

MINUTES

Medical Home System Advisory Council

Friday, February 20, 2009
10:00 am – 2:00 pm
Urbandale Public Library, Meeting Room A

Members Present

Chris Atchison
Jen Badger
Melissa Bernhardt
David Carlyle
Libby Coyte
Kevin de Regnier
Berry Engebretsen
Tom Evans
Carrie Fitzgerald
Richard Haas
Jeffery Hoffmann
Nat Kongtahworn
Mary Larew
Bob Osterhaus
Jane Reinhold

Members Absent

Ro Foege
Naomi Guinn-Johnson
Don Klitgaard
Petra Lamfers
Bret McFarlin
Tom Newton
Bruce Steffen
Jennifer Vermeer
Jerry Wickersham

Others Present

Beth Jones
Julie McMahon
Abby McGill
Tracy Rodgers
Angie Doyle-Scar
Larry Carl
Judith Collins
Deborah Helsen
Jodi Tomlonovic
Nicole Schultz
Leah McWilliams
Kyla Kiester
Daniel Garrett
Kelly O'Keefe
Eric Neemers

* **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>Beth Jones</i></p> <ul style="list-style-type: none"> • The meeting was called to order at 10:00. • Council members and others present introduced themselves.
Legislative Update	<p><i>Lynh Patterson</i></p> <ul style="list-style-type: none"> • See document "Summary of SF 48 2009 Health Care Reform Bill" • The current legislative session deals mostly with the flood relief and the budget. The flood discussion is complete, so the focus is now on the budget. Guidance has not yet been given regarding the stimulus bill. • Sen. Hatch released a second health care reform bill: SF 48. The handout provided provides a great summary of this bill. • Eight divisions make up SF 48. <ul style="list-style-type: none"> • I- Iowa Health Care Partnership <ul style="list-style-type: none"> ○ Allow governmental subdivisions (includes counties, cities, community colleges, quasi-public agencies) small businesses (1-50), and nonprofit corporations to buy-in to state employee health insurance • II- Iowa Choice Insurance Exchange <ul style="list-style-type: none"> ○ Create Iowa Choice Insurance Exchange as nonprofit corporation under the jurisdiction of the insurance commission similar to HIPP Iowa. ○ Revised Iowa Choice health care coverage advisory council will become the board of the exchange, appointed by the Governor, confirmed by Senate • III- Adult Children Health Coverage Revisions

	<ul style="list-style-type: none"> ○ Exempt value of coverage for nonqualified adult dependents from state income tax ○ Allow adult children not currently on their parents coverage who are under 25 to reenroll if otherwise eligible ● IV- Children’s Health Care Network <ul style="list-style-type: none"> ○ Medicaid, hawk-i, hawk-i expansion, Iowa choice for kids ○ Parental Mandate <ul style="list-style-type: none"> ▪ Children below 300 percent FPL must have insurance coverage – soft mandate—use income tax form ○ Legal immigrant children currently ineligible for hawk-i for five years ○ All income-eligible children ● V- Immunity for Free Specialty Care <ul style="list-style-type: none"> ○ Allows providers who work in free clinic to be considered a state agency. ○ A comment was made that many clinics do not have the facilities to provide dental care. Many dentists would be open to providing care if they didn’t have to worry about additional exposure to their malpractice policy. ● VI- Healthcare Workforce Shortage Initiatives and Fund <ul style="list-style-type: none"> ○ Medical Residency Training Grants Program ○ Health Care Professional Loan Repayment Program ○ Nurse Educator Forgivable Loan Program ○ Nursing Faculty Fellowship Program ● VII- Pharmacy initiatives <ul style="list-style-type: none"> ○ Medication Therapy Management (MTM) services ○ Drug Information and Academic Detailing ○ Marketing: Gift Ban and disclosure act and ban data-mining. A comment was made that many smaller pharmacies rely on their free samples and that this ban would greatly affect them. ○ Pharmacy Benefit Manager transparency ● VIII- Healthcare Transparency
<p>Other Health Reform Councils <i>Update</i></p>	<p><i>Julie McMahon/Beth Jones</i></p> <ul style="list-style-type: none"> ● The Electronic Health Information Advisory Council met for the first time on Jan. 16th. Seven workgroups have been formed to address various issues in the formation of an Iowa eHealth network, with an expected federal grant opportunity coming up. Iowa is in the “planning” phase of the eHealth project, but stakeholders from across the health care spectrum are involved in the formation of policy related to the eHealth system. See eHealth ● The Prevention and Chronic Care Management Advisory Council lead coordinator position was not filled, due to the hiring freeze. IDPH reassigned Jane Schadle to facilitate this council. The council last met on Feb. 6th. John Hedgecoth presented research he did on other selected state initiatives regarding prevention and chronic care management. This council is having four workgroups: <ol style="list-style-type: none"> 1. Identifying and Engaging Professionals 2. Health IT/Disease Registry 3. Patient Education/Community Resources 4. Evaluation Process ● The council did a prioritization activity and determined that the top three key priorities regarding prevention and chronic care management are: <ol style="list-style-type: none"> 1. Focus on community for wellness in worksites, school systems etc. 2. Prevention- Important

	<p style="text-align: center;">3. Disease registry</p> <ul style="list-style-type: none"> • The “Check up” is a monthly newsletter that will give an update on all Health Care Reform councils. We expect the first one to come out in 2-4 weeks. It will most likely be in the form of a list serve and you will be able to forward the email onto others who may be interested, and that will allow them to sign up for it also. • The College of Public Health Hansen Award Lecture to be presented by Dr. Stephen Shortell from University of California at Berkeley will be health on <u>September 18, 2009</u> at the Marriott Hotel in Coralville, Iowa. This is presented by the Forkenbrock Series on Public Health and is part of a conference on strategies to connect patients to care. Dr. Shortell is dean at Blue Cross of California and a distinguished professor of Health Policy and Management at the School of Public Health, and professor of organization behavior at Haas School of Business, University of California-Berkeley.
<p>National Governor’s Association Best Practices</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> • See PowerPoint “Summary of the National Governor’s Association’s Best Practices meeting on Medical Homes”. • This conference provided good information on what we need to do to build a medical home <u>system</u>. Health Care Reform should really be addressed as Health System Reform. • If a patient visits the doctor’s office twice a year for 30 minutes each time, they would be spending 99.98 percent of their lives outside the doctor’s office. • The five key areas of system development are <ol style="list-style-type: none"> 1. Forming Key Partnerships- Coordinating Body 2. Defining and Recognizing a Medical Home 3. Purchasing and Reimbursement 4. Support for Changing Practices- Learning Collaborative 5. Measuring Results • Pennsylvania’s System Model is implemented incrementally with regional multi-stakeholders collaboratives. They attend “learning collaborative” meetings, use patient registers to track patients. • Pennsylvania’s Medical Home System is set up very similar to ours. Theirs initially came from an executive order in May 2008. They are now in the process of doing the learning collaboratives. • Louisiana’s Medical Home System was rolled out through Medicaid. They had a convening body, used multi-stakeholder participation in design implementation, and transformed care for all patients. • Lessons learned in Implementation of a Medical Home System: <ul style="list-style-type: none"> ○ By focusing on the most needy recipients, you can have remarkable success in improving health outcomes and cost savings ○ Recipient turn-over is significant in a Medicaid population. ○ The program is too small if it is focused on chronic disease or one small population. • David Carlyle mentioned that Pennsylvania did something to reallocate the way that Medicaid paid. In Iowa, it will take 3-5 years to do this. Tom Evans commented that we have a population full of engaged populations and practices asking what they can do. Which goes first, reimbursement or practice change? Traditionally its reimbursement, but some practices are saying that they want to do practice change now, and that they are confident that the reimbursement will come later on. Kevin de Regnier replied to this by saying that for smaller practices, the reimbursement will

	<p>need to come first. Different practices will take a different amount of time to change</p> <ul style="list-style-type: none"> • Mary Larew commented on NCQA and lack of focus on child services. There is a joint commission statement it is more focused on disease management, rather than wellness. It needs to be clarified to be more inclusive to healthy children. What is interesting is that pediatricians invented the medical home concept. • David Carlyle mentioned that a lot of the work with North Carolina started with pediatrics. NCQA is behind in having pediatrics being more of a key player. It is influence by the population. For example, the majority of North Carolina's population is Medicaid; therefore they have their specific system. We are going to need to have an intelligent conversation on a specific system for Iowa.
<p>Iowa Healthcare Collaborative Learning Community</p>	<p><i>Tom Evans</i></p> <ul style="list-style-type: none"> • See PowerPoint "Medical Home Learning Community- Iowa Healthcare Collaborative" • The goal of the Iowa Healthcare Collaborative (IHC) is to move the provider community forward regarding the Medical Home Initiative. • The Iowa Academy of Family Physicians (IAFP) and the IHC formed a Medical Home Work Group in July of 2008. • Their main goal was to explore the patient-centered medical home system in Iowa. In doing this, they need to 1) create a movement within the provider community, 2) develop a learning community, and 3) explore reimbursement redesign. • They worked to create a movement within the provider community and went after NCQA certification to move this along. We want to raise the standard of care in Iowa by reequipping what we already have. Iowa has some of the highest quality of care yet lowest reimbursement rates. Reimbursement redesign will be necessary to sustain the medical home model. • The medical home model starts with pediatrics, family medicine, and internal medicine, with the patient being the center of all of these. • The Joint Principles of the PCMH are based on two conceptual frameworks- the Primary Care Model and the Chronic Care Model. • Medical "homeness", community application, and reimbursement reform are three categories where we can organize this discussion. • NCQA is a nationally recognized "measuring stick". It establishes criteria and assessment process to determine if physician practices are functioning as medical homes. It also serves as criteria for reimbursement. • NCQA has 9 standards: 1) Access and Communication, 2) Patient Tracking and Registry Functions, 3) Care Management, 4) Patient Self-Management Support, 5) Electronic Prescribing, 6) Test Tracking, 7) Referral Tracking, 8) Performance Reporting and Improvement, and 9) Advanced Electronic Communication. • We need to build a learning community to get these standards going. To do this, IHC has created 5 Medical Home Learning Community Objectives. They are: <ul style="list-style-type: none"> 1. Initial practice assessment- <i>TransforMed</i> 2. Deploy the PCMH culture and techniques 3. Build a project plan and actively participate 4. Progress toward NCQA certification 5. Collect and submit data on an identified population of the practice using selected measure sets • The IHC is hosting three learning sessions. 4/1, 6/17, 9/9. These will be

	<p>free and open to anybody. The learning sessions will be focused on the NCQA certification and moving from reactive to proactive</p> <ul style="list-style-type: none"> • David Carlyle stated that there is a chance that Iowa will not get the CMS demonstration project because we are already doing so much already. We need to be prepared for that. A spotlight for primary care and family medicine is on medical homes. The players there represent many who are committed in investing in the learning group. We are in a really crucial time where we need to act now. One of our main strengths is our delivery system. • Jodi Tomlonovic mentioned the term “medical neighborhood” however that removes accountability. Overall it is all about patient centered communication coordination. • Nat Kongtahworn commented on the New England Journal of Medicine, by Elliott Taylor mentioned the first definition of medical home. In New York, an agreement or contract is required to coordinate Wellmark – <i>TransforMed</i>. • Pediatrics are more Public Health focused- dealing with confidentiality (coordinating with Early Access, etc.) • We need to steer clear of reimbursement driving what medical home is. Medical home is about patient centered needs. There is the issue of us becoming part of the problem. We do not want to be held hostage as a patient to whether or not providers are sharing information. We need to make sure information getting transferred on their behalf.
<p>HF 2539 Medical Home Council Workgroups and Goals <i>Review Legislation Form Workgroups</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> • The five key areas of system development are <ol style="list-style-type: none"> 1. Forming Key Partnerships- Coordinating Body 2. Defining and Recognizing a Medical Home 3. Purchasing and Reimbursement 4. Support for Changing Practices- Learning Collaborative 5. Measuring Results • HF 2539 Medical Home System Key Areas (Match up with above 5) <ol style="list-style-type: none"> 1. Medical Home System Advisory Council 2. Definition and Adoption of Joint Principles/Process to certify based on NCQA 3. Payment and reimbursement methodologies and funding for practice transformation 4. Education and training standards 5. Baseline goals and performance measures 6. Coordinate with Dental Home 7. Integrate prevention and chronic care management recommendations • <u>Work Group 1- Areas 1, 2 and 6</u> • <u>Work Group 2- Area 3</u> • <u>Work Group 3- Areas 4, 5, and 7</u> • These workgroups will help us come up with a structured strategic plan of action to move Iowa’s Medical Home System forward. • Workgroups will meet monthly entire council will meet quarterly. • We need both someone to chair each work group, and someone to oversee all three work groups. • Key stakeholders can participate in the workgroups if needed. • We will put together a structure for these work groups and propose that to you. If you have interest in a certain workgroup, let Abby know.

<p>Legislative Report Draft</p> <p><i>Finalize Report</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> • The report consists of four main recommendations. They are: <ol style="list-style-type: none"> 1. Continue to develop and sustain the Iowa Medical Home System Advisory Council to promote the PCMH concept as a standard of care for all Iowans. 2. Encourage and support the identification and implementation of a multi-payer reimbursement model that supports the PCMH. 3. Support the current efforts to implement and expand the PCMH through existing infrastructures that educate providers and demonstrate best practices. 4. Support health reform initiatives that address health care workforce needs, health care information technology, prevention, and chronic care management. • The conclusion enforces that the Medical Home System Advisory Council will play a key leadership and participant role in all these building block recommendations. • We will need to make it public that this council has filed a report. • Senator Hatch will need to be given this report. Tom Newton should get it to every legislator. Each council member should get it to their specific lobbyist. • A vote was taken to accept this report and it was unanimously voted yes. • When Abby sends the final report to the council, the subject line will say “FINAL Medical Home Report”
<p>Off to a Good Start Policy Recommendations</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> • The one page document for Goal 3- “Increase the Percentage of Children with a Medical Home” is complete. There are six health goals for early childhood in the Off to a Good Start document. Each goal has a one page summary and there is also a shorter document that has a summary of all six goals.
<p>Next Steps <i>Council Discussion</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> • We will work on developing your workgroups; contact Abby if you have a specific group you want to work on or if you want to chair any groups. • Every council member will join at least one workgroup • We will work on meeting schedule for the rest of the year (quarterly) for the entire council • The workgroups will be very flexible and council member will be welcome to sit in on other groups as well.
<p>The next meeting of the Medical Home System Advisory Council will be held April 3, 2009 from 10am-2pm at the Urbandale Public Library, Room A</p>	

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.