

**MINUTES**  
**Medical Home System Advisory Council**  
**Wednesday, December 17, 2008**  
**10:00 am – 12:00 pm**  
**Conference Call**

Members Present

Chris Atchison  
 Jen Badger  
 Melissa Bernhardt  
 David Carlyle  
 Libby Coyte  
 Kevin de Regnier  
 Berry Engebretsen  
 Carrie Fitzgerald  
 Ro Foege  
 Naomi Guinn-Johnson  
 Richard Haas  
 Jeffery Hoffmann  
 Don Klitgaard  
 Petra Lamfers  
 Mary Larew  
 Tom Newton  
 Bob Osterhaus  
 Jane Reinhold  
 Bruce Steffen  
 Jennifer Vermeer

Members Absent

Tom Evans  
 Bret McFarlin  
 Susan Voss

Others Present

Beth Jones  
 Jill Myers Gadelmann  
 Abby McGill  
 Julie McMahon  
 Angie Doyle-Scar  
 Tracy Rodgers  
 John Hedgecoth  
 Sara Schlievert  
 Tom Kline  
 Nancy Schultz  
 Morgan Salinas  
 Dan Royer  
 Larry Carl  
 Daniel Garrett  
 Karla Fultz McHenry  
 Leah McWilliams  
 Jodi Tomlonovic  
 Linda Goeldner

\* **Medical Home System Advisory Council Website (handouts found here):**  
[http://www.idph.state.ia.us/hcr\\_committees/medical\\_home.asp](http://www.idph.state.ia.us/hcr_committees/medical_home.asp)

<b>Topic</b>	<b>Presenter</b>
<p>Introductions  <i>Ground Rules</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• The meeting was called to order at 10:00</li> <li>• Attendance was taken for council members</li> <li>• Others that listened in are asked to email Abby (<a href="mailto:AMcGill@idph.state.ia.us">AMcGill@idph.state.ia.us</a>) to let her know in order for attendance to be accurate on the minutes</li> <li>• The ground rules were discussed. They are available on the website</li> <li>• The attendance policy was highlighted saying that if a committee member is unable to attend a meeting, an alternate may be allowed to sit in the committee members place. If the committee member uses an alternate or misses two consecutive meetings, the IDPH director will designate a new council member.</li> </ul>

	<ul style="list-style-type: none"> <li>• The weather policy was also highlighted saying that we will make every effort to determine if a meeting will be cancelled due to weather 24 hours in advance. If unable to make a meeting due to weather, and absence will not be counted against you.</li> <li>• Send any comments you have about the ground rules to Abby</li> <li>• We will vote at the next meeting to finalize the ground rules</li> </ul>
<p>Other Health Care Reform Councils</p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• The Prevention and Chronic Care Management Advisory Council met yesterday, December 16<sup>th</sup> over conference call. They are still learning more information about the chronic care model. They are going to get started on their report soon.</li> <li>• The Clinicians Advisory Panel will meet this Thursday, December 18<sup>th</sup>. This is a group of nine practicing physicians whose role is to provide information on evidence based practices to both the Medical Home System Advisory Council and the Prevention and Chronic Care Management Advisory Council.</li> <li>• The Iowa Choice Health Advisory Council submitted a report to legislature You can find this report with their recommendations at: <a href="http://insurealllowakids.org/">http://insurealllowakids.org/</a></li> </ul>
<p>Role of Chiropractic in Medical Home System Model</p>	<p><i>Richard Haas</i></p> <ul style="list-style-type: none"> <li>• See handout “Summary of Chiropractic’s Role in the Medical Home System”</li> <li>• He has been in practice in Mason city, Iowa for 32 years. He works with nerve muscle joint problems.</li> <li>• A challenge is to improve the communication between medical doctors and chiropractors.</li> <li>• A chiropractor is defined under law as a primary care provider who may be designated by the patient as his/her personal provider and first point of contact in the medical home system.</li> <li>• Chiropractors currently serve as primary care providers for many of their patients and are the first point of contact for these patients.</li> <li>• While some patients may use and view their chiropractors as “specialists”, this does not change the fact that many patients use chiropractors as primary care providers and the law specifically states that chiropractors are primary care providers and may serve as the patient’s “personal provider” or “medical home.”</li> <li>• The medical home system developed and implemented by the Iowa Department of Public Health, with the assistance of this Advisory Council, MUST allow patients to designate chiropractors as their personal providers and must not be developed or implemented in a manner which would prevent a patient from designating his/her chiropractor as a personal provider.</li> <li>• There are over 800 chiropractors in Iowa. They are well-educated have had 6-8 years of college. They also receive 60 hours of</li> </ul>

	<p>continuing education every year.</p> <ul style="list-style-type: none"> <li>• He wants to develop a common sense of communication between chiropractors and medical doctors so that the process of communication can be simple and utilized effectively.</li> <li>• Carrie Fitzgerald asked a question on if chiropractors do well child exams for children. They do initial physical exams they don't do vaginal/rectal exams. Half of chiropractors might do lab work. Those procedures that are not done by a chiropractors need to be forwarded to a medical doctor.</li> <li>• Jen Vermeer stated that half of Medicaid consists of children. They have very specific requirements for EPSDT. Dr. Haas replied that they are aware of that and they want to be part of the solution and help the best they can.</li> </ul>
<p>North Carolina Model</p>	<p><i>David Carlyle</i></p> <ul style="list-style-type: none"> <li>• See handout and PowerPoint "Community Care of North Carolina"</li> <li>• He had a conversation with a medical home expert from North Carolina. Their major focus is pediatrics. It has won many national awards. It has not been tested in the adult population</li> <li>• North Carolina has a different set of parameters in terms of amount of community care networks.</li> <li>• After listening to Mary Larew's presentation at the first meeting, it is apparent that there is some real connections between her project and the North Carolina model.</li> <li>• The National Committee of Quality Assurance (NCQA) definition states that a patient-centered medical home is a model for care provided by physician practices that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and long-term healing relationship. A medical home also emphasizes open scheduling, expanded hours, and ongoing communication between patients, physicians and staff.</li> <li>• The key components include: <ul style="list-style-type: none"> <li>○ Continuity of care</li> <li>○ Clinical information systems</li> <li>○ Patient and family involvement</li> <li>○ 24/7 care</li> <li>○ Care coordination</li> <li>○ Quality improvement</li> <li>○ Electronic medical records</li> </ul> </li> <li>• Some of the issues they faced were that there was no real care coordination system at the local level. Providers feel limited in their ability to manage care in the current system. Local public health departments and area mental health services are not coordinated with the medical care system. Duplication of services at the local level State "Silo Funding"</li> </ul>

	<ul style="list-style-type: none"><li>• Each of their networks now has a part- time paid Medical Director- role is oversight of quality efforts, meets with practices and serves on State Clinical Directors Committee. A Clinical Coordinator oversees the overall network operations. Care Managers in small practices share/large practices may have their own assigned.</li><li>• They pay \$2.50 per member per month to participate.</li><li>• Their networks assume responsibility for Medicaid recipients, implement improved care management and disease management systems, identify costly patients and costly services, develop and implement plans to manage utilization and cost, and create the local systems to improve care &amp; reduce variability.</li><li>• Keys to success for them:<ul style="list-style-type: none"><li>○ Medical and administrative committees that provide direction on local care management activities.</li><li>○ Dedicated case managers to carry out such population management activities as risk assessment, case management, and disease management.</li><li>○ Care management processes that apply both new and existing resources, such as health department support services, in meeting the needs of enrollees.</li><li>○ Regular reporting and profiling of target initiatives that allow networks to monitor their progress in achieving target goals.</li></ul></li><li>• Each network is given flexibility of how they want to run their system.</li><li>• The cost to their medical home project was 8.1 million dollars. The savings from their project was <b><u>\$60,182,128.</u></b></li><li>• Lessons learned from the North Carolina Model include: providers must be engaged and supported, a primary care based medical home is essential, they must have data to support policy and program, they must establish &amp; support collaborative systems of care, and eliminate unneeded administrative costs</li><li>• Mary Larew commented that the NCQA definition of Medical Home will be modified to fit the pediatric population.</li><li>• Ro Foege brought up a question- What is the incentive for the patient to become part of a medical home? Specifically from the North Carolina model. They have pushed relationship as a way to get services and things dealt with in an individual and up front basis. Their network had enough (750,000) patients signed up.</li><li>• Don Klitgaard added to his commend by saying that patients want a medial home. It's the patient's medical home, not the physicians. The provider is merely trying to create an environment where the patient believes that the provider is truly looking out for their best interest. They want the trust and you don't really need to sell this to anyone.</li></ul>
--	---

	<ul style="list-style-type: none"> <li>• Mary Larew mentioned that we should focus on incentives for patients to improve their health, rather than the incentive to go to medical home.</li> <li>• Tom Kline said that they are a care management learning network. It began in 1991 with the beginning of their Primary Care Case Management Program. They went to primary care providers who had at least 2,000 Medicaid patients and recruited there. Oklahoma is also doing this. It has a feature where it allows different levels of reimbursement and allows providers to move up the scale as they are ready. Higher levels of reimbursement are the incentives.</li> <li>• The North Carolina model will need to be modified for Iowa in terms of urban area and rural areas. Learning how they put their networks together and how it is structured is something we should study.</li> <li>• North Carolina’s program is much bigger than Iowa’s.</li> <li>• If you provide real investment up front, you will see huge savings in the future but not right away.</li> <li>• There are process changes, technology costs, etc. that need to happen. Part of it is cost and another is disruption to office workflow for years. There will need to be health coaches’ and disease management built into office. There is the practice level change but there is also individual transformation the practitioners go through in terms of reacting to care. Spending more time with each patient. To convince practice to do this will be tough</li> <li>• Bery Engebretsen agrees with the challenges of transformation. This is the challenge of the entire Health Care Reform Initiative. There is increasing data that it can improve outcome in intermediate terms. Theoretically there is money but it is down the road money. It is a future investment base on the fact that there will be savings down the road. This is the challenge that we are trying to come up with solutions for.</li> </ul>
<p>Oral Health and the Medical Home</p>	<p><i>Bery Engebretsen &amp; Bob Russell</i></p> <ul style="list-style-type: none"> <li>• See PowerPoint “I-Smile- Iowa’s Dental Home Initiative”</li> <li>• Bery Engebretsen introduced Bob Russell. Data from the Iowa Hospital Association in the outpatient discharges/emergency departments found that for uninsured individuals in Polk County in 2007, the number one reason for admission was for dental problems. We can’t forget the mouth when we are talking about overall healthcare.</li> <li>• I-Smile is Iowa’s dental home initiative. The mouth is still part of the body.</li> <li>• Objective: Ensure that kids have optimal oral health. What exactly constitutes a dental home?</li> <li>• By December 31, 2010, every recipient of medical assistance who</li> </ul>

	<p>is a child 12 years of age or younger shall have a designated dental home and shall be provided with the dental screenings and preventive services, diagnostic services, treatment services, and emergency services as defined under the EPSDT program</p> <ul style="list-style-type: none"><li>• A few years ago, our legislature passed a mandate that all Medicaid-enrolled children must have a dental home and be provided with screenings, prevention, diagnosis, treatment, and emergency services. this really started the ball rolling toward building a state plan for dental home for children</li><li>• In response to the legislation, the DHS (who oversees the Medicaid program) worked with our department, the IDA, the IDHA, and the UI to create what we call the I-Smile dental home initiative</li><li>• Objectives of I-Smile include improving the support system for families, improving Medicaid, and initiating recruitment and retention efforts = with the ultimate goal to fulfill this mandate and ensure children have optimal oral health</li><li>• Dental decay is preventable. If we had a system of care that worked adequately we should not have one single American having dental decay.</li><li>• Even those who have insurance and can pay are not 100 percent seeking care.</li><li>• There are huge holes in our safety net system. In the school based sealant program through IDPH, 26-28 percent of Medicaid exams see decay. Of the insured children we see 21-23 percent need fillings and have untreated decay. Insured children are not that much less than the uninsured.</li><li>• The goal is to prevent that of what is preventable and catch diseases in their earliest stage. We need to provide services to children at the very point in which teeth form in children (6 months)</li><li>• They got their first set of I-Smile data since their program has gone in effect 2 years ago. They have made very positive gains. See document “Inside I-Smile: A Look at Iowa’s Dental Home Initiative”</li><li>• There is a lot of discussion not just here in Iowa, but also nationally about what constitutes a dental home – and it may be easiest to start with what a dental home is not</li><li>• It is not one building, one service, and one relationship.</li><li>• The dental home is a <u>system</u> that allows all children, even those often excluded from receiving dental care, to have early and regular care to ensure optimal oral health.</li><li>• They believe that the dental home is a SYSTEM or a network of assuring care – that allows all children access to early and regular care and that the I-Smile initiative is one way to build this system.</li><li>• Within I-Smile, there is the ability of several different health care</li></ul>
--	---

	<p>providers to provide some of the services within a dental home – and the ability for the services to be provided in many different locations</p> <ul style="list-style-type: none"><li>• Dental hygienists, nurses, and physicians can assist in providing preventive services – most often this is a simple, yet highly effective fluoride applications as soon as teeth erupt and regularly thereafter.</li><li>• Dentists provide definitive diagnosis and treatment when needed. This system does not eliminate the need or importance of dentists – but really attempts to assist them</li><li>• In the end – having access to and receiving all of these services, regardless of location or provider – within a system that offers a way to oversee the linkages, referrals, and care – can be considered a dental home.</li><li>• The need for this network of care within Iowa is due to several reasons, including<ul style="list-style-type: none"><li>○ The limited number of dentists, especially in rural Iowa</li><li>○ The limited number that see children younger than 3</li><li>○ The need to reach at risk families in the places they are found – physicians offices, WIC clinics, schools, and even child care</li><li>○ It is estimated that 25% of children have no payment source for dental care – which gives us an even stronger argument for effective prevention</li></ul></li><li>• At the heart of building the I-Smile dental home system is the use of 24 dental hygienists as regional I-Smile coordinators.</li><li>• These coordinators are assisting families and communities through education, training, care coordination, preventive services, and more. Referrals to dentists are made based on risk assessment.</li><li>• Medical professionals are receiving training – through I-Smile coordinators as well as through a curriculum developed by the Iowa chapter of the American Academy of Pediatrics and the UI College of Dentistry. Even dental office staff are being trained on how to see children younger than 3 and the principles of the I-Smile program.</li><li>• We are pursuing policy initiatives to strengthen recruitment and retention of dental providers, particularly to rural Iowa – including the possibility of creating hospital-based dental clinics.</li><li>• Their hope is the same as everyone else’s—to assure that children are healthy beginning at birth. And in order to do that, any health care reform within the state has got to include efforts to assure that our kids have good oral health.</li><li>• This is an integrated system involving all healthcare providers. We will see benefits and prevention of diseases. The cost savings in the long term will be a benefit to Iowa. We are aware that we know that dental practices and dentists are vital to dental home.</li></ul>
--	--

	<ul style="list-style-type: none"> <li>• Bery Engebretsen commented that the demand for dental services is more the demand for medical services. This is due to shortage of dental providers seeing uninsured/Medicaid patients. It is expensive to set up a dental program</li> </ul>
<p>Next Steps <i>Legislative Report Draft</i> <i>January Meeting</i> <i>Date</i></p>	<p><i>Beth Jones</i></p> <ul style="list-style-type: none"> <li>• Early next week we will send out a first draft of thoughts on what we have discussed so far. It will be a lot of what has come up during the first two council meetings. Please provide comments and feedback through email.</li> <li>• January 9<sup>th</sup> is the next meeting. After that meeting, we will provide a second draft of a report and have final draft by January 30<sup>th</sup>.</li> <li>• By January 9<sup>th</sup>, we should know if Iowa has been chosen to participate in the CMS demonstration project. The council will be informed when we find out.</li> <li>• If you have agenda items to add to the January 9<sup>th</sup> date email Beth or Abby.</li> </ul>
<p>The next meeting of the Medical Home System Advisory Council will be held January 9, 2009 from 10am-2pm at Child Serve in Johnston.</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.