

MINUTES

Prevention and Chronic Care Management Advisory Council

Friday, August 27th, 2010

10:00 am – 3:00 pm

Urbandale Public Library

Members Present

Bill Appelgate
Krista Barnes
Ana Coppola
Trula Foughty
Della Guzman
Terri Henkels
Jason Kessler
Teresa Nece
Patty Quinlisk
Peter Reiter
Donald Skinner
Kim Stewart
John Stites
Jacqueline Stoken
John Swegle
Debra Waldron

Members Absent

Jose Aguilar
Eileen Daley
Steve Flood
Melanie Hicklin
Karen Loihl
Noreen O'Shea
Suzan Simmons
Steve Stephenson
David Swieskowski
Jenny Weber

Others Present

Angie Doyle-Scar
Abby McGill
Jill Myers Gadelmann
Sara Schlievert
Jane Schadle
Laurene Hendricks
Janet Beaman
Carol Hinton
Sarah Dixon Gale
Carlene Russell
Kay Corriere
Anne Kinzel
Linda Goeldner
Jenny Schulte
Eric Nemmers
Dawn Gentsch
Leah McWilliams
Dan Garrett
Debra Helsing
Nicole Schultz

* Prevention & Chronic Care Management Advisory Council Website (handouts found here):

http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp

Handouts:

- [Agenda](#) 
- [HF 2144](#) 
- [SF 2356](#) 
- [Diabetes Focus Groups - Report on Barriers to Chronic Illness Care](#) 
- [IANEPCA Chronic Disease Data Report for PCCM Advisory Council](#) 
- [Exchange Grant Narrative - Final](#) 
- [Exchange Grant - Work Plan and Timeline - Final](#) 
- [Iowa Recommendations for Scheduling Care for Kids Screenings](#) 
- [Iowa Care Medical Home Model](#) 
- [IowaCare Regional Primary Care Network - FQHC Rollout](#) 
- [Maternal and Child Health Care Coordination PPT](#) 
- [Online Registry Improves Diabetes Care in Kansas](#) 
- [Other State Diabetes Registry Information](#) 
- [HCR - Impact and Implementation for Iowa Medicaid](#)
- [State Innovations in EPSDT-NASHP Report](#) 
- [Timeline for HCR Implementation](#) 

Topic	Discussion
Welcome	<ul style="list-style-type: none"> • Council members and others present introduced themselves.
Subgroups	<p data-bbox="378 174 711 212"><u>Prevention Subgroup</u></p> <ul style="list-style-type: none"> • The Prevention Subgroup is focusing on HF 2144 to submit recommendations by December 15, 2011 on strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities. • The Executive Director of IDPH’s Office of Multicultural Health (Janice Edmunds-Wells) provided the subgroup with a packet of information to define the terms used in the legislative language. Staff will be setting up a conference call with Janice. They have an Advisory Council that Angie Doyle Scar presented at a few weeks ago about this legislative charge. They are excited to collaborate with us. <ul style="list-style-type: none"> ○ The term “multicultural” is used to be inclusive of all populations of diversity within Iowa. This term includes minorities, immigrants, refugees, and those who are of multi race and ethnicity. ○ “Race” refers to groupings based on physical traits by which people can be distinguished. ○ “Ethnicity” refers to a population’s or group’s common cultural heritage, as distinguished by characteristics such as: <ul style="list-style-type: none"> ○ “Customs- appropriate and inappropriate behaviors. ○ “Language”- refers not only to different usages of the same language. ○ “History”- a community, region, or country that shapes how we perceive ourselves and others. ○ “National origin”- people who share a common cultural heritage may be affected by the different political and socioeconomic characteristics of different countries of origin. ○ “Culture” includes ethnicity, race, gender, sexual orientation, religion, physical challenges, socioeconomic status, and living environment. <ul style="list-style-type: none"> ▪ Trula Foughty suggested that as we talk about “multicultural”, we need to pay special attention to the aging population in that group. • The National Health Care Disparities Report was mentioned as a great resource. The report was developed by the Agency for Healthcare Research and Quality (AHRQ) and is the first national comprehensive effort to measure differences in access and use of health care services by various populations. The report includes a broad set of performance measures that can serve as baseline views of differences in the use of services. The report presents data on differences in the use of services, access to health care, and impressions of quality for seven clinical conditions, including cancer, diabetes, end-stage renal disease, heart disease, HIV and AIDS, mental health, and respiratory disease as well as data on maternal and child health, nursing home and home health care, and patient safety. It also examines differences in use of services by priority populations. • The Iowa Center on Health Disparities will be doing a webinar with the subgroup, as well as the Office of Multicultural Health’s Advisory Council to give their expertise and advice on the direction the subgroup may go, and will give an overview of the current barriers in Iowa to collecting disparities data and possible solutions. • The Iowa Center on Health Disparities provides statewide academic leadership in addressing and reducing health disparities among minority, immigrant, and medically

underserved populations in Iowa. They work with other innovative and highly successful programs already operating at the University of Northern Iowa, including the Iowa Center for Immigrant Leadership and Integration, and Cultural Connections. Together, these agencies already have extensive ties with many minority and rural populations in the state, and have an outstanding record of conducting innovative research.

- The subgroup came up with a list of questions and topics they would like more information on for Janice Edmunds-Wells and UNI's Center on Health Disparities:

Questions/topics for the Iowa Center on Health Disparities

- The subgroup would like to review their legislative charge with the Center, and tell them about the progress and information they have received so far. They would also like the Center to give a high-level overview of what they do and how they can assist the subgroup.
- Jane Schadle brought up the Center on Health Disparities did a study and looked at where people came from when they moved to Iowa. Many people living in Storm Lake came from a certain area in Mexico. Many living in Perry came from a different area in Mexico. This information was very helpful when serving immigration populations. This is a subject that the subgroup would like more information about.
- There is new social research looking at communities as a whole to judge their relative risk. A correlation is built between a set of measures for that population and their disease risk (correlated with incidence). This gives the degree of rural, transportation, access to fresh fruits and vegetables, etc. It is a nice way to profile communities in the future.

Questions for Janice Edmunds-Wells

- Give a historical review of what led up to the legislation and where we are today. What's been done in the past, what pieces have been worked on by various groups around the state?
- What kind of data she is using in her program that she feels is good, reliable data?
- What is her vision of what she would like to see the outcome to be?
- What's her plan for the next few years? Also, what does she feel are needs for the long-term future in terms of collaboration and putting in processes?
- Give an overview of her grant program and performance measurements that she has to meet for that. (HHS grant for state Offices on Diversity)
- How are the multicultural groups identified within the state?
- Discuss "culture" and what it encompasses.
- Does she have priority target groups among the subgroups legislative charge?
- Have a conversation about defining the parameters. Look at groups that we may not normally consider. Once we define the parameters, we can define our strategic approach.

General Discussion

- The [Healthy Iowans- Iowa Chronic Disease Report](#) from IDPH. This report will be looked at regarding multicultural/disparities data.
- Rural areas in Iowa do not have adequate data about chronic diseases. This requires aggregation- looking at grouping a number of years of data to get a large enough number to improve validity.
- There might be a recommendations coming from this subgroup to the eHealth Advisory Council about group about what should be included in an EHR about racial/ethnicity tracking. Other things that could be included in an EHR could be other barriers to medical care (socioeconomic measures such as transportation, housing,

working environment, exposures etc.)

- Terri Henkels reminded the subgroup that many times, the issue is not that the data isn't being collected or asked, it is that some minorities or cultures won't share that with them.
- Predictive data is becoming more common. Predicting socioeconomic status by income- you could build a model that could predict who is facing a hard situation (gender, age, income)
- Ana Coppola stated that sometimes people don't understand the difference between race and ethnicity. Those coming from low SES don't have that level of education to understand the surveys and questions. This could lead to a recommendation about awareness and education.
- A future issue brief could be "Limitations of Data" to raise this issue to legislature. It could give an overview of this legislative charge and the recommendations. It will determine the data that needs to be used today, but also used to determine long-term plans to put things in place for the future. The data we have we are not addressing things adequately.
- The subgroup was provided draft issue briefs for "Prevention" and "Community Utility Concept" that they gave feedback and suggestions to. These will be modified and sent to the group electronically for further drafting.
- The issue briefs have been having great success so far. Laurene Hendricks was at a national conference "Building the Business Case". The coordinator of the breakout session used our [Chronic Disease Issue Brief](#) as an example of a great issue brief, and they used it as an example to create their own issue brief.

Chronic Care Management Subgroup

- Staff discussed the information and research that was provided per the request from subcommittee at the last meeting. The subcommittee continued to discuss a registry at length. The group concluded that the registry is an instrumental piece to the final plan and the larger council has already made recommendations in the Registry Issue Brief that can be included in the final product.
- Sarah Dixon Gale, staff with the Safety Net Collaborative participated in the subgroup and offered assistance in creating the diabetes care coordination plan. Sarah discussed an earlier meeting that was held with PCCM staff and from that meeting the safety net collaborative staff offered:
 1. Safety Net staff will attend the PCCM chronic disease subgroup meetings.
 2. Safety Net staff will work to set up conference calls between PCCM staff clinic representatives, including Family Planning Agencies, Free Clinics, and Rural Health Clinics.
 3. Safety Net staff offered to disseminate a brief survey to the safety net providers in their database. Subcommittee could craft specific questions related to providing care to diabetics and any barriers (i.e. accessing diabetic test strips) they have experienced.
 4. Provide information in what is already being done by safety net providers around diabetic care. The safety Net collaborative has several examples of pilots that have been undertaken by safety net clinics, including the Community Health Centers through their work with the Health Disparities Collaboratives, La Clinica de la Esperanza (a Free Clinic, in conjunction with Iowa Prescription Drug Corporation), as well as several medical home grantees. Subcommittee will need to decide how they would like to receive this information.

5. Diabetes data from safety net providers.

6. Safety net staff will disseminate information to the safety net sites regarding consensus guidelines, resources, etc. as the subgroup further define what the plan and recommendations will be.

- The diabetic patients that are seen by the Safety Net Collaborative members are the target population for the care coordination plan outlined in [SF 2356](#). The subgroup also discussed the different clientele that is seen in the varying safety net providers' sites. The free-clinics may be one of the hardest to incorporate in a care coordination plan. Free clinics vary in size, services offered, hours etc. Some do not track identifying information about their patients. Sarah was asked how patients pay for services at the safety net providers. She was able to give data for the CHCs and said if the subgroup wanted more information she could get it upon request.
 - CHC source of payments:
 - Total Patients: 137,830
 - Uninsured - 38%
 - Medicaid/SCHIP - 32%
 - Private - 22%
 - Medicare - 7%
 - Other Public - <1%
- Some initial suggestions in assisting such a mobile population were to use USB memory Sticks or Cell Phone applications.
- The [Diabetes Focus Groups - Report on Barriers to Chronic Illness Care](#) findings were discussed. Focus groups were done at four community health centers on participants who's diabetes were in control, and also on participants who's diabetes were poorly controlled. The three key messages from the perspective of the patients were that:
 - 1- stress reduces their ability to manage their disease
 - 2- Family engagement is very important. Families and friends need to be more engaged and understanding their family members' disease.
 - 3- The participants wanted more information about the disease itself, and want it in a variety for forms, one being a focus group type setting.
- The group discussed the importance of patient engagement and personal responsibility. They agreed that this piece had to be an important part of the plan. Bill Applegate offered to look into getting a national speaker on this issue to come and present to the larger council.
- The subgroup also discussed other elements that would need to be included. One of the pieces will be management through pharmaceuticals. The Iowa Pharmacy Association provided information about pharmacists & diabetes education.
 - Under the collaborative practice agreement with local providers, pharmacists have the ability to monitor and adjust drug therapy for diabetic patients (such as insulin, oral diabetes medications, antihypertensives and lipid medications).
 - Recent graduates and residents have been exposed to many components about diabetes management. Drake COP has focused diabetes education track for students interested in this field.
 - In addition to this, a number of pharmacists, many of them who work for Hy-Vee, have gone through Drake's diabetes certificate program.
 - Even without the designation of CDE, many pharmacists have the skills and background to effectively instruct and monitor diabetic patients. Most diabetic patients are on multiple medications and have frequent interaction with their local pharmacies.

	<ul style="list-style-type: none"> ▪ There are other credentials that would allow a pharmacist to work with a patient with diabetes – ie BC-ADM (Board certified in Advanced Diabetes Management). • The subgroup discussed how diabetes consensus guidelines will also need to have a key role in the plan. There was also discussion concerning cultural differences in management, lab access, patient education, prediabetes/Impaired, fasting glucose and motivating providers. More on these topics will need to be discussed in more depth at future meetings. <ul style="list-style-type: none"> ○ A suggestion was made that maybe one component can be discussed at each meeting so that the subcommittee conversations can be more focused. • The subgroup decided that there was more information that needed to be collected and more stakeholders that should be engaged before they could start to create a plan. One of the main topics to investigate is to get data on the populations that are being served by the safety net providers and to find out what care coordination is already being done in these facilities and what is working and what is not working. • The subgroup revisited the Disease Registry Issue Brief and the recommendations: <ol style="list-style-type: none"> 1. Iowa should promote clinical registries and a population-based chronic disease registry capable of measuring multiple health conditions or services. The registry tools should be integrated with EHRs and have ease of use and multiple applications for disease reporting and population management. 2. Build the statewide chronic disease registry incrementally by selecting a small number of high priority diseases initially, and accommodating additional diseases in the future. 3. Pursue national standards for chronic disease reporting measures such as National Committee for Quality Assurance (NCQA) or Physician Quality Reporting Initiative (PQRI) 4. Determine best practices for use of population based information obtained from the registry that will encourage prevention, intervention, and evaluation of chronic diseases. • The subgroup feels that the diabetic disease registry piece of their legislative charge has been thoroughly discussed through the issue brief and recommendations. • Future discussions of this subgroup will be with: <ol style="list-style-type: none"> 1. Bery Engebretsen- discussing the Diabetes Focus Groups - Report on Barriers to Chronic Illness Care. 2. David Fries- the Iowa Prescription Drug Corporation. 3. Wendy Gray- Free Clinics of Iowa 4. Someone to talk about patient engagement. It is important for the patient to have personal responsibility. Team based care needs to be broadened to public health and in the community → population-based care. • The subgroup will work on creating questions to survey the safety net facilities in Iowa about diabetes care. • The subgroup recommended that the PPCM Advisory Council produce an annual report. A lot has been accomplished by the council in the last year and this work should be showcased. The Council agreed to this.
<p>Iowa Collaborative Safety Net Provider Network Sarah Dixon Gale</p>	<p>Overview of the Iowa Collaborative Safety Net Provider Network</p> <ul style="list-style-type: none"> • Almost 700,000 Iowans under age 65, approximately 27% of the total population, do not have health insurance. Thousands more have insurance that only covers catastrophic illnesses and accidents. For these individuals and families, there are limited options available for affordable health care. • Many of these Iowans turn to Iowa’s safety net providers for affordable primary and

preventive health care. Through a unique partnership created in 2005 by the Iowa Legislature, the Iowa Collaborative Safety Net Provider Network (Network), Iowa's health care safety net providers have united to identify common unmet needs that can be addressed cooperatively. Access to pharmaceuticals, specialty care referrals, and health professional's recruitment were identified as the first three areas for collaboration and medical home was most recently added as a priority issue area.

- In the beginning, the Network was comprised of Community Health Centers, Free Clinics, and Rural Health Clinics, but has grown tremendously in the past few years to include Family Planning Agencies, Local Boards of Health, and Maternal/Child Health Centers. Because the demand for these providers' services greatly outweighs their resources, there is an ongoing need to coordinate efforts. The recession and dramatic increases in unemployment have amplified the challenges these clinics face of remaining fiscally solvent while providing care for an increasing uninsured population.
- The Network includes a Leadership Group and an Advisory Group (policy direction). Representatives of these groups include:
 - Community Health Centers
 - Rural Health Clinics
 - Free Clinics
 - Maternal/Child Health Centers
 - Local Boards of Health
 - Family Planning Agencies
 - Child Health Specialty Clinics
 - State Board of Health
 - Insurers
 - Other Safety Net Providers/Partners

Safety Net Awards

- This year's Safety Net Awards include: Rural Health Clinics, Free Clinics, and Family Planning. The Grantees include: the Iowa Prescription Drug Corporation, Specialty Care Grantees, and Medical Home Grantees. The grantees collected a variety of data to submit to IA/NEPCA.
- The presentation went into detail about each of the grantees.
- A Pharmacy Oversight Committee is in place to Provide guidance, recommendations, and oversight of Network-supported programs offered through the Iowa Prescription Drug Corporation (IPDC)
- Four Medical Home Grantees four grants to two Local Boards of Health and two Maternal/Child Health centers to work on medical home development in their communities, which are listed below.
 - Local Boards of Health
 - Calhoun County
 - Dallas County
 - Maternal/Child Health Centers
 - Siouxland Community Health Center – Sioux City
- An issue brief was developed by the Network that focused on lessons learned from these projects, which is available [here](#).
- The Community Utility Concept was then discussed. IA/NEPCA hosted a Medical Home/Community Utility Workshop on June 12th, 2009.
- The Community Utility Concept was originally described by Dr. Ed Schor of The Commonwealth Fund
- Medical Home activities that align with community utility approach include

	<ul style="list-style-type: none"> ○ Care management/care coordination ○ Some aspects of health information technology ○ Health education and prevention ○ Coordination of existing services in the community <ul style="list-style-type: none"> ● The concept plays a unique role for safety net providers, small primary care practices, rural providers. <p><u>General Comments</u></p> <ul style="list-style-type: none"> ● Peter Reiter mentioned that previously incarcerated people moving back into the community have high level of mental needs. In the correction center, they have services available to them, but in the community there is usually nothing available to them. Collaboration needs to be done with local mental health centers. ● Oral health and mental health are issues that have not been addressed at IA/NEPCA, but are high level priority issues that they have been discussing at their meetings. ● The percentage of insurance providers (Uninsured, Medicaid, Medicare, underinsured etc.) will be provided to the Council.
<p>EPSDT Care Coordination <i>Janet Beaman</i> <i>Carol Hinton</i></p>	<p>See PPT Presentation- Maternal and Child Health Care Coordination PPT </p> <p><u>Background</u></p> <ul style="list-style-type: none"> ● The Maternal and Child Health Program at IDPH is funded by the Title V Block Grant. ● The purpose of Title V Block Grant is to: <ul style="list-style-type: none"> ○ Facilitate collaboration in assessing the health status of Iowa’s communities and families ○ Promote access to preventive health care for mothers, infants, and children ● Title V is administered through IDPH’s Bureau of Family Health. ● The Maternal Health program contracts with 24 local community-based agencies. They focus on assuring prenatal and postpartum care for pregnant women, ideally through medical homes. This may include oral health services provided by hygienist and referral to dental homes. ● The Child Health program contracts with 22 local community-based agencies. They focus on assuring that children receive well child screens (exams), ideally through medical homes. This includes oral health services provided by hygienist and referral to a dental home (I-Smile™ Program) ● The target audience for the Title V program is low-income women and children on Medicaid or underinsured/uninsured. <p><u>EPSDT/Care Coordination</u></p> <ul style="list-style-type: none"> ● EPSDT (Early, Periodic, Screening, Diagnosis and Treatment). It is an entitlement program for children age 0-21 in Medicaid. <ul style="list-style-type: none"> ○ E= Identifying problems early, starting at birth ○ P= Checking children’s health status at periodic age-appropriate intervals ○ S= Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems ○ D= Performing diagnostic tests when a risk is identified ○ T= Treating problems identified ● The Periodicity Schedule is patterned after Bright Futures. Bright Futures is referenced in the Federal Health Care Reform Bill as the standard of care for ALL children. ● Care coordination is the process of linking the client to the health care system. ● Care coordination in the Title V program began 20 years ago. The standard at that time was that there should be an 80% screening rate, and Iowa was at a 15% screening rate at that time. ● Care coordination is effective so they can call the patient to remind them about their

	<p>appointment and arrange for transportation (bus tokens, taxi) and medical interpretation services.</p> <ul style="list-style-type: none"> • Care coordination helps families to: <ul style="list-style-type: none"> ○ become independent health consumers. ○ develop healthy beliefs, attitudes, and behaviors. ○ make informed health care choices. ○ improve health and physical well-being of women and children. • The role of a care coordinator is to: <ul style="list-style-type: none"> ○ Educate families on the importance of preventive health care <ul style="list-style-type: none"> ▪ Assess the health needs of the family ▪ Provide information about available health & support services ▪ Answer questions regarding services under the Maternal or Child Health program ○ Assist families in locating medical and dental homes and other service providers ○ Advocate for the woman, child, and family • The community utility concept is an infrastructure that could be utilized. • For more information visit www.iowaepsdt.org
<p>Medical Home Multipayer Collaborative <i>Don Skinner</i></p>	<ul style="list-style-type: none"> • On June 2nd, CMS released the solicitation for the Multi-payer Advanced Primary Care Practice Demonstration Project. • Under this demonstration, CMS will participate in multi-payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. The demonstration will evaluate whether advanced primary care practice will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas. • A large amount of discussion took place among key medical home stakeholders in Iowa, and the Medical Home System Advisory Council. • Iowa decided not to apply for the CMS Demonstration Project for a variety of reasons. • Director Tom Newton convened a Medical Home Multipayer Collaborative Workgroup to move forward. It has been agreed that Iowa needs to do something within the next 6-12 months. All of the key stakeholders have agreed to be at the table, including Medicaid and Wellmark. • There is an expectation that the PCCM Advisory Council will be available to give the workgroup recommendations about the integration of prevention and chronic care management into the proposed project.
<p>Iowa State Planning & Establishment Grant for the Affordable Care Act's Exchanges <i>Angie Doyle Scar</i></p>	<p>Exchange Grant Narrative - Final </p> <p>Exchange Grant - Work Plan and Timeline - Final </p> <ul style="list-style-type: none"> • Angie Doyle Scar, Beth Jones, Lynh Patterson (legislative liaison) and Abby McGill were assigned to take the lead in writing the Iowa State Planning & Establishment Grant for the Affordable Care Act's Exchanges. • It is a one-year planning grant for \$1 Million dollars. Each state can apply for up to \$1 Million, and a total of \$51 Million will be distributed. • The Notice of Grant Award is expected on Thursday, September 30th. • Background of Insurance Exchanges <ul style="list-style-type: none"> • Beginning in 2014, tens of millions of Americans will have access to health coverage through newly established Exchanges in each State. Individuals and small businesses can use the Exchanges to purchase affordable health insurance from a choice of products offered by qualified health plans. Exchanges will ensure that

	<p>participating health plans meet certain standards and facilitate competition and choices by rating health plans' quality. Individuals and families purchasing health insurance through Exchanges may qualify for premium tax credits and reduced cost-sharing if their household income is between 133 percent and 400 percent of the Federal poverty level. The Exchanges will coordinate eligibility and enrollment with State Medicaid and Children's Health Insurance Programs to ensure all Americans have affordable health coverage.</p> <ul style="list-style-type: none"> • Iowa will be conducting focus groups for consumers and business, holding regional meetings across the states, and creating a new advisory council to lead this effort. • IDPH is the leading entity for this planning grant. • If the grant is awarded, twenty-five percent of staff time will be allocated to getting this project up and running. Staff time may be front loaded where more time is required at the beginning and less at the end.
<p>Closing Remarks</p>	<ul style="list-style-type: none"> • Angie Doyle Scar gave an overview of what the PCCM Council has accomplished so far. There is a lot to be proud of. <ul style="list-style-type: none"> ○ Producing the First Report to the Director and State Board of Health ○ Completing the Disease Registry Issue Brief and the Chronic Disease Management Issue Brief ○ Working on the Community Utility and Prevention issue briefs ○ Beginning initial work on two legislative charges- HF 2144 and SF 2356, including the diabetes focus groups ○ Collaboration with the Legislative Healthcare Commission ○ Assisting in the planning of U of I's Wagner Event ○ Various partnerships have been established and presentations conducted ○ Partnering with the Medical Home Multipayer Collaborative project ○ Involvement in the Insurance Exchange Planning Grant • Dr. Skinner announced that this will be his last meeting. Governor Culver has appointed him to serve on the state Board of Health. Dr. Reiter was second in the voting for chairperson, so he will be the new co-chair of the PCCM Council.
<p>Networking Opportunity</p>	<ul style="list-style-type: none"> • Staff presented councilmembers with IDPH's appreciation tokens. Tokens are given to community leaders who have shown themselves to stand out in promoting IDPH's mission of promoting a healthier Iowa. • Terri Henkels discussed issues related to the recent flooding in Polk County. A shelter was set up to do triage, health assessments, and to provide people with walkers, crutches, scooters, diabetes medications etc. • The blizzards that occurred a few years ago were then brought up. Many people that had chronic diseases could only survive for a few days on their own. After that, they left their homes to go to a shelter. The shelters would only accept people with Medicaid conditions, and hospitals wouldn't accept them either because they didn't want to take up beds for those who didn't need that level of care. They had to resort to waivers to hospitals to place them in the hallways. • Patty Quinlisk described the heat wave that occurred in the 1990's. Chicago had thousands of people going to the emergency rooms, and Iowa had zero (and very few from Iowa even accessed the cooling centers that were put in place). This is because Iowa utilized community resources and reached out to neighbors. <ul style="list-style-type: none"> ○ Electronic Health Records would be very beneficial in these situation to access medications immediately. • These examples are part of the Continuum of Care- the community's responsibility to provide care. A statewide disaster plan should be established. Keep in mind that the

- more complex and centralized the plan is, the less likely it will work (unless it is to utilize community resources).
- Bill Applegate commented that the elderly need a special focus. They are involved in a disease management project, along with [Area Agencies on Aging](#). Elderly are asked when they go home that they have an alternative contact in case of a disaster. There needs to be somebody that will take responsibility for them. If they can't name somebody, they will get volunteers to do it.
 - Having more elderly people living at home by themselves these types of conversations are necessary and precautions need to be taken.
 - Peter Reiter commented that he sees a geriatric population. Many of his patients show up broken with no family. Their neighbor brings them in, they call 911, or they are found in their homes. Iowa has the highest populations of octogenarians, and they are very fragile and extremely vulnerable.
 - Services such as Meals on Wheels, Visiting Nurse Services often not very reliable, especially in emergency situations. Volunteers run these programs and they will have their own situations to deal with in times of emergencies. Communities need a plan to make sure these programs are sustained during times of need.
 - Anne Kinzel gave an update on the Legislative Health Care Coverage Commission's workgroups.
 - Four workgroups were created to focus on particular aspects of health care coverage. The passage of the Federal Patient Protection and Affordable Care Act has changed the charges of these workgroups to reflect the Commission's new role in assuring that national health reform is implemented in Iowa in an efficient, high-quality, and practical way. The workgroups include:
 - [Workgroup I- IowaCare Expansion, Medicaid Expansion Readiness, and High-Risk Pool](#) will focus on reviewing, analyzing, recommending, and prioritizing options to provide health care coverage to uninsured and underinsured adults. The Workgroup will concentrate on the expansion of the IowaCare program as specified in SF 2356; how to prepare the state for Medicaid expansion set to take place in 2014; and how to maximize the effectiveness of the existing (state) and new (federal) high risk pools in providing care to uninsurable individuals between 2010 and 2014.
 - [Workgroup II- Value-based Health Care](#) will focus on how to create opportunities for the most cost-effective use of health care resources throughout Iowa in both the publicly and privately purchased health care.
 - [Workgroup III- Insurance Information Exchange](#) will work with the Iowa Insurance Commissioner on the development of the new Insurance Information Exchange.
 - [Workgroup IV- Wellness](#) intends to take testimony from 20-30 organizations from both within and outside the state to discuss cutting edge cost-control efforts, including how to design incentives to change behavior for clients that will bend the curve on health care costs.

The next meeting of the Prevention and Chronic Care Management Advisory Council will be held Wednesday, **October 27th, 3:00 – 4:30 at the Marriot in Coralville** (Following the conference "Addressing Chronic Diseases in Iowa" – Ed Wagner keynote speaker (Hansen Award))

The purpose of the Prevention and Chronic Care Management Advisory Council is to advise and assist the Iowa Department of Public Health to develop a state initiative for prevention and chronic care management as outlined in HF 2539.