

MINUTES

Prevention and Chronic Care Management/Medical Home

Advisory Council

YMCA Healthy Living Center

Wednesday, May 29th, 2013

9:30 am – 3:00 pm

Members Present

Chris Atchison
Melissa Bernhardt (Larry Carl)
David Carlyle
Marsha Collins
Anna Coppola
Chris Espersen
Tom Evans
Michelle Greiner
Jason Kessler
Petra Lamfers
Mary Larew
Linda Meyers
Teresa Nece
Tom Newton
Patty Quinlisk
Trina Radske-Suchan
Peter Reiter
John Swegle
Bill Stumpf

Members Absent

Charles Bruner
Kevin de Regnier
Steve Flood
Ro Foege
Jeffery Hoffmann
Don Klitgaard
John Stites
Debra Waldron

Others Present

Angie Doyle Scar
Abby McGill
Ted Boesen
Sarah Dixon Gale
Janice Jensen
Kala Shipley
Stacey Cyphert
Joe Sample
Bill Applegate
Berdette Ogden
Stephanie Trusty
Janet Beaman
Kathy Stone
Tracy Rogers
Erin Davison-Rippey
Patty Funaro
Jeneane Moody
Jodi Tomlonovic
Mikki Stier
Laura Vollmer
Nicole McCombs
Kristen Heidewald
Marissa Eyanson
Carol Harris
Judith Collins
Laurene Hendricks
Janelle Nielson
Threase Harms
Dennis Groenenboom
Ruth Thompson
Carol Curtis
Nicky Cooney
Cari Spear
Gloria Symons

Meeting Materials

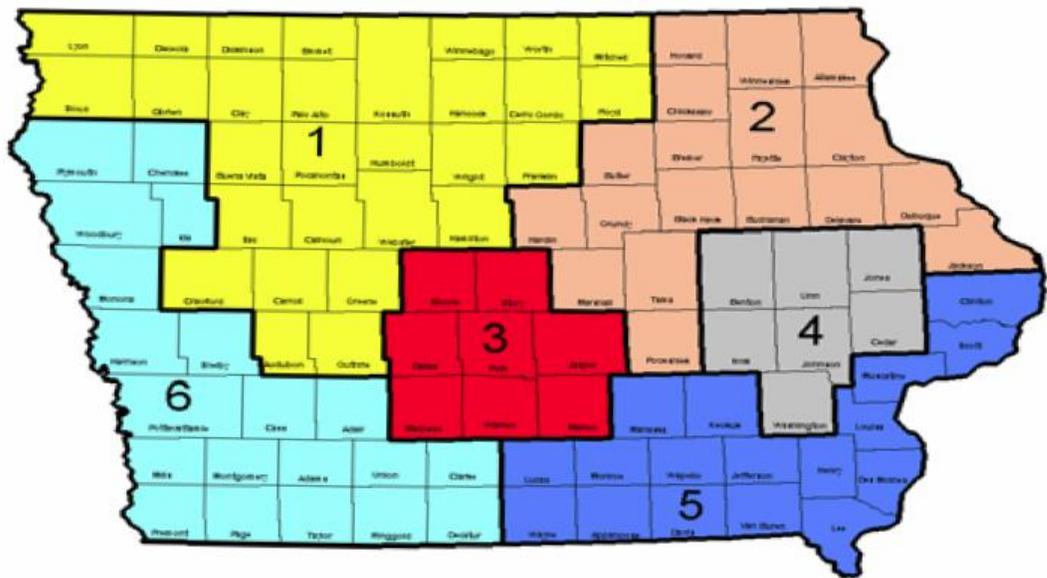
- [Agenda](#)
- [YMCA Healthy Living Center PPT](#)
- [YMCA Handout- Umbrella Graphic](#)
- [YMCA Handout- Client Assessment Form and Y Locations](#)
- [Wellmark ACO- Measuring and Facilitating Care Coordination PPT](#)
- [ADRC PPT](#)
- [Community Care Coordination Plan- Iowa PCA PPT](#)
- [Partnership for Patients- Hospital Engagement Network PPT](#)
- [Medical Home PPT](#)
- [UI Health Alliance ACO](#)

Topic	Discussion
<p data-bbox="131 107 378 212"><u>Patient & Family Engagement Focus</u></p> <p data-bbox="131 260 378 562"><i>YMCA Healthy Living Center- Overview of Programs and the Medically Integrated Facility</i> <i>Trina Radske- Suchan</i></p> <p data-bbox="131 611 378 709"><i>PowerPoint:</i> YMCA Healthy Living Center PPT</p> <p data-bbox="131 751 378 993"><i>Handouts:</i></p> <ul data-bbox="131 793 378 993" style="list-style-type: none"> • YMCA Handout- Umbrella Graphic • YMCA Handout- Client Assessment Form and Y Locations 	<ul data-bbox="402 107 1511 1860" style="list-style-type: none"> • The YMCA Healthy Living Center (Y-HLC) is a partnership between the YMCA of Greater Des Moines and Mercy Medical Center. Located in Clive, Iowa, the HLC brings a new approach to health, healing, and healthy living to our community. Utilizing a "medically integrated" approach, the HLC brings together the experience and expertise of both medical and fitness professionals to more effectively impact a person's health and well-being. • Programs are approved by a medical advisory committee made up of local physicians from a variety of disciplines. From strategic health planning to coordinated care management and personalized fitness plans, the HLC provides services for almost everyone. Whether an individual is undergoing treatment or recovering from an illness or injury, or is striving to improve his or her sports performance, the HLC staff and medical partners are here to provide assistance and support through a wide array of programs and services. • The Y-HLC shifts from a treatment to wellness model and focuses on restoration and prevention. They are taking the expertise of both medical and fitness professionals and developing a team approach with an emphasis on continuum of care. • In the traditional health care model, there is a gap between discharge from hospital and return to previous levels of activity. What happens during this gap decides whether someone readmits to the hospital or is able to regain health living. Simply giving them a brochure about their health issue does not work most of the time. • A community can have excellent medical facilities that provide state-of-the-art treatment, but what can physicians do to alleviate the impact of obesity, inactivity or poor nutrition? For decades, doctors have talked to patients about choices they should make and actions they should take to lead more healthful lives. However, physicians can't watch over patients to monitor and document their detailed nutritional intake and exercise regimens. • The Y-HLC was created in 2009 to support an environment that enhances awareness, changes behavior and embraces the wellness model. The Y-HLC is making a positive impact on the health and wellness of central Iowa and the community and it is the first of its kind in the U.S. It serves as a model for hospitals, fitness facilities, and business. • The Y-HLC is the prescription to managing chronic illnesses, contain costs, and allow individuals to be accountable for their health by tackling each category of prevention. As part of the coordinated care management, the Y-HLC staff measures patient actions and outcomes and then provides feedback to the referring physician. Documented outcomes help people live longer, feel better, prevent future diseases, reach their full potential and connect back to primary care physicians. • Some of the partners in program development include: IDPH, Iowa Department on Aging, Iowa Referral and Resource Center for PD, MS Society, Arthritis Foundation, Community Support Groups, Adaptive Sports Iowa, Alzheimer's Association, DMU, and Mercy. • The Y-HLC operates on an annual budget of \$4.2. They have 8,000 members, 15 full-time employees, and 30% of their members are generated via physician referrals. • There are scholarships available for anyone who needs financial help paying for a membership. • Chris Atchison commented that ACO's in Iowa should consider partnerships in communities to implement this type of model. • A question was asked about implementing this model into rural communities in Iowa. When spreading this model, the focus does not need to be on developing new facilities. It is about thinking about outside the box and simply having enough space in the environment with staff trained to work with people who are obese or have cancer. They bring in an individualized approach and support it with evidence-based group exercise. • Peter Reiter asked about their business model. Funding from membership is their main revenue and next is funding from the referrals.
<p data-bbox="131 1871 378 1976"><u>Health Care Transformation Focus</u></p>	<ul data-bbox="402 1871 1511 2005" style="list-style-type: none"> • Background was given about Aging and Disability Resource Centers (ADRCs) in Iowa. Iowa is one of 43 states that are part of the ADRC grant program, an initiative through HHS, jointly administered by the Administration on Aging and CMS. Iowa's ADRC project is administered by the Iowa Department on Aging.

**Iowa Department
on Aging- Aging
and Disability
Resource Centers**
Joe Sample

PowerPoint:
[ADRC PPT](#)

- ADRC states are expected to change the way services are organized and administered to reduce fragmentation and facilitate access to a coordinated array of long-term supports. The expected outcomes of funding are to:
 - Improve awareness and information
 - ✓ Coordinate the entry point for aging and disability information and referral resources
 - ✓ Enable anonymous information sharing
 - ✓ Engage consumers early on in the continuum of long-term care planning and provide information before services are needed
 - Help consumers evaluate their needs and make early decisions about long-term supports
 - ✓ Open the door to home-based and community-based services
 - ✓ Provide options for consumers to care for themselves and their loved ones
 - Provide access to a variety of home and community-based services and databases
- This model has been around since 2004. The LifeLongLinks Web site (www.lifelonglinks.org) provides a place to start for consumers and providers who are thinking about and planning for long-term living. LifeLongLinks also connects informed consumers and providers with a coordinated entry point to Iowa's information and referral resources:
 - Iowa COMPASS
 - Iowa Association of Area Agencies on Aging
 - Iowa Family Caregiver Support Program
 - Iowa 2-1-1
- Their vision through this site is to provide a coordinated system of information and access for all persons seeking long-term support to minimize confusion, enhance individual choice, and support informed decision-making and access to services.
- ADRCs have been piloting in Cedar Rapids and Waterloo since 2004 and serve 17 counties. Each pilot site works with local aging and disability service providers to:
 - develop and pilot a standardized process that promotes improved access to long-term supports and care; and
 - implement this process through collaboration, enhanced information and referral resources, and the establishment of the position of long-term support options counselors.
- Maps of Iowa were shown (located in the PPT) and an alarming statistic was shared- by 2030, 25 percent of Iowa's population will be over the age of 60. 93% of Iowans 50+ say it is extremely or very important to be able to stay in their own homes as they age.
- Long-Term Supports & Services is the common ground between Aging Network Services, Disability Network Services, and Healthcare Network Services. The website is the entry point where consumers will be able to search at the zip code level for services.
- Additionally, Medicaid has received funds for the Balancing Incentive Payments Program (BIPP). The BIPP is a provision of the Affordable Care Act that is designed to "balance" states' spending on long term supports and services (LTSS). LTSS are home and community based services and services in institutional settings. The goal of BIPP is to provide persons with greater access to home and community based services and reduces unnecessary reliance on institutional services. They are working closely with the Iowa Department of Transportation to ensure the one-click, one-call access to Iowa services.
- On July 1, 2013, 13 Area Agencies on Aging and 16 Planning and Service Areas become 6 Area Agencies on Aging, with 6 planning and service areas. See the Aging Network Reorganization map on the next page.



- Options counselors are a key aspect of the ADRC's. They will help patients transfer back into the community. They provide the right services at the right time as determined by the needs, values, and preferences of the individual. Options counseling includes person-directed, process, information, support, and access to the larger system and services. The core competencies include:
 - Determining the need for options counselors
 - Assessing the needs, values, and preferences
 - Understanding and educating about resources
 - Facilitating self-directed plan
 - Encouraging future orientation
 - Follow-up
- It is important to understand that options counseling is short term and includes follow-up. It is not the long-term case management model. It is person-directed (not person-centered) and the person is at the front and they will direct the optional counselors where they want to go.
- Options counselors assist in the coordination of community supports for people as they transition between settings (ex. Hospital to home). Care transitions will play a role in ACO's as an "open model" assisting in clinical services, community-clinical, community long-term supports and services, and family/personal supports. In the "open model" you have the ability to access multiple partners within the ACO- both clinical community and long term support. The "closed model" on the other hand, would keep everything in-house to work within that specific system.
- A walkthrough of the process was asked to be described. Under the current process, consumers can contact their local Area Agency on Aging, local public health department, or go to www.lifelonglinks.com to search for services in their zip code. The future process will include a 1-800 number that will be available statewide that will give consumers access to multiple partners through the ADRC. The entire long term supports and services will be linked through this number. The process will be seamless to the consumer. Minnesota has already implemented this single communication system model across their entire state.
- Dr. Carlyle commented that this will be huge for Iowa and the ACO's. He encouraged conversations to be taking place about this project with Mercy and Unity Point.

Community Care Coordination Focus

University of Iowa ACO

- The University of Iowa Health Alliance & University of Iowa Affiliated Health Providers includes four equal founding members including:
 - Mercy Health Network
 - Genesis
 - University of Iowa Health Care
 - Mercy Cedar Rapids
- Their mission is to enhance the quality of health and life for Iowans through innovations in

• Overview and efforts to promote care coordination through the ACO model

Stacey Cyphert

PowerPoint:

[UI Health Alliance ACO](#)

care coordination, clinical integration and prevention that reduce cost and improve efficiency.

- The vision is that the University of Iowa Health Alliance will [be a national leader in] transforming health care through innovations in clinical care, research and education; development of new, integrated models of care delivery and financing mechanisms; and optimizing population health.
- Main values include integration, innovation, compassionate care, accountability, respect, and excellence.
- Changes that are driving this collaboration include:
 - Performance improvement skills- the health cost curve is not sustainable
 - Reduced payments from all sources reduces the ability to shift costs
 - Shifting payments from fee-for-services to value
 - Increase in consumer driven health care.
 - Significant new investment required for IT and medical expertise
 - Business and clinical models are rapidly changing and require skill, scale, courage, time and physician and clinical integration
 - Dramatic inpatient utilization decline, wide variation in clinical practice
 - Significant health professional shortages, particularly in rural areas
 - Relentless demographics- boomers aging and increasing chronic diseases
- Distribution of shared savings: Any shared savings received are first applied to ACO operating expenses. These expenses include care coordination personnel to assist patients with their care. During the initial years of ACO participation, it is not anticipated that the ACO should have a surplus after applying any received shared savings to expenses. However, should there be any shared savings remaining after expenses, it will be distributed in the following ways:
 - Reinvested into ACO: 50%
 - Shared with providers: 25%
 - Shared with University of Iowa Health System & MercyCare Service Corporation: 25%
- Discussion took place about the importance of utilizing community resources including public health agencies.
- Their ACO's care coordination strategies include:
 - Data guided population groups
 - High risk conditions: CHF, COPD, DM
 - Coordination with nursing homes, palliative care, hospice
 - Post Hospitalization and E.D. follow up
 - ESRD
 - Dual eligible population
 - Data guided strategies
 - Patient engagement and education
 - Follow up with primary care
- Care coordination Inpatient ACO activity includes the following:
 - UI utilizes inpatient navigators who follow the patient during the stay through the 48 hour discharge call and then do the transitional hand-off to the care coordinators.
 - When they have a Mercy CR care coordinator, the link them at that point as well and ensure the medical record is accessible via CareLink for the PCP team.
 - Conducting 48-hour post discharge telephone calls
 - Post discharge home visits
- Emergency Department ACO activity includes:
 - Transitions from navigator to coordinator for ongoing follow-up needs
- Primary Care Physician visits:
 - Preparing for upcoming visit and pre-ordering overdue health maintenance needs
 - Starting to get referrals from PCP's to follow patients
 - Starting to get inpatient navigator identification to refer to coordinators for continued support

- Ongoing care coordination follow-up to the at risk patients:
 - Building the software support to cue up the health maintenance and disease specific orders
 - Conducting telephonic assessments before PCP visits
- Pilot with a skilled facility (Iowa City Nursing & Rehab) to facilitate transitions easier and avoid readmissions.
- Chris Atchison commented about workforce issues including family caregivers. From a policy context, what needs to be done to encourage this open structure for a wellness approach to the health system, rather than just a new efficient way to deliver health care? Stacey Cyphert responded that as they start to get benchmarks, it will be easier to identify gaps to see where they are and where they would like to be. This going to be data driven to help identify the gaps.
- Bill Applegate asked where the savings would come from after a patient was attributed to the ACO. The response was that if the patient is attributed to the ACO, they will first look at all of the care they are getting and all of the providers they have been seeing. They will assess if they are seeing duplicative providers or taking duplicative prescriptions. They will schedule any missing tests in advance and have them ready at the patient's next scheduled visit. It is to the ACO's benefit to make the patient experience as positive as possible.
- A question was asked about the patients that never visit the doctor. The response was that if the patient does not have any primary care visits, then they will not be attributed to the ACO. That is the avenue. It is incumbent on the ACO to reach out to the patients and have them visit the primary care physician. To add to that, the patient has flexibility to go wherever they choose. They can choose to go to the Mayo Clinic if they wish.
- David Carlyle mentioned the importance of the patient-centered medical home within ACOs. You cannot have an ACO and not have a solid medical home with care coordination.
- More information about the Mercy-CR/UI Health Care ACO can be found at their website: <http://uimercyaco.org>

Community Care Coordination Focus

Community Care Coordination Plan
Ted Boesen
Sarah Dixon Gale

PowerPoint:
[Community Care Coordination Plan-Iowa PCA PPT](#)

- The Iowa Collaborative Safety Net Provider Network is managed by the Iowa Primary Care Association and they award funding to Free Clinics, Rural Health Clinics, Family Planning Agencies and Federally Qualified Health Centers (FQHCs).
- The National Academy for State Health Policy (NASHP) has selected Iowa as one of seven states chosen competitively to participate in an initiative that seeks advance partnerships to improve access to care for vulnerable populations. The University of Iowa Public Policy Center joins the Iowa Primary Care Association and the Iowa Medicaid Enterprise (IME) in the [Medicaid-Safety Net Learning Collaborative](#). This is part of NASHP's ongoing work to provide information and technical assistance to states to help them improve their Medicaid programs.
- Iowa's NASHP Learning Collaborative goals are:
 - Maximizing the participation of eligible safety net provider's in Iowa's 2703 Health Home Program
 - Developing strategies to better integrate primary and behavioral health care for the population served through the program
 - Exploring potential roles for safety net providers in ACO's and other value-based purchasing arrangements.
- This past legislative session, [Senate File 446](#) allocated \$1,158,150 to the Safety Net Network to be used for the development and implementation of a statewide regionally based network (community utility) to provide an integrated approach to health care delivery through care coordination. This legislation still needs to be signed by the Governor.
- The [Community Utility](#) concept has a unique role to play in medical home development, especially among the safety net population (to make sure people don't fall through the cracks) and primary care practices that are smaller or located in rural areas. Many primary care practices in Iowa will be challenged to meet the requirements of serving as a patient-centered medical home without partnering with local community organizations. The

Community Care Coordination/Community Utility concept is a method to address this lack of resources

- On April 25th, the Safety Net Network held a Community Care Coordination Learning Opportunity in which national experts presented. An implementation plan is being developed based on these presentations and what Iowa has learned from other states with similar initiatives. The presentations from the Learning Opportunity on April 25th are located [here](#).
- The PCCM/MH Advisory Council made a recommendation last year to pursue a community utility model in Iowa and the Office of Health Care Transformation who staffs the Council has been working closely with the Iowa Primary Care Association in the development of the plan.
- The vision of the plan is to develop regional community care coordination teams across Iowa which coordinate care for high-risk patients and to support primary care providers regardless of the presence of ACO's.
- They will support small, rural, independent, and safety net practices by employing a team of individuals to provide care management and coordination services. The regional teams will support participating primary care providers with their most high-risk patients and will interface with community resources to improve the care for patients.
- Implementation steps for this initiative include:
 - Conduct community outreach and education session in partnership with an outside technical assistance provider from a state already engaged in building this type of infrastructure.
 - Execute and monitor contracts for at least two and no more than three developmental regional community care coordination entities.
 - Develop state-level infrastructure to support regional community care coordination entities and local practices based on community outreach and education sessions and barriers identified through the RFA process.
 - Develop an evaluation plan for the regional community care coordination entities and statewide entity.
- A question was asked about how regions emerged in other states. Every state could do it differently. For example, in North Carolina, the regionals were community grown and they identified the champion to be the community utility in each region. Colorado had a different approach.
- Another question was asked about who will be the target population. It will likely be the Medicaid population to start with, especially the high-utilizing population.
- Discussion took place about populations that will not have insurance after the Affordable Care Act, such as undocumented, mentally ill, or homeless population. There will always be a need for the safety net and community agencies.

Community Care Coordination Focus

Wellmark ACO: Care coordination in the ACOs and how it is measured
Tom Newton

PowerPoint:
[Wellmark ACO- Measuring and Facilitating Care Coordination PPT](#)

- The overarching goals of an Accountable Care Organization (ACO) are quality outcomes, better experience for the patient, and reduce the rate of increase with the cost of health care. Providers and payers work together to align incentives, share scalable resources, and provide data.
- The Wellmark ACO payment model has three key components:
 - Trigger- As a condition of making a Shared Savings Payment, certain quality measures must be equal to or better than the target.
 - Financial Targets- 50%, 60%, or 70% shared savings. This is a five year agreement- the first two years are upside risk and year three starts downside risk. The two financial targets are Wellmark Trend Target and CPI Target. There must be at least 5000 attributed lives in order to enter into the ACO.
 - Quality Incentive Payment- three quality incentive payment targets compared to Quality Index Score (QIS)
 1. ACO compared to network
 2. ACO compared to baseline
 3. ACO compared to best practice

- Quality Index Score Domains and Measure- This chart is what Wellmark is using to measure ACO performance.

Quality Index Score Domains and Measures					
DOMAINS					
Primary & Secondary Prevention	Chronic & Follow-up Care	Continuity of Care	Tertiary Prevention	Population Health Status	Member Experience
MEASURES					
Breast Cancer Screening	Risk- adjusted % difference in Potentially Preventable Readmissions	% of Attributed Members who are non- users, not risk- adjusted	Risk-adjusted % difference in Potentially Preventable Admissions	% difference of Attributed Members who acquire chronic conditions, risk- adjusted	Patient confidence in managing health problems
Colorectal Cancer Screening	% of Attributed Members with hospital discharge with provider office visit ≤30 days post discharge	% of Attributed with no PCP visit, not risk- adjusted	Risk-adjusted % difference in Potentially Preventable ED Visits	% difference of Attributed Members with chronic conditions that increase in severity, risk- adjusted	Identification of one person as patient's personal doctor or nurse
% of Attributed Members 0- 15 months with recommended # of well-child visits	% of Attributed Members with chronic disease (CRG Categories 50, 60, 70) with ≥3 provider visits	% of Attributed Members with continuity of care, risk- adjusted			Efficiency and organization of provider office
% of Attributed Members 3-6 years old with recommended # of well-child visits					Ease of accessing medical care
Contract Years 1 & 2		Contract Year 3		Contract Years 4 & 5	

- Data availability and care coordination reports:
 - The Performance Dashboard is a resource that Wellmark is bringing to the providers. Wellmark takes the provider's claims data and populates it into a performance report.
 - Hospital Discharge Reports are another resource for providers. Every ACO partner has hospitals, but not all of their attributed members visit that specific hospital. Wellmark sends the providers lists of patients who visited other facilities each week, that way they can do the 30-day follow up.
 - Quality Improvement Gap Reports are from claims data that is populated into reports of the number of patients who fall into categories to receive certain tests and they can compare those lists with the electronic health records. For example, if a patient receives a colonoscopy at age 53, they providers would not need to reach out to them to remind them that they are due for a test. Wellmark is able to remind the patients for tests that need to be done.
 - Reports on care sought outside of ACO partners are done twice a year.
 - Pharmacy reports are done ad hoc.
- A question was asked about a scenario if a patient is in an accident that costs the ACO millions of dollars. The ACO would only be responsible for up to 300,000- it is called stop loss.
- Chris Atchison asked if it would be possible to build in social determinants of health. It would be very difficult to get that type of data. The only data they would have is age, claims data, and possibly address.
- David Carlyle commented about the population under 100% of the federal poverty level that currently doesn't have a primary care physician and has built up unmet needs. He asked about the challenge of setting up a risk arrangement with this population especially since they do not have any claims data. These patients will not get attributed to an ACO until they have seven months of claims data built up with a primary care physician that Wellmark has contracted with.

<p><u>Health Care Transformation Focus</u></p> <p><i>Partnership for Patients</i> <i>Tom Evans</i></p> <p><i>PowerPoint:</i> Partnership for Patients- Hospital Engagement Network PPT</p>	<ul style="list-style-type: none"> • Tom Evans was unable to attend this meeting therefore these notes just give an overview of the Partnership for Patients and reflect key points from the slides. • Overview of the Partnership for Patients Hospital Engagement Network Initiative: Hospitals across the country will have new resources and support to make health care safer and less costly by targeting and reducing the millions of preventable injuries and complications from healthcare acquired conditions. As a part of the Partnership for Patients initiative, a nationwide public-private collaboration to improve the quality, safety, and affordability of health care for all Americans, \$218 million will go to 26 state, regional, national, or hospital system organizations. As Hospital Engagement Networks, these organizations will help identify solutions already working to reduce healthcare acquired conditions, and work to spread them to other hospitals and health care providers. • The Hospital Engagement Networks' will be funded with \$500 million from the CMS Innovation Center, which was established by the Affordable Care Act. Hospital Engagement Networks will work to develop learning collaboratives for hospitals and provide a wide array of initiatives and activities to improve patient safety. They will be required to conduct intensive training programs to teach and support hospitals in making patient care safer, provide technical assistance to hospitals so that hospitals can achieve quality measurement goals, and establish and implement a system to track and monitor hospital progress in meeting quality improvement goals. The activities of the Hospital Engagement Networks will be closely monitored by CMS to ensure that they are improving patient safety. • In order to reduce hospital-acquired complications and avoidable readmissions, CMS identified 12 focus areas: <ol style="list-style-type: none"> 1. Adverse drug events 2. Catheter-associated urinary tract infections 3. Central line-associated bloodstream infections 4. Injuries from fall and immobility 5. Obstetrical adverse events 6. Pressure ulcers 7. Readmissions 8. Surgical site infections 9. Venous thromboembolism 10. Ventilator-associated pneumonia 11. Culture 12. Leadership • The Iowa Healthcare Collaborative (IHC) has categorized these 12 focus areas into four core clinical domains: <ol style="list-style-type: none"> 1. Readmissions 2. Patient Safety 3. Hospital-associated Infections 4. Leadership • The Partnership for Patients establishes national goals: <ul style="list-style-type: none"> ○ By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2012. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over the next 3 years. ○ By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2012. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge. • The majority of the slides showcase a number of Hospital Engagement Network Measure Sets which include charts/graphs.
<p><u>Health Care Transformation</u></p>	<ul style="list-style-type: none"> • This presentation lists all of the NCQA patient-centered medical homes (PCMH) in Iowa. This information is current as of 5/28/13. • Currently, there are 37 clinics and 288 practitioners in Iowa that are NCQA medical homes.

<p>Focus</p> <p>Current NCQA certified Medical Homes in Iowa Janelle Nielson</p> <p>PowerPoint: Medical Home PPT</p>	<ul style="list-style-type: none"> • Regarding the 2703 Health Home Program, there are 24 counties with a health home and 57 practices. In Polk County, there are 26 practices that have become a health home. • There are 14 Federally Qualified Health Centers (FQHCs) in Iowa. A Learning Collaborative will be geared towards the FQHCs focusing on becoming NCQA recognized. The majority of them are planning on submitting a NCQA application by this summer. • Visit NCQ's website to access the current list of NCQA certified physicians/practices in Iowa. Be sure to select in the drop-down list "Physician Practice Connection- Patient Centered Medical Home" and then select "Patient Centered Medical Home 2011". These two lists combined equals the full list in Iowa. <ul style="list-style-type: none"> ○ http://recognition.ncqa.org/PSearchResults.aspx?state=IA&rp=5 • NCQA has a new certification called "Patient-Centered Medical Home Certified Content Expert™". The PCMH Content Expert Certification has comprehensive knowledge of the requirements, the application process and the documentation of the NCQA PCMH Recognition Program. Certified content experts are required to complete two NCQA educational seminars, pass a comprehensive exam and commit to continuous learning and recertification to maintain the credential. <ul style="list-style-type: none"> ○ The list of PCMH Content Experts can be accessed here: http://cce.ncqa.org/pcmh/. ○ Iowa Primary Care Association's Pam Lester is a certified PCMH Content Expert.
<p>Legislative Discussion/ Networking Opportunity</p>	<ul style="list-style-type: none"> • Council members and others in the room were given an opportunity to share what their organization is currently working on to increase networking. They also shared the topics that are most important to them. • At the next meeting, it was suggested that we have a presentation/discussion about how children/pediatrics will fit in. 1st Five will be invited to the next Council meeting. This is a model that supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to 5 and coordinates referrals, interventions and follow-up. • It was also suggested to have a focus on mental health at the next meeting. Magellan is set to come speak to the Council. • Email Abby or Angie if you think of something and we will include that in the future. • During the networking session, Council members mentioned: <ul style="list-style-type: none"> ○ Many were very impressed with the YMCA Healthy Living Center presentation, what they are doing, and are starting to think about a similar model that could be implemented in their communities. ○ The focus on dental care at our last meeting was also mentioned as main topic of interest. After this presentation, Ana Coppola created an event at the Polk County Health Department focusing on Latino women over 50 to help with access to oral care. ○ Many others mentioned at a high-level that they are very excited and optimistic about health care transformation. • Dennis Groenenboom is from Iowa Legal Aid and he presented to the Council about the Iowa Health and Law Project. This project was formed to include legal professionals as part of the treatment team to address issues that patients and their care providers were confronting that could only be resolved through the intervention of the legal system. This project in Iowa started with funding from the U.S. Department of Justice in collaboration with the Iowa Primary Care Association. This is another resource in Iowa that many might be unaware of. If there are any organizations that would like an opportunity to partner with this project, let us know.
<p>The next meeting of the Medical Home and Prevention and Chronic Care Management Advisory Council will be held Wednesday, August 21st, 9:30 – 3:00 at YMCA Healthy Living Center</p>	

Meeting Schedule

- **Wednesday, August 21st, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Friday, November 1st, 2013- Location TBD**