Report of the

Health and Long-Term Care Access Advisory Council

to the

Iowa Department of Public Health

Recommending Strategic Plan Initiatives to be included in the

Health and Long-Term Care Access Strategic Plan

As required by Iowa Code 135.163 and 135.164

September 2009

Health and Long-Term Care Access Advisory Council Members

Name	City	Representing
Cindy Baddeloo	West Des Moines	Iowa Health Care Association
Roy Bardole	Rippey	Consumer
Bobbretta Brewton	Urbandale	Primary Health Care
Shelly Chandler	Urbandale	Iowa Association of Community Providers
Conway Chin	Davenport	Iowa Osteopathic Medical Association
Betsy Chrischilles	Iowa City	Iowa Pharmacy Association
Libby Coyte	Redfield	Iowa/Nebraska Primary Care Association
Sue Curry	Iowa City	College of Public Health The University of Iowa
Michele Devlin	Cedar Falls	Iowa Center on Health Disparities University of Northern Iowa
Molly Guard	Iowa City	Area Health Education Center The University of Iowa
Ryan Hopkins	Urbandale	Iowa Alliance in Home Care
Angela Johnson	Des Moines	Mercy Medical Center
Steve Johnson	West Des Moines	Magellan Behavioral Care of Iowa
Daniel Otto	Ames	Department of Economics Iowa State University
David A. Plundo	Des Moines	Area Health Education Center Des Moines University
Sabra Rosener	Des Moines	Iowa Health System
Art Spies	Des Moines	Iowa Hospital Association
Julie Stauch	Des Moines	Family Planning Planned Parenthood of Greater Iowa
Roger Tracy	Iowa City	Office of Statewide Clinical Education Programs The University of Iowa

Background

House File 2539, Health Care Reform Legislation passed by the Iowa 2008 General Assembly, charged the Iowa Department of Public Health (IDPH) with coordinating public and private efforts to develop and maintain and appropriate health care delivery infrastructure and a stable, well-qualified, diverse and sustainable health care workforce in Iowa. To reach and sustain this goal, IDPH was charged to submit a strategic plan to the Governor and General Assembly by January 2010 and every two years thereafter. The agency was also charged to convene a technical advisory committee to assist in the development of the strategic plan. This committee was developed as the Health and Long-Term Care Access Advisory Council.

Due to the breadth and complexity of the task, Director Tom Newton asked that the first year of work focus on health and long-term care workforce concerns as the initial phase of a comprehensive strategic plan. This council held nine face-to-face meetings from November 2008 through August 2009. To cross-educate one another about the various aspects of this complex issue, members and guests provided subject matter presentations on a variety of health and long-term care workforce issues and concerns. The council held several strategic planning work sessions and discussed a variety of possible strategies. Through consensus, the council set forth a list of critical objectives related to the goal of assuring access for those most vulnerable populations who experience the impacts of health professions shortages earliest and most acutely. This decision was made specifically to assure attention to the desired outcome of access for citizens while still maintaining the focus on workforce.

The following subject matter presentations on health and long-term care workforce concerns were provided:

- A review of the January 2008 report entitled "The Future of Iowa's Health and Long-Term Care Workforce: The Health and Long-Term Care Workforce Review and Recommendations"[i]
- Roger Tracy regarding the work of the Office of Statewide Clinical Education Programs, Carver College of Medicine, The University of Iowa. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/oscep_a_statewide_resource.pdf.
- Mark Imerman, Iowa State University, regarding Economic Considerations and Career Choices. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090327_career_choices.pdf.
- Dr. Michele Devlin, DPH, Center on Health Disparities, University of Northern Iowa, regarding The Need for Diversity in the Health Workforce: Understanding the Changing Demographics of Iowa and the Implications of Health Disparities. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/the_need_for_diversity_in_the_workforce.pdf.

- Dr. Bob Russell, DDS, MPH, Iowa Department of Public Health, regarding I-Smile: A Two-Tiered Dental Home Model, and New Dental Provider Type in Minnesota. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090522_home_model.pdf and http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/new_dental_provider_MN.pdf.
- Bobbi Buckner Bentz, Primary Care Office, Iowa Department of Public Health regarding federal legislation as of the May meeting. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/federal_legis_ppt.pdf.
- Dr. Bernard Sorofman, PhD, College of Pharmacy, The University of Iowa, regarding Medication Managed Health in Rural Iowa. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090625_sorofman.pdf.
- Lorinda Inman, Executive Director, Iowa Board of Nursing, regarding nursing workforce statistics in Iowa. Handouts from this presentation are available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090724_ibon_handouts.pdf.
- Lois Glanz, Iowa Health Home Care, regarding Maximizing Information Technology. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090724_ihhc_presentation.pdf.
- Dr. Cindy Baddeloo, PhD, Iowa Health Care Association, Iowa Center for Assisted Living, regarding Long Term Care Workforce. This presentation is available at: http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20090724_ltc_overview.pdf.

IDPH also provided the council with a list of recommendations from previous reports, and the council drew from these recommendations during its discussion. This list is available as Appendix 10.

Recommendations

The council developed the following as Mission, Vision and Guiding Principles for its work. This was based upon the legislative charge in Iowa Code 135.163 and 135.164.

Mission:

The Council will
- assist the Iowa Department of Public Health to develop, update and monitor a strategic plan for implementation of health care delivery infrastructure and health care workforce resources; and
- inform and advise the department and policymakers regarding issues relevant to health care access for Iowans.

Vision:

Assure a diverse, sustainable, and well-qualified workforce that provides access to quality health care for all Iowans.

Focus:

Year 1: Workforce
Year 2: To be determined –
- workforce ongoing
- health care infrastructure

Year 3: To be determined --
- workforce ongoing
- health care infrastructure ongoing

Future ongoing: To be determined

Annually review and prioritize tasks and issues related to the strategic plan.

Guiding Principles:

1. Promoting and maintaining the health of all Iowans.
2. Providing accessible health care services through the maintenance of an adequate supply of health facilities and an adequate workforce.
3. Controlling excessive increases in costs.
4. Applying specific quality criteria and population health indicators.
5. Recognizing prevention and wellness as priorities in health care programs.
6. Addressing periodic priority issues including disaster planning, public health threats, and public safety dilemmas.
7. Coordinating health care delivery and resource development efforts among state agencies including those tasked with facility, services, and professional provider licensure; state and federal reimbursement; health service utilization data systems; and others.
8. Recognizing long-term care as an integral component of the health care delivery infrastructure and as an essential service provided by the health care workforce.
9. Assessing the availability of health resources in rural and urban areas of the state, assessing the unmet needs of these communities, and evaluating how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural and urban communities.
10. Addressing underserved populations and resources.
11. Assuring affordable health care.
12. Assuring optimal coordination between primary and specialty care.

Goals:

The council held several strategic planning work sessions and discussed a variety of possible strategies. Through consensus, members developed a list of critical objectives related to the overarching goal of assuring access for those most vulnerable populations who experience the impacts of health and long-term care workforce shortages earliest and most acutely. This was to assure attention to the desired outcome of access to care for citizens, rather than on specific professions, while still maintaining the focus on workforce.

1. Assure access for all Iowans living in *rural areas.*
2. Assure access for all Iowans living in *urban underserved areas.*
3. Assure access for *people with disabilities.*
4. Assure access for *the elderly.*
5. Assure access for *ethnic and racial minorities.*
6. Assure access for *the uninsured and underinsured.*

Objectives:

The council recognizes that in addition to the objectives listed in this section, a variety of strategies may address several of the goal areas and overall health and long-term care workforce issues at the same time. These would include, but not be limited to, strategies to increase the number of nurse faculty, address the shortage of mental health providers, assist Community Mental Health Centers with recruitment and retention, and increase and improve data collection on the health and long-term care professions. Specifically, the council suggests attention to the summary document of the strategic planning discussion at its July meeting, presented as Appendix 9.

A full record of the council's discussions and considerations is available at: http://www.idph.state.ia.us/hcr_committees/care_access.asp.

In addition, the council recommends consideration of the following objectives for the strategic plan. Items are not necessarily in priority order. This list reflects council discussion as follows:

- Items in bold type were voted as priority items for that goal.
- Items in regular type were kept as key items but were not top priorities for that goal.
- Items in italics were considered but not kept as its priorities. They remain captured for future dialogue.

Goal 1 – Assure access for all Iowans living in *rural areas*.

1. **Target and fund loan repayment programs to recruit clinicians to work in rural areas. Make funds available to individual rural communities and educational programs to be used for recruitment, training, and retention of necessary health professionals (options: loan repayment, rural scholar, tax incentives).**
2. **Support technology that improves rural access to health care providers (telemedicine/telehealth/call center or resource line/electronic health records).**
    - **Working with Magellan Behavioral Care in Iowa, Inc., expand telehealth to all 99 counties and fund training programs for psychiatrists and practitioners. Eventually expand to include other payers. (Iowa Psychiatric Society, for a couple of years, act as the central coordination entity.)**
3. **Establish best practices for multi-disciplinary care models for rural areas.**
    - **Develop interprofessional core curricula.**
4. **Remove funding and reimbursement barriers to multi-disciplinary care models.**
    - **Address legal/regulatory rules that impede the practice of all rural health care providers, especially mid-level practitioners.**

Additional notes (dialogue that the council did not include in its priorities):

a. *For item 1 above, the words, "at safety net provider facilities" was removed prior to "in rural areas." And, the sentence, "Create a pool of funds that a rural community could apply to for funding depending on that community's need(s)." was taken off the last part of the recommendation.*
b. *Incentivize health care providers and organizations to create meaningful access of Electronic Health Records (EHR) for multidisciplinary team members.*

Goal 2 – Assure access for all Iowans living in *urban underserved areas*.

1. **Promote co-locations and integration between Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs).**
2. **Create a multi-lingual educational campaign including outreach staff to inform the population regarding health care programs available in their area.**
    a. **Fund a multi-lingual educational campaign to increase health care literacy among consumers residing in urban underserved areas.**
3. **Recruit multi-cultural clinicians and staff for urban community health centers (CHCs) and clinics (loan repayment, etc.).**
    a. **Expand interpreter services in Federally Qualified Health Centers (FQHCs).**

Goal 3 – Assure access for *people with disabilities*.

1. **Increase access to professionals providing medication therapy management for people with disabilities who are not on federal programs.**
2. **Fully fund Medicaid waiver programs to eliminate waiting lists.**
3. **Assure adequate, specific training for health care providers that work with people with disabilities.**
    a. **Develop professional training that meets the health delivery needs of people with disabilities (including behavioral challenges).**
    b. **Enhance training opportunities for Community Mental Health Center (CMHC) clinicians who serve individuals who are dually-diagnosed (i.e., experiencing mental retardation/developmental disability while also experiencing mental illness). Once trained, clinicians can become Medicaid Home and Community Based Services (HCBS) crisis intervention providers (billable service) to serve as local resource to residential providers. (Utilize telehealth for training.)**
    c. **Iowa Medicaid Enterprise purchase permanent license to make College of Direct Support (CDS) available to all Intermediate Care Facilities (ICF) habilitative and Home and Community Based Services (HCBS) providers and build into rules ability of providers to be reimbursed for training time.**
4. Address transitional care issues for persons with disabilities moving from children's services to adult status.
5. Provide public education to promote awareness of existing services and programs for people with disabilities.
6. Explore Minnesota model of alternative mid-level provider type (dental therapists).
7. Investigate solutions to geographic access problems for people with disabilities to access health care.

Additional notes (dialogue that the council did not include in its priorities):

a. Establish an ongoing data collection for monitoring health and needs of persons with disabilities.

Goal 4 – Assure access for the *elderly*.

1. **Remove barriers to patient choice of providers, especially in rural communities.**
2. **Create compensation programs that will increase the number and quality of health care professionals providing direct patient care who are willing to work in long-term care facilities, hospice, and home health care.**

3. **Synchronize rules and regulations between Department of Inspections and Appeals (DIA) and the Department of Human Services (DHS) with the goal of improving access and quality and eliminating non-value-based regulations (regulations that do not add value).**
4. Fund a pilot program to integrate transportation service into 3 different local health delivery systems (encourage use of patient-centered medical home concept).
5. Reduce age-related health disparities.
    a. Promote better identification and treatment of depression in the aging by primary care providers.
6. Fund implementation of recommendations of the Direct Care Worker Advisory Council regarding core curriculum and training to serve older Iowans.
7. Evaluate models that provide home and community based care as an alternative to hospitals and long-term care facilities.
8. Fund public awareness of hospice and palliative care as end-of-life care options.

Goal 5 – Assure access for *ethnic and racial minorities*.

1. **Cultivate interest, create incentives and offer early career counseling, planning and recruitment in health professions among minority and disadvantaged students:**
    a. **Support Area Health Education Center (AHEC) partnerships with state and local organizations – beginning in underserved urban and rural elementary school settings.**
    b. **Create pipeline programs within education settings and health care settings targeted toward minority students (use DMACC 2+2, Buena Vista College, and Siouxland Health Center programs as models).**
2. **Create career ladders with increased financial assistance for minority and disadvantaged students in health professions education programs.**
3. **Increase cultural competence among existing members of the health and long-term care workforce, including faculty members, particularly within population "pockets" experiencing a large increase in minority populations. Fund continuing education opportunities specific to cultural competence and expand core curriculum in health education programs specific to cultural competence.**
4. **Create community based, participatory training development programs to form and promote a culturally competent health and long-term care workforce.**

Goal 6 – Assure access for *the uninsured and underinsured.*

1. **Expand and strengthen current primary care programs (rural clinic, free clinic, Community Health Centers (CHCs)) that serve uninsured/underinsured.**
2. **Fund research to determine effective streamlined practice models such as establishment of a new dental workforce model with a mid-level provider, or others as recommended by previous reports (Minnesota model).**
3. **Retool, reinvent, and expand the IowaCare program to allow for coverage in additional settings through the state as recommend by The Iowa Medical Society: Report of the Task Force on Iowa's Health Care Infrastructure so that it truly provides access to less expensive models of care while maintaining the same outcomes.**
4. **Raise the poverty level for existing programs to cover more people.**
5. Increase the reimbursement rates for state participation in federal programs.
    a. Investigate innovative programs that would improve reimbursement and include interdisciplinary care (dentistry).

6. Establish minimum insurance coverage levels for preventive care.

Council members have submitted Appendices 1 - 8 in support of the recommendations and to be used in the development of the strategic plan. Where submissions are large and available via Internet, links are provided in lieu of the document itself.

To provide technical advice to IDPH, the council will continue meeting after submitting this report. The council will continue discussing workforce as well as moving through focus items as listed under "Focus" above. This will assist IDPH to meet the biannual requirement for submission of a strategic plan to the Governor and General Assembly.

References

[i] Iowa Department of Public Health. (2008). The Future of Iowa's Health and Long-Term Care Workforce: The Health and Long-Term Care Workforce Review and Recommendations. Available at: http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf.

Appendix 1

Member: Bobbretta Brewton

Documents:

1. Foreword: The Health Professions Partnership Initiative and Working Toward Diversity in the Health Care Workforce

   http://journals.lww.com/academicmedicine/Fulltext/2006/06001/Foreword__The_Health_Professions_Partnership.2.aspx

2. Promoting Minority Access to Health Careers through Health Profession-Public School Partnerships: A Review of the Literature

   http://journals.lww.com/academicmedicine/Fulltext/2006/06001/Promoting_Minority_Access_to_Health_Careers.3.aspx

3. The Future of the Health Professions Pipeline: A New Call to Action

   http://journals.lww.com/academicmedicine/Fulltext/2006/06001/The_Future_of_the_Health_Professions_Pipeline__A.18.aspx

4. Characteristics of Health Professions Schools, Public School Systems, and Community-based Organizations in Successful Partnerships to Increase the Numbers of Underrepresented Minority Students Entering Health Professions Education

   http://journals.lww.com/academicmedicine/Fulltext/2003/05000/Characteristics_of_Health_Professions_Schools,.8.aspx

Appendix 2

Member: Conway Chin

Document:

Report of the Task Force on the Iowa Physician Workforce
University of Iowa, Carver College of Medicine
University of Iowa Hospitals and Clinics
January 2007

URL: http://www.healthcare.uiowa.edu/CCOM/Administration/IowaPhysicianWorkforce.pdf

Appendix 3

Member: Betsy Chrischilles

Document:

Health and Long-Term Care Access Advisory Council
Pharmacy Profession Information

Summary

The pharmacy profession is entrusted with ensuring safe and effective medication management, known as pharmaceutical care. This includes provision of quality medication services as well as quality pharmaceutical products. Nationally, mistakes by pharmacists, so-called "dispensing errors" account for only a small portion of total medication errors whereas prescribing errors account for the large majority of errors and errors by patients, such as low adherence, are common. Iowa pharmacists are viewed nationally as innovators for including pharmacists in team-based primary care to tackle prescribing errors and patient errors. For example, the Iowa Medicaid program reimburses pharmacists for their role in collaboration with primary care physicians to provided pharmaceutical care management for targeted beneficiaries. This program was one of the models for Medicare part D Medication Therapy Management (MTM) programs available to targeted part D beneficiaries nationwide. These programs focus on helping patients with chronic conditions achieve the desired effects from their medications while avoiding side effects.

Overall, pharmacists are the most accessible health profession and it is important to maintain this accessibility. When pharmacies close, access to both products and services suffers. Fortunately, Iowa pharmacists have steadily increased in number from 1996 to 2008, with about 2/3 of Iowa pharmacists currently practice in a community setting, which includes independent, chain, and franchise pharmacies. Despite the growth in the pharmacist population, though, the number of communities with one or more pharmacists has slightly declined over the same time period. In addition, data suggests the number of pharmacies operating in smaller communities—population less than 10,000—is in a slight decline, while larger communities are experiencing gains. Iowa pharmacists are aging, especially in smaller communities. Older pharmacists in rural settings, where they may be the only pharmacist in town, may mean no replacement when these pharmacists retire. Several rural counties have only one pharmacy, typically with one to two pharmacists, and the average age of pharmacists in these places has increased significantly. Statistics supporting these summary statements are provided below.

***Recommendations*:** Key opportunities in health-care reform to improve patient outcomes through safe and effective medication management involve preserving access to quality pharmaceutical care and products. In Iowa, this can be ensured by:

Insuring a two-way pharmacist portal into health informatics exchanges, not just as a passive e-prescribing receptacle ;

Insuring pharmacist medication therapy management services in medical homes'

Pharmacist inclusion in health care workforce shortage programs (e.g. loan repayment);

Protecting patient choice of providers for pharmaceutical care and products, for example preserving patient's ability to choose a local pharmacy provider over mail order or a health plan-based telephonic pharmacy consultation.

Others?

Statistics about Iowa Pharmacist Trends
Pharmacist growth statistics

From 1996-2008, the total number of Iowa pharmacists increased 15% from 2,342 to 2,697.

Average annual comparison of pharmacists entering practice vs. terminating practice: +27 entering practice.

Of those who terminated pharmacy practices, 57.3% relocated out of state and 20.6% retired.

Pharmacist practice settings statistics

Community pharmacists and hospital pharmacists made up 64% (1,725) and 23% (609), respectively, of all Iowa pharmacists in 2008.

Pharmacist distribution statistics

The number of communities with one or more pharmacist has decreased 6%, from 255 communities to 237 from 1996-2008.

Fifty-six counties now have less than 10 community pharmacists, and 20 of those counties contain less than five community pharmacists.

Distribution of pharmacists by community size [Community population (total Iowa pharmacist %)]: <1000 (1%); 1,000-4,999 (15%); 5,000-9,999 (14%); 10,000-49,999 (23%); 50,000-99,999 (28%); ≥100,000 (19%). These values represent 2008 statistics but have remained relatively consistent since 1996.

Change in number of community pharmacies from January 2004 to September 2007 for the following community sizes [population (pharmacies gained): <10,000 (-7); 10,000-49,999 (+2); ≥50,000 (+17).

From 1997-2008, the ratio of county population: # of practicing pharmacists improved in 54 counties, remained stable in 21 counties, and worsened in 24 counties.

Pharmacist aging statistics

The average age of Iowa pharmacists increased from 42 years to 44 years over 1996-2008.

There are now 25 counties where at least 50% of pharmacists are ≥55 years.

In addition, the percentage of pharmacists practicing in a community of 10,000 or less who are 55 years and older increased from 22.4% (164) in 1996 to 30.8% (250) in 2008.

Iowa pharmacist tracking system: Advisory committee meeting report. (2009, June). The University of Iowa Carver College of Medicine, Office of Statewide Clinical Education Programs, Iowa Health Professions Tracking Center.

Appendix 4

Member: Libby Coyte

Documents:

From the National Rural Health Association's Web site:

Recruitment and Retention of a Quality Health Workforce in Rural Areas

A series of policy papers on the Rural Health Careers Pipeline

Introduction: **Defining the Issues and the Principles of Recruitment and Retention**, June 2005
Number 1: **Physicians**, November 2006
Number 2: **Nursing**, December 2005
Number 3: **Pharmacists and Pharmacy Technicians**, May 2006
Number 4: **Oral Health**, November 2006
Number 5: **Behavioral Health**, October 2008
Number 6: **Rural Public Health**, April 2007
Number 7: **Rural Health Careers Pipeline: Kindergarten to 12th Grade Education**, February 2006
Number 10: **Hospital Administration**, May 2007
Number 11: **Allied Health**, October 2008
Number 12: **Physician Assistants**, October 2008
Number 13: **Emergency Medical Services**, November 2005
Number 14: **Issues of Preserving Rural Professional Quality of Life**, May 2006

URL: http://www.ruralhealthweb.org/go/left/policy-and-advocacy/policy-documents-and-statements/issue-papers-and-policy-briefs/#WrkfrceSeries.

Appendix 5

Member: Molly Guard

Documents:

1. According to Iowa Board of Nursing license database, as of 9/9/09, there are 1026 nurses employed in nursing education positions in the state (self-reported). Faculty are required to keep their licenses current.

   Iowa Administrative Code requirements for nursing faculty:

   655 Iowa Administrative Code, Chapter 2

   2.9(2) *Faculty member requirements. A faculty member who teaches nursing shall meet the following requirements:*

   a. Current licensure as a registered nurse in Iowa prior to teaching. An individual is currently
   licensed when licensed in another state and recognized for licensure in Iowa pursuant to the nurse
   licensure compact contained in Iowa Code chapter 152E.
   b. Two years of experience in clinical nursing.
   c. Academic qualifications:

   (1) A faculty member who was employed on or before July 1, 1992, shall be considered adequately prepared as long as that faculty member remains in that position. A faculty member who was hired to teach in a prelicensure registered nurse program after July 1, 1992, shall have at least a baccalaureate degree with a major in nursing or an applicable field at the time of hire. This person shall make annual progress toward the attainment of a master's or doctoral degree with a major in nursing or an applicable field. An individual who has earned a first professional degree as defined in rule 2.1(152) but who does not hold a master's degree as defined in rule 2.1(152) must meet the requirement for annual progress. One degree shall be in nursing.

   1. *Applicable fields include but are not limited to education, counseling, psychology, sociology, health education, health administration, and public health. A person who wishes to fulfill this requirement with education in an applicable field not listed may petition the board for a determination of applicability.*
   2. *The date of hire is the first day of employment with compensation at a particular nursing education program.*
   3. *"Annual progress" means a minimum of one course per year taken as part of an organized plan of study. A written plan of study shall be kept in the employee's file.*

   (2) A faculty member who was hired to teach after July 1, 1992, in a practical nursing program or at the first level of an associate degree nursing program with a ladder concept shall have a baccalaureate or higher degree in nursing or an applicable field at the time of hire.

   (3) A registered nurse hired to teach in a master's program shall hold a master's or doctoral degree with a major in nursing at the time of hire. A first professional degree as defined in rule 2.1(152) does not meet this requirement. A registered nurse teaching in a clinical specialty area shall hold a master's degree with a major in nursing, advanced level certification by a national professional nursing organization approved by the board in the clinical specialty area in which the individual teaches, and current registration as an

advanced registered nurse practitioner according to the laws of the state(s) in which the individual teaches. Faculty preparation at the doctoral or terminal degree level shall be consistent with the mission of the program.

(4) A faculty member hired only to teach in the clinical setting shall be exempt from subparagraphs (1) and (2) if the faculty member is closely supervised to ensure proper integration of didactic content into the clinical setting. If hired after July 1, 1992, a faculty member hired to teach only in the clinical setting shall have a baccalaureate degree in nursing or an applicable field or shall make annual progress toward the attainment of such a degree.

(5) Pursuant to 655—Chapter 15, the head of a program may petition the board for a waiver of the requirements in subrules 2.6(2) and 2.9(2). Following a review of the circumstances and efforts by the program to meet the requirements, the board may issue a waiver for a specified period of time and indicate conditions that must be met.

2.9(3) *Functions of faculty. Faculty members shall:*

a. Develop, implement, and evaluate the purpose, philosophy/mission, and outcomes of the program.

b. Design, implement, evaluate, and revise the curriculum.

c. Provide students with written policies as specified in subrule 2.10(1).

d. Participate in academic advisement and guidance of students.

e. Provide for admission, progression, and graduation of students.

f. Provide for student evaluation, self-evaluation, and peer evaluation of teaching effectiveness.

g. Participate in activities to ensure competency in area(s) of responsibility

2. From the Web site of the American Association of Colleges of Nursing:

> "According to AACN's report on *2008-2009 Salaries of Instructional and Administrative Nursing Faculty in Baccalaureate and Graduate Programs in Nursing*, the average ages of doctorally-prepared nurse faculty holding the ranks of professor, associate professor, and assistant professor were 59.1, 56.1, and 51.7 years, respectively. For master's degree-prepared nurse faculty, the average ages for professors, associate professors, and assistant professors were 58.9, 55.2 and 50.1 years, respectively."
>
> URL: http://www.aacn.nche.edu/Media/factsheets/FacultyShortage.htm

3. Please refer to the Iowa Board of Nursing 2008 Annual Report, noting pages 24 and 28.

> URL: http://www.state.ia.us/nursing/images/pdf/Annual_Report_2008.pdf

Appendix 6

Member: Art Spies

Document:

2008 Nursing Practice Survey
Iowa Organization of Nurse Leaders

URL:
http://www.iowanurseleaders.org/documents/resources/IONL_Practice_Survey_Final_Report08_D5C95FEDBD28E.pdf

Appendix 7

Member: Julie Stauch

Document:

1. Iowa Board of Nursing 2008 Annual Report, see page 29 for number of LPN and RN licenses. Report also shows key age demographics that can be used to show that a large exodus of nurses is approaching (i.e., the "aging out" issue).

   URL: http://www.state.ia.us/nursing/images/pdf/Annual_Report_2008.pdf

2. Bureau of Labor Statistics, Occupational Outlook Handbook, 2008-09 Edition, Nurses. This is national data regarding occupational outlook for nurses. It shows the areas of nursing experiencing the greatest need for filling vacancies along with some items that nurses see as incentives.

   URL: http://www.bls.gov/oco/ocos083.htm

Appendix 8

Member: Roger Tracy

Document:

IOWA HEALTH PROFESSIONS INVENTORY
Office of Statewide Clinical Education Programs
The University of Iowa
College of Medicine

The Iowa Health Professions Inventory (IHPI) is funded largely through the University of Iowa Primary Care Initiative. The Inventory is operated by the Office of Statewide Clinical Education Programs in the UI College of Medicine.

The Health Professions Inventory is a computer-based tracking system containing demographic, educational and professional information for every active Iowa health practitioner in selected professions. The system tracks Iowa's supply of physicians, dentists, pharmacists, physician assistants and nurse practitioners.

The inventory characterizes the health care workforce (e.g., age, gender, worksite, and supply), monitors trends, and facilitates research on the state's health care workforce. Its benchmarking capacity enables users to track changes in supply and geographic distribution over time. The tracking systems are monitored and updated on a continuous basis, incorporating changes in the health professions workforce due to the deaths, retirements, relocations, and new practitioners entering practice.

Advisory committees for each of the affected health professions have guided the development and operation of systematic workforce tracking for their respective professions. The project staff looks to the committees for advice on the design and use of these databases. Specifically, the committees provide guidance in the following areas:

- selecting the specific date elements
- defining the data fields for specific elements
- identifying the data sources, and
- adopting user guidelines and policies.

The Iowa Health Professions Inventory enables users to chart specific trends; forecast changes in the state's health professions workforce; characterize the workforce demographically; and gauge the return on the state's investments in health professions education.

Appendix 9

Broad categories which cut across goal areas.

Health and Long-Term Care Access Advisory Council
Strategic Planning Work Session discussion
11:00 A.M. – Noon - 7/24/09

Global Strategies were discussed in the header columns with goals/broad topical areas underneath.

Health Promotion/ Disease Prevention	Training	Pipeline	Support of Multi Disciplinary Teams	Data Collection	Quality Assurance	Retention
	Continuing Education	Area Health Education Agencies (2 in Iowa)	Best Practices	State Investment in Data Collection		Culture of practice site
	Patient Education	Training Programs	Connecting to Rural Areas			Technology
		Residency Programs	Training for Inter Disciplinary Teams			Education for providers to use technology
		Incentives for going into health professions				Collaboration with other rural states to address reimbursement issues
		State investment in Pipeline activities				

The group discussed adding a principle to our list of guiding principles. "Preserving Patient Choice."
The group also likes the phrase "Foster Iowa's Rural Voice".

Staff was directed to compile this discussion information and send to the council members along with the strategies and recommendations pulled from each of the reports listed as resources for the group and send by the first week of August.

Council members were charged to review these materials and begin merging the ideas and concepts together to foster the next step in the discussion in August. Clarification was provided that the Global strategies lead to goals, which ultimately will lead to specific recommended activities that the council will want the General Assembly to consider.

Appendix 10

Existing Recommendations
Health and Long-Term Care Workforce in Iowa

August 21, 2009

Repeated Recommendations and Common Themes

1. Increased Medicare/Medicaid reimbursement
2. Need for data and analysis of data
    a. So we know areas (professions, geography) of greatest need
    b. To help project/predict and plan for and address needs
3. Need for definitions of shortages among various professions
4. Need for a lead entity to be point of coordination among efforts; knowledge of efforts; point of contact (i.e., a "center")
5. Technical assistance to local areas/communities about recruitment, retention, planning, etc.
6. Loan repayment and loan forgiveness programs and other incentive programs that work
7. Recruitment strategies – Web sites, promotion of Iowa, etc.
8. Training capacity – mostly post-educational practicums, residencies, clinical, etc.

<table>
<tr><th>Title</th><th>Organization</th><th>Link and URL/Date Produced</th></tr>
<tr><td>A Strategic Plan to Increase Minorities in the Health Professions in Iowa</td><td>Iowa EXPORT Center of Excellence on Health Disparities</td><td>http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/strategic_plan_minorities.pdf
August 31, 2005

Recommendations:
<table>
<tr><th>Strategy</th><th>Lead Agency(s)</th><th>Timeline</th><th>Cost Estimate</th></tr>
<tr><td>8A.1 Review admissions criteria for more individualized screening</td><td>Post-Secondary Health Training Institutions</td><td>Year 1</td><td>Minimal or No Cost</td></tr>
<tr><td>8A.2 Reduce dependence on standardized tests as allowable</td><td>Post-Secondary Health Training Institutions; Exam Vendors</td><td>Year 1</td><td>Minimal or No Cost</td></tr>
</table>
</td></tr>
</table>

		8A.3 Increase financial assistance for minorities in health	Post-Secondary Health Training Institutions; Private Foundations	Year 1	$1,000,000
		8A.4 Implement ethnic- and career-specific health training programs	Post-Secondary Health Training Institutions	Years 2-3	$250,000
		8A.5 Provide mentoring, minority role models, and social services	Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.6 Increase leadership and mentoring training programs for minorities	K-12 Schools; Post-Secondary Health Training Institutions	Years 2-3	$300,000
		8A.7 Explore new and nontraditional paths to the health professions	K-12 Schools; Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.8 Provide bridging programs between two and four year colleges	Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.9 Require cultural competency training and increased MHP percentages for accreditation and graduation	Post-Secondary Health Training Institutions; Licensure Boards	Years 2-3	$500,000
		8A.10 Provide innovative programs to learn second career	Post-Secondary Health Training Institutions	Years 4+	$800,000

Strategy	**Lead Agency(s)**	**Timeline**	**Cost Estimate**
8B.1 Increase experiential learning partnerships	Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
8B.2 Develop partnerships with external mentors and organizations	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
8B.3 Conduct public awareness campaigns specifically with minority businesses, newspapers, radios, faith institutions, etc.	Iowa Department of Public Health	Year 1	$200,000
8B.4 Develop comprehensive academic pipeline partnership programs between K-12 and post-secondary institutions to recruit minorities into health fields, especially at younger ages	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	$500,000

8B.5 Utilize face-to-face and word-of-mouth referrals and recruiting	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
8B.6 Develop recruiting partnerships with minority serving organizations out of the state or nation where possible	Post-Secondary Health Training Institutions	Year 1	$200,000
8B.7 Utilize minorities in training, recruiting, and retaining other minorities in health workforce	K-12 Schools; Post-Secondary Health Training Institutions; Private and Non-Profit Health Providers, NGOs	Years 2-3	Minimal or No Cost
8B.8 Offer training programs on-site where minorities are	Post-Secondary Health Training Institutions	Years 2-3	$400,000

SECTION 9.
RECOMMENDED CORE CURRICULA AND CULTURAL COMPETENCY OFFERINGS

Increasing minorities in the health professions has been promoted as a primary strategy to improve the cultural competency of the workforce in meeting the special needs of diverse and underserved populations, so that health disparities can ultimately be reduced. As such, improving cultural competency and increasing minorities in the health professions are often cited as twin goals that should be addressed simultaneously to be most effective.

Providing culturally competent health care means that a provider or organization is sensitive to the cultural differences between patients; understands the influence of these differences on their health practices and status; and can modify programs from a practical standpoint to meet the specific needs of diverse clients. Assuring that patients receive culturally appropriate care is increasingly necessary with the country's rapidly changing demographics. However, some health training schools have only recently implemented curricular changes so that their students are educated in working with diverse clients, while other schools still have relatively few offerings in the multicultural health field. In order to address the simultaneous and highly correlated issues of increasing minorities in the health professions and improving the cultural competency of providers, the following recommendations are offered for workforce planners:

9.1 *Require at least basic cultural competency training for all health professions in order to graduate or receive licensure.*

9.2 *Require that health training schools offer cultural competency education programs for their students in order to pass accreditation.*

		9.3 *Provide cultural competency training for all staff in health care organizations, including top management, health providers, support workers, and clerical staff.* ***9.4*** *Utilize cultural competency training programs that incorporate conceptual and theoretical information with extensive hands-on learning and experiential activities.* ***9.5*** *Provide first-hand opportunities for minorities in the local community to speak to health care workers and trainees about issues specific to their culture.* ***9.6*** *Emphasize face-to-face, personal learning when teaching cultural competency skills, and allow for ample time to practice and apply knowledge learned.* ***9.7*** *Include training on the traditional health beliefs and practices of minority populations, in addition to standard cultural competency training, so that health providers understand alternative and complementary forms of medicine practiced by others around the world.* ***9.8*** *Incorporate training on working effectively as providers with medical Interpreters.* ***9.9*** *Teach skills to work effectively with low-literacy and limited English proficiency clients, and emphasize health literacy and visual literacy skills when conducted cultural competency trainings.* ***9.10*** *Emphasize practical methods to improve the ability of individual providers to become more culturally competent, but also encourage organizations to serve diverse patients better through the adoption of CLAS (Culturally and Linguistically Appropriate Services) Standards promoted by the United States Office of Minority Health.* ***9.11*** *For health students or workers that may be unable to attend live training programs in cultural competency, utilize on-line training programs or curricular modules, such as those developed by the University of Northern Iowa or Uversity of Iowa.* **9.*12*** *Emphasize to students and professional trainees that cultural competency skills must be learned over time through regular practice and immersion with actual minority groups.* ***9.13*** *Avoid the temptation to try to teach cultural competency skills quickly over a short period, and allow for adequate time to discuss sensitive race issues with audiences and trainees.* ***9.14*** *Teach health providers to conduct "cultural assessments" with minority patients, so that they understand the unique familial, social, economic, political, historical, and related factors that influence the health and wellbeing of their diverse clients.* **9.*15*** *Ensure that cultural competency training is on-going, and that it becomes increasingly detailed and ethnic-specific over time.* ***9.16*** *Incorporate mandatory cultural competency training into organizational strategic plans and goals; and* ***9.17*** *Measure the success of cultural competency training over time through appropriate evaluation methods in order to monitor student and worker changes in knowledge, attitudes, practices, behaviors, and skills.*
The Future of Iowa's Health and Long-Term Care	Iowa Department of Public Health	**http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf** December 2007

Workforce: The Health and Long-Term Care Workforce Review and Recommendations		Recommendations: Short Term (1 to 2 years) 1. Establishment of the Iowa Health Workforce Center: Summit participants agreed that the current system of tracking health workforce is fragmented, and without coordination improvements cannot be achieved. Multiple entities collect varying data regarding health professions. There is a lack of clear lines of communication and a need for increased collaboration to assure resources are leveraged at maximum benefit for Iowans. An aggressive, targeted and comprehensive approach at the state level is needed. An Iowa Health Workforce Center will conduct and coordinate recruitment and retention of health professionals, increase local capacity for recruitment and retention, and prepare for the future by guiding data-driven decision making on priority needs and efforts. 2. Expansion of loan repayment programs: Sustain recruitment/retention/training programs that are working. Recruitment and retention needs were among those most frequently mentioned during summit discussions. Expansion of loan repayment availability in Iowa would strengthen communities' ability to attract quality health professionals to serve Iowans. Increase recruitment, retention, and training/education efforts through known existing tools such as: a. Developing or expanding loan forgiveness and loan repayment programs b. Increasing the number of available Iowa residencies/internships c. Providing technical assistance to communities trying to recruit and/or plan d. Creating mentoring programs, preceptorships, team-based approaches and other similar strategies to prevent turnover/increase retention 3. Continue efforts to increase Medicare/Medicaid reimbursement for Iowa so that providers are able to pay health professionals at rates that are competitive with other states 4. Raise public awareness of the shortages and impact – expanded public awareness of the shortages and impacts will expand the conversations around the state on these issues, and get more people involved in addressing them Long Term (3 to 5 years) [Note: At the summit, the long-term timeframe discussed was 3 to 10 years. This is reflected in Appendix D. Following the summit, based on discussion with stakeholders, the long-term time frame for this report was shortened to 3 to 5 years to more accurately reflect the urgency of health and long-term care workforce needs.] 1. Continue efforts to increase Medicare/Medicaid reimbursement for Iowa so that providers are able to pay health professionals at rates that are competitive with other states (short and long term strategy) 2. Maintain infrastructure (a center) established for coordination of health and long-term care workforce efforts (as established in number 2 above) 3. Maintain and improve data collection/tracking/accessibility 4. Continue to sustain recruitment/retention/training programs that are working, adjust those that need changes, and develop new programs to address emerging workforce needs.

		5. Align licensure scope of practice with scope of practice taught in education programs – so that "mid-level" aka "physician extender" professions are allowed/expected to maximize use of their training/skills. In conjunction with health and long-term care providers, workers, licensing boards and others, review the opportunities to enhance the efficiency and effectiveness of the workforce via changes to scope of practice. Any changes to scope of practice will require appropriate training and appropriate compensation for the responsibilities possessed. 6. Continue and expand efforts toward wellness and prevention, a health care system rather than a sick care system, to reduce demand 7. Maximize best practices and efficiencies in how professionals deliver services – communicate/share
Report of the Iowa Governor and Lt. Governor's Nursing Task Force	Office of the Governor	http://www.governor.iowa.gov/news/2008/03/attachments/080303-Nursing-Task-Force-Report.pdf March 3, 2008 Recommendations: • Develop a Health Workforce Center to be a focal point for nurse workforce data and measures. • Expand programs in public and private sectors to provide forgivable loans and scholarships for nursing education at all levels. • Increase the number of nursing faculty through innovative employment, strengthening recruitment efforts and increasing salaries. • Increase efficiency and effectiveness of education programs and improve their ability to provide easy transitions from community colleges to the private nursing colleges and state universities. • Build a strategy for private investment in nursing, encouraging endowed chairs and program endowments to foster more nurses seeking advanced detgrees. • Foster Iowa's rural voice to assure that those unique challenges and health situations are recognized and addressed as part of each health strategy. • Encourage public sector health facilities employing nurses to increase nursing wages to meet national salary averages. *Subcommittee I – Education* The four focus areas identified to address nursing shortage challenges in education are: 1. Faculty Shortage 2. Student Recruitment 3. Accessibility and Affordability of Education 4. Changing Health Care Needs *Subcommittee II – Rural*

		The Rural Nursing Shortage Work Group recommends the development and ongoing funding of a Health Workforce Center to be charged with the following functions: ○ Measure the professional and paraprofessional nurse workforce supply, identify and designate shortages areas and trends and define the need. ○ Help rural areas grow their own health care providers by developing strategies designed to fit their circumstances and needs and by providing technical assistance for local planning. ○ Make education/training/credentialing accessible in a number of ways and particularly through distance learning. By expanding and coordinating distance learning opportunities the educational needs of local health providers are met for the entry into professional practice and for continuing education to maintain licensure and skills. Provide incentives to enhance collaborative use of existing or newly developing information technology (IT) systems and technologies. ○ Explore ways to increase Medicare and Medicaid reimbursements rates into rural Iowa areas. The workgroup also notes that issues of recruitment and retention should be addressed by public/private partnerships in collaboration. The workgroup supports the efforts of the Nurse/Nurse Aide Task Force appointed by Iowa's Governor (2005-2006) as well as the Direct Care Worker Task Force (2006) and endorses the recommendations of the Health and Long term Care Workforce Summit that met in November of 2007. (Reports available at: http://www.idph.state.ia.us/hpcdp/workforce planning. asp). *Subcommittee III – Shortage* Goals for the Iowa Healthcare Workforce Center: ○ Engage in activities to sustain a competent and diverse healthcare workforce ○ Assess and forecast healthcare workforce supply and demand ○ Promote recruitment and retention of healthcare workforce ○ Support strategies that prevent shortages at the local level. Goals for the Nursing Workforce Center/Leadership Council: ○ Improve image and marketing of nursing as a profession and career choice ○ Health Professions Tracking, Research, and Data Sharing ○ Implement strategies that result in recruitment and retention of Iowa's nursing workforce ○ Support education/ training of nursing workforce ○ Address financing of health and long term care in Iowa ○ Review opportunities to enhance the efficiency and effectiveness of the nursing workforce Nursing Workforce Leadership Council Membership: ○ Practicing Nurses and ARNPs ○ Educators ○ Employers ○ Board of NurSing Professional Associations The Leadership Council Responsibilities:

		○ Build and promote infrastructure assets ○ Assist in identifying funding to support the work of the Center ○ Set Guiding Principles ○ Provide overarching direction for the Center ○ Approve strategic and operational plans for the Center ○ Support Policy Change ○ Endorse projects and activities of the Center Council Projects: ○ Social Marketing ○ Assess and forecast nursing workforce supply and demand ○ Retention of Iowa's nursing workforce ○ Improvement of work environment ○ Recruitment of Iowa's nursing workforce ○ Education and training ○ Financing *Subcommittee IV – Wages* Goals for Wages Subcommittee Long Term Goals ○ Iowa RNs will rank in the top half of the nation for annual mean wages as measured by the USBLS and IWD. Short Term Goals 1. Conduct survey to determine wage distribution by employer and job classification. (i.e. staff nurse, clinical specialist. nurse practitioner, nurse manager). (See IWD Data on Geographic spread). 2. Create competitive wages for nursing faculty 3. Initiate review of rules and regulations 4. Target Medicaid resources to RN wages 5. Assure parity in wages for school nurses
Iowa's Mental Health Workforce	Iowa Department of Public Health	http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf **March 2006** Recommendations: Based on the information found while completing this study, the following recommendations are put forth: 1. That the Bureau of Professional Licensure and the Office of Statewide Clinical Education Programs combine efforts to gather and report detailed employment information about mental health professionals working in

		Iowa. 2. That the Bureau of Professional Licensure continues their efforts to activate an on-line licensure renewal process in order to facilitate collection and reporting of employment and education information. 3. That education programs and professional organizations determine ways and means to recruit and retain more students into mental health professions. 4. That education programs provide to as many students as possible, ease of access to mental health curriculums and continuing education updates through the use of e-learning. 5. That legislators determine ways to provide incentives such as loan repayments to graduates and new hire assistance to potential employers of Iowa mental health graduates who practice in the state. 6. That professional associations assist in developing a working definition of what constitutes a "shortage" in their profession that includes, but is not limited to, budgeted vacancies. 7. That licensure boards review the scope of practice, educational requirements including internships, licensure procurement processes, and procedures for endorsement of out-of-state licensees in order to facilitate timely entry into practice. 8. That citizen groups use the data to inform their constituents and make recommendations to legislators. 9. That practice and education develop collaboratives that expand local opportunities for clinical experiences leading to licensure and/or certification. 10. That health professionals and associations promote awareness among employers regarding competencies, prescribing authority and reimbursement issues impacting advanced registered nurse practitioners, physician assistants, and other mental health professionals 11. That health professions explore practice models that improve the quality and efficiency of mental health services. Numerous publications, agencies, and speech makers have indicated that there is a shortage of mental health professionals in Iowa yet little research has been conducted to quantify or define what constitutes a "shortage." There are several sources of data that provide information about a potential shortage concerning the mental health workforce in Iowa but no studies or groups have assumed the task of matching the workforce supply with demands or needs of the population. The purpose of this study was to add to the growing body of knowledge about the current licensed mental health professionals in Iowa. It details the characteristics of psychiatrists, psychologists, health service workers (licensed psychologists with additional training in the clinical area), marital and family therapists, mental health counselors, physician assistants, and advanced registered nurse practitioners and social workers specializing in psychiatric care. Data relevant to reimbursement, substance abuse, and primary care physician service to the mentally ill were not considered in this report.
A New Day Coming? A Productive Discussion on Dental Workforce Change	Bob Russell, DDS, MPH, Iowa Department of Public Health	http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/a_new_day_coming.pdf Recommendations: • Consider new dental workforce models

		• Implement well-designed evaluations of a prospective new workforce model • A new mid-level dental provider type prepared to focus on needs of high-risk underserved populations • Partnerships to address access to needed services required by high-risk underserved populations
Planning and Training for a Telehealth Workforce for Rural Iowa	Child Health Specialty Clinics	http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/plan_train_telehealth.pdf August 2006 Recommendations: A Plan to Move Telehealth Forward In order to move the telehealth system forward in the state of Iowa, several strategic steps are necessary. First, there are a set of general recommendations for the state: 1. It would be useful to undertake a surveillance effort to determine the current use of telemedicine and the numbers and types of patients being seen in this way should be implemented and monitored over time to see where these efforts are working and being sustained. This will be challenging, since we could find no evidence that this is currently being tracked, but it is necessary to determine capacity for expansion into additional areas. 2. There could also be a surveillance effort to determine the capacity across the state for telecommunications infrastructure that could support telemedicine, i.e. availability of ICN sites, availability of adequate high-speed internet access or T-1 lines. 3. Continued monitoring of the distribution of medical providers across the state is critical. The areas in the state where there are shortages of medical specialties should be assisted in exploring ways in which telehealth systems might be used to address those needs. 4. State policy makers should be given information about the uses of telehealth and given opportunities to talk with providers and consumers who are using it. They should be encouraged to consider policies that provide incentives for physicians willing to learn and practice in this modality as a way of expanding services to children with special physical and behavioral healthcare needs in the rural areas of the state. 5. Medical schools should be encouraged and assisted in developing training and practice opportunities for students who have an interest in using telemedicine in their practices. In addition to these general recommendations, several strategic steps are necessary in order to advance telehealth and, specifically, to create a statewide system of specialty services available to rural populations through telecommunications technology. We are recommending a regional pilot approach, which could then lead, region by region, to the development of a statewide system: 1. Using a variety of population data, including the data included in this report, regarding location of pediatricians and child psychiatrists relative to child population, we would suggest the identification of a group of counties where there is an obvious need, an identified region to use as a pilot universe for the development of a telehealth system. Need would be based on the population and provider data, and on the

		distance from specialty providers. Geo-mapping of child population and physicians would be particularly helpful in this process. 2. Within that region information would be gathered in more specific ways, by interviews or focus groups with local providers to identify priority needs. This information should include data about the incidence of special health needs, with behavioral health being one of those. It would be important to get information from local schools and other human service providers, as well as the medical community. 3. Because most areas of the state have a Child Health Specialty Clinic, and because these clinics have some experience with telehealth and have relationships with local providers, CHSC would be the logical entity to provide technical assistance, training and support in enhancing current systems and adding new telehealth systems. 4. From the data gathered in the region, one could project whether there is a critical need for pediatric services and/or child psychiatry services and/or other specialties, and approximately how much of each. 5. An assessment could then be made of the technology capability in the region. It is worth noting that not every community has access to internet bandwidth adequate for this type of use. On the other hand, hospitals already have T-1 lines in place and may be willing to collaborate with other entities in the use of these. 6. There are then several possibilities for expanding telehealth locations in the region. The CHSC clinic may be able and willing to increase the number of telehealth sessions. There may be a pediatric or family practice office that is able and willing to create a telehealth "studio" where their patients and their office staff could participate in specialty consultations. This would enable the rural practitioners to participate directly in the consultations they request for their patients. There may be a hospital that already has the necessary equipment and would be willing to partner in providing telehealth consultations for the community. 7. Obviously, the other necessary step is the recruitment and hiring of the required specialty providers who now reside and practice in urban settings and in tertiary facilities. They would have to be encouraged to practice in this new way and would need opportunities for training and practice, as well as time to build these new relationships across the state. Hopefully, one part of their telehealth practice would be providing education to the local practitioners who are caring for these patients with special health care needs, through modeling and through professional development, which will ultimately build the capacity of the local providers to deal with these issues.
The Iowa Medical Society: Report of the Task Force on Iowa's Health Care Infrastructure	Iowa Medical Society	**http://www.iowamedical.org/documents/Comm/IMSTaskForceReport.pdf** **April 2008** **Recommendations:** The 40-plus recommendations of the Task Force vary from general encouragement toward a particular course of action to specific ideas for change. The recommendations fall under four topic areas: 1) Iowa's physician workforce; 2) medical education and training in Iowa; 3) caring for Iowa's uninsured; and

		4) Iowa's public health system. 1. **Iowa's physician workforce** To strengthen the security of Iowa's physician workforce and to assure that Iowans will have adequate access to primary and specialty health care, the Task Force recommends: *Enhancing physician recruitment and retention.* 1) Iowa's medical education institutions should assist in recruitment of new physicians to practice in the state. This requires entities other than educational institutions to partner and fund programming that will provide opportunities and incentives for new physicians to remain in Iowa. 2) Collaborative and coordinated recruitment programs should be pursued to identify potential physicians who may be attracted to practicing in Iowa. 3) Medical practices and health care organizations should recognize and develop a diverse set of employment options enabling physicians with differing work/life balance needs to find appropriate practice opportunities, thereby assuring a higher level of professional satisfaction. 4) Noting the issues discussed in this report, IMS, through research and study, should help its members develop new and innovative solutions to bring additional physicians to Iowa. 5) IMS and other organizations should facilitate and support further study of Iowa physician retention and develop strategies to curtail physician migration from Iowa. 6) To support a patient-centered medical home model of care delivery, mechanisms should be identified to assure ongoing and effective primary care physician recruitment and retention. *Encouraging medical liability reform.* Iowa lawmakers should pass a Certificate of Merit law to ensure that only cases with merit move through the court system. As a result, cases would only advance if there was a legitimate possibility that medical standards of care had not been followed. *Improving funding mechanisms.* A variety of financial strategies could affect physician workforce levels in Iowa, including issues outlined below: 1) Funding streams for graduate medical education should be expanded in those specialties that are experiencing a physician shortage to create more residency opportunities. 2) Private entities and federal, state, and local governments should provide greater financial support to assist new physicians with loan repayment in exchange for practicing in the state. 3) IMS members and health care organizations should support efforts to improve fairness in physician reimbursement by payers that currently limit Iowa physician salaries. 4) Efforts to reduce or eliminate indirect medical education funding should be closely monitored and appropriately addressed. *Improving quality of care.*

		1) Iowa's health care community and Iowa's policymakers should maintain their support of the Iowa Healthcare Collaborative. 2) Close ties should be promoted between research and practice. The Task Force believes that there is a great need to close the time gap between a research discovery and the implementation of new patient care practices leading to proven higher quality care. New systems that disseminate and implement evidence-based medicine are needed. *Advancing patient education.* A system should be developed to better educate the public on factors that impact the quality of their health. This includes emphasizing preventive care (including dental care for children), medication education, and family or support group education to help patients understand how best to experience and pursue quality care. Health literacy is an important aspect in effective patient education. Promotion of patient responsibility helps assure better patient outcomes. Strategies for assisting physicians in educating their patients should be promoted. *Providing consistent coverage.* Insurance programs should provide appropriate benefits so patients will be able to focus on their *health* rather than their *coverage*. *Disseminating new technology.* Technology, which includes data management, quality measures, and coordinated records management, should be expanded and coordinated to better link health providers with patients to create a more seamless and complete system of providing care to patients. This enables higher quality care provided in a more efficient manner – both reducing workload and creating a practice environment that is more attractive to potential physicians. Electronic health records should be expanded with an eye toward developing a true patient-centered medical home. *Fixing inadequate reimbursement systems.* Medicare payment inequity is an impediment to recruiting physicians to Iowa. This creates problems in health care access and quality of care. The governor and state legislature should join IMS in advocacy efforts on this issue. To remedy the current inequity, Congress should take the following steps: 1) Fix or repeal the flawed Sustainable Growth Rate formula. 2) Change the current RBRVS funding formula to remove geographic inequities. • *Avoiding waste.* Policymakers and health care providers should continue identifying and reducing waste within the health care system. This should include waste in health care delivery and health care financing. *Increasing public awareness.* The Task Force encourages IMS and other health care organizations to educate the public about today's health care challenges and their impact on patient care. Providers should help the public understand the impact of Iowa's low physician reimbursement on health care access in the state. •

		Supporting physician-directed collaboration. To better effectuate patient health care goals, physicians should continue to lead their teams of providers toward delivery of coordinated, efficient care. **2) medical education and training in Iowa** To maximize Iowa's ability to retain its Iowa-trained medical students and to effectively build partnerships with our state's medical academic centers and other available programs, the Task Force recommends: *Encouraging Iowa residents.* Iowa's medical and residency programs should expand and pursue policies that will further support growth in highly qualified residents of Iowa being accepted into medical school programs. The federal government should approve funding for these expansions. Furthermore, Iowa must be innovative and develop state-specific solutions. *Addressing shortage areas.* Iowa's physician shortage areas should be designated and emphasized in Iowa's medical schools and residency programs. Furthermore, Iowa's residency programs should seek funding to expand capacity for those specialties experiencing a shortage. *Supporting Area Health Education Centers.* Iowa's health care system must support Iowa's new AHECs. Additionally, Iowa's medical education institutions should consider greater use and support of AHECs to expand community-based learning and thus create an expanded presence across the state. Support for the University of Iowa's regional health education system should continue. *Developing new models of delivery.* Along with better linkages between medical student practice experiences in identified shortage areas, new models of delivering care in areas with scarce resources should be developed and tested. *Meeting the employment needs of a new generation*. Iowa's medical education institutions should further recognize and support changes to their programs that will assist physicians in making necessary changes in their practices to better match the needs of new physicians, more of whom are women and/or who represent increasing diversity. If Iowa is to compete for those new physicians, Iowa's medical practices must adapt to the needs of today's graduates. *Expanding support for women entering practice.* Mentoring programs for women should be expanded to encourage opportunities for women to practice in Iowa.

		Enhancing mentoring programs. Mentoring programs for students should be further developed and pursued so students will experience a maximum opportunity for academic success and be educated to the benefits of practicing in Iowa. Joint efforts among Iowa's medical schools, IMS, and practicing physicians could develop such a program. Additional mentoring programs should be developed for physicians already in practice to enhance retention and improve colleague interaction. *Valuing international students.* Iowa's communities and our medical education institutions should invest in programs that encourage international medical graduates to practice in Iowa. Efforts should be made to develop retention efforts for international physicians. *Monitoring enrollment.* Expanded medical school class sizes alone is not a solution to Iowa's current physician workforce needs, and a national increase in physicians will not alleviate geographic maldistribution of physicians. Because factors might change, Iowa's medical schools and residency programs should continue to evaluate the impact of increasing enrollment on Iowa's physician supply. Future consideration of increased medical school enrollment must be supported by valid research, which now suggests a weak link between increasing enrollment and addressing physician shortages in particular areas. *Linking health systems and medical clinics.* Iowa's medical education institutions should further pursue relationships with health systems and medical clinics to create more opportunities for study and understanding of the day-to-day functions of today's practice environment. These relationships can foster greater understanding of issues related to advocacy, policy, regulations, infrastructure, and bylaws. *Linking practicing physicians to education.* Iowa's practicing physicians should be offered mentoring opportunities by Iowa's medical education institutions which will encourage intergenerational learning. *Developing alternative education formats.* Iowa's medical schools are encouraged to further explore the possibility of creating alternative formats for physician education. This could involve reducing by one year the time required to complete a program, for example, through a 3 + 4 (three years of undergraduate work followed by four years of medical school) program or through alternative scheduling for existing academic program designs. *Expanding input for curriculum development.* Iowa's medical education institutions are asked to further develop and pursue curriculum development, with the

		input of medical students and those physicians practicing in Iowa, that emphasizes Iowa specific needs as well as the ability of graduates to work successfully with people and teams. *Increasing financial support of education.* Iowa's medical education institutions should work with organizations that will develop public/private partnerships with local sources to financially support medical education for students who will commit to practicing in Iowa. The growth level of loan burdens is not sustainable. Schools and organizations such as IMS must work to further discover and develop methods to increase tuition assistance for medical students. **3) caring for Iowa's uninsured** To assure that all Iowans can access health care services regardless of their income, the Task Force recommends: *Increasing access to health care.* In keeping with IMS policy, the Task Force believes that all Iowans should be able to access affordable, high quality health care. *Providing universal coverage for children.* Recognizing that universal health care access for children is supported by AMA policy, discussions around access to care for all children should include: o Providing health care to children will reap many social and economic benefits into the future. o Recognition that health care needs to be pursued differently for children than for adults. o Enrollment in existing publicly funded programs should be improved. o Children's services need to be equitable and include mental, dental, developmental, and "well-child" care. o Discussions on the delivery of care to children who are undocumented or live with a parent who is not documented. *Improving care delivery models.* Health care debates are often driven by considerations of cost rather than the health of the population. The Task Force notes that cost factors cannot be ignored; however, the Task Force recommends that examination of appropriate reforms to the health system, including coverage for the uninsured, must focus first and foremost on health improvement and measures for achieving identifiable health improvement goals. *Encouraging preventive care.* Preventive care should be encouraged as it leads to patients living longer and experiencing a higher quality of life. Preventive care helps patients become partners in their wellness activities, and it also may prevent expensive illness-driven health care costs. Physicians who deliver these preventive health care services need to be reimbursed properly. Preventive care alone may not be effective in reducing immediate costs but, along with enhanced systemic care models that coordinate primary and specialty medical care services, it can go a long way to improve patient health and realize long-term savings. *Establishing patient-centered medical homes*.

		Coordinated, systemic care, including further implementation of the patient-centered medical home model of health care delivery, should be supported. Evidence supports the use of the patient-centered medical home as a coordinator of patient health care. Through this effective coordination and management technique, patients will have a true partner in their health care delivery. Incentives should be created to reward systems that coordinate care. State policies should be developed to ensure a stable population of primary care physicians to support a patient-centered medical home model. **Additional Considerations** The previous sections provided information on access and delivery of health care services to Iowa's uninsured population. In discussions surrounding health care coverage for the uninsured, the Task Force understands the importance of comments revolving around three additional topics: state health reform measures, the IowaCare program, and coverage for the underinsured. **Recommendations** To avoid gaps less evident but affecting patient access to medical services, the Task Force recommends: *Establishing unique state programs*. States should be allowed to tailor government insurance programs that meet their unique needs. The federal government should serve as a point of funding for a portion of health care dollars, but it should not over-regulate systems at the local level. States should be allowed to work cooperatively with the federal government to incubate health care coverage programs that best serve their populations. *Improving the IowaCare program*. IowaCare needs restructuring and an improved reimbursement structure. To adequately treat individuals in the IowaCare program and to potentially expand this program, it is necessary to ensure that physicians are reimbursed fairly. Additionally, the program must be reduced in complexity. Finally, consideration should be given to expanding the IowaCare program to allow for coverage in additional settings throughout the state. Physicians at the University of Iowa Hospitals and Clinics and Broadlawns Medical Center should necessarily have a seat at the table to help determine program features and reimbursement rates. IMS, on behalf of Iowa physicians with patients served by this program, should also be involved in discussions, particularly to address program design and funding support. *Acknowledging problems facing the underinsured*. As health care coverage becomes more expensive, we must take note of the growing number of "underinsured." Employers that offer health care coverage are shifting costs to their employees as health insurance premiums rise. Employees may then only be able to afford less expensive insurance plans that offer less coverage. While these Iowans will continue to have health insurance, their less comprehensive insurance coverage may fail to adequately prepare them for the financial repercussions of seeking certain forms of health care. This may, in

		turn, have an adverse impact on the quality of health care they receive. **4) Iowa's public health system.** To better assure that Iowans' health is improved in areas indicating challenge, the Task Force recommends: *Implementing interventions.* Early life interventions should be emphasized to combat obesity in the state. Other interventions should be targeted toward promotion of: o Diet, exercise, and nutrition; o Tobacco prevention and control; o Education in juvenile risk behaviors such as drug use and sexual behaviors; o Improved prenatal care for pregnant teenagers; o Education and prevention of substance abuse; o Pediatric developmental and behavioral assessments to advance primary prevention efforts; and o Oral health. *Utilizing established benchmarks.* A lack of data gathering and implementation of best practices restrain development of coordinated and measurable improvements in the prevention and management of public health threats. Benchmarks should be utilized to objectively measure threats such as: ▪ Diabetes ▪ Obesity ▪ High blood pressure ▪ Asthma ▪ Lack of immunization *Continuing support of public health initiatives.* Public and private support for public health interest groups that cover a variety of topics should be continued. These include: o Groups that promote primary prevention and chronic disease prevention; o Groups that combat obesity and promote healthy lifestyles; and o Groups that promote policies that reduce

		smoking and exposure to tobacco smoke. *Increasing support for mental health.* The Task Force respects mental health and substance abuse as co-occurring disorders and the acute challenges of Iowa's mental health delivery system. Iowa's mental health care system is in crisis and should be addressed with more adequate funding and earlier identification of disorders which would reduce pressure on public systems that deal with persons not receiving early treatment. *Redesigning public health.* The tradition of county-based public health can no longer uniformly meet the needs of all Iowans – especially in lower population rural areas. IDPH should continue efforts to redesign public health to organize services regionally and statewide. *Supporting IDPH initiatives.* IMS and other health care organizations should support the following recommendations put forth by IDPH: o Increased state funding for public health; o Increased connectedness between public health and the community; o Improved communication between public health and private practitioners; and o Placement of adequately trained public health providers able to perform a uniform level of assessment and subsequent care. *Supporting Community Health Centers (CHCs).* The Task Force appreciates the efforts of CHCs in their dual mission of providing episodic and preventive care and accessibility regardless of ability to pay. CHCs provide valuable service of giving access to care for people who otherwise do not have access. The Task Force supports: 1) A greater link between community and critical access hospitals and community health centers; 2) Greater collaboration between specialists and community health centers; and 3) Recognition of CHCs as an integral part of Iowa's health care system. *Using schools as a public health access point*. Schools are serving an expanded role in public health delivery. Schools are a natural avenue to disseminate public health information and provide preventive and public health services. The Task Force supports increased efforts to expand these initiatives. **Additional Considerations** The Task Force understands the importance of public health and prevention activities and believes that this sentiment is shared throughout the physician community. Despite this, physician reimbursement and education do not reflect its importance. Any solution to improve the health of Iowans must include a paradigm shift of

		compensation for a new manner of care that fosters physician/patient dialogue of preventive care. Students in undergraduate and graduate medical education programs, as well as practicing physicians, are often taught the importance of prevention and public health. However, educational systems emphasize the treatment of acute and chronic conditions. Public health matters receive only passing coverage, despite the enormous impact on the health care system. Enhanced focus on educational programs can lead to a greater appreciation and recognition of public and preventive health issues in practice. **Recommendations:** To improve awareness and to reinforce the importance of public health activities among Iowa physicians, the Task Force recommends: *Improving physician reimbursement.* Current reimbursement systems do not value public health and prevention activities. This works against public health and prevention goals and should be restructured to reflect their importance. *Enhancing physician education.* The Task Force recommends that physician education emphasize the value of a public health system and its strengths in preventing illness and disease. *Increasing emergency preparedness.* Emergency preparedness is an essential component of public health and medical care delivery. Existing, well developed structures, such as Iowa's trauma system of care, should continue to play a coordinated role in Iowa's system for emergency preparedness.
Report of the Task Force on The Iowa Physician Workforce	UI Carver College of Medicine, University of Iowa Hospitals and Clinics	**http://www.healthcare.uiowa.edu/CCOM/Administration/IowaPhysicianWorkforce.pdf** 7 MB lengthy download time **January 2007** Recommendations: Physician Education / Training Capacity ○ Increase the class size of the UI Carver College of Medicine modestly (~10%) and increase the proportion of medical school graduates who remain in Iowa for residency training. ○ Increase the enrollment in select Iowa residencies and fellowships based on physician demand data. To that end: promote Iowa's practice opportunities among medical students, residents and fellows, seek state and private funds for additional graduate training positions, energize student interest groups in the specialties for which demand is high, initiate early recruitment programs at the pre-medical school level. ○ Consider adding residency slots in psychiatry and general surgery (rural track) using the community-based

		family medicine residency model. ○ Develop and validate a national index to prospectively identify specialties in which a supply shortage might develop due to downward trends in medical student and resident career choice. (This will require new financial support.) Physician Retention ○ Identify the specific reasons for attrition associated with physician relocation and help in developing strategies aimed at stemming the outflow of physicians. (This will require new financial support.) ○ Establish favorable state, regional and local loan repayment programs for specific specialties using the primary care model of years-of-service in exchange for specified amounts of loan repayment. ○ Publicize Iowa practice opportunities throughout the University's GME system and promote contacts between prospective employers and UI GME program directors and trainees. ○ Establish programs for early pipeline collaborations/connections between students and residents, and specific communities. ○ Work with the IMS, IHA and other stakeholder organizations in developing programs that promote Iowa as a place to practice and live. ○ Set a minimum target for the number of University of Iowa students training in select allopathic residency programs in Iowa. ○ Provide technical assistance to medical groups, health systems and hospitals in designing their recruitment packages, including recommended incentives, contract advice, and recruitment strategies. (This will require new financial support.) ○ Continue to monitor age and gender trends within the Iowa physician community. Recruitment of Physicians from Other States ○ Systematically contact Iowa medical graduates training in other states and promote information concerning Iowa opportunities. (This will require new financial support.) Public Policy Initiatives ○ Seek state tax relief for physician specialties that are in high demand and short supply, in return for entering practice and remaining in Iowa for a specified term. Include penalties for default. ○ Implement tort reform. ○ Improve Medicare and Medicaid reimbursement to Iowa physicians. ○ Seek additional financial support from state and private sources for UI Carver College of Medicine outreach efforts supporting physician workforce analysis, and physician recruitment and retention.
Direct Care Worker Compensation Advisory Committee	Iowa Department of Human Services	**http://www.dhs.state.ia.us/docs/2008-12%20Direct%20Care%20Worker%20Compensation%20Advisory%20Committee%20Report.pdf**

		December 11, 2008 Recommendations: 1. Fully Fund the Current Modified Price-Based Case Mix Reimbursement System 2. Modify Current Reimbursement Methodology to Include an Inflation Update in Non-Rebase Year: 3. Modify Calculation of Direct Care Median Component: 4. Modify Information Reported by Nursing Facilities on the Medicaid Cost Report: Options for Funding the Recommendations 1. General Fund: Policymakers could fund the recommendations from the General Fund and make an investment in the direct care workers, increase the supply of the direct care workers, promote greater workforce stability through increased compensation and reduce costs associated with high staff turnover. 2. State Fines: Under Iowa Code section I 35C.36, the Iowa Department of Inspections and Appeals (DIA) has the authority to issue a fine for violation of state regulations. This money is deposited into the general fund. Policymakers could use a portion of this money to bolster nursing facility quality by investing in a stable workforce. 3. Accountability Measures: The 2001 Iowa Acts (HF 740) created intent by the General Assembly to initiate a system to measure a variety of elements to determine a nursing facility's capacity to provide quality of life and appropriate access to Medicaid in a cost-effective manner. During the 2008 legislative session, Senate File 2425, section 33 made changes to the Accountability Measures including the establishment of a workgroup that is to develop recommendations to redesign the accountability measure program. The. Direct Care Worker Compensation Advisory Committee recommends that consideration be given to using some of these funds to increase the compensation to direct care workers. 4. Provider Tax: In accordance with the legislation that created the Direct Care Worker Advisory Committee, the group recognizes the importance of utilizing additional federal funds to offset the continued growth in overall Medicaid costs. More specifically, portions of increased funding from this source can be directed to wages and other costs of employment for employees in long-term care. This method of drawing down additional federal funding is used by 31 other states. In 2003, House File 619 gave the Department of Human Services (DHS) authorization to assess nursing facilities a quality assurance assessment (provider tax). The DHS submitted a state plan amendment (SPA) to the Secretary of the US Department of Health and Human Services, Centers for Medicaid and Medicaid, to implement the provider tax. In 2005, CMS and the federal government were no longer allowing intergovernmental transfers. In Iowa, the intergovernmental transfer was the mechanism used to fund the Senior Living Trust. Iowa agreed to end the intergovernmental transfers, as a condition of approval for an 1115 Demonstration Waiver, which allowed the state to implement the IowaCare Initiative. As a special term and condition of the 1115 IowaCare Demonstration, DHS agreed to not implement a nursing facility provider tax and was required to withdraw the pending SPA. As a result, the state was not able to implement the nursing facility quality assurance assessment (provider

		tax) created in HF 619. Advocates for the concept of a provider tax believe that Iowa's recent economic challenges imposed by natural disasters and the economy may be cause for this IowaCare agreement to be renegotiated. The IowaCare Demonstration Waiver is scheduled for renewal effective July I, 2010. The Direct Care Worker Compensation Advisory Committee believes that effectively utilizing these additional resources could provide gains in wage and benefit planning and assuring the workforce of compensation growth to keep pace with statewide economic changes. 5. Expanded Medicaid Appropriations: At the time this report was in final drafting, conversations were occurring at the federal level to increase the amount of Medicaid dollars flowing to the states as part of a broadened economic stimulus package. The advisory committee recommends that if additional federal Medicaid funds are made available, and if the funds could be used for the purpose of increasing direct care wages or other forms of compensation, that consideration be given to do so.
IDPH Response and Direct Care Worker Advisory Council Recommendations	Iowa Department of Public Health	http://www.idph.state.ia.us/hcr_committees/common/pdf/direct_care_workers/report_response_nov08.pdf **May 1, 2009** Recommendations: At this time I am requesting the Direct Care Worker Advisory Council address the following during the balance of FY2009 and in the first half of FY2010: 1. Identify the DCW contribution to rebalancing health and long term care 2. Gather more comprehensive stakeholder input regarding the council's existing recommendations including input from the disability community 3. Research similar credentialing efforts to demonstrate such efforts have decreased direct care worker turnover and improved quality of care in other states. 4. Thoroughly review existing regulations governing training of direct care workers in all settings and an analysis of consistency and variance among current requirements. 5. Develop a strategic plan that addresses outreach/education regarding the importance of DCW
Direct Care Worker Advisory Council Recommendations	**Iowa Department of Public Health**	http://www.idph.state.ia.us/hcr_committees/common/pdf/direct_care_workers/report_nov08.pdf **November 2008** Recommendations: Grandfathering Recommendations o Implement a Process to Certify the Existing Direct Care Workforce o Adopt a Regional Phased-In Approach to Grandfathering Communication and Outreach Recommendations o Establish a Phased Plan of Communication and Outreach to Support Implementation

		Supplemental Recommendations ○ Expand Membership on the Direct Care Worker Advisory Council ○ Conduct an Assessment of Existing Technology Resources and Capabilities ○ Complete Estimates of Resources Needed for Technology, Personnel, and Partners to Continue Implementation ○ Support Legislation Establishing the Iowa Board of Direct Care Workers
Senate File 389	**2009 Legislative Session**	**Division V.** Established but did not fund new programs related to health care workforce, including • medical residency grants, • health care provider incentives, • nurse and nurse educator incentives, • safety net provider network incentives, and • a physician assistant mental health fellowship program. Requires annual report on use of funds. Implements this division to the extent that funding is available. (Not funded in 2009.)