September 15-17, 2010, Cedar Rapids, Iowa

Health Resources and Services Administration
Office of Rural Health Policy

Cedar Rapids, Iowa
September 15-17, 2010

Meeting Summary

The 66th meeting of the National Advisory Committee on Rural Health and Human Services was held September 15-17, 2010, in Cedar Rapids, Iowa.

Wednesday, September 15, 2010

The meeting was convened by The Honorable Ronnie Musgrove, Chairman of the Committee. The Honorable Robert Ray, Former Chair of the Committee, welcomed the Committee to Iowa.

The Committee members present at the meeting were: Governor Ronnie Musgrove (Chair); Graham Adams, Ph.D.; April M. Bender, Ph.D.; Maggie Blackburn, MD; B. Darlene Byrd, MNSc, APN; Sharon A. Hansen, Ph.D.; David Hartley, Ph.D., MHA; David Hewett, MA; Donna K. Harvey; Thomas E. Hoyer, Jr., MBA; Todd Linden, MA; A. Clinton MacKinney, MD, MS; John Rockwood, Jr., MBA, CPA; Maggie Tinsman, MSW. Mr. Dennis Dudley attended representing the U.S. Administration on Aging.

Present from the Office of Rural Health Policy were: Tom Morris, Director; Jennifer Chang and Paul Moore. Truman Fellows present were: Catherine Koozer; Natasha Scolnik.

State Office of Rural Health Welcome

Julie McMahon, Division Director, Iowa Department of Public Health

Julie McMahon welcomed the committee to Iowa on behalf of the Iowa Public Health Department. Ms. McMahon said that Iowa is working hard to be a state where healthy people live in healthy communities. She spoke about the Healthy Communities Program in Iowa. It includes approximately 35 communities that have taken Healthy Community Grant dollars to use evidence based programs and local programs to make their communities healthier. She

noted that this is a testament to how large and small communities in Iowa are making a difference. She also referenced the Rural Health and Primary Care 2010 Annual Report. She said that there is information in the report on how Iowa is addressing access to healthcare, prevention and wellness and other issues.

Ms. McMahon noted that Iowa is a small state. The population is close to 3 million. 80% of the State meets the rural definition. She said that Iowa is big in many ways and has many assets and resources. People, agriculture and financial business are assets in Iowa.

There is a strong healthcare system in Iowa with quality hospitals. Critical Access Hospitals are very important in the State. There are exceptional Primary Care Providers and specialists in the State. Access to medical care is vital in rural communities. Transportation is a challenge to healthcare access in rural Iowa and workforce is also a challenge. There have to be primary care providers in rural communities to see patients.

Prevention and wellness, the health home concept and health equity are challenges. She said that there are obesity programs in the rural communities that are making a difference and are necessary throughout rural communities. A health home is a critical challenge and there needs to be partnerships between the public and private sector to create a health home so that there are healthy outcomes. Health Information Technology is a huge challenge moving forward.

The public health system is an asset in Iowa. Boards of Health are an important asset in improving the health of communities and local public health agencies are also vital. There are around 32 public health agencies that are housed in or are part of a hospital system. This has made the public health system stronger in those counties. Community health needs assessments are done by the local board of health every 5 years. They look at health priorities and how to address them. This has contributed to businesses being willing to come into communities because health issues are being addressed.

Making the Public Health Systems stronger is important in the State of Iowa. The challenges include the public health workforce. In the past two years, there is a 28% of public health administration turn over. Most of the turn over is with public health nurses. The State of Iowa is seeing that many public health administrators are only staying a year. She noted that this is due to difficult budgets, grants, sliding fee schedules and health equity issues. The support of the workforce and recruiting more work forces in the public health setting is critical. The changing role of public health as health care reform is implemented will be an issue. If a majority of people are covered in the United States there will still be a need for public health but it may be a different role and the workforce has to be prepared. Oral healthcare and nutrition services are

important. She stated that oral health and nutrition and wellness used to not be part of the public health system.

The education system starts in early childhood and goes through elementary and middle school and into higher learning institutions. The early childhood system is very important and she noted that they have been fortunate with support of the legislators in support of early childhood in Iowa. Ms. McMahon spoke about the challenges of transportation. Getting children to school is an issue. Schools are being consolidated and this makes the commute for children longer. Access to schools is an issue.

Chronic disease is an issue in Iowa. There have been advances in the prevention of tobacco use and there are advances been made in obesity issues. She spoke about movements that are being made on a community level to change peoples' eating habits. Walking paths, bike paths and converting vacated buildings to places for affordable physical activity for communities are ways that Iowa are making a difference in the battle of obesity.

There is a large aging community in Iowa. Personal health services and nursing services for the chronic frail elderly who are living at home is tremendous. The younger population is moving out of the rural communities and they are left with the older population and this needs to be addressed. The Area Agency on Aging is a huge asset in Iowa. Those agencies in partnership with public health and the private sector are a great asset.

Ms. McMahon stated that another asset is the State Office of Rural Health in Iowa. It maintains focus on the rural initiative. She also noted that the people of Iowa are an asset in Iowa and in every rural state of the Country. She closed by stating that they need to make sure that there is access to health and human services in Iowa.

Childhood Obesity in Rural Communities

Deborah Waldron, MD, MPH, FAAP – Chief Medical Officer and Co-Director, Child Health Specialty Clinics

Deborah Waldron began by sharing with the committee that she is the Vice President of the Iowa Chapter of the American Academy of Pediatrics. She emphasized that she is a pediatrician but not a family practice doctor. She cares for the 0-21 population. Dr. Waldron said that she would be talking about childhood obesity, contributing factors, and efforts to combat obesity. She noted that childhood obesity has to be discussed as a public health and legislative issue.

Dr. Waldron stated that the definition of child health is to develop and realize potential, satisfy children's' needs and develop their capacities. These factors allow children to interact

successfully with their biological, physical and social environments. Dr. Waldron said that childhood obesity is a problem that all public health entities and legislative officials have to address.

Healthy People 2020 Initiative is to eliminate preventable disease, disability, injury, and premature death. It includes achieving health equity, eliminating health disparities and creating social and physical environments that promote good health for all. Healthy People 2020 Initiative also includes promoting healthy development and healthy behaviors at every stage of life. Healthy People 2020 talks about social determinants of health and interventions, and policies and programs that need to be put into place.

Dr. Waldron stated that obesity is a chronic disease and is not something that happens overnight. She said that once people become obese it is hard to overcome the related health problems and control the weight issues in the future. The best cure is prevention. She spoke about the Body Mass Index of children and noted that it is calculated differently for children. People want to be between the 5th and 85th percentile. There are Body Mass index differences for age and gender. Dr. Waldron stated that childhood obesity has increased more than 4 times among children ages 6 to 11 years of age in the past 4 decades. September is National childhood Obesity awareness month and this is very important because obesity is a pandemic in the United States. Childhood obesity affects all of a child's systems. There are psychological, neurological, cardiovascular effects as well as the risk for diabetes and early puberty. There is a risk of vascular, muscular and skeletal problems also. Social health is a huge problem for obese children. Dr. Waldron said that an article from 1994 said that there are critical periods in children's life that if they become obese, they will always have a problem with their weight. Gestation and early infancy is a time when it is very important for mothers and babies to have a healthy diet. She stated that every child should be breastfed exclusively until they are 6 months old.

She spoke about the impact of obesity in Iowa. There was an 84% increase from 1990 to 2008 in the number of adults classified as obese. The incidence of obesity of the children in Iowa shows disparities between the rich and poor. Dr. Waldron noted that the socioeconomic factors are what are causing the people who are poor to have a higher rate of obesity.

Dr. Waldron reiterated that if babies were breast-fed up to the age of 6 months that there would be a lower rate of obesity. She also noted that children should be drinking water or milk but not juice. She said that there need to be safe places available for children to get exercise. There needs to be more walking trails and safe places that are affordable for children to get physical activity in rural communities. She said that diet and activity are the key determinants to obesity.

She stated that there are a higher percentage of overweight people in rural areas than in urban areas in Iowa.

Dr. Waldron stated that the national and state solutions to the obesity pandemic include Michelle Obama's Let's Move Initiative that is in partnership with The American Academy of Pediatrics. They are trying to implement it in the Sate of Iowa. The obesity initiative shows that there is an interest in the highest office in the nation to put funding and support into facing the pandemic of obesity. She said that the Rx for Healthy Active Living is something that is being given to patients as a prescription for healthy living. It prescribes 5 or more healthy fruit or vegetables a day, no more than two hours of screen time, 1 hour of physical activity and not to drink sweetened fruit drinks or soda. She said that collaboration, partnerships and linkages at a local, state and federal levels will make are important towards ending the pandemic of obesity. She closed by saying that the people of Iowa are paying attention and trying to make change but they still have a way to go.

Linda Snetselaar, RD, PhD- Professor and Nutrition Center Director , University of Iowa College of Public Health

Linda Snetselaar discussed four different studies that they are doing at the University of Iowa. Two of the studies are related. The Diet Intervention Study in Children started 20 years previous. They are now looking at the women from that study and seeing if the dietary patterns they had when they were younger is making a difference in their 20's. She also spoke about A Childhood Wellness and Prevention Program and a Brief Motivational Interview to Reduce Body Mass Index study.

The Diet Intervention in Children began in 1990 and involved rural and urban children. They randomized intervention and usual care. There were 6 centers throughout the United States. The study compared a reduction in saturated fat intake with usual patterns for the American population. The behavioral strategies used were motivational interviewing. Children were eight years old with elevated cholesterol when they started the program. The study examined the safety of having a diet with lower saturated fat and how it affected their cholesterol levels. Screenings were done at the schools and families were included in the intervention. Work was done with the families to change the way the family looked at food and change their eating habits. The school board and school administrators were involved. The study included a research nutritionist and school psychologist. The Diet Intervention in Children study concluded that the reduction in saturated fat is effective in lowering LDL- cholesterol levels.

The Diet Intervention in Children Hormone sub-study looked at hormone levels in girls. The study found that there was 53% less of a progesterone level in the intervention group in

comparison to the uncontrolled group. Progesterone is related to breast development and lower levels is related to breast density and potentially some types of breast cancer. The sub-study re-examined girls from the study when they were in their 20 have to see if there was a difference in breast density.

In 2006, dietary recalls and the outcomes to look at metabolic syndrome and breast density were done. The study found that mono and saturated fat tended to be associated with breast density. Saturated fat was not associated with breast density. Dr. Snetselaar said they also found that there were lower levels of fasting blood glucose and systolic blood pressure in the group that was consuming lower saturated fat.

Dr. Snetselaar said the Childhood Wellness and Obesity Prevention Program is being done in Muscatine and in Fort Dodge. The study is in partnership with the University of Michigan. In Muscatine they spent 3 years doing a community assessment. They worked with the communities, schools and local officials so that everyone was involved and trusted each other. Dr. Snetselaar said that the Superintendent attended every meeting and was very involved and that was very important. The data is being examined and there will be pre and post intervention data on the study. Motivational interviewing was used for the study and they looked at Body Mass Index, attendance, skill scores and school climate. They did a sub-study in the middle schools and found that children had metabolic syndrome in middle school. The YMCA, a pediatrician and a dietician from the hospital were also involved.

Dr. Snetselaar also shared other school health wellness initiatives. She told the committee about a Breakfast in a Bag Program in Iowa. Students, who were late to school late and missed breakfast, receive a bagged breakfast to take to the classroom and eat. The program assured that children were not hungry and unable to concentrate in class. Another benefit of the program was that many children stopped coming late to school because they wanted to eat with everyone else and not take their breakfast to the classroom. There are walking programs for teachers to walk with students after school. There are also intramural activities during homeroom class for students who finish their homework. They can go to the gym and participate in a physical activity. There is also an after-school swimming program for students that are not able to participate in group sports. The Fort Dodge Schools started the swimming program and it was so successful that they started the program in other schools. Dr. Snetselaar said that they have started working in the pre-schools because the younger the child is the easier it is to make a difference in prevention. Nutrition fairs and family nutrition fairs are a successful way to educate families and children.

Dr. Snetselaar spoke about the Fort Dodge Wellness Initiative. A nurse from the local hospital goes to the schools and helps with programs. There is a program called the Monthly Lunchroom

Challenge in the elementary school. Children get a token with their name on it when they eat healthy. The student's token goes into a bag and if their name is chosen they get a prize.

The Body Mass Index Program is a network of dieticians who are working with pediatricians. The focus of the study is on motivational interviewing and the population is children ages 2-8 years old with BMI's between 85th- 95th percentiles. The focus is on parents working with their children to modify their eating habits. The study includes pediatricians who know how to do motivational interviewing, pediatricians who don't know how to do motivational interviewing and pediatricians and dieticians who are using motivational interviewing. The program looks at the BMI change after a 2 year intervention. It focuses on pediatric practices in rural areas of the United States with private practice expertise. The physicians are trained in mass index and the population is obese but a well population. The purpose is to change the climate culture and change the problems with obesity. Also, it is important to changing the ways to talk to children about what they eat to make it more interesting. Instead of saying "eat one half cups of vegetables everyday", they are working with concepts like "consider coloring your plate with all kinds of great tasting vegetables". Pediatricians are talking to the parents about providing food for their children that is healthy and having healthy selections of food. They are also teaching the parents how to talk to their children about food. An example is instead of saying, "eat that for me", saying "this is kiwi fruit; it is sweet like a strawberry".

In conclusion, Dr. Snetselaar, said that changing a community using evidence wellness based ideas can be difficult. The research can be difficult but the message needs to be simple. She stated that their goal is to translate the research to the community without creating confusion. The community needs to decide the type of intervention that will work the best for that community.

Q&A

David Hartley asked if culture leads to dietary behaviors and if there has been a focus on parents as a way of culture change regarding eating habits.

Linda Snetselaar responded that foods that people grow up with and that are comfort foods make a big difference. If interventions are started early and include the entire family, you are more likely to get behavior change. It is much more difficult to have change even with older children and some studies show that eating behaviors can be formed by age 2 ½. Change needs to happen when mothers are pregnant. There needs to be a very early focus in daycare and pre-school settings also. They are also working with employees on wellness programs and adults are bringing in recipes to learn how to make the foods that they like with healthier ingredients.

Maggie Tinsman asked if children in rural areas have less physical activity than children in urban areas. If so, why is it true?

Dr. Waldron responded that it is true and it may be because there aren't safe areas for children to play. Another reason is that children are using computers more or watching television and being more sedentary. There are not as many places for children to go for activities in rural communities.

David Hewett said that he is from South Dakota and that he works with hospital administrators. He stated that it is commendable to hear practitioners talking about health wellness with patients. He asked if there are enough incentives in the delivery system for hospitals and health systems to be involved, supportive and encourage ways of reducing childhood obesity rates. He gave an example of state Medicaid programs paying providers to keep kids well instead of just treating them when they are sick. Is there something that can be done to enhance programs to do this?

Debra Waldron said that if health reform stays that she thinks there will be an opportunity for things in health reform to make a difference. One is the payment reimbursement and payment redesign. Without payment redesign and insurance companies recognizing that they have a stake to make sure they are funding prevention measures, they will not be able to make a change. Health care systems pay for procedures and taking care of people once they are sick with chronic illness instead of paying to prevent the illness. Health systems in terms of Accountable Care Organizations will be able to achieve it if the reimbursement mechanism is appropriate. If a health system is in charge of caring for a panel of patients, the ultimate goal is to keep the patients healthy.

Maggie Blackburn said that a lot of what they discussed about childhood obesity is based around schools. She noted that in rural communities that is the place that children are as a group. She asked if there are school based health centers in Iowa. She also asked if when working with the superintendents and school systems, if they are looking at what foods the schools are serving. She also asked if there are school based health centers.

Linda Snetselaar said that in Muscatine, the nurses work with children who are having difficulties with obesity. She said it is very important to involve food services also. The school involved the children in purchasing equipment for a salad bar. When the salad bar was actually in the cafeteria the students were more positive because they played a role in creating the salad bar. They also do cafeteria audits to make sure that the healthy foods are in the front and in some cases make the healthier foods less expensive. They also make healthy foods available for the students to purchase to take home.

Deborah Waldron said that there are school based health clinics but not enough. As they develop school based clinics, they need to make sure they are interacting with the health home. Health care needs to be available 24/7 and there needs to be communication between school based clinics and the health home. There is a need for electronic health records to make sure that communication is occurring.

John Rockwood asked what they have learned from the smoking campaign. He said there is now a social stigma against smoking and that it has made a difference. He said it is more difficult to do with children and obesity because you don't want them to lose self esteem. He asked what has been learned about smoking that make a positive change in the issue of obesity.

Linda Snetselaar said that the Body Mass Index study is built on motivational interviewing. They are trying to take what they have learned relative to smoking addiction and apply it to eating behaviors.

United States Department of Agriculture

Bill Menner – Iowa State Director, Rural Development, USDA

Bill Menner shared with the committee that the USDA state directors are also having a meeting in Iowa and are in attendance at the NAC meeting. Mr. Menner stated that their mission is to improve rural America. He said that the First Lady's Let's Move Initiative and the Knowing Your Farmer, Knowing Your Food Program are important in addressing childhood obesity. The Knowing Your Farmer, Knowing your Food Program brings local foods and produce into households, community facilities and schools. Mr. Menner said that supply, distribution and ensuring safety is a challenge for school districts that would like to have more local foods. School facilities are a challenge because the kitchens are not equipped to prepare locally produced foods. They have equipment to warm foods and microwave foods but not prepare foods. He said that the Know Your Farmer, Know Your Food Initiative gives them the opportunity to establish community kitchens. It also gives the opportunity to develop farmers markets and work with farm service agencies and to promote longer, extended growing seasons. He noted that the Know Your Farmer, Know Your Food Initiative is the number one priority for the USDA Deputy Secretary, Kathleen Merrigan.

Mr. Menner said that since the credit crunch, USDA rural development has been the number one investor in rural healthcare facilities in the country. They work with banks and other investors to back the loans. They are making direct loans to eligible facilities and if a community warrants grant dollars, they are supplying grant dollars. He stated that he was at a ground breaking recently for a 14 million dollar expansion at a hospital in Belmond, Iowa and broke

ground for a hospital in Clarinda, Iowa. They are funding a community health center in Columbus Junction because the previous center in Columbus City was destroyed in the flood in 2008. They are also investing in assisted living facilities. They are doing this throughout the country and working with local providers and hospital administrators. Mr. Menner stated that the USDA Deputy Secretary, Kathleen Merrigan, focuses on how to create rural communities that are thriving, repopulating and wealth generating. Mr. Menner said they invest in healthcare facilities for the same reason they invest in clean water, and build fire stations and libraries in rural towns. The reason is to make the rural communities more viable.

Mr. Menner said that 40% of their community facilities program portfolio is invested in rural healthcare facilities. There are forty different programs. He noted that they have been investing in healthcare facilities since 1974 and those projects get funding priority. Having a healthcare facility close by can be a matter of life or death. Since 2005, they have assisted in funding 812 rural healthcare facilities serving around 15 million rural residents. They have also funded 167 hospitals, 105 rural health clinics, 125 assisted living and skilled living facilities. Last year there were 194 rural health care facilities funded in part by USDA rural development through regular funds, disaster fund but most important the recovery act. Mr. Menner closed by thanking the committee for the opportunity to speak to them.

Rural Implications of Accountable Care Organizations and Payment Bundling Panel

Keith Mueller, Ph.D. – Director, Rural Policy Research Institute and Professor and Head, Department of Health Management and Policy, College of Public Health, University of Iowa

Keith Mueller stated that he would like to have an open dialogue about the Affordable Care Act and initiatives major insurance carriers have that are pushing the notion of Accountable Care Organizations. It is important to look at the act and how it changes the landscape. He said that value based purchasing is here to stay. It cuts across all of the payment systems over time. Dr. Mueller said that quality reporting continues to evolve into a more refined notion of what that means. There is a national plan for quality being developed as part of the Accountable Care Act. The new center for Medicare and Medicaid innovation will be pushing some of these initiates.

Dr. Mueller said that Section 3022: Medicare Shared Savings Program emphasis is on shared savings. He said that the title is intentionally shared savings. The program is to coordinate care and the fee for service, and to meet quality standards and be accountable for patients for at least 3 years.

Section 3023 is the National Pilot Program on Payment Bundling. It is intended to provide integrated care during an episode around a hospitalization. Consulting with representatives of

small, rural hospitals is built into the legislation, including Community Access Hospitals and their participation in the program. An episode is 30 days prior to the admission, the length of the mission, and 30 days prior to discharge.

Dr. Mueller also spoke about the Independence at Home Demonstration Program, the Hospital Readmission and Reduction Program, Community-Based Care Transitions Program and Patient-Centered Medical Homes. He noted that these programs reduce cost due to reducing the intensity and location of the service. He said that it is important to look at the total change when looking at transforming delivery systems. The delivery system needs to be focused on quality, generate savings and improve places.

A group of physicians or a hospital can be eligible to be an Accountable Care Organization. There needs to be a formal legal structure to receive and distribute funds. There also has to be a minimum of 5,000 Medicare beneficiaries. There has to be a leadership and management structure, a process to promote evidence-based medicine and report on quality measures and coordinate care.

Dr. Mueller said that in order to get savings from Accountable Care Organizations it must be compared to a benchmark. It must meet clinical standards in the process of care, outcomes, patient experience and utilization. There must be sustained savings over time.

Dr. Mueller spoke about the three tiers approach. Tier I approach is minimal financial risk but eligible to receive shared savings and bonuses for meeting qualified bench marks and reducing per beneficiary spending. There is no risk on Tier 1 and ACO possibilities in rural areas should focus on Tier 1. Tier 2 approach is eligibility to receive a greater proportion of savings if achieving spending rates below target. There is risk for spending above target, partial capitation and more comprehensive data to be reported. Tier 3 is full capitation or extensive partial capitation and bundled payments. There is the highest potential for reward with Tier 3 but also the greatest risk.

Dr. Mueller noted that when measuring performance of Accountable Care Organizations, care coordination, care effectiveness, population health, safety, overuse/efficiency and patient engagement will be considered. Hospital readmission and depression follow-up are examples of care coordination. Cancer care screenings, quality of life and functional outcomes are measures for care effectiveness. Safety measures include tests for patients using high risk medications and outpatient medication errors. Patient engagement is measuring whether or not a physician’s instructions are understood. Examples of overuse and efficiency include imaging for low back pain during first 30 days, to episode-based resource-use metrics linked to quality of life, and functional and patient engagement measures.

Dr. Mueller gave an example of what a large medical care organizations ideal system attributes in the country. The attributes include: information continuity, care coordination and transitions, system accountability, peer review and teamwork for high value care, continuous innovation and easy access to appropriate care.

Dr. Mueller stated that the American Hospital Association did a review of Brookings/Dartmouth and Baylor Medical School, and Premier and published a paper that noted the competencies in the organizations. The competencies included leadership, organizational culture of teamwork, relationships with other providers, IT infrastructure, population management and care coordination. He stated that you do not need single governance organization to achieve these. To participate in ACO's from a rural perspective, these competencies can have a unique organization in order to implement a delivery system that achieves the competencies. The American Hospital Association also stated that it is important to spread the knowledge of best practices, have linkages between ACO's and public health community resources and have regional health exchange.

Dr. Mueller also stated that there is a Vermont Accountable Care Organization Pilot Project that is built on three major principles. The principles are local accountability for defined population, payment reform based on shared savings and performance measurement that includes patient experience data, clinical process and outcome measures.

Dr. Mueller gave policy advice of setting realistic expectations, considering pairing new starts with existing ACO's, providing technical assistance to develop legal and other structures to support new relationships and to provide practice redesign technical assistance. It is important to structure shared savings to consider historic cost-efficiency, offer various levels to financial risk and encourage other payers to develop healthcare delivery and payment models to parallel Medicare ACO programs.

Dr. Mueller said to focus on specific conditions based on a mix of chronic and acute care and surgical and medical in regard to bundled payments. There are opportunities to improve quality while reducing expenditures. There needs to be a variation in the number of readmission and expenditures. There are ways to find savings through bundled payments. The approach should be to measure functional status, hospital readmissions, and admissions to emergency rooms. There are bundled payment implications for rural-urban collaboration. If there is a single payment going to one place, how it is shared across the system has to be considered. Dr. Mueller closed by stating that building a rural network that provides a continuum of care for pre and post discharge in bundled payments is important.

David Swieskowski, MD, MBA – Chief Executive Officer, Mercy Clinics

David Swieskowski began by saying that Mercy Clinics have 27 clinics and 150 physicians. In 2010 they had 877,956 patient visits. Mercy Hospital owns 4 hospitals in Iowa. Mercy Clinics is part of Catholic Health Initiatives with hospitals throughout the nation in rural areas. Dr. Swieskowski stated that they have worked at Mercy Clinics to create a medical home. In 2003 they formally started their project. They based their goals on The Institute of Medicine's six dimensions of quality that include: safety, timely, effective, efficient, equitable and patient centered.

Dr. Swieskowski told the committee that Mercy Clinic has been planning for payment bundling and Accountable Care Organizations for a long time. He noted that bundled payments are clear but ACOs are not clear. He stated that he did not know how patients are going to be assigned to ACOs and how the benchmarks will be determined. He questions how private insurance plans will differ from CMS plans. He thinks there will be a former enrollment in an ACO. Another question is who will organize them. It may be doctors, hospitals, insurance companies or other groups. Another unknown is if health systems will take insurance risks or will someone else carry the insurance risk and they provide services under fee. Will improved quality reduce cost is a huge question. He noted that there is no evidence that this is the case but it is hopeful that this is the case. Quality and costs are two different dynamics that need to be managed.

Dr. Swieskowski stated that there are key points that are clear in regards to ACOs. Providers will be held accountable for utilization and cost of care, performance of quality metrics and patient satisfaction. Another key point is that rural and urban providers will be held to the same standards. If the standards can not be met in the rural environment, then the care should not be provided in the rural area. Sr. Swieskowski said that consolidation, measurement and systems of care are ways to respond to ACOs regardless if it is a rural or urban environment.

Dr. Swieskowski said that it is important to consolidate to reduce the operating inefficiencies. Consolidating is important in order to have the critical mass for contacting and to provide adequate resources and access to capital. Ultimately consolidation will be the most efficient through employment. Immediate ways to consolidate will be through service agreements and joint ventures.

Dr. Swieskowski noted that measurement is important and is a core competency at Mercy Clinics. He said that doctors do not measure themselves. They need to know what percentage of their patients have their blood pressure or blood sugar controlled. He stated that until you have data you can not manage the information and there is no benchmark to know if there is success or not. When looking at policy, doctors need to have ways to measure themselves.

Data should be in the health systems domain and be created and managed in house. Measurement and information needs to be a core line of business and there needs to be actionable data. Mercy Clinics has a disease registry. The clinic can find information on how many patients have diabetes and how many of the patients have had their hemoglobin checked in the last year. They can segment the information by provider, insurance company or payment program. This data gives them the ability to pull the data that they need at the time of need. Dr. Swieskowski said that their doctors are way too busy to manage data and the system has to manage the data. He stated that the system assures the safety of patients. Many times lab results in doctors' offices do not get correct follow-up. The system needs to be responsible for tracking population based outcomes instead of the individual doctor. Mercy Clinics developed an Office Based Health Coach position. They oversee the disease registry, conduct a pre-visit chart review, work with families on self management support and coordinate the care across the care. They are the quality improvement experts. This has improved the quality and reduced costs at Mercy Clinics due to efficiency.

Dr. Swieskowski said that rural providers can become an advanced primary care site by creating a registry and learning to measure their services. They need team based care, self management support and coordination of care systems to ensure quality and safety and access to care. Dr. Swieskowski stated that rural providers still need to be part of an integrated system with multiple specialties and facilities to reduce care variability.

Dr. Swieskowski closed by saying that Mercy Clinics strategy is to become an integrated care system. An Integrated Care System is hospitals and physicians transitioning together to have unified care guidelines, information sharing and unified business models.

Q&A

Governor Ronnie Musgrove asked what policies they would recommend for HHS to change related to rural health care delivery.

Keith Mueller responded he would recommend policies that pair existing ACOs with new ACOs in a shared learning system. It will be difficult to do in one small area at a time because of anti-competition rules and regulations and would take a federal initiative.

David Swieskowski said that having the right measurements in the system will be the way to make improvements and policies need to encourage measurement systems.

David Hewett asked what happens to a Medicare patient that is assigned to an ACO but has care outside of an ACO. What happens with the reimbursement?

David Swieskowski said that he thinks that ACOs will be linked through insurance companies. He said that they will have their networks in all the areas to help control that. There will be some type of access to provider networks to at least get discounted fees.

Clint MacKinney added that from reading the legislation it is a shared program only and there is no risk and mandatory enrollment. The idea is that Medicare will track all costs no matter where in the country and that goes into the potential for shared savings. For now, starting January 1st, 2011, it is a limited ACO.

John Rockwood asked if the conceptual idea is to be accountable for the defined population, what the defined population is. He said he does not understand the premise. He said it seems that things have transitioned from the rudimentary to jumping way ahead of the capability of what can be done in a rural setting. There are many organizational steps that need to be taken. This needs to be recognized and everyone needs to ask what they are trying to accomplish and what the organizational steps to accomplish the goals are.

Tom Hoyer said that it seems that an electronic medical record that is accessible and people would use would eliminate a fair amount of services. Practitioners will know what services have already been provided. Improved communication will save money. He said that physicians do not want to talk to one another but the system has a lot of information that needs to be shared and electronic medical records will cut expenses. A lot of health care reform is process measures that will result in improved communication because they will be done on a common record.

David Swieskowski said he thinks that is the case and when they get utilization data that they can get the same outcome. Managing quality is not managing cost. They are separate things.

April Bender said that it would be beneficial if there was longitudinal data that shows that prevention and wellness leads to increase savings.

John Rockwood said that it is a mindset change and that all businesses have to down size from time to time. There will be downsizing, recognizing that it things will be done more efficiently but won't get the previous number of admissions. People have to recognize that they can not grow at 10% a year so it has to be done smarter and parts of the system are going to have to do less than before.

Tom Hoyer said that everything you read says that insurance reform is going to engulf the health care system with patients. There will be an increase in people that have coverage and it

will use up the empty utilization slots. He said that he feels in the end the same amount of money will be spent but on a larger number of people.

Maggie Blackburn asked about the Fee for Service Model and what it would look like in a different payment system. When looking at rural populations there are less economies of scale and less volume than other models. How does it work for a smaller population base? There are not large numbers of insured people. How do we take it and make predictions for what will happen? Everything that has been set up for ACOs has nothing to do with rural populations, even in terms of how the regulations are written.

David Swieskowski suggested looking at the medical homes. Most rural doctors are primary care doctors and they can get incentives to create a medical home and take advantage of a lot of the same things that Mercy Clinic took advantage of. There are doctors in rural areas that are aggressively working on medical home concepts.

Governor Ronnie Musgrove said that what he is hearing is that all rural hospitals need to consolidate.

Keith Mueller said that the system that currently exists would keep you from reaching the end point. He stated that it will require some form of integration. There are transition steps along the way and one is to integrate with other providers.

David Hewett stated that it seems that a lot is being put into one visit but on a fee for service basis so you are getting the same fee for the visit. The question is how to get paid for doing the right thing. It is a complex production model issue.

Early Childhood Development Place-based Initiatives Panel

Charles Bruner, MA, Ph.D. – Executive Director, Child & Family Policy Center and Former Iowa State Senator

Charles Bruner began by saying that he is glad that there is a focus on children in the health context. Childhood Obesity is a national problem that needs to be addressed. He said that so often when looking at healthcare the focus is on the aging community and he is glad that there is focus on early childhood development. Kids are 100% of our future and it is the first time in this country that we are facing the prospect that our children will live less time than their parents. One reason is the epidemic of obesity.

Dr. Bruner stated that health services play an important role on healthy development but only a small portion of that role. For kids to be healthy and prepared for success there needs to be a focus on social determinants of health as well as clinical care and services. The ecology of the

family, neighborhood and community has to be taken into account. That requires a place based approach. Iowa is a leader in having a place based approach in early childhood health and development.

Dr. Bruner said that there has been an analysis by census track of vulnerable children. He said that Iowa has around 3 million people and 99 counties. Iowa is becoming more diverse. 15% of the young children in Iowa are minorities. The projected future growth of the child population in Iowa shows that 98% of the growth will be among minority children. How Iowa provides for the healthy growth of all of the children is important. The greatest numbers of the minority children are in urban counties. In some rural counties the percentage of minority children has grown from 3% to around 25-40%. This has created major changes in the rural economy. Dr. Bruner said that when they started the Kids Count Program about 15 years ago they divided the counties in three types. The three types were rural, small urban and metropolitan. There was a population change in 2000-2008. The rural areas are declining in population due to the aging population and the urban areas are growing.

Dr. Bruner said that the children in the rural counties are measuring better than metropolitan counties in some areas. Obesity, diet and teen deaths are higher in rural areas. In general the variations are not huge. Some challenges in the rural areas are access to services and less of a community support infrastructure.

Dr. Bruner said that a child's world is bound by their immediate neighborhood. Metropolitan counties had more high or moderate risk census tracts. "Place" is very important and when working with "place" it is important to look at developing strategies within geographical boundaries. The variations and vulnerabilities in the counties need to be identified.

Brain research shows the critical importance of a nontoxic environment for healthy development. Children's bodies and brains are growing during the younger years and they are developing habits of behavior and eating habits. The early years are setting a trajectory for future health and educational success. Improving that trajectory during the early years is important. A contribution to improving school readiness goes beyond traditional public services. It includes health services, quality early childhood learning experiences, early identification and response to needs, and a safe nurturing home, family and neighborhood environment.

Shanell Wagler – Director, Early Childhood Iowa

Shanell Wagler started by sharing information about Community Empowerment and Early Childhood Iowa Initiative. Ms. Wagler said that the Community Empowerment legislation was passed in 1998. When the legislation was done for Community Empowerment the focus was on

the uniqueness of the communities and their individual needs. The legislation required that there be boards formed in local communities and that they address issues and work with partners to provide services. There had to be diversity and different perspectives on the board.

Ms. Wagler said that the Community Empowerment Program was legislated at zero up to the age of 5 so the communities could decide what age to begin. The Community Empowerment legislation required 6 state department directors serve on the state board. At the local level the boards were required to do assessments and work with partners that had done assessments. She noted that Iowa was one of the first states to receive a technical assistance grant from North Carolina Smart Start. They were about 5 years ahead of Iowa in building collaborations. When North Carolina did the two day assessment, many people attended. Through that assessment group, Early Childhood Iowa was formed in 2003. She stated that the Community Empowerment legislations and Early Childhood Initiative started to look similar in 2008 and merged in 2009. They have a common vision of “every child, beginning at birth, will be healthy and successful”.

Early Childhood Iowa does not specify when birth begins. Even prenatal programs can receive funds. Early Childhood Iowa has a state board made up of 21 members. 15 citizens, 6 agency members and governor appointed representatives from congressional districts. The members reflect a geographic balance and ethnic, cultural, social and economic diversity. They are a dedicated board with 6 state agency directors. At the state level they strive to mirror what is happening on a local level with the board. It is instrumental to have different perspectives.

She describes Early Childhood Iowa as related to K-12 and the basic concept for things that need to occur in order for there to be a successful environment for children. A key issue as far as funding and legislation is having a strong focus on kids 0-3. There is data being compiled about families and support programs, and home visits. They are partnering with the Department of Public Health on the home visitation grant that is part of health reform.

Ms Wagler said that they are looking at ways to connect with local boards and local communities. There are component groups set up for Early Childhood Iowa. They are getting great local input through the component groups. She said that in order to include people in work groups who can not attend meetings they are having webinars and conference calls.

Ms. Wagler said that the Early Childhood Stakeholder Alliance has a steering committee to organize, manage, and coordinate the activities of the alliance and component groups. The Early Childhood Stake Holder Alliance is open to everyone. They had a meeting the previous week and 80 people came from various parts of the state. They meet quarterly and the

component groups meet more regularly. They work with not for profit, state government or anyone who would like to be part of the effort.

Early Childhood Iowa staff provides administration support for implementation of the Early Childhood Iowa Initiative and state board. The staff provides leadership for facilitation, communication and coordination of ECI activities. They also work with the state and area boards to provide leadership for comprehensive system development.

Ms. Wagler said there is legislation that has 5 main result areas and they are: Healthy Children, Children Ready to Succeed in School, Safe and Nurturing Childcare Environment, Secure and Nurturing Families and Safe and Supportive Communities. They have identified indicators and performance measures within the result areas.

Q&A

Maggie Tinsman said that there are local empowerment areas throughout Iowa so everyone is covered. When it was first initiated and funds were combined from health, human services and education, they looked for grants. At that time they did not have a level on an amount of money to show that you were combining for services in your area. They gave out 5 of the 6 first grants received to rural areas. The rural areas had the best proposals. She said one rural county said that they were going to get 100% of their children in preschool and they did.

Sharon Hansen asked about the local community empowerment board if they had specific parameters.

Shanell Wagler said that there were some basic parameters but not in deciding geographic boundaries. The state board developed indicators in regards to the 5 result areas.

Sharon Hansen said that they talked about indicators and asked of they assigned children indicators so that they could track the child.

Shanell Wagler said no that they are working on that now. They had indicators that were population based but not individual based data. They also selected data that was available at the community level. The local boards could compare themselves to the state.

Charles Bruner said that at the state level there is an avenue to get childhood data and be able to track children who have participated in early childhood programs. The legislature is asking empowerment to work with the schools in doing that work. It is part of the strategy. He also noted that initially it was a grant program and has expanded. One of the advantages is that there are champions in early childhood in every community. It is an educational process to have

business leaders on the board. It has created a strong commitment because the community has ownership. Community boards want to be able to show results.

Sharon Hansen asked if the funding was still a grant.

Shanell Wagler said it is all allocation now.

April Bender asked about the home visits and getting to parents early on. She asked for recommendations on “thinking differently”. What recommendations would you give the committee that would help the committee when thinking about bringing resources to a home and a neighborhood without having a physical visit? Recommendations on what you have seen work that provides access but does not move people to a site and would be cost effective.

Charles Bruner said that when a child was born and in the hospital, they bring in a touch screen so that the family can answer questions and give information on their situation and they could find resources available for that family. It developed social determinants and whether or not a family should receive home visits. The families saw a value in it too because it gave them information on resources available. There is a First Five Initiative around developmental screening and they work with community practitioners on screening. People need to meet in a place where they feel comfortable. They also need opportunities to connect to others that are going through similar situations to themselves. Creating time, space and opportunities for families to get together for parenting education classes and peer support groups and to have outreach to get to families where they are located is very important. It has to be done at the community level.

Tom Hoyer asked if they could envision the program working in a dense state.

Shanell Wagler said that she can see it working in a dense state. She said that in Polk County, where Des Moines is located, they have taken a unique approach and members of the board had to figure out what to do. They would not have enough funds to reach all of their families. They have found zip codes with the most diverse population and zip codes that have the highest abuse rate. They targeted their efforts in those areas. They recruit board members in order to have the best advocates on the board. It works whether it is a rural or urban area but there has to be the authority to figure out how to target the areas to make a difference.

Charles Bruner said that when looking at the “child’s world” and a person’s definition of neighborhood, you have to get to the elementary school level of planning and contouring of services to be effective. You have to develop appropriate strategies on a local level.

Tom Morris asked what specific programs are getting federal funds.

Shanell Wagler said that some funds come from TANF and they have about 6.3 million that is appropriated through Iowa legislation to be used by the local boards.

Tom Morris asked if the Head Start money is part of the network.

Shanell Wagler said that they are part of the partnership. Part of the planning and assessment and a high percentage of the Head Start Programs receive the wrap around fund. They are state dollars.

Tom Morris asked if they were using state dollars to fill in the gaps in federal programs.

Shanell Wagler said that it is not just the federal programs but what is available in the community.

Tom Morris asked of any specific things that would make it easier from a rural perspective in the guidelines or regulations given the limited population density in rural areas that the committee could recommend?

Shanell Wagler said that seeing the Secretary of Education and the Secretary of Human Services working together is great. Much of the funding is restrictive and if there is a way to make it work easier in the community it would be great.

Tom Morris asked if there are any specifics. They need actionable recommendations.

Charles Bruner said the federal funding streams are more toward block granting and the flexibility for using Title 1 dollars for early childhood and TANF is flexible for using funds for preventive services. The funds come from separate decision making structures so you have to convince different groups of people in order to use the funds. The funding streams have categorical restrictions and it is difficult to get everyone together to agree.

Charles Bruner said that the state legislature directs where TANF is going. Title 1 dollars go primarily to Title 1 local education agencies. There is nothing that says the funds can not be used for preschool and family literacy programs but you have to convince the local school district that they should be doing it.

Governor Musgrove thanked the speakers and Jennifer Chang gave an overview of the site visits.

Public Comment

Dr. John Carroll introduced himself to the committee. He said that he is the past president of the Iowa Academy. He said that he serves as the editor of the Iowa County Physician. Two years ago he reviewed 3 different health manpower studies that were performed in Iowa in 2007. As editor of the magazine he compared and contrasted the three studies. The three groups looked at the things and came up with different approaches related to health manpower. He noted that Iowa is similar to many states. The most important point is that health manpower in rural health is based on teamwork and the rural family physician. He stated that 10% of interns become Primary Care Physicians and 90% go on to subspecialties. Pediatrics is becoming more and more subspecialty care. They have made it work in Iowa because they are ranked 49th in the nation per capita in pediatricians yet the same year the Commonwealth Fund named Iowa number one in pediatric healthcare. This is because they made the connections to get the subspecialist and specialist working with the family physicians and there are board certified family physicians in every county in Iowa who do the bulk of pediatric care. Systems put in place by the state legislature and departments and through Early Childhood Education collaboration work. He said that they are not creating family physicians to replace the physicians who are retiring. He stated that there need to be ways to encourage medical schools to increase enrollment and admit selectively to fulfill rural health needs and look at state and federal ways to make sure that those physicians can afford to be in rural health positions. The average medical student comes out with $150 - $200,000 debt. Dr. Carroll said that states have created some loan repayment programs but that still has to be declared as taxable income.

John Rockwood asked what federal policy could be recommended to make the change. He said that is an issue on the state level.

Dr. Carroll said that there need to be ways to encourage medical schools to create family and rural physicians. He said that shifting the federal research dollars into ways to create those positions, and creating more grant opportunities to come up with solutions to problems of workforce in rural communities would be an opportunity.

Maggie Tinsman asked of he is suggesting that they make a recommendation that there be more incentives on a federal level for family practice.

Dr. Carroll said he is suggesting funding for family medicine. He said the funding for family medicine education has dropped dramatically over the 8 to 10 years.

John Rockwood said that good family physicians that agree to work in rural settings and are quality physicians are vital. It is an important issue. He said that if there are proposals that they can support or put in a letter form, it is important to get it on record.

John Carroll submitted the following additional comments via e-mail:

Governor, as I told you, I was remiss in not addressing the most glaring cause of problems funding the training of family medicine residents. That is the fact that the funding that comes through the Medicare trust fund (the greatest single source of money) is restricted to only covering the hours spent by the resident physician while in the hospital, since the funding comes out of hospital funding. When the office of the Inspector General started cracking down on this several years ago, the funding for the education of the one specialty uniquely trained to reduce and prevent hospitalization lost half of its funds, since the residents spend half or more of their time in outpatient settings. The organizations of the doctors who educate those residents, (the Society of Teachers of Family Medicine, the Association of Family Medicine Departments, etc.) have lobbied our congressmen and senators about this issue, but neither regulatory nor legislative redress or correction of this has occurred. This is classic shooting off the nose to spite the face. It gives incentive to hospitals and health systems to train plastic surgeons and radiologists instead of family physicians. It is a disincentive to create the physician workforce responsible for rural healthcare.

Dr. Blackburn has pointed out to me that the National Rural Health Association has tried to address further funding, and recently announced that they are the recipient of a demonstration grant to improve and increase the rural training track programs that specifically place second and third year residents in rural sites for their last two years of residency. The NRHA website has further details. Those programs have a stellar record for their residency graduates still practicing in rural settings five and ten years later, but are limited in number and many medical students have not committed to a particular practice location when they start interviewing for residency programs.

Thank you for considering this issue.

John R. Carroll, M.D.

FAAFP, D-ABFM, CAQ-Geriatrics

Thursday, September 16, 2010

Thursday morning the Subcommittees departed for sites visits as follows:

Rural Implications of Payment Bundling and Accountable Care Organizations Subcommittee: Grinnell Regional Medical Center.

Childhood Obesity in Rural Communities Subcommittee: Pick A Better Snack Program, Wapello Elementary School and Iowa State University Extension Office.

Rural Early Childhood Development Place-Based Initiatives Subcommittee: Kids Corner and Iowa State University Extension Office.

The subcommittees returned to the hotel Tuesday evening.

Friday, September 17, 2010

The meeting was convened by Governor Musgrove, Chairman of the Committee.

Review of Subcommittee Visits

Rural Early Childhood Development Place-Based Initiatives Subcommittee: Kids Corner and Iowa State University Extension Office.

The subcommittee members are: April Bender, Deborah Bowman, Sharon Hansen, Donna Harvey and Maggie Tinsman. Deborah Bowman was not on the site visit.

April Bender presented for the subcommittee. She said that some of the key takeaways for the visit will be formulated as recommendations but most of them will be in a summary as information to the Secretary.

One recommendation was to keep the decision making at the local level. In other words, not to do anything that interferes with relationships being built at the local level. The relationships create the caring communities that serve the children ages 0-5, who will be transitioning to school, and their families. Dr. Bender said they asked how the transition was made from 0-5 programs to school. They said they make the transition but do not pay for it. She said that people do things in rural areas because they are the right think to do, but they are not necessarily funded.

Another recommendation is emphasizing the proper use of dollars and making sure money is spent appropriately. People need to be encouraged to use funds appropriately so that would release other funds to be used other ways.

The sharing of data is another recommendation. She noted that they are meeting each week and sharing data verbally. Dr. Bender said they talked about an infrastructure with technology for sharing information. They thought that would be helpful but have figured out a way to share data without the technology. Technology was not a priority but shared data is important to keep up with core elements. An example is that one woman sees the same child for four different agencies and has to input the information four times.

Place Based was discussed and the importance of “meeting people where they are at”. This may be at the hospital, school or at neighbors home. There was also a discussion at about in home care. The key point was that “place based” would be their determination.

Dr. Bender said that they recommended funding for innovation that is non-categorical. They would like to receive funds to try something for 3-4 years to try and make it work.

They said that HHS is making progress with “Place Based” but they would like to know what some of the promising practices are and being able to share promising practices on a local level.

Childhood Obesity in Rural Communities Subcommittee: Pick A Better Snack Program, Wapello Elementary School and Iowa State University Extension Office.

The subcommittee members are: Maggie Blackburn, David Hartley and Robert Pugh. Robert Pugh was not on the site visit.

David Hartley presented for the subcommittee. Dr. Hartley said that the subcommittee visited Wapello and started at the elementary school. They sat in the classroom and observed the Pick a Better Snack Program. He said that the SNAP-Ed program has money for nutrition education that can be funneled through states. He stated that because the program is funded through SNAP-Ed, it is for low income children. They can only offer it in schools with 50% or more children on free or reduced lunch. He said that Wapello Elementary is probably better off economically than some of the schools that are receiving the program. He said that the children were very well behaved and active. The subcommittee was very impressed. There were very few obese children in the classroom.

Dr. Hartley said that the subcommittee was impressed with Iowa’s ability to get funds to run the programs and with doing work with the research dollars. He stated that they were having difficulties that seem to come from federal regulations. They want to combine the nutrition education program with social marketing in some rural communities to research the impact. They can not prove to USDA that the social marketing campaign is targeting the low income

population and can not qualify for USDA funds. They had to take all of the rural sites out of their research. A problem is that the poverty in Iowa is not concentrated but spread out. That makes it difficult to target the low income population. When federal programs require that type of targeting, rural areas are at a disadvantage.

There were issues with funding coming through silos. Funding from CDC, USDA and the Department of Education have different requirements and geographic definitions. They would like to have blended funding from those entities. A suggestion to the Secretary could be that there is more effort to collaborate across agencies. Maybe a working committee could be created with people within the agencies to find ways to collaborate funding in local communities. He said that maybe some of the funds should not go through the state department and go directly to the people who will be using the funds. Sometimes the state will send funds to places that have a track record and those counties tend to be places that have recieved funding in the past.

Building on Eat Smart Move More Campaign is a recommendation. The gold standard from that campaign could be used for school lunch programs across the country. That may make it easier for vendors to deliver food service to schools.

Transportation was also an issue. Kids can not participate in after school activities because they do not have transportation.

Dr. Hartley said that the subcommittee discussed what rural hospitals can do to be part of the effort to combat obesity. The rural hospitals with fitness centers may be able to play a role for low income families.

Rural Implications of Payment Bundling and Accountable Care Organizations Subcommittee: Grinnell Regional Medical Center.

The subcommittee members are: Graham Adams, Darlene Byrd, Larry Gamm, David Hewett, Tom Hoyer, Todd Linden, Clint MacKinney and John Rockwood.

Tom Hoyer presented for the subcommittee. Mr. Hoyer said that a physician named Thomas Evans said that the Sustainable Growth Rate is a huge stress for physicians and they are not able to think about Accountable Care Organizations or anything else very clearly.

Michael Fay, with Blue Cross in Iowa, shared with the subcommittee that the new system needs to have new ways of computing payments so that they are properly associated with the services. Eric Bodenheimer, with the Iowa Hospital Association, said that whatever happens in

healthcare reform, the cost structure and behavior of Iowa hospitals is in the position that they are likely to benefit. He thinks that there needs to be a high concentration of physicians who are employed by health systems and hospitals in order to make it work. He spoke about the SGR issue and said that there needs to be a method for making sure that physicians are getting the payment that they need to have faith in the system.

Sheila Laing, with the grocery store chain Hy-Vee, said that they need to involve employers and employees and the community in implementing Accountable Care Organizations.

Mr. Hoyer said that he thinks that an effort should be made to educate the insurance companies on what is happening and where they fit in the process.

Mr. Hoyer said that they need to model ACO behavior and results before implementing them in rural areas. There should be rural pilots and demonstrations.

Discussion

Governor Musgrove added that he was part of the subcommittee visit. He noted that Hy-Vee is the largest employer in Iowa. He said that Sheila Laing was positive about ACOs.

Governor Musgrove said that a concern of the subcommittee was the groups choosing the most advantageous rural communities and leaving many communities with a substandard health delivery system. He said that this needs to be put into a recommendation because once it takes place; many of the areas will be left behind.

Tom Hoyer said that one way to eliminate that problem is to focus on where the patients already go when forming ACOs.

David Hewett said that it starts on a community level and the community needs to decide what they want. He said that ultimately you have to go to the larger tridiciary care center to form a larger more comprehensive ACO. The rural community that is trying to position themselves needs to do it so that they are negotiating from a position of strength. They need to have strong quality and patient safety number and be efficient.

John Rockwood said that there should be pilot programs and the first part should be organizational. Most of the small hospitals do not have people to assign to this and there needs to be consultants. They should decide who should be partnered with, where services are being duplicated, and what the role definition is. These are critical first steps instead of going directly into a reimbursement system when there is not an infrastructure in place. Pilot programs should start with existing system relationships.

Report Discussion

Tom Morris said that the place based chapter needs revisions in the report. He said that they will do revisions and edits to all three chapters by the end of October. The Childhood Obesity and ACO chapters will have fewer revisions. He said there should be a conference call with the Place Based Initiative group because there are so many changes. It should be finalized by the end of October and the committee will get it for approval at the first of November. If there is approval by mid November then it should be ready to go to the Secretary sooner than the previous year.

2011 Workplan

Governor Musgrove noted that the Affordable Care Act brings things to front and center. He said that the committee should be making comments about the implementation to have an opportunity to focus on rural issues.

He suggested look at the timeline of the act and raising concerns on related issues to the Secretary as the regulation process and implementation is happening. Governor Musgrove said that the issues can be raised in contest from a rural perspective.

Governor Musgrove suggested writing a letter in addition to the report. The letter can be delivered in a timely manner and include concerns from the rural perspective on provisions that are part of the Affordable Care Act.

Tom Morris added they could divide the year into 3 increments. They can review provisions in the Affordable Care Act and the deadlines and when regulations are going to be posed. In February, 5 issues will be highlighted between the February and June meeting. For the June meeting there will be different set issues. There will be a work plan from February to June, from June to September, and from September to the following February. At the end of the year they will all be included in a report.

Letter to the Secretary

Tom Morris said that the individual letter to the secretary needs to be targeted and very specific recommendations and considerations.

Preview of February Meeting

Jennifer Chang told the committee that the February meeting will be held in the St. Regis Hotel in Washington, DC, February 23-25, 2011.

Tom Morris said that he will be inviting the Secretary or HHS leadership to speak at the February Meeting. The meeting will convene to plan for the next three months.

Public Comment

There were no public comments and the meeting was adjourned.