

# MINUTES

## Prevention and Chronic Care Management Advisory Council

Friday, February 6, 2009

10:00 am – 3:00 pm

Urbandale Public Library, Room A

### Members Present

Jose Aguilar  
Bill Appelgate  
Mary Audia  
Krista Barnes  
Steve Flood  
Della Guzman  
Terri Henkels  
Melanie Hicklin  
Noreen O'Shae  
Patty Quinlisk  
Peter Reiter  
Suzan Simmons  
Donald Skinner  
Steve Stephenson  
Jacqueline Stoken  
John Swegle  
David Swieskowski  
Debra Waldron  
Jenny Webber

### Members Absent

Tom Kline  
Kathryn Kvederis  
Rahul Parsa  
Rev. Dr. Mary E. Robinson

### Others Present

Jane Schadle  
Jill Myers Gadelmann  
Julie McMahon  
Beth Jones  
Tom Newton  
John Hedgecoth  
Judith Collins  
Abby McGill  
Leah McWilliams  
Nicole Schultz  
Kelly O'Keefe  
Shirley Roberts  
Deborah Helsen  
Kathy Kunath  
Kelly Taylor  
Sara Schlievert

\* **Prevention & Chronic Care Management Advisory Council Website (handouts found here):**  
[http://www.idph.state.ia.us/hcr\\_committees/prevention\\_chronic\\_care\\_mgmt.asp](http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp)

Topic	Discussion
Welcome/Introductions -Staff/Budgeting	<p><i>Beth Jones, Tom Newton, Jane Schadle</i></p> <ul style="list-style-type: none"><li>• The meeting was called to order at 10:00</li><li>• Introductions were given</li><li>• Jane Schadle is the new facilitator for this council</li><li>• Tom Newton gave updates about the budget. He stated that this advisory council and Health Information Technology Advisory Council have been hit hard by the budget crisis. IDPH went under a hiring freeze; therefore we could not hire anyone to fill the new positions to move these councils forward. We are looking for other ways to fund this council such as federal grants or other grants. Beth and Abby will continue to support this council and we need to keep this council and the Medical Home Advisory Council linked.</li><li>• The fact that this council is still going strong shows you how important we think that prevention and chronic care management really is.</li><li>• The 2010 budget will have a 6.5% cut across the board. HHS will need to identify where it would be appropriate to expend funds. They could create new focus areas and would have to go through congress to receive approval. They are talking about getting a bill passed by President's Day and expending funds by March 1<sup>st</sup>.</li></ul>
Updates	<i>Jane Schadle</i>

<ul style="list-style-type: none"> <li>- <i>Work Timeline</i></li> <li>- <i>Report Plan</i></li> </ul>	<ul style="list-style-type: none"> <li>• The purpose and goals of the workgroup sessions to take place later in the meeting were discussed. There are four different workgroups, each having a specific topic. We need to develop a system approach to develop prevention and wellness strategies.</li> <li>• Ground rules were discussed. They include: everyone participates, different options are welcome, disagree in private; unite in public, silence is agreement, limit side conversations, start on time; end on time, and follow through on action plans.</li> <li>• We will work in the meetings, send you stuff between meetings, and bring reactions back to the next meeting. There are essentially three meetings to write the report.</li> </ul>
<p>Other Health Care Reform Councils</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• The Medial Home System Advisory Council had wanted to have the report done by the end of January. However that date is being pushed back because they want to make sure that the report has strong recommendations dealing with a system wide approach. There is going to have one more revision.</li> <li>• The report has four major recommendation areas. The first is to continue the work of the advisory council. The second deals with a multi-payer reimbursement model. The third is about expanding on existing infrastructures. The final recommendation touches on supporting initiatives dealing with workforce, information technology, and prevention and chronic care management.</li> <li>• The report will be presented by a member of the council to the legislator.</li> <li>• Beth recently attended the National Governors Association (NGA) meeting. The materials from this meeting are located at: <a href="http://www.subnet.nga.org/center/meeting/">http://www.subnet.nga.org/center/meeting/</a> Beth was able to learn many best practices from other states. The finished product from this council will be shared with this council and also be posted on the website.</li> <li>•</li> </ul>
<p>Selected State Initiatives</p>	<p><i>John Hedgecoth</i></p> <ul style="list-style-type: none"> <li>• See PowerPoint “Selected State Initiatives” and document “50 State Summary of Disease Management Laws”</li> <li>• There are more ideas put into action than we can discuss. This document and PowerPoint summarizes the main ones.</li> <li>• HF 2539 gave us very specific directions by giving us 14 recommendations that we have grouped into 5 broad categories. These categories include 1) First Steps/Prioritization, 2) Identifying and Engaging Professionals, 3) Health IT/Disease Registry, 4) Patient Education/Community Resources, and 5) Evaluation Process.</li> <li>• The category “Health IT/Disease Registry is becoming very important and there will be some stimulus money to move this forward. That may happen yet this spring. This council may wan to have a subgroup to work on this.</li> <li>• Concept 9, “Methods to involve public...and sustain the initiative” is very important. What is the long term sustainability of this initiative? The challenge will be to change the culture of Iowa and make it a more long term thing.</li> <li>• We will need to write a report this that changes population and has results. It will demonstrate success. There is a justification to prevention and chronic care management because this report is a request from the</li> </ul>

legislator.

- **VERMONT**

- Their Blueprint for Health Strategic Plan is the same process as what our council is working on. The key components of the Vermont Model are: evidence based guidelines, clinical information systems, payment incentives aligned with quality goals, self management, chronic care management, and health systems change. Vermont thought they were doing with their Blueprint for Health Strategic Plan is health care reform, but what they were really doing was prevention and chronic care management in a medical home environment. They adopted the chronic care model and used it for their 15,000 diabetes patients.
- Their results were very community and information technology based. They had a locally defined outcome and gave empowerment to those local practices to those who signed up. It took them 8 years from the time they started the blueprint.
- Noreen O’Shea mentioned the difficulties of the HIPA regulations in regard to referring to other community resources. The council decided that we should made recommendations to what needs to be changed with the HIPA privacy law.
- Kathy Kunath made a few observations. She stated that this council has a great amount of power because the legislation asked us to develop recommendations. Also, HF 841 is a wellness program through the Medicaid population. It is something that we can look back at that and help us move forward. We could make a recommendation to address that legislation or a similar concept. We need to develop something that gets into the private market. If there is a way to do both, that would be great. We could craft something that would be relevant.
- Kelly Taylor stated that when dealing with different populations in the office, it needs to be done for everybody. It can’t just be for the Medicaid population because it adds a great deal of chaos in a physician setting. Mercy is dealing with that regarding immunizations and the Vaccine for Children (VFC) program. They have two different schedules and it is very hard. You have to build a system for everyone, and not for different types of patients.
- Jose Aguilar agrees with this statement. The patient systems should be uniform for all patients. Massive intervention is a very big problem with chronic conditions. You need positive leadership for this.
- Peter Reiter commented on community resources and how there are more population dense areas in Iowa than others. That may be the place for public private partnerships to get the programs that require intensives. He brought up the fact that it is difficult to get men over 50 to get screened.
- **INDIANDA**
- Healthy Indiana Plan started in early 2007 as a CMS demonstration project.
- Each participant has a power account in their name and it covers the cost of their deductible. It is based on a sliding scale on their ability to pay (5% of their gross family income). Each year, the balance rolls over and everything you have left over goes onto next year’s account.
- This is a voluntary account that is for individual insurance plans. You need to be uninsured for 6 months prior. This plan is aimed at the uninsured population and the self-employed. Under 200% of poverty level.
- A chronic disease registry was also created.
- Steve Flood brought up a point that he thinks there needs to be an

	<p>incentive for members of this plan to show up for their preventative physicals and screenings.</p> <ul style="list-style-type: none"> <li>As a result, they found lower costs and got their emergency room visits down.</li> </ul>
<p>Council Work Session</p>	<p><i>Council Workgroups</i></p> <ul style="list-style-type: none"> <li>A discussion took place about the key priorities for this council to focus on. 25 different topics came up, and then they were voted on with first, second, and third highest priorities. Scores were calculated and the results are below: <ol style="list-style-type: none"> <li>Focus on community for wellness- worksites, school systems etc.</li> <li>Prevention- Important</li> <li>Disease registry</li> <li>Efforts need to be measurable- show outcomes</li> <li>Cost effectiveness efficacy</li> <li>Patient responsibility</li> <li>Include mental health</li> <li>Rewards for wellness at community/business-based entities- integrated or built in</li> <li>Self management empowerment</li> <li>More points of contact for patients</li> <li>Education for patients</li> <li>Develop strategies for each partner in chronic care model</li> <li>Address co-existing chronic disease</li> <li>Short-term gain- long term effects</li> <li>Fiscal responsibility</li> <li>Look for opportunities that can be expended</li> <li>Public health systems</li> <li>Medications</li> <li>Change views on disease cause and personal management</li> <li>Cardiovascular disease improvements will be realized through existing/new efforts (state tobacco tax)</li> <li>Include dental/oral health</li> <li>Health by example</li> <li>Policy for the masses</li> </ol> </li> <li>The council then broke into four different groups: <ul style="list-style-type: none"> <li>Group 1- Identifying and Engaging Professionals</li> <li>Group 2- Health IT/Disease Registry</li> <li>Group 3- Patient Education/Community Resources</li> <li>Group 4- Evaluation Process</li> </ul> </li> </ul> <p><b><u>Group 1- Identifying and Engaging Professionals</u></b></p> <ul style="list-style-type: none"> <li>Create a chronic disease management system which includes: case management best practice, multiple providers, community resources, technology</li> <li>There is a lot of disconnect among different professionals and a lack of care coordination. Guidelines need to be developed. <ul style="list-style-type: none"> <li>Have a chronic disease management system that includes anybody that has interaction with the patient</li> <li>Try to find what guidelines are considered best practice.</li> <li>Determine all community resources, especially related to wellness.</li> </ul> </li> <li>This needs to be outcome based, simple, and we need to have the patients involved in order for them to be accountable and take ownership.</li> <li>Licensing boards <ul style="list-style-type: none"> <li>The culture needs to be changed through chronic disease CEU/CME requirements. These need to be mandatory at no cost. Also, more</li> </ul> </li> </ul>

training in chronic care management needs to be provided to both medical schools in Iowa (DMU & Iowa). The medical students need to know how interact and council about chronic diseases and the management of them.

- A discussion took place about the value of CEU/CME's. Some did not think they were valuable and that their effect was not measured. Noreen O'Shea said that it should be about the whole system of chronic chare management, rather than just training on the material they are already studying. It is valuable to make sure that all providers have a common vocabulary. The patient would get consistent advice and providers would be able to link them effectively.
- The barriers/silos created by insurers, professional organizations/societies, and the legislator need to be removed. For example, why can't fluoride treatments be given in schools? This council could give a recommendation regarding licensing restrictions. That would not take a lot of legislation or money and it is something that could change within our current structure.

### **Group 2- Health IT/Disease Registry**

- Everybody should be eligible for prevention and chronic care management services, especially on the preventative side. We need to identify the people that have the most risk factors for chronic diseases. Implement provider "teams" including both individuals and the community. These "teams" could provide education, community media, and outreach.
- Have nationally or state wide excepted standards for all which measure the same thing. We don't need to reinvent the wheel. All of this has to be simple and easy to implement, otherwise it will not be implemented in the office.
- There needs to be a free state wide disease registry/EMR. Hospital EMR system can talk to you office EMR system. Make everything compatible. This group came up with some questions about disease registries that will be further researched:
  - Number reporting and number of practices
  - Other examples
  - Which diseases
  - Is it statewide
  - Time to implement
  - Who chose the registry
  - What measures
  - Who chose the measures
  - What does it cost
  - Who bears the cost
  - What time does it take to enter the data
  - How many measures right now
- We need to be patient. A lot of the things we are trying to do require change management and they are not going to happen over night or as quickly as the legislator will like. You need at least 3 years and that message needs to come about loud and clear.
- We also need to be flexible. If you are already an office that has a registry that is working well, we don't want them to have them change to the one the state has picked. You can take advantage of people that are already using it, and offer it to the clinics that are not using one. The mandatory cancer registry in Iowa it takes 4 full-time employees to

	<p>manage it. It is very time consuming.</p> <p><b><u>Group 3- Patient Education/Community Resources</u></b></p> <ul style="list-style-type: none"> <li>• This group had many ideas of things that are needed or should be further discussed. They are: <ul style="list-style-type: none"> <li>○ Community screenings targeted at the appropriate people, and we need to determine an efficient way to do this.</li> <li>○ A patient care doctor where there is electronic sharing/patient portals where patients can get in and see what has been written about them and diagnosed.</li> <li>○ A general health risk assessment where people can go online and fill the assessment out themselves and send it to their medical home.</li> <li>○ Empower the community to support this initiative, and let them know that they are not alone and will be backed up.</li> <li>○ Health coaches are very effective if there is team involvement.</li> <li>○ Develop a community resource calendar. For example, you would be able to see where the diabetes support group is going to meet and on what night. Require communities to gather all of this information and display it at easy access points in the community, such as grocery stores, churches, malls and libraries. Along with this, have a system where members of the community can dial in by phone and log online to find this same information.</li> <li>○ When working with patients, we need to point out to them what they will get out of their treatment. We will want to track and keep them accountable for their success. Encourage them to set guidelines and benchmarks. Make it fun for them.</li> <li>○ Community education should be multimodal and sustained. Reach out by utilizing public services announcements, online resources such as facebook, public health outreach, and reaching out to the school systems. We need health education as part of all school curriculums, teaching life skills and reemphasizing physical fitness.</li> <li>○ Market the Live Healthy Iowa Initiative to families, as well as businesses and corporations.</li> </ul> </li> </ul> <p><b><u>Group 4- Evaluation Process</u></b></p> <ul style="list-style-type: none"> <li>• Determine the population, standardized objective, and assessment. We also need to develop incentives to engage private insurers to expand their data.</li> <li>• The organizational structure of this initiative should have professional oversight, such as Iowa Department of Public Health, Iowa Health Care Collaborative, or Information Management System. This will help get the data in a centralized location.</li> <li>• Engage a large number of people. It takes quite a campaign and a strong partnership between the public and private. To get people to do this, you need to use incentives and stay positive.</li> </ul>
<p>Next Steps</p>	<p><i>Jane Schadle</i></p> <ul style="list-style-type: none"> <li>• Work done at this meeting will be taken and developed for the next three meetings work. The ranked priorities will be looked at and next steps will be created.</li> </ul>
<p>The next meeting of the Prevention and Chronic Care Management Advisory Council will be held March 6, 2009 from 10am – 3pm at Urbandale Public Library, Room A</p>	

**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.**