire draft whitepaper. More information <http://www.concordcoalition.org/>

September 18th Meeting- Dawn Gentsch

All day 8:00-4:00, Marriott Hotel in Coralville, Iowa. The College of Public Health Hansen Award Lecture to be presented by Dr. Stephen Shortell from University of California at Berkeley. Talking about the patient-centered medical home. This is presented by the Forkenbrock Series on Public Health and is part of a conference on strategies to connect patients to care. The focus of this event is on Medical Homes. **The MHSAC Meeting will be held in the afternoon on this date.**

There will be three panel discussions. 1) developing the concept behind the patient-centered medical home, 2) examples of current practices at the state level (CO, NC, PA), and 3) Iowa perspective on redesign, reimbursement, and incentives. – Dawn would like members of the MHSAC to provide input in developing the talking points/agenda for this third panel discussion. Main audience- MHSAC and constituents. Context is around policy. Redesign- focus on the IHC MHLC
Iowa school nurse- providing preventative care within the school setting.
Reimbursement- invite Jennifer Vermeer (Iowa Medicaid)

Workgroup Reports and Discussion

Policy and Reimbursement- David Carlyle

Pre-discussion

- o Wellmark has laid out their thoughts on primary care transformation and have embraced a primary care redesign element. There is not one single definition, and a lot of the principals in medical home come into place. We are very anxious to see the unfolding of their initiatives. We should push to modify NCOA to become more patient-centered.
- o Nat Kongtahworn- we need to operationalize the definitions into a way to reimburse. One limitation is how you demonstrate it. It is measured through dollars.
- o Bob Osterhaus mentioned that capitation is going to be a factor. Will there be a fixed fee per day per month? You will be paid to oversee a practice

and be given a per member per month amount. Nobody is going to pay you unless you can prove you are doing something. Remember that it will take many years to transform practices from what we've been doing the past 30 years to the new medical home model.

- o Richard Haas brought up the 3 buckets that were referred to earlier (Specialists, Public Health, and Primary Care). A lot of burden is falling on primary care, especially small entities where they don't have the resources to develop a medical home model. We could develop a control center to funnel into a 4th bucket. There would be a communication and information flow between these three buckets. The HIT Council agreed on a hybrid model, and they are thinking about this idea.

Post-discussion

Accountable Care Organizations (ACO) - (tied to medical neighborhood). It is an approach to creating a model for payment that would increase efficiency while achieving outcomes. It integrates primary care physicians, specialists and hospitals. These three groups would share responsibility for the quality of care and the cost of care received by the ACO's patients. If the ACO achieves both quality and cost targets, it could receive a bonus; if it fails, its members could face lower Medicare payments. The incentive is to deliver coordinated, efficient care. The challenge is that they are not popping up all over the country and not everybody has access to one.

David Carlyle added that ACO's are efficient without duplication. Even though Iowa is known for effective, high-quality care, we still have a problem with duplication of care because providers are not speaking to each other. ACO's could be a mechanism to look at quality of care rather than quantity of care. Tom Evans commented on this that the medical home model fits within the ACO, and we should look at it as a funding vehicle. Medical home's care coordination is a key for an ACO being successful.

There is going to be movement nationally and state on medical home pilots. Within 6-8 months, we will have a Wellmark pilot going. PCPCC going strong in Washington and we are setting up the infrastructure for Iowa to be ready.

Education/Learning Community- Don Klitgaard

Pre-discussion

The MHLC has been covered in the updates. They are discussing what the next learning community cycle should look like. They've talked about developing an Iowa based resource for medical home learning, starting with locating all the resources out there and putting them in one place. The audience will range from providers, consumers, legislatures etc. We don't need to recreate information and resources. The IHC will host the website and they are currently discussing the types of resources that should be included and how they should be organized.

Post-discussion

The MHLC first series is focused on education. Next years learning community will be look at more targeted days. They are thinking about having it set up so that not everybody comes to every single session. There will be more practice groups getting together to share thoughts and ideas with each other. They are moving from a group education model to learning

from one another with smaller workshops. It is going to be a longer process and to get at that level of detail will take more than one day.

For consumers it would be more effective to show a video that easily explains what a medical home means, rather than a lengthy journal article. There is a 9 minute video AAFP put together that explains the medical home system, what it would look like for consumers, for providers, how your office might change, and them implications of transforming. 90 percent of this video was shot in Harlan, IA. We want to continue to enhance provider side, but want to push further the consumer side. The video is found at:

http://www.transformed.com/pcmh_video.cfm

Definition/Certification- Bery Engebretsen

Pre-discussion

“Evaluating the Tools Used to Assess the Medical Home” (Report)

http://www.idph.state.ia.us/hcr_committees/common/pdf/medical_home/09_0626_evaluating_tools.pdf - 9 tools were assessed and it was concluded that it is a process of transforming primary care. This will be very guiding on how we will move next years MHLIC.

David Carlyle says that we have the ability to make statements on the right way to do it. That might have a guiding force on what happens nationally. At the end of the day, what happens nationally will effect Iowa, but Iowa can also effect what is happening nationally.

Post-discussion

They came up with four core components/operational definitions of a medical home. On page 22 of the report “Building MH in State Medicaid and CHIP Programs” there are four broad terms that relate. They are 1)Team approach (care coordination and comprehensiveness), 2) Patient-centered and include family involvement/engagement, 3) include a registry function, and 4) quality improvement measures and accountability. There is a lot of consensus and things are coming together. Some use different terms and emphasis more than the other, but there is a core set of elements that are uniform.

We need a process in place for improving performance. Patients can have input in the EHR through SF-36 (a set of questions that measures the patient’s perception of the quality of care). <http://www.sf-36.org/tools/sf36.shtml>

There are a lot of national disease state guidelines, but the problem is co-morbidity patients. Which disease is causing the most harm? Preventative care is different because you are taking well people and keeping them healthy, how do you measure what you prevented?

Have an EHR that is meaningful to the patient but also useful to the provider. One example of this is giving a 10 question survey before the child’s appointment to discover the focus of the upcoming visit. You can ask things online that you might not want to share in person. This type of technology and access is available to providers currently.

	<p>Colorado has 24/7 access to provider or team. It would involve a team of people doing it. The patient is informed and knows how to get access after hours. For example, 2:00 am, the patient should be instructed to call the ER, not the primary care provider. The primary care provider needs immediate notification when their patient goes to the ER. Force the relationship and interest between primary care doctors and specialists/care coordinators.</p> <p>This workgroup is to carefully review the "Building MH in State Medicaid and CHIP Programs" report before the next work session. (located on website under "June Meeting Materials")</p>
Closing	Beth and Abby will be working with the leadership team in the near future to plan workday meetings for the workgroups.
The next meeting of the Medical Home System Advisory Council will be held September 18 th , 2009 at the Coraville Marriott.	

The purpose of the Medical Home System Advisory Council is to advise and assist the Iowa Department of Public Health to develop a medical home system as outlined in HF 2539.