

MINUTES

Medical Home System – Prevention and Chronic Care Management Advisory Council

West Des Moines Public Library

Thursday, December 1st, 2011

9:30 am – 3:00 pm

MH Members

Present

Melissa Bernhardt
(Larry Carl)
David Carlyle
Kevin de Regnier
Tom Evans
Jeffery Hoffmann
Petra Lamfers
Linda Meyers
Tom Newton
Elayne Sexsmith

MH Members

Absent

Chris Atchison
Libby Coyte
Bery Engebretsen
Ro Foege
Don Klitgaard
Mary Larew
Jane Reinhold
Anne Tabor
CoraLynn Trewet
Jennifer Vermeer
Kurt Wood

PCCM Members

Present

Bill Appelgate
Judith Collins
Marsha Collins
Ana Coppola
Jason Kessler
Teresa Nece
Janelle Nielsen
Patty Quinlisk
Peter Reiter
Kim Stewart
John Stites
Jacqueline Stoken
John Swegle
Debra Waldron
(Vicki Hunting)

PCCM Members

Absent

Jose Aguilar
Krista Barnes
Eileen Daley
Steve Flood
Della Guzman
Terri Henkels
Noreen O'Shea
Suzan Simmons

Others Present

Beth Jones
Angie Doyle Scar
Abby McGill
Jill Myers Gadelmann
Laurene Hendricks
Cathy Lillehoj
Sarah Dixon Gale
Jane Schadle
Tracy Rodgers
Nicole Schultz
Jenny Schulte
Meg Nugent
Marni Bussell
Julie Freeman
Kim Norby
Theresa Armstrong

Meeting Materials

- [Agenda](#) 
- [Adult Intellectual & Developmental Disabilities Summary](#) 
- [Adult MH Redesign Summary](#) 
- [BMI Registry Factsheet](#) 
- [Brain Injury Report Summary](#) 
- [Children's Disability Summary](#) 
- [DHS Mental Health Summary SF 525 Workgroups and Recommendations](#) 
- [Diabetes Clinical Subcommittee Final Recommendations](#) 
- [Diabetes Numbers at a Glance NDEP](#) 
- [Difference Between Intellectual Disability & Developmental Disability Summary](#) 
- [Iowa Algorithm for Prediabetes and Type 2 Diabetes](#) 
- [Iowa Diabetes Action Plan](#) 
- [Iowa Diabetes Care Flowsheet](#) 
- [Iowa Diabetes Care Plan Definitions Document](#) 
- [Judicial DHS Summary](#) 
- [Medicaid PPT- Iowa Section 2703 Health Home Development](#) 
- [Regional Redesign Summary](#) 

Topic	Discussion
<p>Welcome</p>	<p>Council members and others present introduced themselves.</p>
<p>Overview of Council Consolidation Plan</p> <ul style="list-style-type: none"> • Council Input/feedback <p><i>Beth Jones</i> <i>Council Discussion</i></p>	<ul style="list-style-type: none"> • Legislation passed this session which combines the Prevention and Chronic Care Management Advisory Council and the Medical Home System Advisory Council by January 1, 2012. The PCCM Advisory Council will be eliminated from code and their initiatives will be incorporated into the MHSAC's code. • Member organizations that are listed in the MHSAC code must continue to serve on the council. Many member organizations overlap between the MH and PCCM Councils. Staff will work with those organizations' members to decide which person will serve. A number of members on the PCCM Advisory Council will be incorporated into the membership to continue moving forward the prevention/chronic disease management initiatives that the Council has been working on. • Workgroups will continue to be a part of the new Council. By January, membership will be determined and a strategic planning session will take place at the next meeting to determine the overall goals/vision and what the Council wants to accomplish during 2012. Workgroups will also be developed during the strategic planning session. • Tom Newton suggested that we send out a membership interest survey to ensure that the Council members have an opportunity to opt-out if they are no longer are interested in serving as a member. • Discussion took place about the vision of the council. In 2008 when these Councils were established, the main goal was to bring a variety of key stakeholders to the table to have discussions about spreading medial homeness across Iowa and equipping them to do so. Today, the focus is shifting in many ways to care coordination. The Federal Government has developed a National Strategy for Quality Improvement in Health Care which describes that we not only need to focus on the process of the health care system, but to focus on sustainability and changing communities. How do we use the same resources to do more and to eliminate or reduce waste? Both MH and PCCM Councils focus on aspects that are absolute critical to success. • Peter Reiter commented that medical home is an idea is on how to deliver comprehensive care to a defined set of people. The Chronic Care Model embeds the idea of community of processes. Therefore it is logical and beneficial to have our councils combine and work together. The medical home is about care delivery. We need to address the populations that are not attached to a care delivery system and make sure they do not fall through the cracks. It is is crucial that we don't lose the prevention aspect.
<p>Mental Health Redesign</p> <p><i>Theresa Armstrong</i> <i>Council Discussion</i></p> <p>Handouts:</p> <ul style="list-style-type: none"> • DHS Mental Health Summary SF 525 Workgroups and Recommendations • Adult Intellectual & Developmental Disabilities Summary • Adult MH Redesign Summary 	<ul style="list-style-type: none"> • An overview of the SF 525 workgroups and recommendations was given. • SF 252 defines a disability services as "services and other supports available to a person with mental illness or an intellectual disability or other developmental disability." • The overall intent is to ensure that people are getting the services that they need and to redesign the system for adult disability services to implement all of the following: <ul style="list-style-type: none"> ○ Shifting the funding responsibility for the nonfederal share of adult disability services paid for by the Medicaid program, including but not limited to all costs for the state resource centers, from the counties to the state. ○ Reorganizing adult disability services not paid for by the Medicaid program into a system administered on a regional basis in a manner that provides multiple local points of access to adult disability services both paid for by the Medicaid program and not paid for by the Medicaid program. ○ Replacing legal settlement as the basis for determining financial responsibility for publicly funded disability services by determining such responsibility based upon residency. ○ Meeting the needs of consumers for disability services in a responsive and cost-effective manner. • The duties of the Interim Committee are to: <ul style="list-style-type: none"> ○ Make recommendations concerning established work group proposals

- [Brain Injury Report Summary](#)
- [Children's Disability Summary](#)
- [Difference Between Intellectual Disability & Developmental Disability Summary](#)
- [Judicial DHS Summary](#)
- [Regional Redesign Summary](#)

- Address property tax issues
- Devise means for ensuring the state maintains funding commitments to the redesigned system
- Recommend revisions to Chapter 229 regarding MH professionals who are involved in involuntary commitment and examination proceedings
- Recommend revisions to Chapter 230A amendments in order to ensure conformity with system redesign recommendations
- Amend existing code references from "mental retardations" to "intellectual disability"
- Consider issues proposed by the July 1, 2013 repeal of county disability services administration and funding and consider all funding sources to replace the county authority to levy for adult disability services.
- Decisions that were made include:
 - Opposition to having a county based system. Instead, there would be regions. DHS developed a regional system.
 - Shifting of funding responsibilities to make it the state responsible instead of the counties.
- DHS was tasked with forming workgroups which included a wide variety of stakeholders and consumers. The workgroups started in August and they had 11 weeks to make decisions and recommendations. The workgroups include:
 - Redesign Workgroup
 - Children's Disability Services Workgroup
 - Regional Workgroup
 - Brain Injury Workgroup
 - Judicial Branch and DHS Workgroup on Involuntary Committal Process Workgroup
 - Service System Data and Statistical Information Integration Workgroup
 - Psychiatric Medical Institutions for Children and Related Services Workgroup
- Summaries of their decisions are included in summary documents in the handouts.
- Common themes among the workgroups include:
 - Crisis services are very much needed. A recommended was created for a 24-hour crisis hotline, diversion programs, training for police offices, crisis intervention, etc.
 - There needs to be a common assessment for individuals based on their diagnosis that is consistently used across Iowa.
 - The need for health homes was greatly expressed across the workgroups. Discussions took place regarding partnerships with community mental health centers.
 - Systems of care for children were also discussed across the workgroups.
 - Employment for individuals with disabilities is very important.
 - Utilization of peers who have recovered from a mental illness should be used for peer support services.
 - Navigators should be utilized to help people with mental illness navigate the system.
- The final report from DHS is being presented to a legislative interim committee who will then draft legislation for this legislative session.
- Peter Reiter suggested starting with the list of things that are currently not in place and are needed to improve the mental health system in Iowa. Iowa is extremely under-populated with mental health professionals, and payment is so poor that it is difficult to get people consistent care.
- The payment system needs to be able to leverage other resources by taking advantage of affordable health care and utilizing Medicaid services to their maximum potential.
 - Obtaining data is a huge piece of it.
 - Regarding workforce development, utilizing peers in the most effective way is essential. Iowa needs to partner and look at best practices in other states. The Brain Injury Workgroup looked at best practices from other states.
- Kevin de Regnier made a comment that the discussion seems to focus on the actual services. He wanted to know if there has been discussion on who was going to provide those services. How do we leverage existing resources?
 - Many discussions about workforce issues took place in the workgroups. There is no clear

	<p>answer.</p> <ul style="list-style-type: none"> • Discussion took place on the view of chronic mental health care. Health homes play an important role in this regarding care coordination. Further discussions need to take place about the integration of chronic mental health care into primary care/health homes and accountability. John Swegle commented that many primary care providers may not be comfortable in treating patients with mental illness. Most get very little training on this during medical school.
<p>Health Benefit Exchange <i>Angie Doyle Scar Council Discussion</i></p>	<ul style="list-style-type: none"> • In September 2010, IDPH was awarded a one-year grant to plan for the Health Benefits Exchange (HBE) for \$1 M. A no-cost-extension is in place to allow us to continue the efforts from the planning grant and continue drawing down the funds. An Interagency Workgroup has been formed with IDPH, Iowa Department of Human Services (DHS) and the Iowa Insurance Division (IID). • A major part of the planning grant was a series of regional meetings and focus groups across Iowa to ensure considerable stakeholder involvement throughout the planning of the HBE. The information gathered from the meetings was compiled into a Final HBE Regional Meeting and Focus Group Summary. • Iowa has recently been awarded almost \$8 million to continue the planning process through Level 1 of the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. The grant narrative can be found here: Iowa HBE Level 1 Narrative. The purpose of this Level 1 grant application is to continue the planning process for a HBE in Iowa. IDPH is the lead applicant for this grant and is collaborating closely with IID and DHS as part of the Interagency Planning Workgroup. The last page of the July-October 2011 Check Up describes the activities that each agency will be completing during the Level 1 project period. • The Affordable Care Act requires states to have an exchange certified or conditionally certified on January 1, 2013, or the federal government will operate an exchange for the state.
<p>Medicaid Health Care Reform Implementation</p> <ul style="list-style-type: none"> • ACA's Health Homes for Enrollees with Chronic Conditions • IowaCare Expansion <p><i>Marni Bussell</i></p> <p>PowerPoint: Medicaid PPT- Iowa Section 2703 Health Home Development</p> <p>Handouts:</p> <ul style="list-style-type: none"> • Medicaid PPT- Iowa Section 2703 Health Home Development • Regional Redesign 	<p>Council members were encouraged to give any feedback or advice, and ask any questions about the Health Homes initiative and the IowaCare Medical Home Expansion Project. Questions or comments can be sent to contact Marni Bussell at mbussel@dhs.state.ia.us.</p> <p><u>ACA's Health Homes for Enrollees with Chronic Conditions</u></p> <ul style="list-style-type: none"> • 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 • 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"> • Mental Health Condition • Substance Use Disorder • Asthma • Diabetes • Heart Disease • Obesity (overweight, as evidenced by a BMI over 25) • Hypertension • Note that dual eligible's for Medicaid and Medicare are eligible to participate. • Medicaid anticipates beginning enrolling providers starting mid 2012. • Kevin de Regnier asked if there is a plan to provide practices with resources to identify patients that would be eligible. He suggested that technical assistance be available to practices on how to change practice workflow to meet the needs of this project. • A question was raised if Medicaid requires that participants identify a primary care provider.

Summary

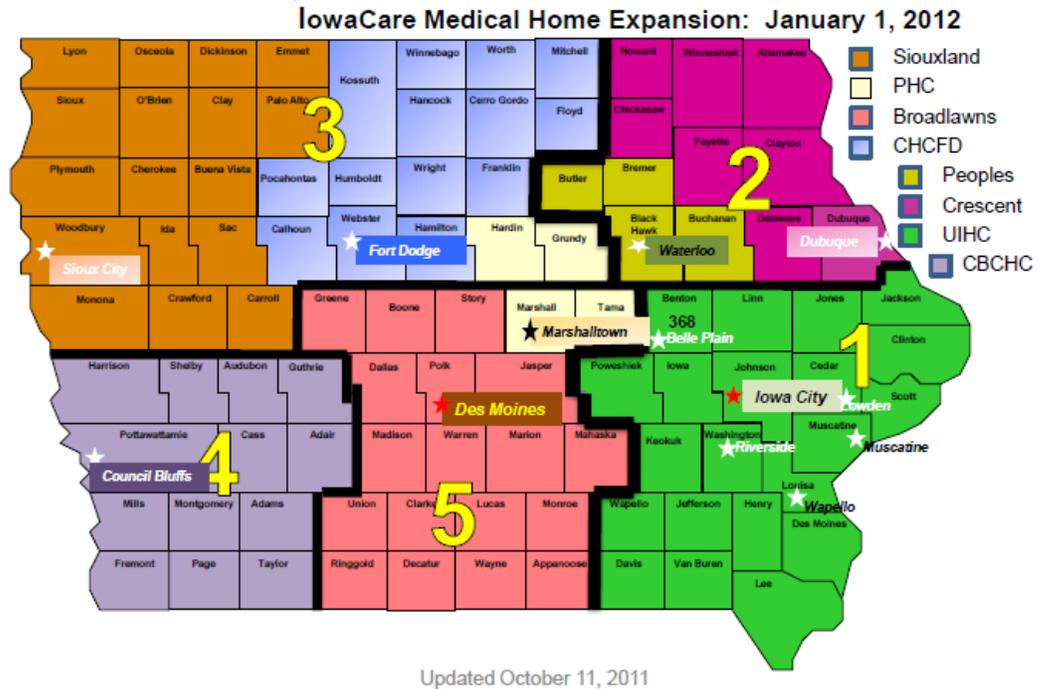
Medipass members have to identify their primary care provider. This health home program is not requiring the member to pick one primary care provider. Once an established network is in place, more advanced targeted enrollment can take place.

- Tom Newton raised a concern that members could enroll multiple times with different providers. There could be a portal which prevents members from enrolling multiple times and have all of their care go through a central hub.
- Jason Kessler responded by stating that Medicaid has developed a Member Agreement Form that the member will sign which says they understand what a health home is and that the health home is the primary place they should go to receive care. Members will be allowed to change their health home over time.
- Council members are encouraged to provide feedback on this Member Agreement Form.
- Jeffery Hoffman commented that one issue could be the time required for the patient to read and understand the form they are signing. There should be a mechanism in place so that the patient understands what they are getting into. As primary care provider, he stated they need that mechanism of education for the patient.
 - Peter Reiter stated that the payment incentives for providers should be substantial in order to make a difference because this is a very small population of people in this program. Determining eligibility and educating patients is asking a lot of the primary care providers.
 - Marni responded that Minnesota is paying around \$10 - \$70 per month for each patient, depending on the chronic condition. An additional 15% is paid on top of that if the patient is not English proficient or has a disability. Iowa is modeling our payment structure off of Minnesota's.
- A question was asked if the quality bonus was only for the patients who have selected a health home, or is it broader? Marni responded that the bonus is for the members in the health home and the metrics are around the chronic condition.
- Another question was raised- what does the patient get out of this program? The PCP gets the bonus, but what about the patient? Most patients don't care about their care or who their PCP is. The incentive for the patient is to receive higher quality and more consistent/comprehensive health care.
- A question about sustainability was raised. The health home program will be budget neutral. Medicaid has done many studies and analysis.
- Comments were made about the need to incentivize Medicaid members to improve their health. There was a recent grant opportunity which Iowa applied for called "Medicaid Incentives for Prevention of Chronic Diseases- ACA Section 4108". This grant opportunity allows states to offer incentives to Medicaid enrollees who adopt healthy behaviors. An effective way to encourage healthy lifestyle changes is to offer incentives to those who reach goals. States will adopt such strategies as rewarding Medicaid enrollees who meet goals established for them such as weight loss, smoking cessation or diabetes prevention or control. Rewards could range from direct cash incentives, gift cards to grocery stores or other retailers, reduced Medicaid program fees or offering services not normally available through Medicaid. For more information <http://www.cms.gov/MIPCD/>. Iowa was not awarded. It will be interesting to see the results of the pilot projects that did get awarded.

IowaCare Expansion

- Collaboration continues with Medicaid in the development of the [IowaCare Medical Home Model](#), established in SF 2356. The expansion is phasing in FQHCs to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. Initially, the FQHC's will be required to meet a set of medical home minimum standards.
- As of December 1, 2011:
 - Council Bluffs Community Health Center joins the IowaCare Provider Network.
 - Broadlawn Medical Center begins serving as a secondary hospital for central and western Iowa (see map regions 3,4,& 5)
- All counties will be assigned a Medical Home as of January 1, 2012.

- Recent changes to the IowaCare model include:
 - Noncontiguous counties to the medical home will be evaluated to identify potential disparities in care
 - Medical Homes will be measured on their outreach efforts for both contiguous and non-contiguous counties
 - Funding pools established to support Medical Home activities around coordination and transitions of care
- David Carlyle commented that it is important to distinguish between contiguous and noncontiguous counties. Data on a true medical home should be with contiguous counties- the county in which the medical home is physically available.
- Below is a map of what the IowaCare Expansion will look like January 1, 2012



Iowa Collaborative Safety Net Provider Network
Sarah Dixon Gale

Commonwealth Fund Grant

- The University of Iowa Public Policy Center (PPC) has been working closely with the Iowa Collaborative Safety Net Provider Network (Network) on a Commonwealth Fund-supported project to determine how Iowa's health care safety net will be impacted by health care reform. The 18-month project will examine the impact of health care reform on the safety net of medical, dental, mental health, and pharmacy providers in Iowa, as well as other related services that deliver health care to uninsured, Medicaid, and other vulnerable patients.
- The Network's Leadership and Advisory Groups, which are made up of state officials and safety net providers, have been meeting and working to determine the current funding, expenditures, and infrastructure of Iowa's safety net, and will then develop strategies for improving it. A National Advisory Committee made up of representatives from the RAND Corporation, US Department of Health and Human Services, Robert Wood Johnson Foundation, The Commonwealth Fund, National Academy of State Health Policy, National Association of Community Health Centers, National Association of Rural Health Clinics, and George Washington University has also been convened to provide input and guidance to the project.
- Currently, the main focus of the project has been preparing reports focused on the implications of health care reform for a variety of payers and safety net providers including but not limited to:
 - Rural health clinics
 - Free clinics
 - FQHC's

- Family planning agencies
 - Title V
 - Medicaid
 - Medicare (related to Part B)
 - IDPH and DHS play an active role in the Safety Net Collaborative and will be assisting in the Commonwealth grant. IDPH will continue to be a resource on state level health care reform issues, in particular the HBE. More information about the project can be found at the following website: <http://ppc.uiowa.edu/pages.php?id=263>.
- Behavioral Health**
- Bery Engebretsen is very interested in and is looking at different models of integrating behavioral health and primary care services. He is involved with one of the Magellan projects. Bery is looking at a variety of models- one is looking at it the other way where the primary care practice providers are integrating with the behavioral health side. They are also looking at modeling off of Cherokee Health Systems in Tennessee and another group in Wisconsin.
- Community Transformation Grant**
- The Safety Net Network is also very involved with the Community Transformation Grant.
 - In September, IDPH was awarded \$3,007,856 per year for up to five years subject to the availability of funds and satisfactory progress of the project from the CDC.
 - Statewide, health providers will be offered training and toolkits from existing or newly developed initiatives that align with promotional materials promoting smoking cessation, routine health screenings, improved nutrition and increased physical activity. Consistent messaging will be promoted through healthcare, public health and the community.
 - More intensive interventions will be offered to a local subgroup of 26 county local boards of health.
 - The work of the Iowa Community Transformation Grant: Community-Based Strategies for a Healthier Iowa will be guided by a 10-member leadership team and supported by an advisory committee. Local boards of health will partner with their local coalitions.
 - The Safety Net Network is participating on the leadership team and will be making enhancements to six of the local boards of health and maternal child clinics that they provide funds to.

Diabetes Clinical Subcommittee
Angie Doyle Scar

Handouts:

- [Iowa Diabetes Action Plan](#)
- [Iowa Diabetes Care Flowsheet](#)
- [Iowa Diabetes Care Plan Definitions Document](#)
- [Diabetes Clinical Subcommittee Final Recommendations](#)
- [Diabetes Numbers at a Glance NDEP](#)
- [Iowa Algorithm for Prediabetes and](#)

- The PCCM Advisory Council's Chronic Disease Management Subgroup is focusing on [SF 2356](#) to develop a plan to coordinate care for individuals with diabetes who receive care through safety net providers.
- As a first step, the Iowa Primary Care Association (Iowa PCA) conducted focus groups in the Federally Qualified Health Centers (FQHC) to determine the barriers that people with diabetes face. The Iowa PCA produced a report for the Council summarizing the results of the focus groups. The main conclusions from the focus groups are that patients want more information about diabetes in a way other than written material; the patients felt that their diabetes was triggered by stress; and they wanted their family members to be more engaged in the management of their diabetes. The focus group report can be found [here](#). PCCM Staff have been meeting with members of the Iowa Collaborative Safety Net Provider Network, including the free clinics, community health centers, family planning clinics, and rural health clinics to discuss this legislative charge and begin collaboration for the diabetes care coordination plan.
- The Subgroup has finalized an [Iowa Diabetes Issue Brief](#) which will include initial recommendations concerning issues that have quickly become high priority while working on the diabetes care plan. The recommendations are:
 1. Coordinate with existing programs to ensure that test-strips are made available for underinsured and uninsured people with diabetes in Iowa.
 2. Ensure that certified diabetes education is available statewide and that outreach is conducted to patients to ensure awareness of this critical service.
 3. Ensure the utilization of educational tools, resources, and programs to promote the

<p>Type 2 Diabetes</p>	<p>engagement of people with diabetes and self-management of both obesity and its complications, including diabetes and metabolic syndrome.</p> <ul style="list-style-type: none"> • A Diabetes Clinical Subcommittee was created to make clinical recommendations for the PCCM Advisory Council’s legislative charge. The Subcommittee has finalized 10 recommendations and a number of Iowa specific documents to be used in the clinic to manage and prevent diabetes, including a Diabetes Care Flowsheet, Diabetes Action Plan, Algorithm for Prediabetes and Type 2 Diabetes, and a variety of educational materials from the American Diabetes Association and the American Association of Diabetes Educators. The Council’s looked over the diabetes documents and recommendations. • The Subcommittee initially did an environmental scan and researched what other states were doing with diabetes care plans and New York has an excellent website that many of these documents were modeled off of. New York’s website can be accessed here: http://fulldiabetescare.org/ • Discussion took place around the use of Electronic Health Records (EHR) to link the Diabetes Care Flowsheet. It was asked if any conversations have taken place with major health record systems to see if this could be implemented. This gives the opportunity to have the same questions asked for all patients at every visit, such as questions about depression and oral health. All Scripts is the EHR that Mercy uses and it was stated that it is unworkable. This could be a place to look into to link the documents. • The PHQ 9 (Patient Health Questionnaire) tool was discussed. The tool should be used by asking the first two questions as the screening (PHQ 2), and if results are positive, then the full questionnaire should be given. • Kim Stewart gave suggestions to improve Action Plan and make some of the wording more positive rather than negative. These suggestions will be incorporated into the document. • These documents will be piloted in a safety net clinic to make further improvements before spreading to all safety net clinics and eventually beyond. • Bill Applegate suggested that a future council agenda should be focused on actionable steps to move this project forward. He suggested that it needs to be determined who is accountable for leading the movement. He emphasized that Iowa currently does not have consensus guidelines and it is a very powerful thing to establish. <ul style="list-style-type: none"> ○ It was suggested to survey a broad section of Iowa providers to see what diabetes guidelines they are currently using- (Iowa Medical Society or the Iowa Osteopathic Medical Association could help with this). The data could greatly improve buy in. The Iowa Collaborative Safety Net Network is willing to send out questions to their safety net providers. The survey questions should be very specific and list specific elements of the different guidelines.
<p>Overview of PCCM workgroups/ legislative charges</p> <ul style="list-style-type: none"> • Diabetes Care Plan • Multicultural Report • BMI Registry <p><i>Angie Doyle Scar</i> <i>Abby McGill</i></p>	<ul style="list-style-type: none"> • The Councils were given an overview/update on the projects that the PCCM Advisory Council and Workgroups have been focusing on. The two subgroups of the PCCM Advisory Council are Prevention and Chronic Disease Management. The Diabetes Care Plan (described in the section above) is a major project that the Chronic Care Management subgroup has been working on. • The Prevention Subgroup has been focusing on HF 2144 to develop 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 report was finalized on December 13th and is now available here: Data Collection of Chronic Diseases in Multicultural Groups of Racial & Ethnic Diversity in Iowa • The Prevention Subgroup also focused on the creation of the Social Determinants of Health Issue Brief and the Community Utility Issue Brief, which were both recently finalized. These issue briefs were developed collaboratively with the MHSAC. Community Utility and Social Determinants of Health are topics that come up frequently in conversations, therefore these issue briefs were created to ensure that everyone is on the same page and knows

	<p>what each term means. They define the term, give background information, and showcase a number of different programs and initiatives currently going on in Iowa that relate to the topic.</p> <ul style="list-style-type: none"> • The Issue Briefs, Multicultural Report, and the work of the Diabetes Clinical Subcommittee have wrapped up. This is a great ending and transition for the combination of the MH and PCCM Advisory Councils.
<p>Networking Opportunity/Public Comments</p>	<p>Council members were given an opportunity to provide comments on topics they would like addressed or to showcase any initiatives or projects they are working on.</p> <ul style="list-style-type: none"> • A BMI Registry Factsheet was introduced to the Councils. This is a topic that has not yet been introduced to either Council. An internal workgroup has been formed at IDPH to begin initial brainstorming of this idea. The factsheet lists the background of the need, the purpose, outcomes, and potential solutions. This could be a topic that a future workgroup could focus on. Discussion took place about the BMI registry idea. <ul style="list-style-type: none"> ○ A comment was made that a BMI registry would be very expensive and requires a large amount staff time to maintain. The registry needs more value than just reinforcing the fact that there is a growing obesity epidemic. There needs to be a clearly defined purpose for the registry, rather than identifying the problem. Once the population of obese children is identified, how can we help them and intervene? ○ Another comment was made that Iowa has a goal of being the healthiest state in the nation. This could be tied to something like that. Discussion took place about interventions in the school setting. How can we encourage schools to do more? A number of shocking stories exist in Iowa of what schools are doing to improve the health of students with no extra money. Schools are the best place right now to improve health. ○ It was suggested that a workgroup on obesity/prevention be created to focus on a population-based management approach rather than patient-by-patient care management (such as diabetes management). • Linda Meyers wants to ensure that the oral health component is addressed and fits in the medical home model. I-Smile does a great job with care coordination. • At a future meeting, the Health Information Network will be reviewed to discuss how this tool can help implement a patient-centered medical home model and assist with care coordination. • The Council need to always remember that keeping the patient first is the main goal. It is the overarching goal of a medical home and we can't lose touch of it. • Discussion took place about the future "vision" of the Council, and what products/accomplishments would be developed. • At the January Council meeting, a strategic planning session will take place to brainstorm and determine what the vision/goals of the Council will be. Workgroups will also be developed during the strategic planning. Both MH and PCCM Advisory Councils have had significant successes and accomplishments since their creation. These are outlined in annual reports and issue briefs. Summary documents of these accomplishments will be provided at the January meeting.
<p>The next meeting of the Medical Home/Prevention and Chronic Care Management Advisory Council will be held Wednesday, January 25th, 9:30 – 3:00 at the Iowa Hospital Association, Education Center Room</p>	