



**Iowa Department of Public Health**  
Promoting and Protecting the Health of Iowans

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Thomas Newton, MPP, REHS  
Director

Chester J. Culver  
Governor

Patty Judge  
Lt. Governor

Dear Interested Party:

The Medical Home System Advisory Council (MHSAC) is pleased to submit the attached progress report. The report defines a patient-centered medical home and gives four major recommendations needed to build a medical home system in Iowa.

The MHSAC has been meeting monthly since November and has been working hard to develop this progress report. The work of the MHSAC is directed from HF 2539, the Health Care Reform Act. HF 2539 establishes that the patient-centered medical home model is a major quality improvement strategy for Iowa's reformed health care system.

If you would like any further information regarding the work of the MHSAC, the report or the recommendations, please contact either Dr. Tom Evans at 515-288-1955 or [evanst@ihonline.org](mailto:evanst@ihonline.org), or Tom Newton at 515-281-8474 or [newton@idph.state.ia.us](mailto:newton@idph.state.ia.us).

Sincerely,

A handwritten signature in black ink that reads "Thomas Newton". The signature is fluid and cursive, with the first name being particularly prominent.

Thomas Newton, MPP, REHS  
Director, Iowa Department of Public Health

A handwritten signature in black ink that reads "Thomas C. Evans". The signature is cursive and somewhat stylized, with the last name being the most legible part.

Thomas C. Evans, MD  
Chair, Medical Home System Advisory Council

## ***Medical Home System Advisory Council***

<b>Name</b>	<b>City</b>	<b>Position</b>
Chris Atchison	Iowa City	University of Iowa College of Public Health
Jen Badger	Carroll	Dental Hygienist
Melissa K. Bernhardt, DDS	West Des Moines	Iowa Dental Association
David Carlyle, MD	Ames	Iowa Academy of Family Physicians
Libby Coyte	Redfield	Iowa Physician Assistant Association
Kevin de Regnier, DO	Winterset	Iowa Osteopathic Medical Society
Bery Engebretsen, MD	Urbandale	Iowa Nebraska Primary Care Association
Tom Evans, MD	Des Moines	Iowa Healthcare Collaborative
Carrie Fitzgerald	Des Moines	The Child and Family Policy Center
Ro Foege	Mt. Vernon	Consumer
Naomi Guinn-Johnson	Des Moines	Governor's Developmental Disabilities Council
Richard Haas, DC	Mason City	Iowa Chiropractic Society
Jeffrey Hoffmann, DO	Guttenberg	Iowa Academy of Family Physicians
Don Klitgaard, MD	Harlan	Iowa Medical Society
Nat Kongtahworn	Des Moines	Wellmark Blue Cross Blue Shield
Petra Lamfers, ARNP	Belmond	Iowa Nurses Association
Mary Larew, MD	Iowa City	American Academy of Pediatrics, Iowa Chapter
Bret McFarlin, DO	Des Moines	Broadlawns Medical Center
Tom Newton	Des Moines	Iowa Department of Public Health
Bob Osterhaus	Maquoketa	Iowa Pharmacy Association
Jane Reinhold	Bettendorf	Consumer
Bruce Steffen, MD	Moline	Federation of Iowa Insurers
Jennifer Vermeer	Des Moines	Department of Human Services
Jerry Wickersham	Des Moines	Iowa Insurance Division

## Summary

### Medical Home System Advisory Council Progress Report #1

The Medical Home System Advisory Council (MHSAC), established under House File (HF) 2539 and assembled by the Iowa Department of Public Health, is charged with developing and implementing a patient-centered medical home (PCMH) system in Iowa. The MHSAC has met monthly since November 2008. Although not required, the MHSAC is pleased to provide the legislature with the accompanying progress report. The report provides a definition and background information about the PCMH, followed by four major recommendations with supporting rationales to build and spread the PCMH model to benefit all Iowans as intended by HF 2539.

**Background** – During the 2007 interim legislative session, a *Legislative Commission on Affordable Health Care Plans for Small Businesses and Families* (Commission) was authorized (2007 Iowa Acts, Chapter 218, section 127). Two of the Commission's eight guiding principles are "everyone should have a medical home" (principle #3) and "reforms should drive quality improvements and contain costs" (principle #6). In 2008, motivated by the Commission's report and guiding principles, the Iowa General Assembly enacted HF 2539, the Health Care Reform Act. Among other provisions, HF 2539 provides a blueprint for establishing and spreading the patient-centered medical home (PCMH) model as a major quality improvement strategy for Iowa's reformed health care system.

**Definition** – According to HF 2539, "medical home" means a team approach to health care that:

- originates in a primary care setting;
- fosters a partnership among the patient, the personal provider, other health care professionals, and the patient's family when appropriate;
- utilizes the partnership to access all medical and non-medical health-related services needed by the patient and patient's family to achieve maximum health potential;
- maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and
- includes the following characteristics: a personal provider; a provider-directed medical practice; whole person orientation; coordination and integration of care; quality and safety; enhanced access to health care; and payment.

**MHSAC Building Block Recommendations** – To build, spread, and sustain the PCMH model to benefit all Iowans, the following building block recommendations are considered top priority by the MHSAC:

*Building Block Recommendation 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.

*Building Block Recommendation 2:* Encourage and support the identification and implementation of a multi-payer reimbursement model that supports the PCMH.

*Building Block Recommendation 3:* Support the current efforts to implement and expand the PCMH through existing infrastructures that educate providers and demonstrate best practices.

*Building Block Recommendation 4:* Support health reform initiatives that address health care workforce needs, health care information technology, prevention, and chronic care management.

## Medical Home System Advisory Council Progress Report March 2009

### Introduction

During the 2007 legislative session, HF 841 established a commission on health care coverage affordability that met to establish plans to provide health care coverage to all Iowa children and analyze needs for broader statewide health reform.<sup>1</sup> The commission developed recommendations, which included a plan that would assure a patient-centered medical home (PCMH) for all Iowans.

In 2008, the Iowa General Assembly enacted HF 2539, the Health Care Reform Act.<sup>2</sup> The Health Care Reform Act provides a blueprint for the future of a PCMH system in Iowa. The blueprint focuses on the joint principles of a patient-centered medical home (as agreed to by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association), defines PCMH, and outlines needs for a statewide structure. In addition, the Health Care Reform Act outlines implementation phases that start with children enrolled in Medicaid.

This Medical Home System Advisory Council (MHSAC) Progress Report is designed to provide background information on development of a PCMH system, describe briefly the current major PCMH-building efforts in Iowa, and recommend pertinent building blocks to a PCMH system that meets the needs of all Iowans.

### What is a Patient-Centered Medical Home?

*Iowa's Medical Home Definition (HF 2539):* "medical home" means a team approach to providing health care that:

- originates in a primary care setting;
- fosters a partnership among the patient, the personal provider, other health care professionals, and the patient's family when appropriate;
- utilizes the partnership to access all medical and non-medical health-related services needed by the patient and family to achieve maximum health potential; and
- maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and
- includes the following characteristics: a personal provider; a provider-directed medical practice; whole person orientation; coordination and integration of care; quality and safety; enhanced access to health care; and payment.

This PCMH system will strive to:

- reduce disparities in health care access, service delivery, and health status;
- improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage within a sustainable health care system; and
- provide a pragmatic method to document that each Iowan has access to health care.

The National Academy for State Health Policy conducted a review of health reform efforts in states that included a PCMH model. They identified key areas for advancement of the PCMH that contributed to success in selected states. These key areas include: forming key partnerships through a coordinating body; defining and recognizing a PCMH; purchasing and reimbursement reform; and supporting practice change through measuring outcomes of

demonstration and pilot projects.<sup>3</sup> Based on these key areas and lessons learned from other states, the following building block recommendations have been established.

**Building Block Recommendation 1: Continue to develop and sustain the Iowa Medical Home System Advisory Council (MHSAC) to promote the patient-centered medical home concept as a standard of care for all Iowans.**

The MHSAC is the designated body to plan and implement the PCMH related provisions of Iowa's health reform legislation. In that capacity, the Council's leadership would be highly influential in spreading and sustaining the PCMH concept and providing a mechanism for continued coordination among key partners (including, but not limited to, physicians, dentists, pharmacists, nurse practitioners, physician assistants, nurses, chiropractors, dietitians, physical therapists, professional organizations, and public and private insurers).

The MHSAC's importance remains high during these still early times of medical home growth and spread. While it is challenging to gather data on Iowans who have a PCMH, the Behavioral Risk Factor Surveillance Survey from 2007 reported that 77 percent of respondents stated they have "one person you think of as your personal doctor or health care provider."<sup>4</sup> However, a PCMH encompasses many characteristics. It is accessible, comprehensive, culturally competent, and coordinated. According to the Commonwealth Fund, when all four aspects were evaluated only 27 percent of respondents reported the care they received fit as a medical home.<sup>5</sup>

The MHSAC is charged with leading a quality-enhancing transformation of how primary care is delivered. Without a PCMH, a patient with acute or chronic illness is typically seen briefly in the office, a diagnosis made, and a prescription and/or lifestyle advice given. Getting the prescription filled, taking the medicine, changing behavior, and returning for follow-up if things aren't going better are left to the patient. Little attempt is made to provide care coordination or build productive partnerships with patients and other community service providers. This typical scenario represents an unacceptable quality of care and highlights a need for trained care coordinators, especially to follow the medically and socially complex patients once they leave the office.<sup>6</sup> Without a PCMH, even patients with insurance coverage might not have reasonable access to basic primary care services, and the care they do receive may likely be of lower quality and higher cost. Proponents argue that if the PCMH model is properly spread and supported, primary care, which currently receives about 7 percent of health care expenditures, can help reduce the remaining 93 percent of expenditures.<sup>7</sup> Therefore, additional spending on the PCMH represents an investment that will pay dividends.

The MHSAC stands to make a major contribution to creating health equity among Iowa's residents. According to a 2006 Commonwealth Fund study, disparities in terms of access to and quality of care largely disappear when adults have a PCMH, insurance coverage, and access to high quality services and systems of care. Hispanics and African Americans are especially vulnerable - their uninsured rates are higher and they are less likely than whites to have access to a regular health care provider or source of care. But when minorities have a PCMH, racial and ethnic differences, in terms of access to medical care, disappear. Three-fourths each of whites, African Americans, and Hispanics with a PCMH reported getting the care they need when they need it.<sup>5</sup>

## **Building Block Recommendation 2: Encourage and support the identification and implementation of a multi-payer reimbursement model that supports the PCMH.**

The first step toward the PCMH must be meeting the health care coverage needs for all Iowans. Recommendations from the Iowa Choice Advisory Council comprehensively address meeting the needs of all Iowa children, but much still must be done to address health care coverage for adults.<sup>8</sup> Implementation of these recommendations would be an excellent foundation for further spread of the PCMH model.

Iowa must be poised to implement the PCMH should a demonstration site opportunity become available. Every indication is that Iowa is a strong candidate for a Medicare demonstration project with the Centers for Medicare and Medicaid Services (CMS). A strong primary care workforce and a high level of quality performance and value of care make Iowa competitive. Many entities have been supportive of Iowa's selection as a CMS demonstration site. Letters of support were sent to CMS from Senators Harkin and Grassley, Governor Chet Culver, the Iowa Department of Public Health, the Iowa Healthcare Collaborative, and Wellmark Blue Cross and Blue Shield.

If selected, eligible primary care practices will participate in a three-year demonstration providing reimbursement in the form of a care management fee to the practices for the services of a "personal physician." A rigorous study design will allow identification of relationships between "medical homeness," patient outcomes, and service utilization efficiencies. The Office of Management and Budget continues to evaluate the availability of funds for the project. The site selection announcement is expected in early 2009, but has not been released as of this report's date.

In 2009, Wellmark will be piloting a medical home support initiative called, *Collaboration on Patient-Centered Care*, to support the needs of clinician practices in becoming medical homes. *Collaboration on Patient-Centered Care* provides participating clinicians with access to an electronic data registry and Wellmark's clinical support staff at no cost to enable more effective population health management of patients who are Wellmark health plan members.

Also in 2009, Wellmark will be undertaking a second pilot with selected clinicians that will involve: testing reimbursement designs that support development of the PCMH; sharing data to assist clinicians in understanding both individual patient and population health management opportunities and risk; and facilitating a learning forum for pilot participants to share best practices and lessons learned. While Wellmark has taken a leadership role as a private payer, it is necessary to continue to develop a systematic, integrated, and expanded public/private payment approach for the PCMH to streamline processes within a provider office.

## **Building Block Recommendation 3: Support the current efforts to implement and expand the PCMH through existing infrastructures that educate providers and demonstrate best practices.**

Roll out of a PCMH system requires providers who are ready, willing, and able to adopt the PCMH model. As a provider-led community, the Iowa Healthcare Collaborative (IHC) has the capacity to educate and support practices in becoming a PCMH. A PCMH workgroup has been established through the IHC. Workgroup members and their respective organizations are motivated and enthusiastic about the opportunity to spread the PCMH model throughout the

state to improve quality, patient safety, and value. Represented on the workgroup are Iowa's major health systems, community health centers, large physician groups, and independent practices.

Currently, the workgroup is developing a Medical Home Learning Community aimed at educating and enabling participating practices to deliver a PCMH. This learning community will focus on practice transformation and meeting the standards of the National Committee for Quality Assurance (NCQA) recognition (see addendum A).<sup>9</sup> Learning session dates have been set and curriculum development is well underway. The workgroup is moving forward with these efforts despite current absence of guaranteed financial incentives. The workgroup continues to work with stakeholders, including Wellmark, the Iowa Medicaid Enterprise, and the MHSAC.

Iowa's community health centers (CHC), rural health clinics (RHC), and free clinics – along with maternal and child health clinics, family planning clinics, and local boards of health – collectively represent Iowa's safety net providers. Local boards of health are working to streamline public health services through implementation of Iowa's Public Health Standards. With the aid of funding from the state legislature, safety net providers strive to improve the coordination and quality of services for the uninsured. The Iowa Safety Net Collaborative Network was established in 2006. Initial planning focused on meeting the highest identified needs of access to pharmaceuticals and specialty care, along with recruitment of primary care providers.

With a statewide patient registry and ongoing training interventions, the CHCs are the furthest along of the safety net providers in progress towards a PCMH model of care. Some RHCs have made considerable progress toward PCMH goals, while free clinics are using some Title V technical assistance opportunities to deliberate the best ways to fit the PCMH model to their varied organizational structures and resources. The intention for all safety net providers is to move toward a PCMH model to the extent possible.

The PCMH infrastructure under consideration must integrate all health services in a fashion that is both patient- and family-centered and easy to navigate. For example, Iowa is leading the nation in demonstrating the effectiveness of care coordination and collaboration through I-Smile, Iowa's dental home initiative. Through I-Smile, systems of health care providers ensure that children have access to early and regular oral health care. The I-Smile program links primary care and dental delivery systems through a patient- and family-centered approach. This same method can be implemented and expanded to provide a service delivery model and risk assessment protocol to meet various combinations of health care needs of patients in various settings.

**Building Block Recommendation 4: Support health reform initiatives that address health care workforce needs, health care information technology, prevention, and chronic care management.**

Currently, 45 percent of the nation's population has a chronic medical condition.<sup>10</sup> Patients with chronic diseases account for 75 percent of the nation's health care spending.<sup>11</sup> A good starting point for reducing U.S. health care expenses overall is to implement a long-term strategy to reduce the costs associated with unmanaged or poorly managed chronic conditions.

The PCMH model integrates and coordinates care across the health care system and the community, ensures that care is patient- and family-centered, and delivers care that is linguistically and culturally appropriate. Three trends are helping to build momentum around the

PCMH model: 1) a growing shortage of primary care clinicians; 2) the increasing prevalence and cost of chronic diseases among the U.S. population; and 3) a growing recognition of the importance of evidence-based quality improvement in health care services.

PCMH spread and sustainability rely heavily on the continued development and support of the current primary care workforce; implementation of a health information technology system that connects all providers and collects appropriate data to analyze and demonstrate outcomes; a statewide prevention strategy that targets patients' behavior when not in the provider office; and a definable, coherent strategy that connects systems. When adults have a PCMH, their access to care and rates of preventive screenings improve substantially, and they report better management of chronic conditions.<sup>5</sup>

While the PCMH promises positive impacts on the health of Iowans through providing care that is accessible, comprehensive, culturally competent, and coordinated, true health reform cannot be done in a vacuum. Spread of the PCMH model should gain momentum as other system needs are addressed.

## Conclusion

Guided by combinations of resource capacity and partnerships, the Medical Home System Advisory Council is poised to play leadership and participant roles in all of these building block recommendations to move the PCMH concept forward in Iowa. In these roles, the MHSAC will form workgroups to assist with implementing the recommendations. Discussions are currently progressing on how to spread the PCMH throughout the provider community, including the essential role of Medicaid. The MHSAC commits to viewing and addressing the building blocks as instrumental to a reformed health care system.

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<sup>1</sup> <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&qa=82&hbill=HF841> accessed January 2009.

<sup>2</sup> <http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&qa=82&hbill=HF2539> accessed January 2009.

<sup>3</sup> M. Takash, National Academy of State Health Policy, Leading the Way: How states are advancing medical homes through Medicaid and SCHIP, presented to the National Governor's Association Best Practices Forum on Medical Homes, held January 27-29, 2009 in New Orleans, LA.

<sup>4</sup> Health in Iowa, Annual Report 2007, from the 2007 Iowa Behavioral Risk Factor Surveillance System <http://www.idph.state.ia.us/brfss/common/pdf/2007BRFSSAnnual.pdf> accessed January 2009.

<sup>5</sup> A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey, The Commonwealth Fund, June 2007

<sup>6</sup> C.F. Wilson, Community Care of North Carolina: Saving State Money and Improving Patient Care, NC Med J, May/June 2005, Volume 66, Number 3.

<sup>7</sup> A.H. Goroll et. Al., Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, Journal of General Internal Medicine 22 no. 3 (2007).

<sup>8</sup> <http://www.insurealllowakids.org/IowaChoiceHealthCareAdvisoryCouncilReport.pdf>, accessed January 2009.

<sup>9</sup> National Committee for Quality Assurance (NCQA), Physician Practice Connections (PPC) and the Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH), Version 2008 can both be found at <http://www.ncqa.org/tabid/141/Default.aspx> and at <http://www.ncqa.org/tabid/631/Default.aspx> See Addendum A (attached) for Summary of NCQA Guidelines

<sup>10</sup> Wu S, Green A. Projection of Chronic Illness Prevalence and Cost Inflation. RAND Corporation, October 2000.

<sup>11</sup> <http://www.cdc.gov/nccdphp/overview.htm>, accessed February 2009.

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## ADDENDUM A

### What is NCQA certification?

Most medical home demonstrations and pilots are using the National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH) tool to measure whether a practice is a medical home. Basically, the tool has nine standards (listed below) and a scoring system to assess degree of accomplishment of each standard. Total scores correspond to level of “medical homeness” and, perhaps ultimately, to practice recognition and reimbursement. The standards are:

- access and communication;
- patient tracking and registry functions;
- care management;
- patient self-management support;
- electronic prescribing;
- test tracking;
- referral tracking;
- performance reporting and improvement; and
- advanced electronic communication.