Prevention and Chronic Care Management

Advisory Council

First Report to the Director and State Board of Health

In response to House File 2539:
Iowa's 2008 Health Care Reform Bill

Table of Contents

Executive Summary

The 2008 Iowa Legislative Assembly created health, promotion, and chronic disease prevention initiatives within Iowa's Health Care Reform legislation, House File (HF) 2539. This legislative language created the Prevention and Chronic Care Management (PCCM) Advisory Council to make recommendations for state initiatives that would address prevention and chronic care management (See PCCM language in HF2539 in attachments).

The PCCM Advisory Council was appointed in the summer of 2008 and convened in November to begin their deliberations. This then is the first report to the Director of the Iowa Department of Public Health (IDPH) and the State Board of Health identifying priorities and initial recommendations.

The council's legislative charge is to study and develop strategies to improve health promotion, prevention, and chronic care management. The Council coordinates this work through the IDPH Health Care Reform Connections and Integration Team. The team was created to facilitate communication and referrals among all nine advisory councils created by HF2539.

Two different priorities were identified – a prevention priority addressing overweight/obesity and a chronic disease priority addressing diabetes

Prevention and chronic disease management are distinctively different and require different strategies for intervention. To acknowledge this, two different priorities were identified — a prevention priority addressing overweight/obesity and a chronic disease priority addressing diabetes. The complete proiority lists are printed on page 4.

The PCCM Advisory Council met throughout 2009 to begin deployment of strategies and to draft a state action plan. This is the initial report of the advisory council in compliance with the legislative charge. The

following six recommendations encompass fourteen focus directives (see attachments) from the legislation and lay the ground work for the ongoing work of this advisory council. The recommendations are:

1. Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management.
2. Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses.
3. Identify and recommend consensus guidelines for the use in chronic care management beginning with those that address the state chronic disease and prevention priorities.
4. Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices.
5. Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination.
6. Improve the health workforce and their skills in prevention and chronic disease management.

Ongoing work of the Advisory Council will create strategies and actions to implement their six global recommendations and build this evaluation process to measure impact.

Introduction

The transformation of Iowa's health care system from one providing "sick care" for those experiencing illness to one that focuses on the well-being of every Iowan, is among the most significant challenges existing in U.S. health care. It is well documented that prevention can save lives and reduce the number and severity of maladies Iowans experience.

Perhaps no health burden is greater for Iowans than the impact of chronic disease. Measured in lives shortened, productivity lost, and quality of life limited, the impact of chronic disease makes this one of our most urgent health care reform needs.

The Iowa Legislature has elevated these efforts to real priorities within Iowa's health care reform process. Legislators created the Prevention and Chronic Care Management Advisory Council (in HF 2539) to make recommendations for state initiatives that would address prevention and chronic care management. The Council is an interdisciplinary, multi-stakeholder group. Input is encouraged and deliverables have been and will continue to be identified and completed. The list of Council members is printed inside the back cover.

Perhaps no health burden is greater for Iowans than the impact of chronic disease.

The Iowa Department of Public Health (IDPH) has been assigned to facilitate and oversee the work of the Advisory Council, as well as the other eight advisory councils established in this legislation. The specific charge to this council is to study and develop strategies to improve health promotion, prevention, and chronic care management. The Council coordinates this work through the IDPH Health Care Reform Connections and Integration Team. The team was created to facilitate communication and referrals among all nine advisory councils.

Throughout 2009, the Advisory Council has met to identify priorities, develop strategies and draft an action plan. This is the initial report of the Advisory Council in compliance with the legislative charge.

Initial Report and Recommendations

This Advisory Council Report documents the strategies determined by consensus agreement. Fourteen focus directives (set out in the enabling legislation and attached) are gathered into six Council recommendations. They are:

1. Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management.
2. Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses.
3. Identify and recommend consensus guidelines for use in chronic care management beginning with those that address the state chronic disease and prevention priorities.
4. Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices.
5. Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination.
6. Improve the health workforce and their skills in prevention and chronic disease management.

In the tables beginning on page 5, the recommendations are listed with their focus areas. Also listed are some strategies for action and the justification language for that work.

Identified Priorities

Among other tasks, the Council has been charged with identifying two chronic disease priorities for our state. One of the ongoing initiatives of the Council will be the drafting guidelines to address the identified disease priorities and as well as developing guidelines for emerging priorities.

The Council discussed prioritization and concluded priorities for treatment and prevention were distinctly different. Prevention priorities are broader and impact several diseases as they address the underlying causes of disease. The disease priorities were built upon the incidence and impact of chronic disease and related to treatment and management. The council elected to identify two rank-ordered lists; one related to prevention and the other related to chronic disease management:

Prevention Priorities

1. **Obesity**
2. Cancer
3. Coronary Artery Disease
4. Diabetes
5. Human Immunodeficiency Virus (HIV)
6. Lower Back Pain
7. Neurological/Behavioral
8. Chronic Obstructive Pulmonary Disease (COPD)
9. Hypertension
10. Mental Illness
11. Hyperlipidemia (High Blood Fats)
12. Arthritis
13. Congestive Heart Failure (CHF)
14. Asthma

Chronic Disease Priorities

1. **Diabetes**
2. Congestive Heart Failure
3. Hypertension
4. Mental Illness
5. Hyperlipidemia (High Blood Fats)
6. Cancer
7. Neurological/Behavioral
8. Lower Back Pain
9. Chronic Obstructive Pulmonary Disease (COPD)
10. Asthma
11. Arthritis
12. Coronary Artery Disease

The lists above reflect the selection of obesity and diabetes as the top priorities from each category, and therefore the focus areas for Iowa as set forth in the enabling legislation. Working from those priorities, the Council continues to devise strategies for intervention, patient education and other actions that make up efforts to battle these two major health challenges.

Next Steps

The Council expects to continue meeting and developing work plans to address the identified priorities. Meetings take place approximately monthly, with occasional conference calls facilitating the work of individual workgroups. A second report to the Governor and legislators is due on or before July 1, 2010.

1 RECOMMENDATIONS Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management.

FOCUS AREAS (FROM HF2539)

Focus Area 1

Appoint a multi-stakeholder partnership group to provide leadership and oversight, and to manage the process.

Focus Area 2

Identify leading health professional champions through boards, societies, and peers, as well as other advocates to partner in unifying existing initiatives and programs.

Focus Area 9

Maintain Health Care Reform Advisory Councils in support of IDPH and other wellness and health initiatives.

STRATEGIES AND ACTIONS

Create the Chronic Care Advisory Council: charges to the Council:

- Provide regular reports to the Director regarding wellness, prevention, and chronic disease management.
- Provides guidance and oversight for Iowa Department of Public Health's development of the Chronic Disease State Plan.
- Integrate and coordinate Iowa public and private wellness, prevention, and chronic disease programs, services and research.
- Provide guidance (oversight) for implement new models and programs meeting the needs of Iowans and partner in dissemination of evidence-based programs.

JUSTIFICATIONS

The function of this recommendation is to make the Prevention and Chronic Care Advisory Council permanent and to empower it with the authority to provide leadership and direction for wellness and prevention matters.

At this time, multiple government and private groups provide a patchwork set of wellness, prevention and chronic disease management programs for Iowans. The lack of reimbursement for wellness within the current health care treatment systems means that there is always a challenge to finance wellness, prevention and chronic disease management, despite proven cost effectiveness. Field research to identify evidence-based intervention models is needed in some areas, and in others effective programs have not had the financial support or human resources to be widely disseminated.

For the most part, data and measures of wellness are limited to specific intervention program data or the state Behavior Risk Factor Surveillance Survey (BRFSS) and its counterpart which addresses young people. Public Health data provides information about mortality and morbidity and disease incidence. Wellness and health status is often extrapolated as being relevant to those measures as well. Better data is necessary to build, evaluate and monitor wellness and prevention programming and to measure the ability to produce cost savings using these strategies.

continued

JUSTIFICATIONS (continued)

The Council will provide coordination, oversight and leadership for public and private stakeholders to move the plan forward and integrate efforts. Development of a state plan is a priority, as is funding the models to identify what works. As the population ages and the incidence of chronic disease grows, the support services to manage and minimize the impact of both become increasingly important. The time to begin this work is now, with a deliberative approach and a team of champions with vested interest in a healthy future. This creation of an advisory body to direct statewide planning and implementation is a strong first step.

Chronic Disease State Plan

- Coordinate the efforts of health care professionals and resources to promote the health of Iowans and the prevention and management of chronic conditions;
- Develop and implement arrangements for delivery of prevention services and chronic care management;
- Develop significant patient self-care efforts;
- Provide systemic support for the health care professional-patient relationship and options for channeling chronic care resources and support to health care professionals;
- Provide for community development and outreach and education efforts; and
- Coordinate information technology initiative with the chronic care information system.

2 RECOMMENDATIONS Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses.

FOCUS AREAS (FROM HF2539)

Focus Area 5

Provide the necessary support that allows individuals to collect and use their own health care data and to manage their own chronic disease.

Focus Area 10

Provide individual access to personal electronic health records.

Focus Area 6

Build awareness, understanding and ability to manage individual health and wellness through community resources.

continued

FOCUS AREAS (FROM HF2539) (continued)

Focus Area 6

Identify community wellness practices that work and publish those best practices and success stories.

Focus Area 12

Implement a multi-venue marketing campaign promoting education in prevention and chronic care management that is culturally and geographically specific.

STRATEGIES AND ACTIONS

- Collaborate with the ongoing efforts of the Electronic Health Information Advisory Council and Executive Committee to secure public and private funds for the purpose of creating and promulgating tools that build an individual's knowledge and understanding (health literacy) and access to their own health data, their health resources and the means to access health information for decision making defined as a "personal health record" (PHR).
- Design strategies that expand access to useful health information for individuals to support health decision-making. The information may be used to increase personal wellness or to manage a chronic disease (enhanced* health literacy). This concept includes interpretation of the results of medical tests and studies, especially for Iowans who are managing one of the identified priority disease conditions.
- Design strategies that build continuity of care and care coordination into care programs and practices for management of multiple providers and multiple tests with the goal of disease management.
- Identify and share successful practice models in which individuals have access to their electronic PHRs.
- Identify and share the community-based models that provide referral reference points for providers and aid the support of individuals in the management of their own or another's chronic disease, or in living a healthy lifestyle.
- Encourage communities to implement environmental and community-based changes that lead to improved population health status, i.e. green spaces, parks, trails, wellness ctrs., community gardens, transportation or Healthy Iowans 2010/2020 etc.
- Identify and share a community model that partners public health and other public and private providers with community planners and designers for development of cities and communities that foster healthful living and healthy choices.
- Using statewide partnerships provide resources, information, support, and technical assistance for communities seeking to become healthy communities, with specific emphasis on the identified priority disease states.
- Commission the development of a social marketing plan designed to build awareness and motivate behavior change toward more healthful living and making healthier choices.

JUSTIFICATIONS

Iowans often are challenged to make the right choices for living a healthy life. A very high level of knowledge and understanding is required for healthful living and medical decision-making, especially if one is managing a chronic disease. Access to information about one's own health status can be difficult to obtain; education about healthy choices and healthy living often are not accessible; and the environment may present barriers such as affordability or access to those most basic of health elements such as proper nutrition or exercise.

**From the National Network of Libraries of Medicine: "Health Literacy" is the degree to which the individual has the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.*

continued

JUSTIFICATIONS (continued)

Among medical providers, important topics in current health discussions include health literacy, electronic health records, personal health records, health risk assessments, continuity records, practice registries, disease management, and electronic medical records. Within the community health sphere, dialogs include available fresh produce, community green spaces and parks, bike trails and street and community design for safety. Public health dialogs around health include access to health services, health policies, clinics for screening and immunizations, population specific services, disease control, risk mediation, chronic disease management, and health education. Like the blind men viewing an elephant, all of the elements that contribute to the ability to live a healthful life stem from a multitude of places.

At the core of all of these discussions is the fundamental principle that every Iowan has the right to know and understand their health status, and should be empowered with the knowledge necessary to make the changes necessary to improve their own health status.

A broad array of gaps in the opportunities for optimal health and healthful living present themselves and dozens of strategies can be identified to improve the circumstances leading people to better lifestyles, either in making daily life choices or in managing chronic disease. An entity that would lead and provide oversight for a partnership of stakeholders; to identify strategies and address their implementation, would be important because of the broad nature of this elephant we are trying to move.

There is a lack of consistent and uniform definitions, programs and electronic products for providers to use, much less for the public to understand. Electronic medical records (EMR) may or may not be a part of provider practices, and they may or may not support registries that allow the provider to analyze the practice compliance with standards and guidelines for disease treatments. Those EMRs may or may not be compatible with any other practices and may or may not be able to provide the patient with a personal health record (PHR). These EMRs may or may not provide continuity or coordinative functions allowing communication among all providers serving a client to avoid multiple duplicated tests or procedures or avoid a lack of communication among specialist and consultants. Significantly, there is a lack of resources for interpretation and consultation for patient decision-making, now being referred to as “patient coordination.”

There is a lack of evidence-based and field-tested health promotion and disease management models that would support community based education about the most common of chronic diseases and almost no resources for ongoing provision of these programs and support groups in every community. This would include the current identified priorities for the Iowa prevention and chronic disease management project. The models that are in place for disease management or chronic disease education do not reach a critical mass of Iowa populations, much less every patient with the diagnosis. There are plenty of opportunities for improvement.

The beginning recommendations that come out of this work can set the stage for ongoing and higher level work as we identify what works and what is making a difference. The Council finds solutions reside in broad approaches, partnerships for solutions, and use of a core oversight body to monitor and lead the work.

Consensus guidelines are care parameters that are developed by experts in the field and adopted widely as standard and quality practice.

3 RECOMMENDATIONS Identify and recommend consensus guidelines for use in chronic care management beginning with those that address the state chronic disease and prevention priorities.

FOCUS AREAS (FROM HF2539)

Focus Area 4

Develop a standard of data collection for prevention and chronic care management.

Focus Area 6

Promote the use of web based resource sites by publishing credible resources for use by individuals, providers and communities and by use of existing health information technology to enhance patient self management and health care information.

Focus Area 11

Develop an evaluation component to provide content on both the process of developing prevention and chronic disease management systems as well as identifying outcome successes and population impacts.

STRATEGIES AND ACTIONS (continued)

- Work with the Electronic Health Information Advisory Council and Executive Committee to incorporate data gathering and measurement that will monitor and evaluate benchmarks and change related to the current priorities. This needs to be a population-wide effort in Iowa. Providers will benefit from the tools and the mandate to collect and report relevant health information from patients.
- Develop and publish the State Chronic Disease Plan and the collected relevant data in a regular chronic disease report.
- Publish credible (in multiple venues – web sites, 211 systems, telephone referrals and newsletters) sources of information and promote the sources to people.
- Work with Electronic Health Information Advisory Council, IDPH and others to build a chronic disease plan for the state which includes an evaluation component and the systems for gathering and analyzing data to judge success and impacts.

continued

JUSTIFICATIONS

Consensus guidelines are care parameters that are developed by experts in the field and adopted widely as standard and quality practice. The standards allow the planning of treatment that meets the quality standards, accommodates the services to patients across multiple providers, and provides the basis for generation of the data needed to evaluate practice performance and set benchmarks for quality improvement.

The importance of the metrics and data to judge performance cannot be underestimated – in fact, measurement and evaluation of impact is one of the underpinnings of medical or public health practices. It is the only way we know we are improving the lives of patients or of the public. This work could take multiple directions – clinical values compass (a sort of dashboard for clinical practice measures), or health risk assessments (individual measures of health status and risk for targeted populations) or patient portals (vehicles for individuals to gain access through their health provider to their own health data and information), but the type of data and the mechanism for measuring would reflect the goals of the initiative.

Individual efforts at measuring outcomes have been made in Iowa, with some success. Most notably, the Iowa Healthcare Collaborative has measured hospital infection rates and created some transparency around that information. However, Iowa has yet to experience a system of quality improvement that is based on individual patient data and health behavior changes.

The importance of the metrics and data to judge performance cannot be underestimated – in fact, it is the only way we know we are improving the lives of patients or of the public.

4 RECOMMENDATIONS Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices.

FOCUS AREAS (FROM HF2539)

Focus Area 7

Develop a chronic disease registry that links to medical home practice population registries and collects incidence, treatment, and outcome data.

Focus Area 13

Analyze registry data to assess opportunities for improving outcomes and expanding model practices.

STRATEGIES AND ACTIONS

- Explore and certify chronic disease registry products that meet Iowa standards for practice based registries. Maintain and update those Iowa standards over time.
- Develop a state supported chronic disease practice registry product to make available to local practices and provide support technical assistance (practice coaches) for implementation.
- Provide technical assistance and training for practices to learn to work with their registries and create analysis of practice performance.
- Partner with the Electronic Health Information Advisory Council and Executive Committee and the Medical Home Advisory Council to seek federal and state funding to make chronic disease practice registries available in every Iowa doctor's office for chronic disease management and function as a coordinating body for practice registries
- Encourage the Iowa eHealth Project to incorporate practice registries as one of the required functions of a certified Electronic Health Records option for Iowa providers.

JUSTIFICATIONS

Disease registries are databases from which reports can be generated that identify patients with a diagnosis, groups with certain treatments, compliance with standards and guidelines or other data sorts that assist in evaluation of practice and treatment processes. While some electronic medical record systems have a registry function, many do not. Some practice registries are fairly basic and others facilitate the analysis and reporting functions for the general medical user.

The cost for implementation of a practice registry can be substantial and limit the use in private and public clinic practices which also limits practice improvements for chronic disease patient populations. The staff cost and the training time to make use of the registry adds an additional barrier. Finally, a patchwork of different types of software, systems and data recorded could create incompatibility and defeat the purpose of any statewide reporting system. It is important that before any eHealth system is promulgated in Iowa, it have as one of its functions a basic interactive patient-centered disease registry.

The Advisory Council felt there is a role for the state in support of this practice tool given the impact it has on improvement of chronic disease management once implemented. Practice based registries make a large difference in population based performance within a practice.

continued

JUSTIFICATIONS (continued)

Several groups have developed practice registries and have had success with implementation of their products: Wellmark BCBS uses a product called MD Data Corps; The Iowa Foundation for Medical Care developed a practice registry product called CareMeasures; the Academy of Family Physicians uses a product called TransforMed; and several Iowa practices implemented this product. There is a national model available for Community Health Centers that also has a network component that allows clinics to replicate successful initiatives from other communities in the network. Iowa Healthcare Collaborative is doing this as well and has the ability to do the analysis of practice data.

The Advisory Council finds a statewide chronic disease registry is not recommended. Members feel the physicians would be reluctant to participate, that the motivations for the physician participation would be low, and that a state registry would have to have programs that wrapped around the registry for it to be able to have any measurable impact on chronic diseases in the state.

Never doubt that a small committed group
can change the world in fact
it is the only thing that ever has.

– Margaret Mead

5 RECOMMENDATIONS Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination.

FOCUS AREAS (FROM HF2539)

Focus Area 8

Develop methodologies to align prevention and chronic care services to support wellness health improvement objectives and advocate for these methodologies in public and private sectors.

STRATEGIES AND ACTIONS

- Work with the Medical Home System Advisory Council to identify methodologies in support of practice patient registries within medical homes and work to advocate for these methodologies.
- Recommend and highlight payment methodologies that support providers to give more attention to prevention and chronic disease management.

continued

STRATEGIES AND ACTIONS (continued)

- Work with the "Reimbursement Strategies" workgroup which has been formed by the Medical Home System Advisory Council.
- Support community prevention and chronic disease management programs as a resource for medical referrals and build individual capacity to self manage chronic disease.

JUSTIFICATIONS

Prevention and chronic disease management at the community level arise out of medical practices and out of public programming from public health or as community outreach from institutions or clinics. Lack of adequate funding for public health and public sector programs such as these have limited their availability to physicians. Additionally, a lack of connectedness to either hospitals or physicians in the community has limited referral potentials.

There is a strong opportunity to develop evidence-based community programs that would provide individual and group education and supportive services for chronic disease management. There is a high-level opportunity to partner the medical practice in monitoring and the community programs in support and education to find models that are highly successful in minimizing disease impact, and complications, and improving patient well-being.

Much of the direction coming out of the development of the American Recovery and Reinvestment Act of 2009 (the federal "stimulus package") and other federal legislation is focusing on accountable care organizations, medical homes, bundled payments and direct disease management.

There is a lot of conversation about care coordination and integrating services. The payment for this uses providers other than physician services and encourages other providers as supplements to the medical care of the physician and is designed to expand the medical care with care management education and care coordination strategies. Most chronic diseases involve a cadre of practice specialists and the patient is frequently the communicator among the providers and the treating institutions with varying degrees of success. Care coordination, health coaches, wellness coordinators and multiple other system facilitators are being identified as important to the overall success of modern treatment for chronic disease. As these become the new brokers for health care services, successful models will need to establish those with success for chronic and ongoing disease and for wellness and health improvement goals.

Care coordination, health coaches, wellness coordinators and multiple other system facilitators are being identified as important to the overall success of modern treatment for chronic disease.

6 RECOMMENDATIONS Improve the health workforce and their skills in prevention and chronic disease management.

FOCUS AREAS (FROM HF2539)

Focus Area 14

Develop and implement wellness, health maintenance and chronic disease management content to all state credentialed health professional curriculums.

STRATEGIES AND ACTIONS

- Partner with health workforce educational and regulatory and licensing bodies to review prevention and chronic disease management content of current curriculums, and recommend changes to support the skill base of health professionals.

- Enhance professional prevention and chronic care management continuing education opportunities for all providers.

- Provide continuing education for providers related to counseling techniques that are effective for making behavior change (motivational interviewing) and culturally sensitive teaching techniques that are effective and in skill development related to creating written materials that are readable and easily understood by the target audiences.

- Inform the Health and Long-Term Care Access Advisory Council, which is leading Iowa's health work force efforts, about these priorities

JUSTIFICATIONS

One of the keys to changing practice is embedding the new learning objectives into the primary preparation of the health practitioner. Current focus on acute services in our education and the absence of chronic disease management content hinders our ability to provide adequate education or support to a population with high incidence of chronic disease. The lack of preparation for teaching or motivating compliance with healthy lifestyles is exacerbated by health provider shortages which further force the focus on acute treatments.

The need for prevention services is universal, yet the professional preparation is lacking in many cases–with the exception of a few professions that target health education methodology (nursing, health education). Increased learning opportunities which address wellness within each health professions curriculum would enhance provider capacity to become wellness coaches for patients and clients. Curriculum adjustments should remain coordinated with the strategic plan for health care delivery infrastructure and health care workforce resources required by Iowa Code 135.163 and 135.164. The Health and Long-Term Access Advisory Council should receive updates as appropriate during the development of such curricula, given its makeup and charge.

Health care is ever changing and ongoing continuing education is a must and never more important than for prevention and chronic disease management. This council recommends that the curricula should include those skills of motivational interviewing, health assessments, culturally competent education and development of written materials that produce the learning they intend.

continued

JUSTIFICATIONS (continued)

Many current certification programs already value the prevention and health promotion components related to that health profession – Continuing Medical Education (CME) have this content as a requirement of many medical certifications; nursing advance practice certifications also include this content as part of their curriculums and their continuing educational requirements, etc.

Finally, it is important to recognize the impact of other factors on chronic disease and the extent of the burden it may become for the individual and family. These are social and community factors such as: education, income, housing, and access to health care or medications and support systems. Employment is a factor related to the impact of chronic disease as are other community factors such as social connectedness and outlook on life. Some very effective support strategies for improvement in health may be social supports, and innovative approaches might facilitate grass roots community strategies that have a great impact on health.

Social and community factors have great impact on health. Effective health improvement strategies include community-based, grass roots social support programs.

Conclusion

The Prevention and Chronic Care Management Advisory Council looks forward to continuing its work with other councils, and state and private stake holders in fulfillment of its legislajtive charge.

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.

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/The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and 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.

8. Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals

9. Methods to involve public and private groups, healthcare 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.

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 to review prevention and chronic care management education provided to licensees and recommendations regarding educa tion resources and curricula for integration into existing and new education and training programs.

DIVISION IX

PREVENTION AND CHRONIC CARE MANAGEMENT

DIVISION XXIII

PREVENTION AND CHRONIC CARE MANAGEMENT

Sec. 50. NEW SECTION. 135.160 DEFINITIONS.

For the purpose of this division, unless the context otherwise requires:

1. "Board" means the state board of health created pursuant to section 136.1.

2. "Chronic care" means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.

3. "Chronic care information system" means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.

4. "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

5. "Chronic care plan" means a plan of care between an individual and the individual's principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient's own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.

6. "Chronic care resources" means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.

7. "Chronic condition" means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.

8. "Department" means the department of public health.

9. "Director" means the director of public health.

10. "Eligible individual" means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance, is a member of the expansion population

pursuant to chapter 249J, or is an inmate of a correctional institution in this state.

11. "Health care professional" means health care professional as defined in section 135.157.

12. "Health risk assessment" means screening by a health care professional for the purpose of assessing an individual's health, including tests or physical examinations and a survey or other tool used to gather information about an individual's health, medical history, and health risk factors during a health screening.

Sec. 51. NEW SECTION. 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.

Prevention and Chronic Care Management Advisory Council

Name	City	Position
Jose Aguilar, MD	Des Moines	Iowa Nebraska Primary Care Association
Bill Appelgate	Des Moines	Des Moines University
Mary Audia, DC	Coralville	Iowa Chiropractic Association
Krista Barnes	Des Moines	Iowa Physician Assistant Association
Steve Flood	Des Moines	Holmes Murphy and Associates
Trula Foughty, RN	Des Moines	Iowa Healthcare Collaborative
Della Guzman	Des Moines	Iowa Health System
Terri Henkels	Des Moines	Iowa State Association of Counties
Melanie Hicklin, ARNP	West Des Moines	Iowa Nurses Association
Tom Kline, DO	Des Moines	Iowa Medicaid Medical Director
Kathryn Kvederis, MD	Des Moines	Iowa Psychiatric Society
Noreen O'Shea, DO	Elk Point	Iowa Academy of Family Physicians
Rahul Parsa	Des Moines	State Board of Health
Patty Quinlisk, MD	Des Moines	State Government
Peter Reiter, MD, FACP	Ottumwa	Internal Medicine
Rev. Dr. Mary E. Robinson	Waterloo	Consumer
Suzan Simmons, PhD	Des Moines	Iowa Psychological Association
Donald Skinner, MD	Carroll	McFarland Clinic
Steve Stephenson, MD	Des Moines	Pediatrics
Jacqueline Stoken, DO	West Des Moines	Iowa Academy of Osteopathic Medicine
John Swegle	Mason City	Iowa Pharmacy Association
David Swieskowski, MD	Des Moines	Iowa Medical Society
Debra Waldron, MD, MPH	Iowa City	Child Health Specialty Clinics/IDPH
Jenny Weber	West Des Moines	Wellness Council of Iowa

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Iowa Department of Public Health
Promoting and protecting the health of Iowans

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