

MINUTES

Medical Home/Prevention and Chronic Care Management Advisory Council

Iowa Hospital Association
Friday, September 21st, 2012
9:30 am – 3:00 pm

Members Present

Chris Atchison
Melissa Bernhardt (Barb Blough)
Charles Bruner
David Carlyle
Marsha Collins
Anna Coppola
Chris Espersen
Tom Evans
Michelle Greiner
Jeffery Hoffmann
Jason Kessler
Petra Lamfers
Mary Larew
Linda Meyers
Teresa Nece
Tom Newton
Patty Quinlisk
Trina Radske-Suchan
Peter Reiter
John Swegle
Debra Waldron (Sonali Pateli)

Members Absent

Kevin de Regnier
Steve Flood
Ro Foege
Don Klitgaard
Bill Stumpf
Kurt Wood

Others Present

Angie Doyle Scar
Abby McGill
Marni Bussell
Sarah Dixon Gale
Theresa Armstrong
Joe Sample
Jodi Tomlonovic
Laurene Hendricks
Janelle Nielson
Leah McWilliams
Jill Meyers-Geadelmann
Kala Shipley
Doreen Chamberlin
Jay Iverson
Dennis Tibben
Patty Funaro

Meeting Materials

- [Agenda](#) 
- [Balancing Incentives Payment Program Overview](#) 
- [IDA- Patient and Family Engagement- Options Counseling PPT](#) 
- [IME Health Homes PPT](#) 
- [North Carolina and Community Utility Overview- Safety Network](#) 

Topic	Discussion
Welcome/ Introduction	<p>Council members and others present introduced themselves. We are starting to organize our presentations and updates around the three workgroups:</p> <ol style="list-style-type: none"> 1. Community Care Coordination Workgroup 2. Health Care Transformation Workgroup 3. Patient and Family Engagement Workgroup <p>In the afternoon of this meeting, we will be breaking down into the first two workgroups. The December 5th meeting will be focused around the third workgroup.</p>
<u>Health Care Transformation Focus</u>	<p><u>Health Homes</u></p> <ul style="list-style-type: none"> • Section 2703 of the Affordable Care Act gives states the option to submit a State Plan Amendment (SPA) depicting a health home model of care. There is a drawdown of funding a 90/10 Federal match rate for eight quarters for specific health home services. States are

Medicaid Updates

• Health Homes

Marni Bussell

PowerPoint:

[IME Health Homes](#)

[PPT](#)

• **Balancing Incentives Payment Program**

Theresa

Armstrong

Handout:

[Balancing](#)

[Incentives](#)

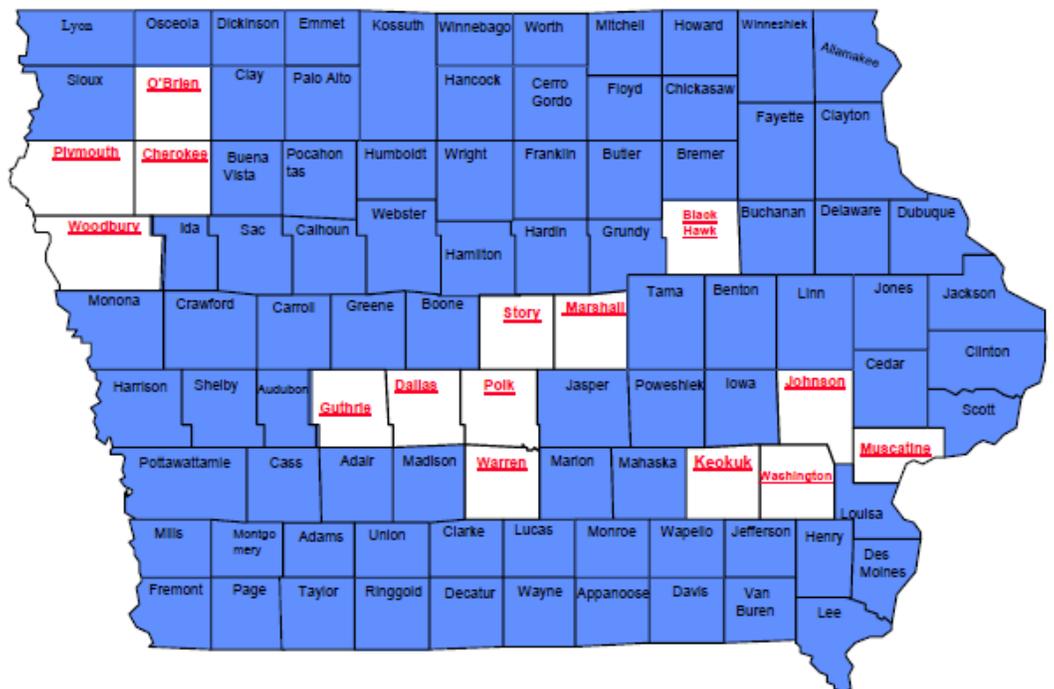
[Payment Program](#)

[Overview](#)

required to consult with SAMSHA to ensure integration of mental and behavioral health services. The project

- Individuals eligible for the program include those diagnosed with at least one serious and persistent mental health condition, has at least two chronic conditions or has one chronic condition and is at risk for a second chronic condition from the following list of categories:
 - Mental Health Condition
 - Substance Use Disorder
 - Asthma
 - Diabetes
 - Heart Disease
 - Obesity (overweight, as evidenced by a BMI over 25 or 85 percentile for children)
 - Hypertension
- Note that dual eligible's for Medicaid and Medicare are eligible to participate.
- On June 8th, Iowa Medicaid Enterprise received word that the Primary Care SPA for Health Homes had been approved by CMS. The drawdown of 90/10 Federal match rate for eight quarters is effective on July 1st, 2012.
- Currently enrolled are 11 health home entities covering 41 different practice locations in 12 counties with more than 450+ individual practitioners.
- In September, there were 1155 members assigned to Health Homes. Below is a breakdown of the percentage of enrollees in each of the four tiers:
 - Tier 1 (1-3 chronic conditions)- 44%
 - Tier 2 (4-6 chronic conditions)- 40%
 - Tier 3 (7-9 chronic conditions)- 13%
 - Tier 4 (10+ chronic conditions)- 3%
- Almost half of the current enrollees are dual eligible and 100 (9%) are under the age of 19.
- The link to the Health Home Map (below) can be found here: [Iowa Medicaid Health Home Map](#)

Iowa Medicaid Health Homes – August 2012



- The IME Health Home Website can be found here: <http://www.ime.state.ia.us/providers/healthhome.html>. This website includes a number of links on how to enroll as a health home provider and other tools:

How to Enroll as a Health Home Provider:

- [Provider Application](#)
- [Health Home Provider Agreement](#)
- [TransforMED PCMH Self Assessment](#)
- [Individual Practitioners and Health Home Locations](#)

Health Home Tools for Providers:

- [Health Home Provider Standards](#)
- [Patient Tier Assessment Instruction Form](#)
- [At-Risk Guidance for Providers](#)
- [Health Home IMPA Access Request Form](#)
- [IMPA \(Tool to enroll members into your Health Home\)](#)
- [PMPM Fee Schedule](#)
- A second SPA is currently being developed which is a “specialized” Health Home focusing on Medicaid members with serious or consistent mental illness for adult and children. IME is currently working with CMS and receiving technical assistance. Their target date for this second SPA is early 2013. The key details of this second SPA are likely to include:
 - Specialized provider requirements due to special population needs
 - Administered through the Iowa Plan
 - Additional payment tiers above the current 4 tiers due to high need of the population
 - Patient/Family Centered, peer support, and team approach
- Dr. Reiter commented that within electronic health records, there are a number of codes to designate cognitive impairment that have to do with memory loss and aging. He suggested educating participating providers which codes would be eligible for the health home program.
- Dr. Bruner commented that the 0-3 population would rarely fit into one of these seven chronic conditions to be eligible for the health home program. He suggested looking at 0-3 and 0-5 age population data to see how many are meeting the diagnosis to enroll in the health homes. He suggested exploring looking at the needs of the child’s family and not just the child. Dr. Carlyle reminded that which children, overweight and obesity qualifies as a chronic condition for the health home program.
- Dr. Larew mentioned that the Child Health Specialty Clinics sees the 0-5 population. Many of them have severe behavioral problems, but most insurance providers will not categorize them as a severe mental illness. Marni responded that with Magellan, they have defined serious and persistent mental illness as an umbrella of serious mental illness and serious emotional disability (from the ACA).

Balancing Incentives Payment Program (BIPP)

- The BIPP is a provision of the ACA that is designed to “balance” states’ spending on long term supports and services (LTSS). LTSS are home and community based services and services in institutional settings. The goal of BIPP is to provide people with greater access to home and community based services and reduces unnecessary reliance on institutional services.
- Iowa applied and receive approval in 2012 and we were the 3rd state that applied and was approved.
- As an incentive to states to increase access to home and community based services, CMS is authorized to provide enhanced federal Medicaid matching funds for those services. As of July 2012, Iowa currently spends approximately 46.5% of its Medicaid LTSS funds on home and community based services.
- Iowa’s BIPP grant was approved effective July 1, 2012 through September 20, 2015. The award, up to \$61.8 million, is based on an increased federal match of 2% for non-institutional community base services.
- BIPP grantees are required to implement specific steps to streamline access to services, improve efficiency, consistency and fairness in eligibility determination and assessments, and ensure conflict-free case management. These steps are consistent with the final Mental Health and Disability Services redesign and implementation of this project will coordinate with the redesign.

	<ul style="list-style-type: none"> • To qualify for the enhanced match, Iowa must apply for and be accepted by CMS to participate in BIPP. Iowa’s application must meet the following 3 expectations: <ol style="list-style-type: none"> 1. A No Wrong-Door/Single Entry Point system for the LTSS. Iowa will streamline and simplify access to services through a coordinated network of local entry points. 2. Conflict free case management. Case managers work with individuals and families to develop a service plan, arrange for services and supports, and direct and monitor their delivery to assure they meet the individual’s needs and achieve the desired outcomes. 3. A core standardized assessment instrument. These tools identify eligibility for non-institution services and supports and are used as a guide to develop person-centered service plans to address unique needs. Non-institutional services and supports including brain injury, aging, intellectual disability, and mental health. • A comment was made that the BIPP could be linked to and collaborate with the Direct Care Worker Advisory Council and the Health and Long-Term Care Access Advisory Council. Direct worker initiative will develop a standardized credential system.
<p><u>Community Care Coordination Focus</u></p> <p>Community Care of North Carolina <i>Sarah Dixon Gale</i></p> <p><i>Handout:</i> North Carolina and Community Utility Overview- Safety Network</p>	<ul style="list-style-type: none"> • The National Academy for State Health Policy (NASHP) has selected Iowa as one of seven states chosen competitively to participate in an initiative that seeks advance partnerships to improve access to care for vulnerable populations. The University of Iowa Public Policy Center joins the Iowa Primary Care Association and the Iowa Medicaid Enterprise (IME) in the Medicaid-Safety Net Learning Collaborative. This is part of NASHP’s ongoing work to provide information and technical assistance to states to help them improve their Medicaid programs. • Additionally, the Iowa Primary Care Association was awarded a contract with IDPH through its Community Transformation Grant to make funding available to local organizations to build referral networks, a piece of a community utility. This funding has been directed to the selected medical home development counties in order to enhance their Safety Net Network-funded projects. • As part of the Community Transformation Grant contract, Denise Levis Hewson, a key leader from Community Care of North Carolina was retained to provide technical assistance to the six counties and also led an educational session with a state level focus on their model. Both sessions were well-received by attendees. • The key aspects of the North Carolina Model- North Carolina’s vision included building a delivery system where: <ul style="list-style-type: none"> ○ Physicians and providers are the champions ○ Primary care is the foundation ○ Patients with chronic illnesses are the target ○ Physicians and other health care providers are engaged ○ Local collaboration and support is in place ○ Meaningful data is available and used to enhance quality which results in cost reductions ○ Performance expectations are clear and aligned ○ Performance is tracked and constructive feedback is provided ○ Processes are in place to drive on-going improvement • North Carolina started out with seed money to create 9 pilot projects and used their Medicaid data. Their geography is very similar to Iowa’s in that they have 100 counties, many of which are rural. • Additional technical assistance will be provided through NASHP about the North Carolina Model. If interest exists, the Safety Net Network could convene a planning session focused on how Iowa could adapt what has been built by other states and communities to support community utility development through the state. • Denise Levis Hewson also called in and presented to the Safety Net Provider Network meeting on September 13th. At that meeting, the partners around the table agreed and recommend that Iowa should move forward in adopting a model similar to Community Care of North Carolina.

<p><u>Patient and Family Engagement Focus</u></p> <p>Options Councilors <i>Joe Sample</i></p> <p><i>PowerPoint:</i> IDA- Patient and Family Engagement- Options Counseling PPT</p>	<ul style="list-style-type: none"> • The presentation started off by stating an alarming statistic that by 2030, 25 percent of Iowa’s population will be over the age of 60. • The definition of Aging and Disability Resource Centers was given- To have ADRCs serving every community as highly visible and trusted places where people of all incomes and ages can get information on the full range of long term support options and a single point of entry for access to public long term support programs and benefits. • ADRCs have been piloting in Cedar Rapids and Waterloo since 2004 and serve 17 counties. Each pilot site works with local aging and disability service providers to: <ul style="list-style-type: none"> ○ develop and pilot a standardized process that promotes improved access to long-term supports and care; and ○ implement this process through collaboration, enhanced information and referral resources, and the establishment of the position of long-term support options counselors. • The expected outcome of these activities is to demonstrate a standardized entry process and streamlined access to long-term supports for aging persons and adult persons with disabilities. • ADRC’s involve networks of state and local organizations working together in a coordinated manner to provide consumers with integrated access points to all long-term services and supports. • Key functions of ADRC’s include: <ul style="list-style-type: none"> ○ Information Referral and Access (access point) ○ Eligibility Determination ○ Care Transition Support ○ Quality Assurance ○ Options Counseling (includes person-directed, process, information, support, and access to the larger system and services) • Options counselor’s help patients transfer back into the community. They provide the right services at the right time as determined by the needs, values, and preferences of the individual. • The core competencies include: <ul style="list-style-type: none"> ○ Determining the need for options counselors ○ Assessing the needs, values, and preferences ○ Understanding and educating about resources ○ Facilitating self-directed plan ○ Encouraging future orientation ○ Follow-up • It is important to understand that options counseling is short term and includes follow-up. It is not the long-term case management model. It is person-directed (not person-centered) and the person is at the front and they will direct the optional counselors where they want to go.
<p>Workgroups</p>	<p>The MH/PCCM Advisory Council has developed the following three workgroups:</p> <ol style="list-style-type: none"> 1. Community Care Coordination Workgroup 2. Health Care Transformation Workgroup 3. Patient and Family Engagement Workgroup <p>This meeting we are breaking down into the first two workgroups. The December 5th meeting will be focused around the third workgroup- Patient & Family Engagement.</p> <p><u>Community Care Coordination Workgroup</u></p> <ul style="list-style-type: none"> • The focus of this workgroup is to promote the coordination of community and health care services to advance patient-centered transformation of the local health care system. • A major focus will be placed on Community Utilities/Community Care of North Carolina Model and the Patient-Centered Medical Home (PCMH). • The workgroup discussed where Iowa is at with the PCMH. It should be a statewide goal that all Iowans have access to medical care in that model- not just insured patients or

safety net patients, but everybody).

- Currently, there are resource impediments that the community utility could fulfill, especially where the PCMH is not available. There are silos which make it hard to access community resources, which leave a lot of opportunities to improve. The workgroup explored ways to develop a community utility model in Iowa. There needs to be ownership and buy-in from community members. This must be community driven so that the community takes responsibility for it.
- Sarah Dixon Gale offered to coordinate with this workgroup and have the Community Care of North Carolina presentation as part of our December meeting.
- The MH/PCCM Advisory Council developed a Community Utility Issue Brief which can be accessed here: [Community Utility Issue Brief](#) 
- The workgroup made a recommendation to endorse and pursue the community utility model in Iowa.

Health Care Transformation Workgroup

- The focus of this workgroup is to encourage partnership between community health care partners in Iowa who are working on new system-level models to provide better health care at lower costs by focusing on shifting from volume to value based health care.
- The workgroup will focus on the following:
 - a. Health Benefit Exchange
 - b. Accountable Care Organizations
 - c. Diabetes Care Coordination Plan
 - d. Behavioral/Mental Health
 - e. Partnership for Patients
 - i. OB
 - ii. Adverse Drug Events
- The workgroup initially discussed the scope of work that can be accomplished. It is important to keep in the back of our mind that the capability of this workgroup is to develop policy recommendations and strategies. The workgroup then discussed each of the focus areas.
- **Health Benefit Exchange:** The workgroup suggested that the MH/PCCM Advisory Council make a recommendation that Iowa should not pursue a federal-based exchange. This recommendation was brought back to the full Council to vote and unanimously all were in favor.
- **Accountable Care Organizations-** Discussion took place that having a good PCMH system in place is a prerequisite to developing a successful ACO. It would be best to spend our effort right now on getting a strong PCMH system in place in Iowa. The ACO is a vehicle which creates a funding pool to sustain the PMCH model.
- As a takeaway, the workgroup summarized that ACO's will not be successful without a successfully functioning medical home. The workgroup will monitor innovative ACO projects to promote and spread the model, with the intent of spreading lessons of community engagement, performance improvement, and sustainability.
- The workgroup suggested that at every Council meeting, there should be an educational presentation from an ACO. At the December meeting, Dr. Carlyle and Dr. Hoffmann will present about the Primary Care Medical Home ACO Model. They will tie in what Nebraska is doing with the Heartland Regional Medical Center IPA (Independent Practice Association), as well as what Massachusetts is doing.
- **Diabetes Care Coordination Plan-** A background summary of the diabetes care coordination plan was given. [SF 2356](#) charged the PCCM Advisory Council to develop a plan to coordinate care for individuals with diabetes who receive care through safety net providers.
- As a first step, the Iowa Primary Care Association conducted focus groups in the FQHCs to determine the barriers that people with diabetes face. The main conclusions from the focus groups are that patients want more information about diabetes in a way other than

	<p>written material; the patients felt that their diabetes was triggered by stress; and they wanted their family members to be more engaged in the management of their diabetes. The focus group report can be found here. PCCM Staff have been meeting with members of the Iowa Collaborative Safety Net Provider Network, including the free clinics, community health centers, family planning clinics, and rural health clinics to discuss this legislative charge and continue collaboration for the diabetes care coordination plan.</p> <ul style="list-style-type: none"> • An Iowa Diabetes Issue Brief was created which includes initial recommendations concerning issues that have quickly become high priority while working on the diabetes care plan. The recommendations are: <ol style="list-style-type: none"> 1. Coordinate with existing programs to ensure that test-strips are made available for underinsured and uninsured people with diabetes in Iowa. 2. Ensure that certified diabetes education is available statewide and that outreach is conducted to patients to ensure awareness of this critical service. 3. Ensure the utilization of educational tools, resources, and programs to promote the engagement of people with diabetes and self-management of both obesity and its complications, including diabetes and metabolic syndrome. • A Diabetes Clinical Subcommittee was created to make clinical recommendations for the legislative charge. The Subcommittee has finalized 10 recommendations and a number of Iowa specific documents to be used in the clinic to manage and prevent diabetes, including a Diabetes Care Flowsheet, Diabetes Action Plan, Algorithm for Prediabetes and Type 2 Diabetes, and a variety of educational materials from the American Diabetes Association and the American Association of Diabetes Educators. • An environmental scan was done on what other states are doing with diabetes care plans and New York has an excellent website that many of these documents were modeled off of New York's website can be accessed here: http://fulldiabetescare.org/ • This Health Care Transformation Workgroup made a recommendation that we present the diabetes care coordination plan and tools at our December Council meeting and have the council vote to approve the work. We will then package it as a toolkit and post it on the IDPH, IHC, and Safety Network websites and push providers to use these as a standard of care. The workgroup agreed that these tools should be reviewed on an annual basis. • <i>Behavioral/Mental Health-</i> The workgroup will continue to monitor this topic and look for opportunities for engagement. • <i>Partnership for Patients-</i> Discussion took place about the OB program with the University of Iowa and IDPH's parental program to reduce parental mortality. The goal of this program is to have infants stay in until 39 weeks. Hospitals are now developing guidelines that do not allow women elect labor until 39 weeks. The sooner babies are born, the more problems arise. • The Workgroup made a recommendation to explore obstetrical applications to the patient-centered medical home model to improve maternal and child health outcomes. • Regarding Adverse Drug Events, the Workgroup made a recommendation to develop a strategy to align the MH initiative with statewide medication safety. Iowa should focus on reducing adverse drug events in anticoagulants, opioids, and glycemic (blood glucose).
<p>Networking Opportunity</p>	<p>Council members were given an opportunity to provide comments on topics they would like addressed or to showcase any initiatives or projects they are working on.</p> <ul style="list-style-type: none"> • On November 13, 2012, the University of Iowa Health Sciences Policy Council will host "Rebalancing Health Care in the Heartland 5: Shaping Iowa's Health Care Landscape" at the Embassy Suites in Des Moines. Join fellow Iowans for this non-partisan, one-day conference focused on the significant changes and resulting challenges in health services delivery today. Your participation is vital to shaping an outstanding health care system for Iowa. Visit www.healthcare.uiowa.edu/cme/ for more information. • Discussion took place around Medicaid expansion. It is a possibility that the Council could weigh in on what to look for and implications. A report was cited from Nebraska about implications for Medicaid expansion. The report can be found here: http://www.unmc.edu/publichealth/docs/medicaidexpansion.pdf

The next meeting of the Medical Home and Prevention and Chronic Care Management Advisory Council will be held **Wednesday, December 5th, 9:30 – 3:00 at YMCA Healthy Living Center**

2013 Meeting Schedule

- **Wednesday, December 5, 2012- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, February 20, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, June 26th, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, August 21st, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Friday, November 1st, 2013- Location TBD**