

MINUTES

Prevention and Chronic Care Management/Medical Home

Advisory Council

YMCA Healthy Living Center
Wednesday, February 20th, 2013
9:30 am – 3:00 pm

Members Present

Chris Atchison
Melissa Bernhardt
Charles Bruner
David Carlyle
Marsha Collins
Anna Coppola
Chris Espersen
Tom Evans
Michelle Greiner
Jeffery Hoffmann
Jason Kessler
Petra Lamfers
Linda Meyers
Teresa Nece
Tom Newton
Patty Quinlisk
Trina Radske-Suchan
Peter Reiter
John Swegle
Debra Waldron (Vicki Hunting)
Kurt Wood (John Stites)

Members Absent

Kevin de Regnier
Steve Flood
Ro Foege
Don Klitgaard
Mary Larew
Bill Stumpf

Others Present

Angie Doyle Scar
Abby McGill
Bob Russell
Karith Remmen
Jill Myers-Gadelmann
Pete Damiano
David Swieskowski
Eric Laine
Marni Bussell
Sarah Dixon Gale
Janice Jensen
Sarah Dixon Gale
Kala Shipley
Larry Carl
Jacqueline Stoken
Deb Kazmerzak
Judith Collins
Laurene Hendricks
Janelle Nielson
Pete Damiano
Christina Scharck
Tracy Peclen
Jane Allen
Rachel Dijinanm
Sarah Schlievert
Nicky Cooney
Sandy Nelson
Leah McWilliams
Daniel Patton
Andy Eastwood
Gretchen Hageman
Marcus Johnson-Miller
Jennifer Anderson
Cynthia Steidl Bishop
Koreen Rayl
Kim Gau
Kristin Brandt
Dave Stout

Meeting Materials

- [Agenda](#)
- [Oral Health PPT- Feb 2013](#)
- [Inside I-Smile 2012](#)
- [White Paper- Oral Health Integration in the PCMH Environment](#)
- [Returning the Mouth to the Body- Integrating Oral Health and Primary Care](#)
- [Oral Health in Primary Care- HHS-HRSA](#)
- [Health Homes and SIM PPT- IME](#)
- [Mercy ACO PPT](#)
- [Iowa HBE Consumer Education and Outreach Report](#)
- [Guidelines for the Management of Chronic Conditions in Iowa Schools](#)
- [Heartland Rural Physician Alliance- IPA- Carlyle PPT](#)
- [Iowa Health- Laine PPT](#)
- [Hospital Engagement Network and Care Coordination- Tom Evans PPT](#)

Topic	Discussion
Welcome/ Introduction	Council members and others present introduced themselves.
<p><u>Community Care Coordination Focus</u></p> <p>Dental Home/Oral Health Discussion <i>Jason Kessler Bob Russell</i></p> <p><i>PowerPoint: Oral Health PPT- Feb 2013</i></p> <p><i>Handouts:</i></p> <ul style="list-style-type: none"> • Inside I-Smile 2012 • White Paper- Oral Health Integration in the PCMH Environment • Returning the Mouth to the Body- Integrating Oral Health and Primary Care • Oral Health in Primary Care- HHS-HRSA 	<ul style="list-style-type: none"> • Dr. Kessler gave an overview and summarized the White Paper- Oral Health Integration in the Patient-Centered Medical Home Environment. This white paper includes a number of different case studies in Boston, Seattle, Wisconsin, and Idaho. These case studies are outlined in the PowerPoint. • The American Dental Association estimates that 30 percent of the population has difficulty accessing dental services. • 44% of 5 year-olds already have cavities and cavities are considered the most prevalent chronic health condition • Iowa Medicaid Enterprise (IME) does not: <ul style="list-style-type: none"> • Mandate oral health integration • Require Medical Home/Health Home providers to be responsible for oral health • Excuse Medical Home/Health Home providers from coordinating oral health services • IME does: <ul style="list-style-type: none"> • Encourage providers to consider creative models to improve oral health • Consider oral health to be part of “whole person” care • Pay for appropriate oral health care for members • Dr. Russell then summarized Iowa’s oral health landscape and the I-Smile™ program, which is unique in Iowa and involves multiple providers: dentists, hygienists, nurses, and physicians in multiple locations. 24 dental hygienists in Iowa serve as I-Smile™ coordinators. I-Smile™ Coordinators are successful in building partnerships and local infrastructure. • Dental home means a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services. • More Iowa children are receiving dental care. Since 2005, more than 1 ½ times as many Medicaid eligible children saw a dentist. More than 3 times as many Medicaid eligible children received dental care from a public health (Title V) agency. • In 2011, 62% of Medicaid eligible children ages 6-12 saw a dentist. This is something that Iowa is leading on and makes us unique. Iowa has a model that works and that can be built upon. • <i>hawk-i</i> has a dental-only option for families who previously paid out-of-pocket for care. No other state in the country has this and it is Iowa specific. • To move forward in integration, these will need to happen: <ul style="list-style-type: none"> • Seek additional public-private partnerships for funding and collaborative opportunities to ensure that oral health is a priority • Have a stronger linkage with primary health care and dentistry • Expanding childhood access • Workforce considerations • Increase public education and oral health promotion • Gap-filling services within public health to prevent disease • For more information- http://www.ismiledentalhome.iowa.gov • Chris Atchison asked about reimbursement strategies regarding the IME Health Home program. The Health Home program strives to have good health outcomes for their patients and they are tracking dental measures, but reimbursement is not specifically built into the Health Home model. The Health Homes have things specifically in place for PCMH and consider to some degree coordination of health care needs addressing the whole person, which is expected under PCMH. There is not anything in place to fund specific models and they do not want to dictate a certain model. • A comment was made about dentists not accepting Title 19 because of low

reimbursement. This is being looked at as well as increasing the dental provider network. It is a challenge and it is not just about money- there is more to it than that. Larry Carl commented that it should be funded and administered similar **hawk-i**. **Hawk-i** has no barriers to care and it is how it is administered and funded that makes a difference.

- Dr. Russell discussed adoption of electronic medical records in rural Iowa, which has been a slower process. The problem in dentistry is integrating in medical EMRs. A large barrier is the language that they use and the different forms of diagnostic coding.
- The importance of early intervention of oral health in children was discussed. Charlie Bruner commented that there needs to be an oral health focus on the 0-5 year old population. Dr. Russell agreed and stated that age 3 and below, it is very hard to get access to care for these children because there are not many pediatric dentists. Also, some parents do not think that baby teeth mean anything because they will fall out. However, this could cause dental infections that are not just limited to the teeth and it can spread to the body and cause permanent damage.
- Risk assessments and reimbursement for them were discussed. This is currently not being reimbursed, however CMS will eventually start reimbursing for risk assessments.
- A question was asked about practitioners having trouble with high-risk patients because of not showing up for appointments. Dr. Russell responded that a huge advantage of I-Smile™ is that the I-Smile™ Coordinators make sure that the children get to the dentists. This makes the dentists more willing to work with the I-Smile™ Coordinators and their clients.
- Dr. Pete Damiano from the University of Iowa Public Policy Center shared that they are doing a study with the Commonwealth Fund to survey private practice dentists in Iowa looking at electronic medical records, Medicaid patients, etc. Dr. Damiano will come to a future meeting to share these results.

Health Care Transformation Focus

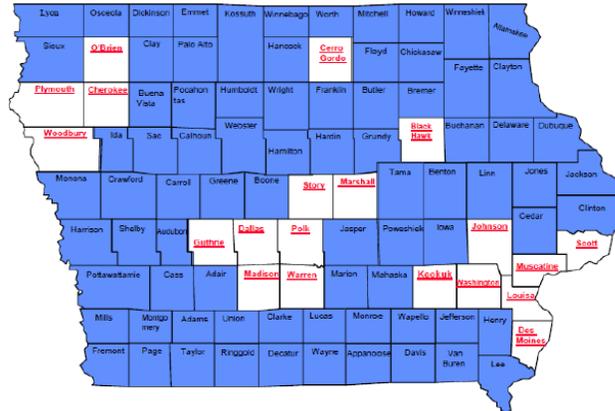
- **Health Homes**
- **Iowa Medicaid-State Innovation Model**
Marni Bussell

PowerPoint:
[Health Homes and SIM PPT- IME](#)

Health Homes

- Section 2703 of the Affordable Care Act gives states the option to submit a State Plan Amendment (SPA) depicting a health home model of care. There is a drawdown of funding a 90/10 Federal match rate for eight quarters for each approved SPA. States are required to consult with SAMSHA to ensure integration of mental and behavioral health services.
- Individuals eligible for the program include those diagnosed with at least one serious and persistent mental health condition, has at least two chronic conditions or has one chronic condition and is at risk for a second chronic condition from the following list of categories:
 - Mental Health Condition
 - Substance Use Disorder
 - Asthma
 - Diabetes
 - Heart Disease
 - Obesity (overweight, as evidenced by a BMI over 25 or 85 percentile for children)
 - Hypertension
- Dual eligible's for Medicaid and Medicare are eligible to participate.
- The Primary Care SPA was effective on July 1st, 2012, with a drawdown of 90/10 Federal match rate for eight quarters.
- There are 22 health home entities enrolled covering 54 different clinic locations in 21 counties with 535 individual practitioners.
- As of February 1st, there are 2,270 members assigned to Health Homes throughout 13 different HH entities. Below is a breakdown of the percentage of enrollees in each of the four tiers:
 - Tier 1 (1-3 chronic conditions)- 45%
 - Tier 2 (4-6 chronic conditions)- 40%
 - Tier 3 (7-9 chronic conditions)- 13%
 - Tier 4 (10+ chronic conditions)- 2%
- Almost half of the current enrollees are dual eligible.
- Payment is directed to only practices that commit to providing:
 - Comprehensive care management

- Care coordination
- Health promotion
- Comprehensive transitional care
- Individual and family support services
- Referral to community and social support services
- There have been over 6,272 claims reimbursed so far and 7 health homes have been successfully paid.
- The link to the Health Home Map (below) can be found here: [Iowa Medicaid Health Home Map](#). Counties in white currently have medical homes. Click on the county to see a current list of the health homes.



- The IME Health Home Website can be found here: <http://www.ime.state.ia.us/providers/healthhome.html>. This website includes a number of links on how to enroll as a health home provider and other tools:

How to Enroll as a Health Home Provider:

- [Provider Application](#)
- [Health Home Provider Agreement](#)
- [TransforMED PCMH Self Assessment](#)
- [Individual Practitioners and Health Home Locations](#)

Health Home Tools for Providers:

- [Health Home Provider Standards](#)
- [Patient Tier Assessment Instruction Form](#)
- [At-Risk Guidance for Providers](#)
- [Health Home IMPA Access Request Form](#)
- [IMPA \(Tool to enroll members into your Health Home\)](#)
- [PMPM Fee Schedule](#)

Specialized Health Home- SPA

- A second SPA is currently being developed which is a “specialized” Health Home focusing on Medicaid members with serious or consistent mental illness for adult and children. IME is currently working with CMS and receiving technical assistance. Their target effective date for this second SPA is June 2013. For children, a “System of Care model” will be used for SED.
- The key details of this second SPA are likely to include:
 - Specialized provider requirements due to special population needs
 - Administered through the Iowa Plan
 - Additional payment tiers above the current 4 tiers due to high need of the population
 - Patient/Family Centered, peer support, and team approach.
- This is being built off of a model that currently exists- an integrated health home pilot with 5 sites in Iowa focusing on adults. In this pilot, the patients must receive primary care from care in their mental health center. One assumption was that these patients were not getting medical care they needed. However, in the pilot, they found out that patients were getting medical services and they were not ready to switch provides to receive medical

care. Now, as the second SPA is being rolled out, they will be flexible on where the medical home is located and are not going to force patients to switch medical homes.

Financial Alignment Model for Dual Eligibles (Medicare-Medicaid Members)

- There are two options to integrate care for duals:
 1. Capitated- three way contract between MCO, CMS, and State
 2. Managed Fee-For-Service- Memorandum of Understanding between CMS and State with the ability to Share Savings.
- Iowa is pursuing a managed fee-for-services to CMS. Iowa must meet quality standards and conditions, and also must commit to a three year demonstration project.
- CMS conversations have led to the following shifts from the original plan:
 - It is now likely to start in early 2014
 - Focus on Health Home as the chief strategy
 - Likely require a benchmark volume of dual eligible members enrolled to start
- The dual eligible population is almost equally disabled or elderly.

State Innovation Model Initiative

- Iowa submitted an application on September 24th, 2012 on behalf of the Governor's office and found out that they were awarded on February 21st. More information about the awards can be found here: [State Innovation Models initiative awards](#).
- The [CMS Innovation Center](#) awarded up to \$50 million to up to 25 states
- There is a potential round two for design awardees in Spring of 2013.
- The SIM design is looking at a broad vision of Health System Transformation including multipayer, high quality, value based, etc.
- There is a six month design phase to produce:
 - Detailed State Health Care Innovation Plan
 - Stakeholder engagement process
 - Testing model for implementation
- Iowa's strategies involve IME adopting the Wellmark ACO model which is already used by many Iowa Healthcare systems. It includes Medicare and a significant percentage of the population is managed under the same ACO model. Iowa will also address the Medicaid Long-Term Care population and will also include the [Healthiest State Initiative](#) in the design.
- Iowa received \$1,350,711 million dollars and will use a vendor to perform analytics (same vendor that Wellmark is using), a technical assistance vendor to help in Medicaid Administrative work, and will use Milliman to perform actuary activities.

Health Care Transformation Focus

- **Hospital Engagement Network**
Tom Evans

PowerPoint:
[Hospital Engagement Network and Care Coordination- Tom Evans PPT](#)

- Dr. Evans set the stage to his presentation by describing the need to shift from "health care reform" to "health transformation". This is no longer an individual effort; it is now a team effort.
- In the ACA, there is a National Quality Strategy with the following priorities:
 1. Making care safer by reducing harm
 2. Ensuring that each person and family are engaged in their care
 3. Effective communication and coordination
 4. Effective prevention and treatment for leading causes of mortality, beginning with cardiovascular disease
 5. Promote the wide use of best practices
 6. Making quality care more affordable by developing and spreading new health care delivery models
- An overview of the Partnership for Patients Hospital Engagement Network Initiatives was given. 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:
 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:
 1. [Readmissions](#)
 2. [Patient Safety](#)
 3. [Hospital-associated Infections](#)
 4. Leadership
- The Partnership for Patients establishes national goals:
 - 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.
- This is a 3 year federal campaign that is voluntary. Iowa was the first state in the country where 100% of the hospitals have signed up. IHC has a contract with CMS to work with all Iowa hospitals (some in Nebraska and Illinois) to prepare them for 2014 by promoting care coordination and patient safety. All hospitals in Iowa are on a 2 year performance cycle. They have all signed a charter and will build a workplan to identify a statewide measure set and begin to improve on 2 categories (readmissions and care coordination).

Health Care Transformation Focus

- **Mercy ACO**
Dr. Swieskowski

- Mercy ACO is an LLC set up to meet Medicare ACO rules. Mercy ACO functions are:
 - Clinically Integrated network- “program to evaluate and modify practice patterns... to control costs and ensure quality “
 - Data management
 - Care Management
 - Quality improvement
 - Comply with all Medicare ACO rules

<p><i>PowerPoint:</i></p> <ul style="list-style-type: none"> • Mercy ACO PPT 	<ul style="list-style-type: none"> ○ Business / contracting- Shared savings, others • Dr. Swieskowski described how shared savings work. Patients are attributed by the primary care doctor. Then the risk adjusted cost target is calculated (Wellmark is about \$80M for 23,000 patients). Fee for service payments made as usual. At the end of one year, costs below or above the target are shared with the ACO. Quality and Patient Satisfaction targets must be met to share savings. The ACO then distributes savings to stakeholders • An ACO is different than a HMO because in an ACO, patients are free to self refer, whereas in an HMO, primary care must authorize referrals. In an ACO, the sickest patients are wanted, whereas in an HMO, the healthiest patients are wanted. • Discussion took place about how the United States has very high health care spending and not as high life expectancy than other industrialized countries. We need to switch from a system that rewards volume to a value-based reimbursement system. This value-based reimbursement system will reward keeping people healthy, require taking financial risk for populations of patients, and require better care at lower cost • Mercy's ACO Accountable Care Contracts include: <ul style="list-style-type: none"> ○ Wellmark (started 4-1-12) ○ CMS (Started 7-1-12) ○ Mercy Employees (Starts 1-1-13) ○ Coventry (Medicare Advantage) • The total ACO lives covered through these equal 62,000. • Primary care transformation includes: <ul style="list-style-type: none"> ○ Access ○ Information Technology and Data Warehouse ○ Coordination of care- Measure documentation of f/u for testing and referrals ○ Population based delivery of preventive and chronic disease services for low risk patients- Immunizations, screening, BP control and Assistance Programs ○ Health Coaches which function as Case Managers and care coordinators ○ Disease management for higher risk patients • One Health Coach is assigned to around 2,000 Mercy ACO patients. The Health Coaches do self-management support and motivational interviewing, where the patient sets their own goals. The goals are determined by the patient, and whatever the patient's goal is, is what they focus on. • Currently, there are 24 office-based health coaches and they are expecting about 50 high-risk patients per coach. All health coaches are RN's right now, but they are thinking about changing that, especially within rural areas. • Employee Care Management is starting March 1 for Mercy Employees and disease management is going to take place within their ACO now. The Employee Care Management includes: <ul style="list-style-type: none"> ○ Coaching based on risk assessments- Provided in physician offices not over the phone ○ Registry tracking and follow-up on cancer screening, immunizations, and chronic disease standards ○ Assistance Programs including smoking cessation, weight loss, nutritional counseling, exercise, and health behavior change counseling • The presentation ended with Mercy's ACO mission and values: <ul style="list-style-type: none"> ○ Mission- Mercy ACO will improve health, improve care, and lower healthcare costs for the communities we serve. ○ Values- Patient centeredness- All decisions will be made in the context of what is best for the patient and continuous Improvement- Mercy ACO will continually improve the value it creates
<p><u>Health Care Transformation Focus</u></p> <p>Iowa Health</p>	<ul style="list-style-type: none"> • Dr. Laine discussed the transition from the old to new world in health care. • "New Group" is System-Wide Medical Group at Iowa Health with nine regional senior affiliates. Their vision is to be a highly integrated, highly functioning, high performance, and high value constituent with the health system. Sustainability is an important thing that is driving health system transformation.

<p>System ACO <i>Dr. Laine</i></p> <p><i>PowerPoint:</i> Iowa Health- Laine PPT</p>	<ul style="list-style-type: none"> • The five lessons learned include: <ol style="list-style-type: none"> 1. Complexity- many moving parts with complex systems that are very sophisticated 2. Culture- the system is having to reinvent themselves 3. Structure 4. Roles- clarifying roles of individuals 5. Planning- compelling idea, concept, and vision • Through each lesson learned, the “old world” vs. “new world” health systems was described. Numerous visuals depicting this are included in the PowerPoint. • Some reoccurring themes of the presentation include: Expertise=Responsibility=Accountability=Authority • Patient-centered physician driven transformation- physician-driven is payer driven and hospital centric and it is trying to identify the role of physicians and other providers have in providing care to the patients. • A comment was made about the commitment of working with physicians on a regular basis. What is the commitment today with the New Group staff and what progress are you making to get buy in into the new world? Dr. Laine responded that value is the driving factor. It starts with candid conversations about what needs to be done and the restraints around it. • Another question was asked about how do they incentivize the providers to sign up for this? Dr. Laine respond that money is important, but that can only do so much. There are other ways to incent, such as the opportunity to walk into an organization and completely understand their role and how it relates to the rest of the staff. They understand that incentive and it resonates with them. • Discussion took place about bending the cost curve and the need to use appropriate utilization, in which medical homes can help with.
<p><u>Health Care Transformation Focus</u></p> <p>Heartland Regional Medical Center IPA <i>Dr. Carlyle</i></p> <p><i>PowerPoint:</i> Heartland Rural Physician Alliance- IPA- Carlyle PPT</p>	<ul style="list-style-type: none"> • The ACA creates a new type of non-profit health insurer, called a Consumer Operated and Oriented Plan (CO-OP). These insurers are run by their customers. CO-OPs are meant to offer consumer-friendly, affordable health insurance options to individuals and small businesses. The federal government is offering loans to non-profit organizations to help establish CO-OPs. • CO-OPs are a private sector alternative to the “government option” originally proposed and are predicated on the same concepts as cooperatives. • They are member-owned and governed organizations formed for the common good of their members. They have HHS/CMS oversight and must be operational no later than January 1, 2014. • CoOpportunity Health will utilize a medical home program to fulfill its “integrated care” requirement for this grant application. CoOpportunity Health will be the first private payer for medical homes in Iowa, following the example of the Iowa Department of Human Services’ program. • In order to provide sufficient provider interest, input, and willingness to sale the program, CoOpportunity Health will help these providers create an Independent Providers Association (IPA). • Iowa’s IPA is joining four other states – California, Massachusetts, Pennsylvania, and Connecticut. There is around 15-20,000 covered lives between these 4 states and a larger population of people means more opportunity for savings. • This medical home-focused IPA will be the entity that works with CoOpportunity Health to provide to providers help becoming certified, creating the reimbursement formulas for the care coordination fee and end of the year bonus, the quality and bonus parameters, and a data collection system for these parameters. • In addition, the IPA will work with other entities such as Medicaid and ultimately, Medicare to spread medical home-like programs throughout the state. • Integrated care includes an “approach to care. . .includes a payment process that incentivizes a system of care coordination to provide safe and clinically based quality health care in the most efficient and evidence-based manner”

	<ul style="list-style-type: none"> • Heartland IPA is part of successful Shared Savings Application of Accountable Care Associates of Massachusetts, which is a virtual ACO with multiple states. • This will provide the benefit of being part of bigger pool of patients, years of care coordination experience, interstate exchange of best practices, and offer the CareScreen web portal. • The desired outcomes for care coordination include: <ul style="list-style-type: none"> ○ i. Tracking of members ○ ii. Identifying member utilization trends ○ iii. Identifying gaps in care for prevention opportunities ○ iv. Recommending treatment plans ○ v. Recommending preferred specialists ○ vi. Recommending preferred facilities • IPA Partners include: <ul style="list-style-type: none"> ○ CoOpportunity Health- Health Partners (Minneapolis) ○ SERPA ○ Accountable Care Associates ○ State Public Policy Group • Tom Newton asked how they are determining who is at risk. Dr. Carlyle responded that this Heartland IPA chose the non-risk option. • IME Health Homes will have another set of patients to add to this and adds more patients to the infrastructure. • For more information about CO-OP's click here: http://www.healthcare.gov/law/features/choices/co-op/index.html
<p>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. • Council members were asked if there were any topics for future meetings that they would like to discuss and have on the agenda. Readmissions and data were two topics that were mentioned. Email Abby or Angie if you think of something and we will be sure to include that in the future. • Teresa Nece described a CMS proposed rule on therapeutic diet order regulation, which is significant to Registered Dietitians and would permit Registered Dietitians to write patient diet orders. The proposed rule change is the culmination of over two years of work between the Academy of Nutrition and Dietetics and CMS. The proposed rule <ol style="list-style-type: none"> 1. Would permit RDs to order patient diets; 2. Allow privileged RDs to order lab tests to monitor the effectiveness of dietary plans and orders, 3. Seeks comment on new strategies for provider reimbursement in rural health clinics (RHC), and 4. Seeks comment on other overly burdensome or redundant regulations in all facilities' Conditions of Participation that may negatively affect dietetic practice. • The report Accountable Care Strategies from the Commonwealth Fund is an excellent resource that describes the need for the patient-centered medical home within an ACO and the role that public health can play.
<p>The next meeting of the Medical Home and Prevention and Chronic Care Management Advisory Council will be held Wednesday, May 29th, 9:30 – 3:00 at YMCA Healthy Living Center</p>	

Meeting Schedule

- **Wednesday, May 29th, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Wednesday, August 21st, 2013- YMCA Healthy Living Center, Rooms 4 and 5**
- **Friday, November 1st, 2013- Location TBD**