

MINUTES

Patient-Centered Health Advisory Council

Iowa Hospital Association

Friday, March 14th, 2014

9:30 am – 2:00 pm

Members Present

Chris Atchison
 Melissa Bernhardt
 Marsha Collins
 Anna Coppola
 Chris Espersen
 Tom Evans
 Michelle Greiner
 Jason Kessler
 Mary Larew
 Linda Meyers
 Teresa Nece
 Tom Newton
 Patty Quinlisk
 Peter Reiter
 Bill Stumpf
 John Swegle
 John Stites

Members Absent

Charles Bruner
 David Carlyle
 Kevin de Regnier
 Steve Flood
 Ro Foege
 Jeffery Hoffmann
 Don Klitgaard
 Petra Lamfers
 Trina Radske-Suchan
 Debra Waldron

Council Staff

Angie Doyle Scar
 Abby Less

Others Present

Gerd Clabaugh
 Daniel Garrett
 Ashley Engelbrecht
 Marni Bussell
 Lindsay Buechel
 Kim Norby
 Jeremy Whitaker
 Judith Collins
 Tracy Rodgers
 Jodi Tomlonovic
 James Olson
 Laurene Hendricks
 Nick Lund
 Cari Spear
 Janelle Nielsen
 Kari Prescott
 Madison Williams
 Kady Hodges
 Jennifer Walters
 Michelle Stephan
 Joyce Taylor
 Tom Slater

Meeting Materials

- [Agenda](#) 
- [Public Health and the Pioneer ACO PPT](#) 
- [Community Care Coordination PPT](#) 
- [NASHP Article- Supporting Iowa Rural Provider Capacity Through Community Care Teams](#) 
- [Heartland Rural Physician Alliance PPT](#) 
- [Partnership for Patients PPT](#) 
- [Health Home-SIM-Iowa Health and Wellness Plan PPT](#) 

Topic	Discussion
<ul style="list-style-type: none"> • Welcome/ Introductions <i>Tom Evans</i> <i>Gerd Clabaugh</i> 	<ul style="list-style-type: none"> • Council members and interested parties introduced themselves. • Dr. Evans made an announcement that he is resigning as chair of the Council due to increased demand of his time working a numerous projects. • Gerd Clabaugh, interim Director of the Iowa Department of Public Health, introduced himself and thanked Tom and the Council for all of their hard work and dedication over the years.

**Pioneer ACO-
Webster County
Health
Department**
Kari Prescott

PowerPoint:

[Public Health and
the Pioneer ACO
PPT](#)

- On January 1, 2012 a partnership between the Center for Medicare and Medicaid Innovation and Trinity Regional Medical Center in Webster County was formed to create Trinity Pioneer ACO - nationally, one of only 32 Medicare Pioneer ACO. This is an eight county area.
- The Pioneer ACO Model encourages health care providers to work together to coordinate patient care across the continuum, enhance communication with patients and among providers and other health care partners, improve access to health professionals, empower patients and families to make informed choices about their care, and create a more efficient and cost effective care delivery system. Geographically, the Trinity Pioneer ACO is the most rural of the Medicare Pioneer ACOs, while having the one of the smallest population bases.
- The Webster County Health Department is a key partner serving as a community utility in this ACO. All of the public health administrators in the eight counties were brought together to coordinate and integrate services. It is important to keep in mind that integration does not happen overnight and is a continuous process.
- The public health agencies communicated to the primary care providers the services available in their community. Not everyone in the community knows what public health does or the variety of resources they may offer.
- When Webster County Health Department got a seat at the table, they laid everything on the table and showcased what they did well. There was already a strong Maternal and Child Health (MCH) program running in 6 of the counties. Stakeholders in the community did not realize what the MCH program could offer and it is now being utilized in the ACO. The referrals for the MCH program have now doubled.
- The PowerPoint includes a handout that Webster County Public Health created for the ACO which summarize all of the services they offer across the lifespan.
- A “public health referral” is now incorporated into the ACO’s IT system to utilize these services.
- A Public Health Summit was held which was a regional approach to integrated services and was the first time they have public health, primary care, hospitals, boards of health, boards of supervisors- everyone at the table to discuss their vision and goals.
- Communication and integration strategies in years 3 and 4 were discussed. Some highlights include:
 - In the beginning, building and maintaining relationships was a barrier. Through the process, they have strong partnerships and continue to build relationships.
 - Local Boards of Health need to be on board with the changing role of public health in the community.
 - They made sure that everyone in the ACO was using the same depression screening tool so that they were talking the same language.
 - Speaking a common language between providers and community leaders is essential.
 - Implementation of a Tri-Navigation Initiative where there is a primary care provider navigator, mental health navigator, and public health navigator. These navigators would be the staff who would talk and coordinate with one another. The navigators have care plans for the top 5 percent of their sickest patients and include how they can utilize community resources.
- Results for Webster County Health Department include an increase in MCH program referrals. The program began at 87 referrals and as of February 2014 there are 535 referrals. Public Health Program referrals started with 4 clients/6 visits, and now have 40 clients/105 visits.
- Webster County Health Department was awarded the Community Care Team grant to provide an integrated approach to health care delivery. Their project summarized the benefits of working with a Community Care Team which include:
 - Client Centered
 - Linking to Community Resources

	<ul style="list-style-type: none"> ○ Integration- Blending of Services ○ Exchange between Providers ○ Navigate- Directing Clients to Services ○ Target Care ● Key lessons learned from a public health perspective include: <ul style="list-style-type: none"> ○ It is NOT business as usual – you have to change the way you think ○ Evolutionary process ○ Ask questions ○ Keep everyone informed of the vision/mission ○ Continually analyze: structure, capacity, workforce, partners ○ Take advantage of opportunities ○ Communicate, communicate, communicate ○ What is best for the patient/client is always your goal ○ Silo’s are not allowed ○ Listen and learn ○ You don’t know what you don’t know ○ Failures are successes
<p>Community Care Coordination Project Michelle Stephan</p> <p>PowerPoint: Community Care Coordination PPT</p> <p>Handout: NASHP Article- Supporting Iowa Rural Provider Capacity Through Community Care Teams</p>	<ul style="list-style-type: none"> ● Senate File 446 allocated funding to the Safety Net Network to be used for the development and implementation of a statewide regionally based network (community utility) to provide an integrated approach to health care delivery through care coordination. The purpose of the network is to provide an integrated approach to health care delivery through care coordination that supports primary care providers and links patients with community resources necessary to empower patients in addressing biomedical and social determinants of health to improve health outcomes. The two Iowa organizations that have been selected to pilot this approach in their communities within the state are Mercy Medical Center-North Iowa and Webster County Health Department. ● The two teams were awarded funding in December of 2013 and were given one month to develop their team, educate their regions and begin the referral process. ● The two projects will likely have many similarities and differences. Similarities include: <ul style="list-style-type: none"> ○ Common issues regarding access to medications ○ Significant number of behavioral health patients seen in the emergency room ○ High number of overutilization of the emergency room for inappropriate visits ○ Disconnect amongst community partners ○ Often times a lack of communication amongst community providers thus resulting in errors or lack of follow up ○ Lack of education and understanding by the patient ● No two communities are going to look alike or be structured the same. Each community utility model will differ. Differences identified initially in these two pilots include: <ul style="list-style-type: none"> ○ Different community resources available ○ Staffing to some degree ○ Hospital awardee vs. a public health entity ○ One county region vs. a 6 county region ○ Partnerships established ● Mercy Medical Center-North Iowa’s primary partnerships are with Cerro Gordo Public Health Department and North Iowa Community Action Organization. Their project will enroll patients into one of 4 pathways: <ul style="list-style-type: none"> ○ No primary care provider ○ No insurance or payer source ○ Diabetes/Cardiovascular Disease ○ Lack of payment for or access to medications ● They are utilizing TavHealth to track enrollment, referrals made and successful completion of each pathway.

	<ul style="list-style-type: none"> • Webster County Health Department’s primary partnerships are with Unity Point Hospital, the FQHC, local clinics, Berryhill Mental Health, and the five remaining public health departments (Calhoun, Hamilton, Wright, Pocahontas, and Humboldt). They are serving the following high risk population: <ul style="list-style-type: none"> ○ Children ○ Medically Complex Patients and/or those with multi-occurring behavioral health conditions <ul style="list-style-type: none"> ▪ Frequent the ER ▪ On 6 or more medications ▪ Need of PCP established • A patient story was discussed which shows the importance of utilizing the resources in the community to assist patients with their needs and recognizing that anyone who walks through the provider’s office could benefit from the community care coordination initiative. • Some of the key lessons learned include: <ul style="list-style-type: none"> ○ Social Determinants of Health can impact a patient’s health ○ Resources that may be available within a region that may have been underutilized or uncertain of services provided ○ Patients may not understand everything that we assume they do just because they left with written instructions ○ It’s beneficial for overall patient care to get the patient engaged in their care by setting self-management goals ○ Additional partners have been added to the regional team ○ That an entire community CAN take care of a patient effectively • Next Symposium on Primary Behavioral Health Integrated Care is on April 28th and it will focus on the provider's role in primary behavioral health integration. On February 4th, the Iowa PCA hosted the first symposium. They are working with Cherokee Health Systems in Tennessee to provide technical assistance in behavioral health integration to not only the Community Care Coordination regions but to any interested parties throughout the state.
<p>Iowa Heartland Rural Physician Alliance: CoOpportunity Health- Medical Home Initiative <i>Indira Blazevic</i> <i>Tom Slater</i></p> <p><i>PowerPoint:</i> Heartland Rural Physician Alliance PPT</p>	<ul style="list-style-type: none"> • The Heartland Rural Physician Alliance, or HRP, is Iowa’s Independent Physician Alliance (IPA). It was formed as a non-profit in June 2012. The members are independent-minded physicians or administrators of smaller hospital systems and clinics. • The mission of the HRP is to engage and support member physicians and practices in providing world-class, patient centered health care in alignment with the Patient Centered Medical Home model. • The HRP is currently linked to an ACO and is utilizing the HRP organizational structure to enter in additional ACO agreements with payers- both public and private. • HRP is participating in implementation of transitions that will benefit both patients and the members while maintaining their independent practices within their communities. These transitions will help members and HRP take advantage of the new opportunities offered under the ACA. • CoOpportunity Health is working with HRP members on developing various Patient-Centered Medical Home Pilot Sites. Currently, Patient Experience Baseline Surveys are being conducted of HRP Member Pilot Sites, which is a step toward NCQA PCMH accreditation. • Six practices are participating in the 2 year pilot project. They anticipate that physicians and practices will progress to NCQA certification. The goal is that the practices will truly transform and not just check the boxes to get the certification. • A white paper was developed to frame the pilot proposal and includes preliminary organizational plan and approach, rationale for HRP to be a part of the CoOpportunity Pilot Project, and HRP’s organizational support and commitment to the Patient-Centered

	<p>Medical Home model.</p> <ul style="list-style-type: none"> • A number of milestones were achieved including: <ul style="list-style-type: none"> ○ Practice commitments to CoOpportunity PCMH Initiative ○ Baseline data survey on patient satisfaction ○ Data census analysis of all pilot project practices ○ Technical assistance in the form of clinical, administrative, and collegial support ○ NCQA submission and achievement. • The patient survey is a key piece of the pilot. They discovered that practices were using many different survey tools, and they settled on the CAHPS PCMH survey tool because it covered the goals of the project and was NCQA certified. • For more information, visit www.heartlandrpa.org or contact Indira Blazevic at iblazevic@sppg.com.
<p>Hospital Engagement Network Tom Evans</p> <p><i>PowerPoint:</i> Partnership for Patients PPT</p>	<ul style="list-style-type: none"> • Overview of the Partnership for Patients Hospital Engagement Network Initiative: Hospitals across the country will have new resources and support to make health care safer and less costly by targeting and reducing the millions of preventable injuries and complications from healthcare acquired conditions. As a part of the Partnership for Patients initiative, a nationwide public-private collaboration to improve the quality, safety, and affordability of health care for all Americans, \$218 million will go to 26 state, regional, national, or hospital system organizations. As Hospital Engagement Networks, these organizations will help identify solutions already working to reduce healthcare acquired conditions, and work to spread them to other hospitals and health care providers. Hospital Engagement Networks' will be funded with \$500 million from the CMS Innovation Center, which was established by the Affordable Care Act. • Two key aspects of the Affordable Care Act that this initiative focuses on include: <ul style="list-style-type: none"> ○ In 2012, penalties for high readmission rates began. ○ In 2014, reduced payment for high levels of hospital acquired conditions. • The Partnership for Patients established national goals: <ul style="list-style-type: none"> ○ By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2012. ○ 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. • The Partnership for Patient scope of work includes: <ul style="list-style-type: none"> ○ Readmissions ○ Adverse drug events ○ Venous thromboembolism (VTE) ○ Falls ○ Pressure ulcers ○ Obstetrical adverse events ○ Catheter-associated urinary tract infections (CAUTI) ○ Surgical site infections ○ Ventilator-associated pneumonia ○ Central line infection • The Iowa Healthcare Collaborative (IHC) is working with 127 hospitals to execute strategies on these. Readmission is tied to care coordination, and the rest of the areas on this list are what the hospital doesn't get reimbursed for readmissions. • Data was given that shows that nationally the Partnership for Patients is bending the curve in providing better care. Hospital Acquired Conditions were reduced from 4.7 M to 4.3 M. • Each hospital has a charter/workplan to align and equip providers and communities and drive rapid cycle improvement. The hospitals complete monthly reporting including hospital-specific reports and aggregated results. There is also collaborative learning

	<p>including learning communities, improvement advisors on site, and a variety of national resources available.</p> <ul style="list-style-type: none"> • A chart showing Iowa’s Hospital Engagement Network (HEN) reporting performance was presented showing the percent of Iowa hospitals reporting outcome measures. • Iowa’s HEN has been nationally recognized because it is highly rural and able to execute and obtain results faster than most other states’ HENs. Iowa has been leading national calls on rural strategies and sustainability. • Data was presented on Catheter-associated urinary tract infections (CAUTI) and OB high performers. Nationally, CAUTI are not improving and rates are increasing- Except in Iowa. Since the start of the campaign, there has been a 44.24% improvement. Regarding Early Elected Delivery (EED), there has been a 90.59% improvement. This is unique to Iowa because of the hard stop policy for early deliveries. Currently, there is only one hospital that does not have this policy in place. This shows that as a provider community can build a case for change and execute to show outcomes. • In 2013, it is estimated the hospitals in Iowa’s HEN avoided 4,344 total events, decreased the length of stay by 17,758, saved 32 lives, and avoided \$51,240,122 in opportunity cost. Patrick Connolly from CMS stated that “this is the most successful short term project CMS has ever done”
<p>Health Home Program <i>Pamela Lester</i></p> <p>State Innovation Model <i>Marni Bussell</i></p> <p>Iowa Health and Wellness Plan <i>Lindsay Buechel</i></p> <p><i>PowerPoint:</i> <u>Health Home-SIM-Iowa Health and Wellness Plan PPT</u></p>	<p><u>Health Home Initiatives</u></p> <p>Primary Care Health Home Program</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 targeting chronic conditions. The Primary Care SPA became effective July 1, 2012. The Serious and Persistent Mental Illness (SPMI) SPA has a mental health focus and was effective in July 2013. There is a drawdown of funding a 90/10 Federal match for eight quarters for each approved SPA. • Individuals eligible for the Primary Care Health Home 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"> o Mental Health Condition o Substance Use Disorder o Asthma o Diabetes o Heart Disease o Obesity (overweight, as evidenced by a BMI over 25 or 85 percentile for children) o Hypertension • There are 36 health home entities enrolled covering 73 different clinic locations in 29 counties with 648 individual practitioners. • Click here to view the Health Home Map as of January 2014. Click on your county to see if Health Home services are available. Counties in blue currently have Health Homes. Members living in neighboring counties of Health Homes may be able to enroll in the Health Home. • As of March 1, 2014 there are 5,122 members assigned to 36 Health Home entities. 870 or 12% are under age 19. Below is a breakdown of the percentage of enrollees in each of the four tiers: <ul style="list-style-type: none"> o Tier 1 (1-3 chronic conditions)- 38% o Tier 2 (4-6 chronic conditions)- 40% o Tier 3 (7-9 chronic conditions)- 16% o Tier 4 (10+ chronic conditions)- 6% • As of March 1, 2014, there was \$1,434,888.78 in per member per month payments made and 17 Health Homes were successfully paid. • Health Home 2.0 is an updated version of the Primary Care Health Home Program

including the following updates:

- As of April 1, 2012, providers will be able to have automatic payment instead of submitting a claim.
- IME is working on a Program Toolkit and a Transformation Toolkit to help with the implementation of the program.
- In the summer of 2014, there will also be a Health Coach Pilot
- The purpose of Health Home 2.0 is to engage providers, boost enrollment, increase savings and improve outcomes.

Integrated Health Home Program for Serious and Persistent Mental Illness (SPMI) Population

- An “Integrated Health Home” is a team of professionals working together to provide whole-person, patient-centered, coordinated care for all situations in life and transitions of care to adults with serious mental illness (SMI) and children with Serious Emotional Disturbance (SED).
- SMI is defined as:
 - Psychotic Disorders
 - Schizophrenia
 - Schizoaffective Disorder
 - Major Depression
 - Bipolar Disorder
 - Delusional Disorder
 - Obsessive-Compulsive Disorder
- SED is defined as a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental disorders (DSM) published by the American Psychiatric Association or its most recent International Classification of Disease (ICD) equivalent that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.
- Members are automatically enrolled in this program, and they can request to be disenrolled. Members can not participate in both programs.
- As of March 2014, there were 16,548 members enrolled are children and 10,051 (61%) of those were children.
- Discussion took place about Minnesota’s Health Home program. Minnesota created their own health home certification mechanism. If there is a provider in Iowa near the border of Minnesota, IME will accept that instead of NCQA.
- The IME Health Home Website can be found [here](#).

State Innovation Model

- The State Innovation Model (SIM) is an effort funded by the CMS and led by Iowa Medicaid Enterprise to develop a Medicaid ACO model for Iowa. In February 2013, Iowa was awarded around 1.4 M dollars for a Design phase to develop a State Health Care Innovation Plan over a six month period. When the design phase is complete, Iowa will have six months to submit a Health Care Innovation Plan to CMS as an application for a Model Testing Award. DHS hopes to implement the State Health Care Innovation Plan in 2016.
- The vision for Iowa’s SIM is to transform Iowa’s health care economy so that it is affordable and accessible for families, employers, and the state, and achieves higher quality and better outcomes for patients.
- The three strategies that DHS submitted to CMS include:
 - Strategy 1- Implement a multi-payer ACO methodology across Iowa’s primary health care payers
 - Strategy 2- Expand on the multi-payer ACO methodology to address integration of

- long term care services and supports and behavioral health services
- Strategy 3- Population health, health promotion, and member incentives
- Four workgroups with specific design objectives met four times between July and early September. More information about the four workgroups can be found here:
 - [Metrics and Contracting Workgroup](#)
 - [Long Term Care Workgroup](#)
 - [Mental Health and Substance Abuse Workgroup](#)
 - [Member Engagement Workgroup](#)
- Two consumer focused workgroups were held in October. Consumer advocates and consumers were given the educational overview/presentation and then were given an opportunity to provide comments and ask questions.
- The first step in implementation was the completion and submission of the [State Healthcare Innovation Plan](#). This document was submitted to the Centers for Medicare & Medicaid Services in December 2013. It outlines Iowa's approach to ACOs, research and stakeholder input received, and lays the groundwork for the next steps. It also includes a 5 year visionary plan and 19 required components. The State Healthcare Innovation Plan is targeted to be implemented in 2016.
- The second step is to pursue a model testing grant proposal. This will be a very competitive process and it is unknown how many awards will be given.
- Medicaid's plays an important role in delivery reform. Medicaid relies on the same health care system as all other payers to deliver care. They are the second largest payer covering 23% of Iowans and they are the primary payer of Long Term Care Services.
- The key concepts of the State Healthcare Innovation Plan are to:
 - Develop a regional approach to care coordination and contract requirements for Medicaid ACOs with clearly defined accountability at the community level and provider relationships with other systems is important.
 - Align with other payers in reimbursement, quality, measurement, and reporting
 - Increased transparency/data sharing
 - Member engagement/healthy behaviors
- Treo Solutions conducted an analysis a drafted 6 naturally occurring ACO regions (map found in slides). Regions were derived by examining medical neighborhoods at zip code level and drawing geographic lines at county borders.
- More information about the SIM can be found here: <http://www.ime.state.ia.us/state-innovation-models.html>
- Discussion took place around mental health and it was agreed that one of the Council's future meetings will be focused around this topic.

Iowa Health and Wellness Plan

- The [Iowa Health and Wellness Plan](#) began on January 1 and covers Iowans age 19-64 with income up to and including 133 percent of the Federal Poverty Level (FPL). The Plan provides a comprehensive benefit package and provider network, along with important program innovations that will improve health outcomes and lower costs.
- Under the full Iowa Health and Wellness Plan, there are two separate programs. The "Iowa Wellness Plan" is for individuals with incomes between 0 and 100 percent of FPL and they will have access to health insurance coverage similar to the health insurance plan offered to State of Iowa employees. The "Iowa Marketplace Choice Plan" is for individuals with incomes between 101 and 133 percent of the FPL and they will have access to health insurance coverage through the federal Marketplace utilizing the subsidies provided under the ACA. Eventually, it is predicted that more than 150,000 Iowans will be covered by this innovative plan. For current enrollment numbers, click here: [March Iowa Health and Wellness Plan Enrollment Maps By County](#).
- Iowa Wellness Plan members have 1,322 primary care providers available, in addition to other contracted Medicaid providers. All members have access to local providers and in 88

counties; members will be assigned to a primary care physician of their choice in their county. For more information: [Iowa Medicaid Managed Care Fact Sheet](#) and [Iowa Wellness Plan Managed Care Map](#).

- Provider incentives for the Iowa Wellness Plan are outlined in the PowerPoint and include a primary care case manager monthly payment of \$4 per member per month (PMPM), a wellness exam incentive of \$10 per member annually, and a Wellness Plan Medical Home Value Index Score Bonus of \$4 PMPM.
- DHS has released an [Iowa Health and Wellness Plan Provider Toolkit](#) that provides fact sheets, talking points, and sample media materials. The materials will help tell the story of how the Iowa Health and Wellness Plan will benefit individuals and families in Iowa communities.
- Healthy behaviors and monthly contributions key features include:
 - No copayments except for using the emergency room when it is not an emergency
 - No monthly contributions during the first year (2014)
 - No contributions for those with income below 50% FPL
 - Iowa Wellness Plan contribution: \$5 per month
 - Iowa Marketplace Choice Plan contribution: \$10 per month
- Monthly contributions are waived beginning in 2015 if the member completes wellness activities. For the first year (2014), members need to complete a health risk assessment and wellness exam. Year 2 and beyond will offer other wellness activities. Click here for more information: [Healthy Behaviors Program - Rewards White Paper](#)
- The [Dental Wellness Plan](#) will begin on May 1, 2014 and will serve both the Wellness Plan and the Marketplace Choice Plan. The provider network will be recruited and managed by Delta Dental of Iowa. Interim urgent care services are available to members through a prior authorization process.
- Key features of the Dental Wellness Plan include:
 - Adequate reimbursement rates for dental services.
 - Contracting with a commercial dental plan to cover dental services.
 - A 'population health' approach to dental care that will include care coordination, member education and outreach, and accountability for dental outcomes.
 - Member incentives by providing coverage for a basic array of services, with ability to earn higher cost restorative services.
- Members who are considered "Medically Exempt" must be given the option of enrolling in regular Medicaid. Medically Exempt members will receive the choice of State Medicaid Plan or the Wellness Plan. "Medically Exempt" includes individuals with disabling mental disorders (including adults with serious mental illness), individuals with chronic substance use disorders, individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or individuals with a disability determination based on Social Security criteria. Below are documents related to Medically Exempt:
 - [Medically Frail/Exempt Provider Referral Form](#)
 - [Medically Frail/Exempt Definition](#)
 - [Iowa Health and Wellness Plan vs. State Medicaid Plan Benefit Comparison](#)

The next meeting of the Patient-Centered Health Advisory Council will be held
Wednesday, June 18th, 9:30 – 3:00 at the Iowa Hospital Association

Meeting Schedule

- **Wednesday, June 18th, 2014- Iowa Hospital Association**
- **Wednesday, September 24th, 2014- Location TBD**
- **Friday, November 21st, 2014- Location TBD**