

# MINUTES

## Medical Home System – Prevention and Chronic Care Management Advisory Council

YMCA Healthy Living Center

Wednesday, July 25<sup>th</sup>, 2012

9:30 am – 3:00 pm

### Members Present

Chris Atchison  
Melissa Bernhardt  
David Carlyle  
Marsha Collins  
Ana Coppola  
Chris Espersen  
Tom Evans  
Ro Foege  
Michelle Greiner  
Petra Lamfers  
Linda Meyers  
Teresa Nece  
Tom Newton  
Trina Radske-Suchan  
Peter Reiter  
Bill Stumpf  
John Swegle  
Debra Waldron (Sonali Pateli)

### Members Absent

Charles Bruner  
Kevin de Regnier  
Steve Flood  
Jeffery Hoffmann  
Don Klitgaard  
Mary Larew  
Patty Quinlisk  
Jennifer Vermeer  
Kurt Wood

### Others Present

Angie Doyle Scar  
Abby McGill  
Kari Prescott  
Kala Shipley  
Debra Thompson  
Sarah Dixon Gale  
Jenny Schulte  
Marni Bussell  
Judith Collins  
Theresa Armstrong  
Dan Garrett  
Anthony Pudlo  
Marcia Stark  
Mikki Stier  
Patty Funaro  
Leah McWilliams  
Laurene Hendricks

### Meeting Materials

- [Agenda](#) 
- [Council Vision](#) 
- [IME Health Home PPT](#) 
- [Iowa Collaborative Safety Net Provider Network PPT](#) 
- [Iowa CTG and Ashville-like Pharmacy Model PPT](#) 
- [Iowa Health System- Wellmark ACO PPT](#) 
- [Wellmark ACO PPT](#) 

Topic	Discussion
<b>Welcome/ Introduction/ Theme/</b>	Council members and others present introduced themselves. Dr. Tom Evans set the stage by describing the theme of the meeting. Many things are going on in the health care world today with the Affordable Care Act (ACA). Regardless of what happens in the November election, the need for change is necessary and health care will be shifting. The theme for this meeting is to discuss and educate on the top emerging issues related to the ACA in Iowa. The key focus of these discussions relate back to the need for community care coordination and the instrumental role that public health will play in convening partners to achieve this. The morning presentations and discussions are focus around execution, and the afternoon is focused on execution (to create sustainability and infrastructure). At the next Council meeting on September 21 <sup>st</sup> , we will be breaking down into workgroups to determine the focus and work products.

**Iowa Collaborative Safety Net Provider Network - NASHP Technical Assistance**  
*Sarah Dixon Gale*

**PowerPoint:**

- [Iowa Collaborative Safety Net Provider Network PPT](#)

- 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.
- This project seeks to:
  - Develop a plan to maximize participation among eligible safety net providers and patients in IME's 2703 Health Home Program with the goal of recruiting at least 25,000 Medicaid members to participate in the first year of the program and at least 50,000 in the second year.
  - Expand integrated health home services available to members with behavioral health needs by closely exploring the lessons learned from several pilot projects working to integrate primary care and behavioral health services.
  - Gather information to understand how safety net providers can meaningfully participate in value-based purchasing agreements such as Accountable Care Organizations.
- Iowa's NASHP team participated in an in-person technical assistance opportunity July 16 – 18, in Portland, Maine. Six states participated including: Alaska, Iowa, Maryland, Maine, Minnesota, and Texas. Community based care teams were the focus for Iowa.
- Dr. Peter Reiter, Internal Medicine in Ottumwa, mentioned that a high percentage of children seen by pediatricians and family physicians in Ottumwa are covered by Medicaid. Dr. Peter Reiter also brought up the issue that their only psychiatrist is a doctor in New York doing telemedicine. How should they access mental health services? The response was that this is more of a workforce issue and is a nationwide problem. At the technical assistance in Portland, telehealth was discussed as an important aspect of mental health services. The FQHC in Marshalltown is one of the Magellan pilot projects. They are trying to manage as much as they can at the primary care level, and then do a warm hand off to the community mental health center for patients needing advanced care.
- Child Health Specialty Clinics set up a similar system with a partnership with the primary care practices and psychiatrists. It is called Psych Iowa. The goal of Psych Iowa is to provide a consult with the child at the primary care level to offer guidance and tools. If they can't be managed at the primary care level, then they would help facilitate the care transfer.
- Sarah discussed their Community Transformation Grant activities and their Referral Project. The goals of this project are:
  - Partnership between the IDPH and the Safety Net Network.
  - By September 29, 2012, increase from 0 to 6 the number of counties that have developed local referral systems to support control of high blood pressure, high cholesterol, diabetes, and cancer screenings. (Blood pressure and cholesterol as priorities)
  - Expand to 19 additional counties through project period ending in 2016. Priority to work with counties with highest poverty rates. First Phase (though September 2012):
    - Dallas
    - Dubuque
    - Johnson
    - O'Brien
    - Polk
    - Woodbury
- All of the above received funding from the Safety Net Network medical home development funds directed to Local Boards of Health and Maternal/Child Health Centers during SFY12 and will again during Fiscal Year 2013.
- It was mentioned that Dallas County Public Health has a great Health Navigation Program. Residents of Dallas County now have access to available health resources in the county through one point of contact, with emphasis on more timely referrals, fewer steps to

	<p>receipt of care, efficiency, increased options and improved outcomes. Individuals can be referred to health navigation via a health care provider, community agency, or the individuals may self refer. During Fiscal Year 2012, the Health Navigation Program served 456 clients.</p> <ul style="list-style-type: none"> <li>• Sarah mentioned that public health agencies are already very well suited to perform as a community utility role.</li> <li>• Community care of North Carolina will be coming to Iowa for further technical assistance on Thursday, August 30<sup>th</sup> from 8:30 to 11:30.</li> </ul>
<p><b>Council Workgroups</b></p>	<p>At the September 21<sup>st</sup> Council meeting, we will break down into workgroups and move into implementation. A Survey Monkey will be sent out to you to start brainstorming ideas and determine which workgroup you would like to participate in. Below are the workgroups and some initial options for focus areas.</p> <ol style="list-style-type: none"> <li>1. <u>Community Care Coordination</u>- to promote the coordination of community and health care services to advance patient-centered transformation of the local health care system. <ol style="list-style-type: none"> <li>a. Community utilities</li> <li>b. Patient-centered medical home</li> <li>c. Diabetes Care Coordination Plan</li> </ol> </li> <li>2. <u>Health Care Transformation</u>- to encourage partnership between community health care partners in Iowa who are working on new system-level models to provide better health care at lower costs by focusing on shifting from volume to value based health care. <ol style="list-style-type: none"> <li>a. Provider engagement</li> <li>b. Mental Health Redesign/Health Benefit Exchange/Accountable Care Organizations</li> <li>c. Utilization of evidence-based practices and sustainability</li> </ol> </li> <li>3. <u>Consumer Engagement and Education</u>- to educate Iowans and ensure that they have access to tools to be engaged in their health and lead healthy lives. <ol style="list-style-type: none"> <li>a. Prevention</li> <li>b. Spreading of Health Promotion Programs to communities</li> </ol> </li> </ol>
<p><b>SF 2336- Guidelines for the Management of Chronic Conditions in Schools</b></p>	<ul style="list-style-type: none"> <li>• This past session IDPH was given a legislative charge through <a href="#">SF 2336</a> (Section 3, Paragraph j- Page 14) for IDPH along with DE to work on guidelines for the management of chronic conditions for distribution in Iowa schools. The language states:</li> <li>• “No later than December 15, 2012, the department of public health, in collaboration with the department of education and other interested parties, shall develop guidelines for the management of chronic conditions that affect children to be made available to public schools and accredited nonpublic schools throughout the state.”</li> <li>• An initial brainstorming meeting is taking place on August 1<sup>st</sup> to discuss a game plan and determine a direction for the most pressing chronic diseases to include in the guidelines.</li> </ul>
<p><b>Partnership for Patients</b></p> <p><b>Hospital Engagement Network</b></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> </ul>

	<p>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.</p> <ul style="list-style-type: none"> <li>• In order to reduce hospital-acquired complications and avoidable readmissions, CMS identified 12 focus areas: <ol style="list-style-type: none"> <li>1. Adverse drug events</li> <li>2. Catheter-associated urinary tract infections</li> <li>3. Central line-associated bloodstream infections</li> <li>4. Injuries from fall and immobility</li> <li>5. Obstetrical adverse events</li> <li>6. Pressure ulcers</li> <li>7. Readmissions</li> <li>8. Surgical site infections</li> <li>9. Venous thromboembolism</li> <li>10. Ventilator-associated pneumonia</li> <li>11. Culture</li> <li>12. Leadership</li> </ol> </li> <li>• The Iowa Healthcare Collaborative (IHC) has categorized these 12 focus areas into four core clinical domains: <ol style="list-style-type: none"> <li>1. <a href="#">Readmissions</a></li> <li>2. <a href="#">Patient Safety</a></li> <li>3. <a href="#">Hospital-associated Infections</a></li> <li>4. Leadership</li> </ol> </li> <li>• The Partnership for Patients establishes national goals: <ul style="list-style-type: none"> <li>○ 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.</li> <li>○ 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.</li> </ul> </li> <li>• 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).</li> <li>• Discussion took place about an OB program with the University of Iowa and IDPH's parental program to reduce parental mortality. The goal of this program is to have infants stay in until 39 weeks. Hospitals are now developing guidelines that do not allow women elect labor until 39 weeks. The sooner babies are born, the more problems arise.</li> <li>• Bill Stumpf discussed the possible impact for nursing facilities. His organization serves a number of individuals with chronic conditions and they are finding that it is difficult to get them admitted to the hospital. Then the insurance companies want to push them to the nursing facility. They then will usually have to call 911 and get them back to the hospital. With respect to wound care, they are released too soon sometimes with infections. More improved care coordination could be provided to provide IV antibiotics. Dr. Tom Evans responded that these are problems with our current health care system and moving from a volume-based reimbursement system to a value-based reimbursement system will hopefully fix these types of issues.</li> </ul>
<p><b>Asheville-like Pharmacy Model</b></p>	<ul style="list-style-type: none"> <li>• Iowa's Community Transformation Grant (CTG) Goal is to improve statewide awareness for clinical prevention screenings and healthy lifestyle behaviors through consistent messaging in public health, primary health care, business, and community settings; and to create</li> </ul>

<p><i>Anthony Pudlo</i> <i>Kala Shipley</i></p> <p><b>PowerPoint:</b> <a href="#">Iowa CTG and Asheville-like Pharmacy Model PPT</a></p>	<p>community-based strategies for systems and environmental changes in a 26 county subgroup to improve access for healthy opportunities.</p> <ul style="list-style-type: none"> <li>• Four CTG Clinical Prevention Strategies include: <ol style="list-style-type: none"> <li>1. By September 29, 2013, increase the number of counties that have developed local referral systems to support control of high blood pressure, high cholesterol, diabetes, and cancer.</li> <li>2. By September 29, 2016, increase the number of dental practices having systems in place for blood pressure and tobacco use screening and referral.</li> <li>3. By September 29, 2016, increase the number of self-insured employers in the state who support an <b>Asheville-like</b> pharmacist model for employees addressing at a minimum the control of high blood pressure, high cholesterol, and diabetes.</li> <li>4. By September 29, 2014, increase the number of counties with access to evidence-based chronic disease programs.</li> </ol> </li> <li>• The Asheville-like Model has inspired a new health care model for individuals with chronic conditions. The Asheville Project® began in 1996 as an effort by the City of Asheville, North Carolina, a self-insured employer, to provide education and personal oversight for employees with chronic health problems such as diabetes, asthma, hypertension, and high cholesterol. Through the Asheville Project, employees with these conditions were provided with intensive education through the Mission-St. Joseph’s Diabetes and Health Education Center. Patients were then teamed with community pharmacists who made sure they were using their medications correctly.</li> <li>• In Asheville, employers agreed to provide wellness programs for disease states. The incentive for participation was that their co-pays were waived for agreeing to participate in the program.</li> <li>• The program emphasized that each player does what they are good at. Physicians diagnose and implement treatment plans. Patients are educated and self-manage 24 hours a day- medications are taken as prescribed, more effectively and safely. Pharmacists coach patients to ensure compliance with their treatment plan. Patients are regularly assessed, monitored, and changes are recommended when the treatment plan isn’t working. Employers encourage participation by providing incentives and resources that are already available in the community are utilized.</li> <li>• Overall, the program had a return on investment of 4 to 5 dollars per 1 dollar.</li> <li>• Medication Therapy Management (MTM) utilizes pharmacists to build upon existing pharmacist-patient relationships (coordinating the care, discharge counseling, etc.). A MTM type program was set up in Iowa and had a return on investment of \$8.83.</li> <li>• Key elements of success in Iowa are that patients have frequent and consistent face-to-face interaction with pharmacists. The patients’ information is communicated between pharmacists and other health care providers to ensure safe medication use and that self-management goals are in line with MD treatment plans. Another key to success is to incentivize patients to keep them engaged.</li> <li>• Dr. Tom Evans emphasized that the patients role needs to expand beyond simply taking medicine as prescribed. It is also about lifestyle choices.</li> <li>• Dr. Peter Reiter wants to ensure that this model does not create another silo of care that replicates what is already happening. He would like to see it integrated in a more fundamental way so that the patient recognizes it as part of their care plan.</li> </ul>
<p><b>Medicaid Health Care Reform Implementation</b></p> <ul style="list-style-type: none"> <li>• <b>ACA’s Health Homes for Enrollees with Chronic Conditions</b></li> </ul>	<ul style="list-style-type: none"> <li>• 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 specific health home services. States are required to consult with SAMSHA to ensure integration of mental and behavioral health services. The project</li> <li>• 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: <ul style="list-style-type: none"> <li>• Mental Health Condition</li> </ul> </li> </ul>

<ul style="list-style-type: none"> <li>• <b>IowaCare Expansion</b></li> </ul> <p><i>Marni Bussell</i></p> <p><b>PowerPoint:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">IME Health Home PPT</a></li> </ul>	<ul style="list-style-type: none"> <li>• Substance Use Disorder</li> <li>• Asthma</li> <li>• Diabetes</li> <li>• Heart Disease</li> <li>• Obesity (overweight, as evidenced by a BMI over 25 or 85 percentile for children)</li> <li>• Hypertension</li> </ul> <ul style="list-style-type: none"> <li>• Note that dual eligible’s for Medicaid and Medicare are eligible to participate.</li> <li>• On June 8<sup>th</sup>, Iowa Medicaid Enterprise received word that the SPA for Health Homes had been approved by CMS. The drawdown of 90/10 Federal match rate for eight quarters is effective on July 1<sup>st</sup>, 2012.</li> <li>• The Health Home project benefits Iowa by: <ul style="list-style-type: none"> <li>○ Improved health for a segment of Iowa Medicaid population with difficult health challenges.</li> <li>○ Savings due to reductions in usage of health care services (expect reduced use of ER and increased avoidance of hospital admissions)</li> <li>○ The projected savings are between \$7 million and \$15 million in state dollars over 3 years (\$4.9 M built into the Governor’s budget).</li> <li>○ Access to enhanced funding (temporary 90% Federal match) under the ACA to implement.</li> </ul> </li> <li>• Currently enrolled are 9 health home entities covering 39 different practice locations in 10 counties with more than 330 individual practitioners. IME projects that August enrollment numbers will approach 1000 members assigned</li> <li>• 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. The key details of this SPA are likely to include: <ul style="list-style-type: none"> <li>○ Specialized provider requirements due to special population needs</li> <li>○ Administered through the Iowa Plan</li> <li>○ Additional payment tiers above the current 4 tiers due to high need of the population</li> <li>○ Patient/Family Centered, peer support, and team approach</li> </ul> </li> <li>• Council members were encouraged to give any feedback or advice, and ask any questions about the Health Homes initiative. Questions or comments can be sent to contact Marni Bussell at <a href="mailto:mbussel@dhs.state.ia.us">mbussel@dhs.state.ia.us</a>.</li> </ul>
<p><b>Wellmark ACO Model</b></p> <p><i>Tom Newton, Wellmark</i></p> <p><b>PowerPoint:</b></p> <p><a href="#">Wellmark ACO PPT</a></p> <p><i>Marcia Stark, IHS</i></p> <p><b>PowerPoint:</b></p> <p><a href="#">Iowa Health System- Wellmark ACO PPT</a></p>	<p><b>Tom Newton- Wellmark</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• For clarification, Wellmark ACOs are <b>not</b>: <ul style="list-style-type: none"> <li>○ <u>Insurance products</u>- existing Wellmark insurance products remain in effect and provider networks are the same as they have been based on the product for which a provider is a participating provider.</li> <li>○ <u>“Organizations”</u>- Wellmark has not gone and is not going into the medical care business with our ACO partners.</li> <li>○ <u>Impacted by the Affordable Care Act (ACA)</u>- The ACA does not influence the Wellmark ACO strategy.</li> <li>○ <u>Changing provider payment for services</u>- Provider payment for services remains fee schedule, outpatient payment system, inpatient payment system etc. Potential ACO dollars result from creating and sharing savings and quality bonuses.</li> </ul> </li> <li>• A Quality Index Score will be used which is an aggregate score that accounts for each measure within all six domains: <ol style="list-style-type: none"> <li>1. Patient experience</li> <li>2. Primary and secondary prevention</li> <li>3. Tertiary prevention</li> </ol> </li> </ul>

	<ul style="list-style-type: none"> <li>4. Continuity of care</li> <li>5. Chronic and follow-up care</li> <li>6. Population health status</li> </ul> <ul style="list-style-type: none"> <li>• Potential preventable events are imbedded in the Quality Index Score. This is all risk adjusted, therefore they use clinical risk groups.</li> <li>• ACO's will account for about 1/3 of Wellmark's total spending.</li> <li>• Wellmark is collaborating with three health systems in 2012: <ul style="list-style-type: none"> <li>1. Iowa Health System (Des Moines, Cedar Rapids, Waterloo, Fort Dodge)</li> <li>2. Mercy (Des Moines)</li> <li>3. Genesis (Davenport)</li> </ul> </li> </ul> <p><b><u>Marcia Stark- Iowa Health System</u></b></p> <ul style="list-style-type: none"> <li>• Iowa Health System is involved in 3 separate ACO's. Therefore, the first thing they did was defined what an ACO was- "A clinically integrated network of physicians, hospitals, and other providers committed to using and advancing the latest thinking in clinical care, quality, and efficiency." The ACO is designed to achieve the triple aim: better health, better healthcare, and better value.</li> <li>• The Iowa Health System ACO infrastructure is divided into 5 organizational categories: <ul style="list-style-type: none"> <li>1. Advanced Care Innovation</li> <li>2. Population Care Management</li> <li>3. ACO Analytics</li> <li>4. ACO Program Management</li> <li>5. Integrated Care Organization (ICO) – non-hospital category</li> </ul> </li> <li>• The three ACO's that Iowa Health System is involved with are: <ul style="list-style-type: none"> <li>1. TriHealth Pioneer ACO- Fort Dodge</li> <li>2. Wellmark ACO- Fort Dodge, Des Moines, Cedar Rapids, Waterloo</li> <li>3. Medicare Shared Savings Program- Des Moines, Cedar Rapids, Waterloo, Quad Cities, Peoria, Quincy Medical Group</li> </ul> </li> <li>• The next steps are to refine the technology requirements and analytic services to support Wellmark, the Medicare Shared Savings Program, and the Pioneer ACO performance. Also, to develop, at the beneficiary level, the performance integration of services to encompass all care settings.</li> </ul>
<p><b>Pioneer ACO Model- Webster County</b> <i>Kari Prescott</i></p>	<ul style="list-style-type: none"> <li>• Kari Prescott is the Director of the Webster County Health Department. She shared her experience working with the Pioneer ACO and the role of public health.</li> <li>• Public health plays a vital role in community care coordination and linking patients to community resources. Public Health agencies are the experts in knowing their communities and the resources that are available. Other organizations and partners do not fully understand what public health agencies do until they see it firsthand.</li> <li>• Additionally, public health agencies are already a trusted source where community members know to go when they have health issues or any questions.</li> <li>• In this new era of health care reform, the role of public health will shift, but the need for them will be essential. Health departments already have the infrastructures in place to work with community resources and are well suited to provide the care coordination for patients. Regarding ACO's, the hospitals cannot do it without public health, and public health cannot do it without the hospitals.</li> <li>• One performance measure through the Community Transformation Grant is to implement the Chronic Disease Self-Management Program (CDSMP) into their community. Kari mentioned that by the end of July, their entire staff will be trained on the CDSMP program and go out into the community to implement it.</li> <li>• There is no specific direction that the care coordination must occur in the primary care office for the Health Home Model. Especially in rural areas, the primary care setting may not have the capacity to do the care coordination in-house and would need to utilize public health and other community resources.</li> </ul>

<p><b>Networking Opportunity/ Public Comments</b></p>	<ul style="list-style-type: none"> <li>• There are a number of great programs and initiatives currently taking place and it is important to realize that every community will be different and the relationships that are being built are essential for success.</li> <li>• These solutions are focused on executing community care coordination. Providers need to be aligned and equipped for change and use data to drive change. To raise the standard of care, better access and quality is vital as we move from a volume-based to a value-based system.</li> <li>• It was mentioned that it would be helpful if we created an acronym cheat sheet so all Council members know what we are talking about. Examples include: ACA, ACO, and HBE.</li> <li>• On November 13, 2012, the University of Iowa Health Sciences Policy Council will host “Rebalancing Health Care in the Heartland 5: Shaping Iowa’s Health Care Landscape” at the Embassy Suites in Des Moines. Join fellow Iowans for this non-partisan, one-day conference focused on the significant changes and resulting challenges in health services delivery today. Your participation is vital to shaping an outstanding health care system for Iowa. Visit <a href="http://www.healthcare.uiowa.edu/cme/">www.healthcare.uiowa.edu/cme/</a> for more information.</li> <li>• The Council discussed the timing of Council meetings and if a morning meeting before lunch would be better. It was decided that the current meeting time of 9:30 – 3:00 is best, especially for those traveling a distance to make their time worth the drive.</li> </ul>
<p>The next meeting of the Medical Home and Prevention and Chronic Care Management Advisory Council will be held <b>Friday, September 21<sup>st</sup>, 9:30 – 3:00 at the Iowa Hospital Association</b></p>	