135.161 Prevention and chronic care management initiative — advisory council.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management. The state initiative consists of the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self-care efforts, providing systemic support for the health care professional-patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative or as federal law directs.

3. *a.* The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence-based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. Public members of the advisory council shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

b. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

c. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:

(1) The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXII. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.

(2) A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.

(3) A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence-based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.

(4) A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a health risk assessment.

(5) The methods for increasing communication between health care professionals and patients, including patient education, patient self-management, and patient follow-up plans.

(6) The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

(7) The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the "best in class" estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

(8) Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

(9) Methods to involve public and private groups, health care professionals, insurers, third-party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

(10) Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

(11) Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

(12) Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

(13) A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment-of-patients approach, and any results of health outcomes of the patients participating.

(14) A means of collaborating with the health professional licensing boards pursuant to chapter 147 to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

4. Following submission of initial recommendations to the director for the state initiative for prevention and chronic care management by the advisory council, the director shall submit the state initiative to the board for approval. Subject to approval of the state initiative by the board, the department shall initially implement the state initiative among the population of eligible individuals. Following initial implementation, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council shall continue to review and make recommendations to the director regarding improvements to the initiative. Any recommendations are subject to approval by the board.

2008 Acts, ch 1188, §51
Referred to in §135.162, 136.3