

# MINUTES

## Patient-Centered Health Advisory Council

Iowa Hospital Association

Friday, November 15<sup>th</sup>, 2013

9:30 am – 3:00 pm

### Members Present

Chris Atchison  
Melissa Bernhardt (Larry Carl)  
Anna Coppola  
Chris Espersen  
Tom Evans  
Michelle Greiner  
Jason Kessler  
Mary Larew  
Linda Meyers  
Teresa Nece  
Tom Newton  
Patty Quinlisk  
Trina Radske-Suchan  
Peter Reiter  
John Swegle  
Kurt Wood

### Members Absent

Charles Bruner  
David Carlyle  
Marsha Collins  
Kevin de Regnier  
Steve Flood  
Ro Foege  
Jeffery Hoffmann  
Don Klitgaard  
Petra Lamfers  
Bill Stumpf  
Debra Waldron

### Council Staff

Angie Doyle Scar  
Abby Less

### Others Present

Gerd Clabaugh  
Carlene Russell  
Daniel Garrett  
Frann Otte  
Kim Downs  
Marni Bussell  
Lindsay Buechel  
Leah McWilliams  
Meg Harris  
Debra Thompson  
Kim Norby  
Patty Funaro  
Holly Hansen  
Sarah Dixon Gale  
Jeremy Whitaker  
Dennis Tibben  
Tracy Rodgers  
Jill Myers Gadelmann  
Jodi Tomlonovic  
Marcus Johnson-Miller  
James Olson  
Laurene Hendricks  
Holly Hansen  
Terry Meek  
Kady Hodges  
Victoria Brenton  
Rachel Digmann

### Meeting Materials

- [Agenda](#)
- [SDH- Chris Espersen PPT](#)
- [Data Resources for Public Health- Meg Harris PPT](#)
- [ACA Impacts on Medicaid PPT](#)
- [SIM Steering Committee Executive Summary Report](#)
- [Iowa Health and Wellness Plan- Dental Plan- DRAFT](#)

Topic	Discussion
<ul style="list-style-type: none"> <li>• <b>Revisit Council's Legislation</b></li> <li>• <b>Council Name</b> <i>Tom Evans</i></li> </ul>	<ul style="list-style-type: none"> <li>• Dr. Evans led a discussion to revisit the Council's legislative charges and the name of the Council. The Council's legislative charges laid out in HF 2539 includes: <ol style="list-style-type: none"> <li>1. Convene a taskforce to develop a plan for implementation of a statewide medical home system in Iowa.</li> <li>2. Adopt rules to administer a medical home system</li> <li>3. Adopt standards and a process to certify medical homes based on NCQA standards</li> <li>4. Adopt education and training standards for health care professionals participating in the medical home system</li> <li>5. Provide for system simplification through the use of universal referral forms, internet-based tools for providers, and central medical home internet site for providers</li> <li>6. Recommend reimbursement methodology and incentives for participation in the medical home system to ensure the providers enter and remain participating in the system</li> <li>7. Coordinate the medical home system with requirements and activities of the dental home for children</li> <li>8. Provide oversight for all certified medical homes, and review the progress of the medical home system and recommend improvements to the system</li> <li>9. Evaluate annually the medical home system and make recommendations to the governor and general assembly regarding improvements to and continuation of the system</li> <li>10. Obtain approval from the board on recommendation and other activities resulting from the authorized duties of the department prior to any subsequent action or implementation</li> </ol> </li> <li>• Legislative charge #1 states to convene a taskforce (which we have done) to plan for a "statewide medical home system". Dr. Evans discussed that this "system" is not something that can be easily defined and the concept of the patient-centered medical home (PCMH) has evolved from a noun to a verb. Instead of being a thing or place, it is really an additional skillset based on the joint principles of a medical home to deliver improved outcomes and value-based care.</li> <li>• The Council discussed their accomplishments and progress so far, and then began the discussion about changing the name of the Council. Some of the key accomplishments they discussed include: <ul style="list-style-type: none"> <li>○ Convened a highly engaged taskforce of leaders and stakeholders in Iowa. The Council adapts to emerging issues with the ACA and they discuss the "big picture" off all of the initiatives in Iowa and bring it all together. They make recommendation for Iowa-based solutions to do population based care.</li> <li>○ Brought together the key payers in Iowa to discuss reimbursement methodology</li> <li>○ Creation of numerous Issue Briefs and Progress Reports as well as fulfilling three legislatively mandated tasks</li> <li>○ The Council voted on a medical home definition. The definition they voted on was the definition laid out in HF 2539 which is based of the joint principles of a medical home.</li> <li>○ Stakeholder input for various state health care programs with medical home emerging developments such as Health Home program, Iowa Health and Wellness Plan, State Innovation Model, and Community Care Teams.</li> </ul> </li> <li>• A few years ago, the Council voted on using NCQA as the avenue to certify medical homes in Iowa. They looked at what other states were doing and decided that this nationally recognition method would work best in Iowa. Iowa Medicaid Enterprise has taken this recommendation and applied it to their Health Home Project, having their Health Homes become NCQA certified within one year. While this recommendation has been made in the past, the Council recognizes that the PCMH concept continues to evolve and national standards have been released and modified over the years. We are cautious not to limit movement in the development of PCMHs since some providers have</li> </ul>

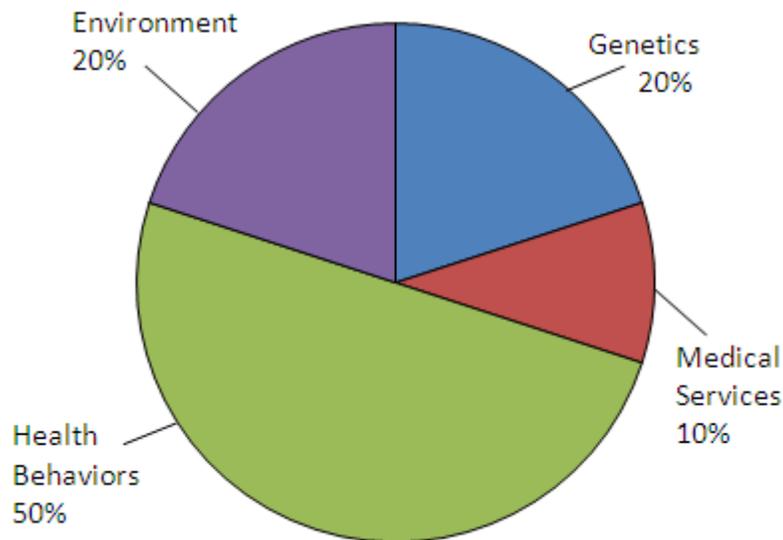
found that NCQA recognition could potentially be costly/time consuming, especially for smaller rural practices.

- Discussion took place about the role of the PCMH in an ACO system. The PCMH is the foundation that will hold up ACO, which is the payment delivery model. An ACO is powered by the PCMH. It has to remain flexible because 10 years from now the health care system could look very different. Additionally, to create sustainability we need to eliminate the waste of the system but keep the value by eliminating duplications and increasing patient safety, etc.
- Dr. Kessler commented that services cannot all take place within the PCMH and there needs to be other centers of care coordination. He said to think of it like a bicycle tire with the patient in the middle and the spokes going out to other organizations. If you don't have that actual tire and wheel it doesn't work. The needs of the patient are met and not just the needs of all of the spokes.
- The "Prevention and Chronic Care Management/Medical Home Advisory Council" makes it appear that the Council's focus is rather narrow and describing this name to the legislature can be difficult. The Council agreed that the name should be changed to a name that truly represented the broad work that the Council focuses on. In addition, the name of the Council is too long and needs to be more concise.
- Some of the key design principles for a new name include
  1. Simplicity (not representative of a single initiative and less turf)
  2. Directional
  3. Communicable- easier to describe what we do
- Kurt Wood brought up three key areas that he thinks are the most important- patient-centeredness, outcome focused, and cost efficient. It boils down to economics, sustainability, and outcomes.
- Trina Radske-Suchan commented that we are really looking toward improving health transformation. She emphasized that the system should shift efforts and money more towards the prevention side of things rather than only focusing on acute care and rehab.
- Some of the options for new name that the Council considered include:
  - Community Care Coordination Council
  - Health Care Reform Council
  - Patient-Centered Care Coordination Advisory Council
  - Patient-Centered Health Advisory Council
  - Advisory Council on Health Care Coordination
  - Advisory Council on Patient Care Coordination
  - Advisory Council for Health Coordination
  - Advisory Council for Patient-Centered Care Coordination
  - Health Care Transformation Advisory Council
  - Advisory Council for Iowa Health
  - Triple Aim Advisory Council
- The Council agreed that the term "Advisory Council" should remain in the name. The option of "Triple Aim Advisory Council" was discussed and members said it seemed too much like a business plan and many people do not know what the "triple aim" is. Using the term "care coordination" in the name was also discussed and members agreed that care coordination is defined differently by different people. Some think of it is case management; therefore "coordination" would not be a good term to use.
- Deborah Thompson, IDPH's legislative liaison, recommended keeping the name generic and using something that isn't the catch phrase of the time or day.
- The Council voted on the "**Patient-Centered Health Advisory Council**". Kurt Wood proposed it and Mary Larew seconded it. All Council members voted and all were in favor of this new name. Nobody was opposed.

**Social Determinants of Health**  
Chris Espersen  
Council Discussion

PowerPoint:  
[SDH- Chris Espersen PPT](#)

- The “Social Determinants of Health” (SDH) are conditions under which people live and work that influence health and quality of life.



- This graphic is from the [Social Determinants of Health Issue Brief](#) (from Healthy People 2010) and shows that 70% of factors contributing to healthy development are related to the SDH.
- An example of a patient story was given that shows how important addressing SDH are. The patient experienced multiple complications with adherence including cultural barriers, lack of perceived severity, side effects and perceived side effects of the drug, and ended up dying. It's not that this patient was not compliant and didn't listen to the provider; it was because of the SDH and the language/cultural barriers.
- This [map](#) shows the potential impact of the ACA on Medicaid and the uninsured at the local level. It shows that there would have been 50% reduction in uninsured rate if Medicaid was fully expanded.
- The population and demographics of the insured population will change substantially with the ACA. This newly insured population will have insurance for the first time and will need additional resources and support to use it.
- With pay for performance, SDH are not paid for under care coordination, while clinical care coordination is paid for. Discussion took place about the importance of including SDH in future payment reimbursement methodologies. The hard thing is quantifying the SDH to determine how they can be paid for. One member discussed looking at the highest risk patients and determining the cost associated with them, and then see if they improve because of SDH interventions, also including costs associated with the savings.
- Risk Assessment looks at income, social barriers, access barriers, and any other health barriers. This shows that we need to make sure the right care coordination is happening. The Health Risk Assessment results chart in the PowerPoint shows that the largest SDH barrier is access barriers. 67% of the patients do not make regular scheduled appointments. Mental health barriers are a small percentage at 12%. (although this is probably under-reported as it is self-reported data)
- A question was asked about how their Community Health Center funds their clinical pharmacist. The response was that they make it work and know it is the right thing to do. They have relationship with the Drake pharmacy program and also utilize 340b drug students etc. It was also noted the importance of clinical pharmacy services to achieving the Triple Aim and the necessity of having clinical pharmacists be considered eligible providers.

## Health Data

### Discussion

Meg Harris

Council Discussion

PowerPoint:

[Data Resources for Public Health-](#)  
[Meg Harris PPT](#)

- Meg Harris, the Iowa Department of Public Health's Data Manager, gave an overview of the data resources available and public health tracking. There are numerous data systems collecting data currently, but almost none of them connect with each other. We have reached to point where we need to improve the interoperability of these sources.
- Data is becoming more and more popular and becoming more central. It is not about how much data we can get, but what we do with that data. We need to figure out how we can have health care feed into the data systems. Additionally, we need to be able to track people throughout their life course. Currently, the data we have on people does not ascertain risk or how likely someone is to develop a condition, it merely gives a snapshot at that point of time.
- What is needed from healthcare data?
  - Population coverage
  - Reporting standardization
  - Reporting on individuals over the life course
  - Standard measures of factors influencing population health must exist
- What is needed from public health?
  - Requires new legal authority
  - Data and transmission standards
  - Public and political acceptance of new uses of electronic health records
  - Capacity to receive and analyze data
- Creating a common understanding of data terminology is very important. For example, what constitutes a data set versus a data system? What does ownership imply?
- Informatics is another key buzz word. Public health informatics is the systematic application of information and computer science and technology to public health practice, research, and learning. Interoperability is the ability of information technology systems from various programs and software applications to communicate, to exchange data accurately, effectively and consistently.
- The data warehouse included birth, death, SID, BRFSS, and Census data. Now, the public health tracking portal includes birth, death, BRFSS, SID, Census, as well as water quality, housing, poverty, child blood lead, air quality, and birth defects.
- The [Iowa Public Health Tracking Portal](#) is a state of the art environmental and public health tracking program, and part of a national initiative led by the CDC to close the gap in what is known about the impact of environmental hazards on health.
- **The portal can be accessed here:** <http://pht.idph.state.ia.us/>
- This portal is very interactive. At the top you can select specific counties and specific dashboards to get graphs, tables, charts etc. This link is to the public site, and there is also a secure site. The county snapshot reports can give a report that has around 78 indicators built into it.
- A question was asked about what data populates these dashboards? It is all behind the scenes and the data comes from statewide discharge data and SID (statewide inpatient data). They just started looking into outpatient data from emergency rooms (anything that has an ICD code) and dental indicators. Dental is the primary reason for many emergency room visits.
- The CDC has been driving states to have consistent data information and indicators from state to state, and currently there are 22 other states that have this same information.
- Significant potential exists to better access healthcare utilization, community health, tracking of medical treatments and interventions, the burden of disease, as well as to support substantial improvements in healthcare and in identifying cost-effective treatments through the use of data available through the Iowa Health Information Network (IHIN).
- For the next several years, efforts should be focused on enrollment in the IHIN and use of IHIN data for purposes of improving clinical healthcare for individual Iowans.
- In the meantime, stakeholders and policymakers should monitor the use of the IHIN data for clinical improvement of healthcare both at the system and community level to ensure

that the system is positively contributing to population-based improvements in the local healthcare delivery system.

- Once the IHIN approaches a completely functioning exchange with a sufficient majority of the State’s population and providers invested in the technology system, and process, policymakers should conduct a thorough evaluation of the feasibility of developing either a centralized query or repository system to enable access to the IHIN data for research, and the costs associated with its development and ongoing operation.
- Meg Harris described the need to make the transition from providing information to the consumer to being an information broker. Questions to be considered include:
  - What system changes are needed for public health agencies to meet effectively the information needs of its community partners?
  - How do we keep pace with the growing demands to electronically exchange information with physicians, hospitals, and other public health agencies?
  - How do we, within the public health agency, ensure we are maximally collecting and utilizing data to provide our best community service?
- Council members gave very positive feedback saying that this is a fantastic tool. This transforms data to information and then into knowledge. It utilizes the existing data sets to repackage the information and reduces the reporting burden.
- More information about the Iowa Tracking Program can be accessed here: <http://www.idph.state.ia.us/EHS/EPHT.aspx>

**Chronic Disease Registry Discussion**

- IDPH is working on a project regarding chronic disease registries and they have asked the Council for some feedback. There was a proposal that was submitted to Iowa Medicaid Enterprise to obtain funds from CMS related to IDPH Meaningful Use activities. A section was included on Chronic Disease Registries. From this section are the following goals for the project:
  1. identifying chronic disease registry components available for the clinical setting,
  2. developing specifications for a statewide chronic disease registry compatible with corresponding components used in the clinical setting
  3. promoting adoption of chronic disease registry components by healthcare providers throughout Iowa.
- A few years ago, the Council produced a [Disease Registry Issue Brief](#) and staff brought this up to see if it was still a priority to the Council.
- Overall feedback from the Council was that we should pursue utilizing the new data avenues available today rather than create a statewide chronic disease registry system. This will create another reporting barrier and be duplicative. If we want to track population trends, we can get that information from the Iowa Public Health Tracking Portal and wouldn’t need to create a new registry system. Things are already moving in that direction and creating this new system would be duplicative and very costly. Council members agreed that clinical registries are still very important.

**State Innovation Model**

**IowaCare Transition**

**Iowa Health and Wellness Plan/Dental Plan**  
*Marni Bussell*  
*Lindsay Buechel*

**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:

## Council Discussion

### PowerPoint:

- [ACA Impacts on Medicaid PPT](#)
- [SIM Steering Committee Executive Summary Report](#)
- [Iowa Health and Wellness Plan- Dental Plan- DRAFT](#)

- 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.
- Recommendations were submitted to the Steering Committee on October 30, 2013. The recommendations can be accessed here: [SIM Steering Committee Executive Summary](#). All four workgroups included these areas in their recommendations:
  - Care Coordination/Community focus
  - Communication/Technology
  - Regulatory
  - Financing
  - Measures/data transparency
  - Provider supports
  - Patient supports
  - Access/benefits

### Iowa Health and Wellness Plan

- The [Iowa Health and Wellness Plan](#) was enacted to provide comprehensive health coverage for low-income adults. The plan must receive approval from the federal government and DHS is working with them to obtain approval.
- Beginning January 1, 2014, the Iowa Health and Wellness Plan will cover all Iowans age 19-64 with income up to and including 133 percent of the Federal Poverty Level. The Plan will provide a comprehensive benefit package and provider network, along with important program innovations that will improve health outcomes and lower costs.
- Patient Manager (PM) benefits include a fee for service or encounter based fee, an administrative fee of \$4.00 per member per month, a wellness exam incentive (If providers can get 85% of their wellness members a wellness exam within the first year, they can get a \$10 incentive), and up to \$4.00 wellness plan medical home Value Index Score bonus.
- Medicaid may contract with ACOs for the Wellness Plan and the ACO can earn the wellness exam and medical home bonus for attributed population. By year 3, the Wellness ACO option will likely be replaced with the SIM initiative to develop a statewide Medicaid ACO program
- Iowa will pay incentives to physicians and ACOs for achieving quality metrics consistency with Wellmark metrics since there is no claims history. This provides a starting point to begin and learn, and will eventually be merged under the larger Medicaid SIM designs.
- 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.
- 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](#)

### **IowaCare Transition**

- The IowaCare Program is ending on December 31, 2013. Current members will continue to have the same access to services until the program ends.
- DHS will check to see if all IowaCare members can get coverage from the Iowa Health and Wellness Plan by verifying member income. IowaCare members received a letter in late October 2013 telling them if they are eligible. If a member is eligible, they do not need to apply for the Iowa Health and Wellness Plan. If a member is not eligible, they will receive instructions on how to apply for coverage.
- 150,000 people will join the Iowa Health and Wellness Plan, including IowaCare members. This is the long-term projected enrollment. 80,000 members are expected initially.
- Sarah Dixon Gale mentioned that Massachusetts expanded in 2006 and their uninsured rate is between 3-5% at the state level overall. At safety net provider level, it is around 20-25% uninsured.
- Click here for the [Iowa Health and Wellness Plan vs. IowaCare Benefit Comparison](#)

### **Accountable Dental Care Plan in the Iowa Health and Wellness Plan**

- Overview document can be found here: [Iowa Health and Wellness Plan- Dental Plan- DRAFT](#)
- This Dental Plan will serve both the Wellness Plan and the Marketplace Choice Plan.
- The Iowa Health and Wellness Plan includes coverage for comprehensive dental benefits, equivalent to the Medicaid dental benefit for adults ages 19 through 64. The current Medicaid dental program has several deficiencies that, without changes, would not provide this new population of 140,000 Iowans with sufficient access to dental care. DHS recommends implementing a new approach to dental care for the Iowa Health and Wellness program. Key features of a new approach to dental care:
  1. Adequate reimbursement rates for dental services, including performance incentives.
  2. Contracting with a commercial dental plan to cover dental services.
  3. A 'population health' approach to dental care that will include care coordination, member education and outreach, and accountability for dental outcomes.
  4. Member incentives by providing coverage for a basic array of services, with members earning the use of higher cost restorative services through demonstrated use of preventive services, compliance to treatment plans, and maintaining good oral health.
- DHS will be contracting with a commercial dental plan to cover services. There will be an extensive RFP process for this plan.
- Accountable Dental Care Plan Design Strategies include:
  1. Contract with a commercial Dental Plan
  2. Covered benefits and earned benefits model
  3. Population health management
  4. Care coordination and member engagement
  5. Increased provider reimbursement and pay for performance
  6. Accountable care approach to contracting
- Covered vs. Earned Benefit Model means that members would be guaranteed a certain set of dental benefits such as preventative services, cleanings, screenings, and emergency services. They can earn other benefits such as restorative services, crowns, bridges and dentures.

- Discussion took place about restorative services and some Council members feel that this should be under covered benefits. DHS will clarify which category this falls under.
- Some examples of how benefits may be earned include things like a follow-up visit completed within 6 months of the initial visit, oral health education and instruction, dental health risk assessment, and follow up treatment plans.
- This program is still being developed and is not set to be launched on January 1<sup>st</sup>.

**Networking Opportunity**

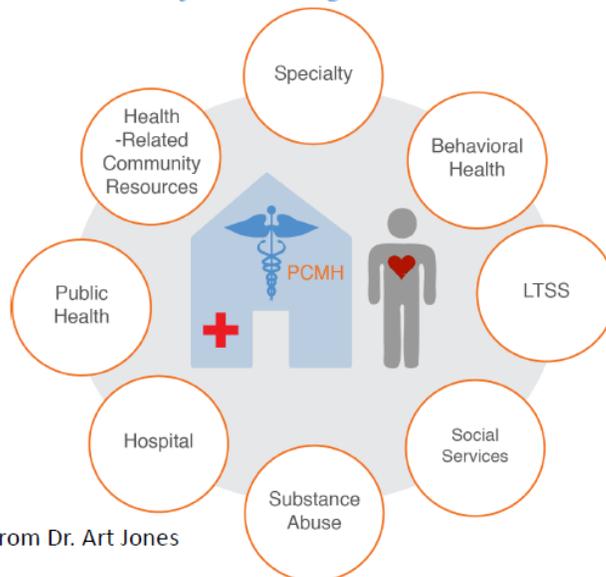
**Community Care Coordination Project**

- Sarah Dixon Gale reported the status of the Community Care Coordination project. Iowa Primary Care Association announced the evening of November 15<sup>th</sup> that that two Iowa regions have been selected as recipients of State funding to improve patient care coordination for underserved populations. **Mercy Medical Center-North Iowa and Webster County Health Department** each will receive \$300,000 in Community Care Coordination funding to develop and implement an integrated health care delivery approach. As a reminder, this past legislative session, [Senate File 446](#) allocated \$1,158,150 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.
- Below are the phases of implementation for the model for care coordination entities:
  - Letter of Intent Released August 12, 2013
  - Letter of Intent Due September 13, 2013
  - Release of Request for Proposal September 23, 2013
  - Answers to Questions Posted As available
  - Proposals Due by 5 pm CT October 25, 2013
  - Contract Award Notification November 15, 2013
  - Begin Work December 2, 2013
  - Contract End Date June 30, 2014

**Integrated Health Care Models and Multi-payer Delivery Systems Study Committee (2013 Iowa Acts, SF 446, §§182 & 183)**

- An “Integrated Health Care Model” is a more coordinated and integrated form of care delivery that is very patient-focused. The WHO gives the following definition: *Integrated care is a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion. Integration is a means to improve services in relation to access, quality, user satisfaction and efficiency.* Below is a visual that illustrates a comprehensive, community-based, integrated health delivery system:

*Comprehensive, Community-based, Integrated Health Delivery System*



Slides from Dr. Art Jones

- This legislative committee met on November 19<sup>th</sup> and 20<sup>th</sup> and had all day presentations/discussions on a variety of topics including ACOs, Patient-Centered Medical Homes, Social Determinants of Health, Care Coordination, Population Health, prevention, data, eHealth etc.
- Their charge is to “review and make recommendations for the formation and operation of integrated care models in Iowa; review integrated care models adopted in other states that integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams; recommend the best means of incorporating into integrated care models nonprofit and public providers that care for vulnerable populations; review and make recommendations regarding development and implementation of a statewide medical home infrastructure to act as the foundation for integrated care models; review opportunities under the ACA for development of integrated care models; address consumer protection, governance, performance standards, data reporting, health information exchange, patient attribution, and regulation issues relative to integrated care models; and perform other duties specified in the legislation. In addition serve as a legislative advisory council on multipayer health care delivery systems to guide the development by DHS of Iowa’s design model and implementation plan for the SIM. The study committee may request that legislative leaders authorize supplementing the study committee membership to ensure there is a comprehensive review process and adequate stakeholder participation.”
- Their website including the committee members, agenda, and all of the handouts/presentations can be accessed here:  
<https://www.legis.iowa.gov/Schedules/committee.aspx?CID=922>

The next meeting of the Patient-Centered Health Advisory Council will be held **Friday, March 14<sup>th</sup>, 9:30 – 3:00 location TBD**

### Meeting Schedule

- **Friday, March 14<sup>th</sup>, 2014- Location TBD**
- **Wednesday, June 18<sup>th</sup>, 2014- Location TBD**
- **Wednesday, September 24<sup>th</sup>, 2014- Location TBD**
- **Friday, November 21<sup>st</sup>, 2014- Location TBD**