# COUNCIL ON HUMAN SERVICES PUBLIC HEARING
## JULY 12, 2006

| Time | Presenter | Organization |
|---|---|---|
| 8:30 am | Dana Petrowsky | Iowa Association of Homes and Services for the Aging |
| 8:35 am | Doug Johnson | Iowa Health Care Association & Iowa Council for Health Care Centers |
| 8:45 am | Dr. Jay Davidson | Iowa Dental Association & Delta Dental |
| 8:55 am | Shanell Wagler | Empowerment |
| 9:00 am | Dale Woolery | Drug Control Policy |
| 9:05 am | Maja Rater | Citizen |
| 9:10 am | Dr. Wayne Zemelka | Iowa Chiropractic Society |
| 9:20 am | Lynhon Stout | Iowa Foster and Adoptive Parent Association |
| 9:25 am | Brock Wolff | Orchard Place |
| 9:30 am | Linda Goeldner | Iowa Nurses Association |
| 9:35 am | Dr. Jeffrey Lobas | Child Health Speciality Clinics (University of Iowa) |
| 9:40 am | Kathy Nesteby | Future Net |
| 9:45 am | Shelly Chandler | Iowa Association of Community Providers |
| 9:55 am | John Wauters & Candice Bennett | Chief Juvenile Court Officers |
| 10:05 am – BREAK | X X X X X X X X X | X X X X X X X X X X X X X X X X X X X X |

## COUNCIL ON HUMAN SERVICES
## JULY 12, 2006
## CONTINUED

| | | |
|---|---|---|
| 10:20 am | Tonya Diehn | March of Dimes |
| 10:25 am | Suzanne Overton | Citizen |
| 10:30 am | Becky Elson | State Child Care Advisory Council |
| 10:35 am | Shannon Strickler | Iowa Hospital Association |
| 10:40 am | Kim Schmett | Coalition for Family & Children Services |

**Written Comments Submitted (No oral testimony):**

- **Becky Harker, Governor's DD Council**
- **Jill June, Iowa Planned Parenthood Affiliate League**
- **Di Findley, Iowa Caregivers**
- **Jodi Tomlonovic, Family Planning Council**
- **Iowa State Association of Counties**
- **Sylvia Piper, Iowa Protection and Advocacy Services**

**Statement**
**By Dana Petrowsky, President/CEO**

**Iowa Council on Human Services**
**Wednesday, July 12th, 2006**
**Des Moines, IA**

Since 1964, the Iowa Association of Homes and Services for the Aging has represented providers of high quality healthcare, housing and services for seniors. Our mission-oriented and community-sponsored members number 143 nonprofit nursing facilities, continuing care retirement communities, senior housing, residential care facilities, assisted living programs, and community service providers. Our mission is to inspire leadership and benevolence in our members through networking, education, information and advocacy.

**Quality First – My Innerview**

In support of our continuing commitment to Quality First we are please to announce that we are recommending "My Innerview" as the tool to capture the most effective data. Quality First is our profession's commitment to the public that we will make significant advances in the quality of care to those we serve. At the core of Quality First is the systematic collection and analysis of quality indicator data that goes beyond traditional clinical indicators. The goal is to consistently achieve results that meet or exceed the expectations of the customer and the best practices for clinical and other services.

My InnerView provides long-term care leaders with evidence-based management tools to better achieve their organization's goals. Their Quality Profile™ tracks monthly progress toward goals, complete with bench-marking and trending reports. Satisfaction surveys help monitor, analyze, and advance quality-improvement efforts. The Risk Monitor™ supports more aggressive risk monitoring and management.

With an effective quality management system and visible results, a provider can sustain a framework that will drive continuous quality improvement efforts that lead to satisfied customer, workforce excellence and respect and acceptance from the community.

**Statement**
**By Dana Petrowsky, President/CEO**

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**Federal and State Civil Money Penalties (CMP) Fines: Opportunities to Improve Resident Quality of Life and Care**

The Department of Human Services currently has $2.5 Million in the Civil Money Penalty (CMP) fund. This money is collected from skilled nursing facilities that are not in compliance with the requirements of the federal Social Security Act. Federal and state civil money penalties and fines levied against nursing facilities offer nursing facility residents a two-fold opportunity to make their lives better: (1) federal and state CMPs/fines may be a deterrence to poor care; and (2) when CMPs/fines become necessary and are collected, they offer an additional pool of money for fiscally constrained states to improve the quality of life and care for nursing facility residents.

We recommend the Department work with the long-term care profession to tap this pool of money to help fund quality improvement efforts with the use of My Innerview.

**Modified Price-Based Case-Mix Reimbursement**

Chapter 192 of the 2001 Act of the Iowa General Assembly instituted the Modified Price-Based Case-Mix Reimbursement System (Case-Mix System). The Case-Mix System rate paid to nursing facilities is calculated using the statewide median cost, adjusted to reflect the acuity of the residents. As a result nursing facilities must submit cost reports to the Department. It is the intent of the Iowa General Assembly to increase direct care to and provide a quality of life and care to nursing facility residents. We recommend the Department work with the long-term care profession to create a method of recognizing the cost of using the My Innerview satisfaction survey in the cost reports.

# Statement
## By Dana Petrowsky, President/CEO

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## Wednesday, July 12th, 2006
## Des Moines, IA

### Accountability Measures

Currently, the State of Iowa provides a system that measures a variety of elements to determine a nursing facility's capacity to provide quality to life and appropriate access to the Medicaid program in a cost-effective manor. Accountability measures are objective, measurable, and when considered in combination with each other deemed to have a correlation to a resident's quality of life. My Innerview is an opportunity for the State of Iowa to measure resident and staff satisfaction. We recommend the Department work with the long-term care profession to consider using My Innerview as the Satisfaction Survey in receiving Accountability Measure #4, Resident Satisfaction.

We will continue to work with the Department to determine the method that My Innerview can be utilized in improving resident quality of life and care.

### Personal Needs Allowance

We would like to express our thanks for the increase of the personal needs allowance for Medicaid recipients in nursing facilities. The understanding that the $30 each resident is allowed to retain for personal needs does not provide enough resources to cover the cost of such things as a hair care, greeting cards, or clothing. We will continue to work in a positive and collaborate way with the Department until the state plan is approved by CMS and the personal needs allowance is implemented.

### Tobacco Tax

We were disappointed to see that the tobacco tax issue was left on the table. We support an increase in the tobacco tax to help alleviate the strain of the Medicaid budget.

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# Statement
## By Dana Petrowsky, President/CEO

## Iowa Council on Human Services
## Wednesday, July 12th, 2006
## Des Moines, IA

### HCBS Support

We support a payment system which reflects more closely actual costs for all home and community-based alternatives and services. We support a plan that puts money into the continuum of services, including assisted living and adult day programs, in addition, Continuing Care Retirement Community (CCRC) type services, and home health and CDAC services be expanded to Medicaid recipients.

House File 617 as signed by the Governor requires that DHS request from CMS a waiver to add assisted living service to the HCBS elderly waiver. We will continue to work in a positive and collaborate way with the Department until the state plan is submitted and approved by CMS.

### Preserve the "Safety Net"

In funding home and community based services, the Department must not compromise the safety net provided by nursing facilities for the most needy and vulnerable population. We support full implementation of the case-mix reimbursement methodology for nursing facilities without reductions.

We stand ready to work with you and the Department as we move forward together to serve Iowa elderly population.

Thank you!

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# DHS Council Presentation

July 12, 2006

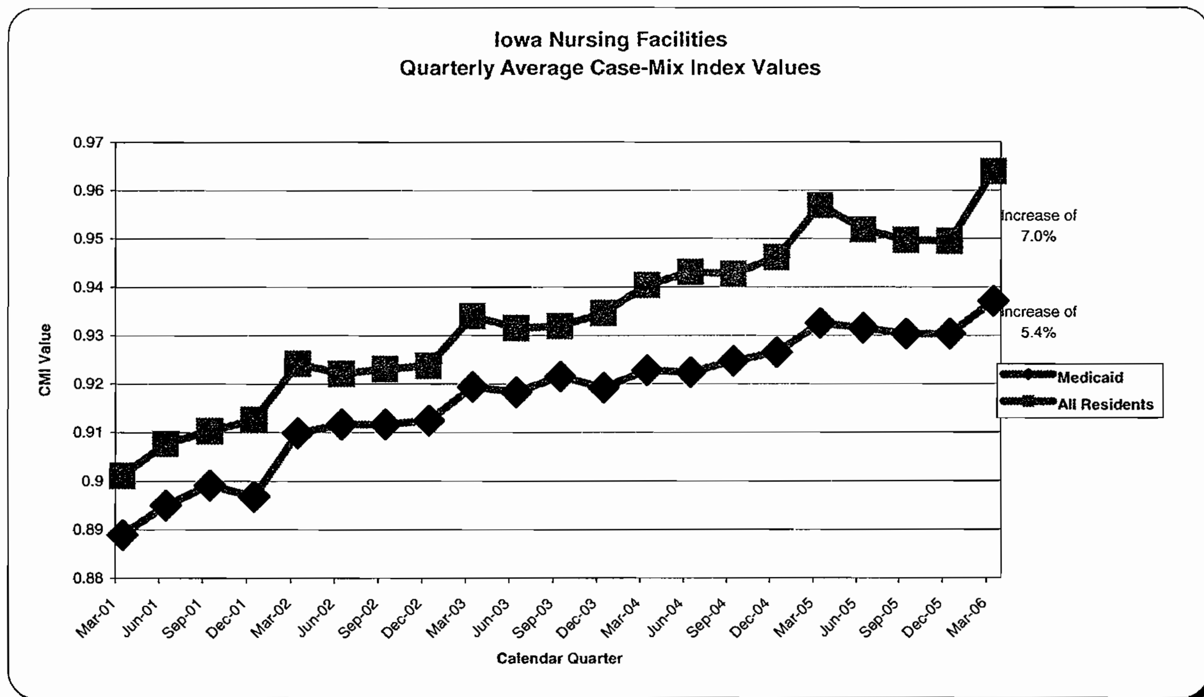
Iowa Health Care Association (IHCA), the Iowa Council of Health Care Centers (ICHCC) and the Iowa Centers for Assisted Living (ICAL) come together to present concerns and recommendations for FY 2008 appropriation requests. Together these organizations represent nearly 360 Iowa nursing facilities (81 percent) and 232 assisted living centers, residential care facilities and senior living programs. Our members provide daily 24-hour, person-directed care for nearly 21,000 elderly Iowans and accommodate thousands more in residential settings. Many of these providers offer a wide range of available home and community based services. We actively employ more than 20,000 professional and other health care workers across the state.

As a testament of the quality of long term care service provided in our state, Department of Inspections and Appeals Director Steve Young accompanied a delegation of Iowa providers to meet with Iowa's senators and congressmen in Washington, D.C. in June.

**Skilled Nursing Facility Services**

The clinical data used to support our current reimbursement system is summarized in the chart below. (See Figure 1.) Growth in skilled nursing facilities' resident acuity is a significant reason for continued cost growth.

**Figure 1**




An important concern is adequate funding for the case-mix reimbursement system. Current payments have been artificially reduced by DHS budget limitations. A skilled nursing facility's per-patient-day loss for Medicaid services provided has increased each year for the past three years. Excerpts from a national study prepared by BDO Seidman, LLP, (see attached) show the national data on Medicaid funding shortfalls. Iowa's shortfall increased from ($7.75) per day in 2003 to ($10.40) per day in 2004 compared to the national average of ($14.62) in 2003 and ($12.55) in 2004. Initial estimates for 2005 and 2006 appear to indicate that Iowa will continue

with losses near the national averages. Such an outcome is unacceptable in light of recent policy decisions. In 2004 only three states (Oklahoma, South Dakota and Texas) reported lower Medicaid payment rates than Iowa. Iowa's average payment rate for FY 2006 will be approximately $110.30 (see Figure 2 note) compared to the highest rates in the nation: Massachusetts, $177.16; New Jersey, $187.10; Oregon, $169.31; and Pennsylvania, $179.17.

Skilled nursing facilities across Iowa have experienced significant cost growth in recent years. Costs have increased due to a number of factors including higher acuity levels (see Figure 1). Wage and employment costs have increased by 5.6 percent each year since 2001. Average staffing levels increased by 6.1 percent between 2001 and 2004 to an average of 5.25 hours per patient day. Our analysis shows that 66.5 percent of all skilled nursing facility costs in 2004 were directed to wages, benefits and other employment costs. Higher energy costs and insurance premiums have also increased operation costs.

The most startling figure is the State's share in the cost of caring for its Medicaid beneficiaries. Our data shows that in 2006, the State – with no federal match – paid skilled nursing facilities approximately $31.40 per patient day for 24-hour nursing care, meals, room, activities, etc. – an average of $1.31 per hour for each of the approximately 13,400 Medicaid residents served. (See Figure 2.)

**Figure 2**

| FY 2006 (estimate) | Iowa average per patient day | National average per patient day |
|---|---|---|
| **Average Medicaid payment rate** | $110.30 | 152.24 |
| **Average State share** | $31.40 | $68.51 |
| **Estimated FMAP** | 64% | 55% |
| **Average State cost per hour** | $1.31 | $2.85 |

***NOTE: The Figure 2 estimates for Iowa are calculated after considering impact of SPA submitted for April 1, 2006 through June 30, 2006 rate changes.***

We advocate designing a proactive fair rental value payment system so nursing facilities can better prepare for the coming wave of aging Baby Boomers. As providers continue to upgrade and replace existing out-of-date facilities to prepare for the future services demands of Iowa's aging population and increasing regulatory requirements, the cost of these upgrades statewide have been as high as $45 million annually in recent years.

Iowa's rural providers that make up nearly 71 percent of available capacity in the state are important economic engines in their communities. Data shows that in many smaller communities an average 10 percent of the population either resides in or are employed by the local skilled nursing facility. In one community, it is as high as 19 percent.

We ask that the system be funded so it can work as designed. We believe that adequate resources are available to remove limitations based upon budget projections. Iowa needs a predictable funding mechanism to maintain and enhance the quality of life for so many of its frail and elderly.

**Assisted Living Services**
Many of our members seeking to provide low-income assisted living services find their efforts restricted by the piecemeal assisted living reimbursement system through state programs such as HCBS waiver, in-home health, Medicaid home health, and rent subsidy. In 2005 the legislature approved adding assisted living as a waiver service with a multi-tier reimbursement system based on level of services needed. We anticipate that the Department will act on this legislation and submit a plan to CMS this year.

We ask that serious consideration be given to increasing the HCBS waiver cap to accommodate multiple level payments for assisted living services under Medicaid as many states currently do. The limited Medicaid funding provided by the current $1,052 cap forces Medicaid-recipient tenants to leave their assisted living homes and enter nursing facilities oftentimes earlier than their acuity level requires. This has resulted in an unintended two-tiered system that in effect forces assisted living Medicaid recipients into nursing homes while private-pay tenants can afford to remain in assisted living. Even with an exceptions process, the HCBS waiver creates an additional funding restraint limiting care options for Medicaid tenants and assisted living providers.

In Iowa, less than 3 percent of assisted living is funded under the HCBS waiver. In neighboring states, that figure ranges from 14 to 28 percent.

**Residential Care Facility Assistance**
The State Supplementary Assistance (SSA) reimbursement rate for residential care facilities (RCF) services is significantly lower than the cost of providing services. In FY 2004, RCFs provided services at a loss of almost $30 per day. The average cost reported by the Department in FY 2004 was $55.53 per day.

Today RCFs' average per-day cost is estimated at $65 to provide 24-hour supervision, three meals a day, mediation administration, financial management, housekeeping, laundry, activities and psycho-social intervention. The current reimbursement rate of $25.85 per patient day seriously limits access to alternative long term care services for low-income Iowans. We ask that the SSA funding for RCF services be increased from the current $25.85 to $45.00 per day.

## Recommendations

- Adequate funding for skilled nursing facility services
  - Rebasing effective July 1, 2007
  - Update to include full SNF Market Basket Index
  - Design a fair rental value payment system
- Adequate funding for assisted living services
  - Fund and implement multi-level tiered payment system
  - Add assisted living as an HCBS Waiver service (per 2004 legislation)
  - Apply annual inflation index to $1052 HCBS waiver cap
  - Prepare to fund growth in Medicaid usage
- Increase reimbursement rate for residential care facility services to $45 per day.

## Summary
We are prepared to continue the discussion of the priorities addressed in this presentation. We appreciate the opportunity to engage in proactive and productive planning to share goals and strategies to achieve the highest quality of life for Iowans.

reporting cost data in 2004 (or 2005), current rates were available and obtained for 31 of them and the 2006 projected shortfall reflects the comparison for these 31 states.

### Medicaid Shortfall: 2003

In 2003, the average shortfall in Medicaid reimbursement was $14.62 per Medicaid patient day.[3] The 2003 average shortfall is 16% higher than the 2002 average shortfall of $12.58 per Medicaid patient day. Figure I illustrates trends in the overall shortfall in Medicaid reimbursement rates over time. Table I depicts the average rates, costs, and shortfalls in Medicaid reimbursement by state. Based upon this shortfall and extrapolating to all 50 states, the Medicaid shortfall in nursing facility funding was estimated at over $5.1 billion in 2003, an increase of 14.9 % from the estimated 2002 shortfall of $4.4 billion.

### Medicaid Shortfall: 2004

By contrast, the situation improved somewhat in 2004, with the average shortfall in Medicaid reimbursement decreasing to $12.55 per Medicaid patient day. Extrapolating to all 50 states, the estimated shortfall in total nursing facility Medicaid funding was estimated at over $4.3 billion in 2004. New or expanded provider tax programs in many states helped to reduce the 2004 shortfall in Medicaid funding to nursing facilities. Of the 9 states whose shortfalls decreased by more than $2.00 per Medicaid patient day from 2003, 7 were the result of provider tax programs.

### Projected Medicaid Shortfall: 2006[4]

Even though the implementation or expansion of provider tax programs helped improve nursing facility reimbursement from 2004 to 2006, reimbursement rate increases in 2005 and 2006 have still not kept pace with projected nursing home cost inflation. The projected 2006 shortfall in

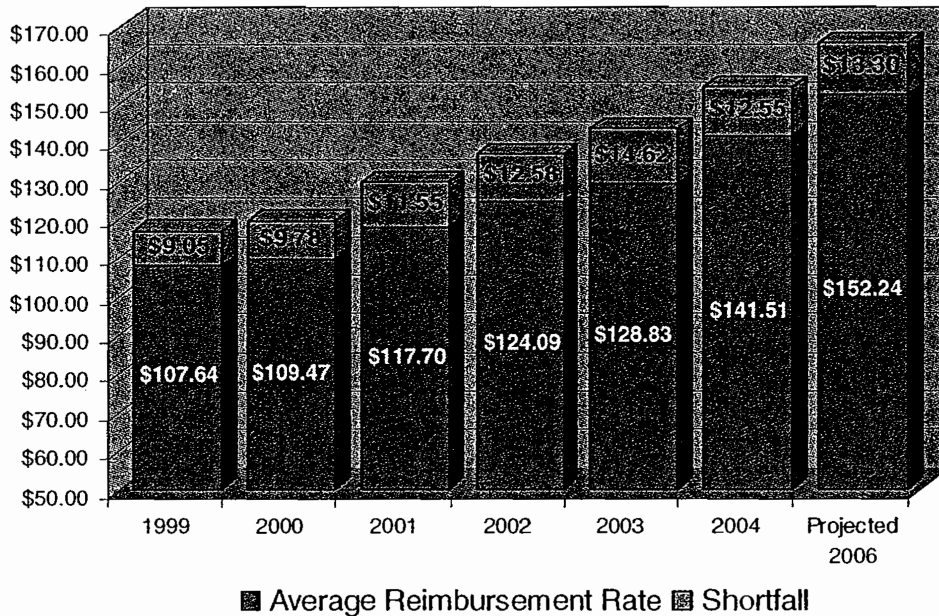
[3]Applying an estimated audit adjustment factor of 1.38% in 2003 and 1.67% in 2004 to the costs in those states where as-filed reports were utilized still resulted in a shortfall of $13.67 and $11.17 per Medicaid patient day, in 2003 and 2004, respectfully. The 1.38% and 1.67% factors were a weighted average of the historical difference between audited or desk-reviewed cost reports and as-filed reports in these states. The information was obtained from the AHCA state affiliate in each of these states.

[4] No determination of the Medicaid shortfall could be made for 2005, since 2005 cost reports were unavailable in all but four states. The 2006 Medicaid shortfall is a projection based upon trending the most recently available cost reports to 2006 and comparing these trended costs to current rates.

Medicaid reimbursement, was estimated at $13.30 per patient day; an increase of 6% over the 2004 shortfall. Again, extrapolating to all 50 states, the projected shortfall in Medicaid reimbursement to nursing facilities was projected at nearly $4.6 billion in 2006, an increase of 4.9 percent from the estimated shortfall in 2004.

Taken together, in the years that we have compiled this study, the shortfall in Medicaid nursing home funding has increased 47%, from $9.05 per patient day in 1999 to a projected $13.30 in 2006. If all costs of operations were considered, not just Medicaid allowable costs, the shortfall would be significantly greater. The charts on pages 15-18 reflect the per diem shortfall and the fiscal impact of the shortfall in each state by year.

**FIGURE I**
**Shortfall per Medicaid Patient Day**
**All States in Each Year**



## TABLE I
## STATE-BY-STATE COMPARISON OF RATES AND COSTS

| State | Rate 03 | Cost 03 | Difference 03 | Rate 04 | Cost 04 | Difference 04 |
|---|---|---|---|---|---|---|
| Arizona | $ 119.23 | $ 137.18 | $ (17.95) | $ 126.46 | $ 139.84 | $ (13.38) |
| California | $ 115.10 | $ 128.02 | $ (12.92) | $ 120.15 | $ 131.89 | $ (11.74) |
| Colorado | $ 136.63 | $ 148.17 | $ (11.54) | $ 144.82 | $ 155.95 | $ (11.13) |
| Connecticut | $ 168.29 | $ 182.20 | $ (13.91) | $ 168.40 | $ 187.47 | $ (19.07) |
| Florida | $ 148.22 | $ 159.98 | $ (11.76) | $ 148.84 | $ 163.22 | $ (14.38) |
| Georgia | $ 99.03 | $ 108.26 | $ (9.23) | $ 114.16 | $ 121.01 | $ (6.85) |
| Hawaii | $ 184.19 | $ 193.28 | $ (9.09) | $ 186.53 | $ 197.55 | $ (11.02) |
| Illinois | $ 90.74 | $ 113.26 | $ (22.52) | $ - | $ - | $ - |
| Indiana[1] | $ 103.68 | $ 112.14 | $ (8.46) | $ 106.87 | $ 115.14 | $ (8.27) |
| Iowa | $ 97.80 | $ 105.55 | $ (7.75) | $ 101.89 | $ 112.29 | $ (10.40) |
| Kansas | $ 101.18 | $ 114.32 | $ (13.14) | $ 104.93 | $ 119.09 | $ (14.16) |
| Maryland | $ 162.20 | $ 169.64 | $ (7.44) | $ 169.20 | $ 175.86 | $ (6.66) |
| Massachusetts | $ 154.94 | $ 174.66 | $ (19.72) | $ 165.96 | $ 182.42 | $ (16.46) |
| Michigan | $ 134.94 | $ 143.87 | $ (8.93) | $ 154.68 | $ 155.51 | $ (0.83) |
| Minnesota | $ 135.46 | $ 149.07 | $ (13.61) | $ 138.24 | $ 153.13 | $ (14.89) |
| Missouri | $ 99.23 | $ 122.94 | $ (23.71) | $ 104.90 | $ 126.98 | $ (22.08) |
| Montana | $ 121.20 | $ 122.17 | $ (0.97) | $ 125.70 | $ 129.19 | $ (3.49) |
| Nebraska | $ 121.15 | $ 127.48 | $ (6.33) | $ 118.84 | $ 129.73 | $ (10.89) |
| Nevada | $ 151.79 | $ 155.65 | $ (3.86) | $ 158.54 | $ 169.12 | $ (10.58) |
| New Hampshire | $ 146.08 | $ 169.69 | $ (23.61) | $ 162.40 | $ 184.04 | $ (21.64) |
| New Jersey | $ 151.19 | $ 177.92 | $ (26.73) | $ 166.27 | $ 187.93 | $ (21.66) |
| New Mexico | $ 110.17 | $ 124.88 | $ (14.71) | $ - | $ - | $ - |
| New York | $ 179.54 | $ 206.99 | $ (27.45) | $ 189.11 | $ 213.50 | $ (24.39) |
| North Carolina | $ 107.87 | $ 122.76 | $ (14.89) | $ 129.67 | $ 133.55 | $ (3.88) |
| North Dakota | $ 130.11 | $ 133.00 | $ (2.89) | $ 135.96 | $ 138.10 | $ (2.14) |
| Ohio | $ 152.71 | $ 160.57 | $ (7.86) | $ 158.09 | $ 165.93 | $ (7.84) |
| Oklahoma | $ 94.61 | $ 101.36 | $ (6.75) | $ 98.96 | $ 104.95 | $ (5.99) |
| Oregon | $ 116.77 | $ 135.23 | $ (18.46) | $ 142.47 | $ 148.84 | $ (6.37) |
| Pennsylvania | $ - | $ - | $ - | $ 173.97 | $ 182.06 | $ (8.09) |
| South Dakota | $ 94.31 | $ 113.31 | $ (19.00) | $ 97.65 | $ 121.10 | $ (23.45) |
| Texas | $ 94.91 | $ 99.60 | $ (4.69) | $ 95.99 | $ 103.82 | $ (7.83) |
| Utah | $ 104.41 | $ 123.91 | $ (19.50) | $ 133.70 | $ 148.28 | $ (14.58) |
| Vermont | $ 143.04 | $ 165.05 | $ (22.01) | $ 149.01 | $ 171.69 | $ (22.68) |
| Virginia | $ 109.23 | $ 118.43 | $ (9.20) | $ 114.01 | $ 124.11 | $ (10.10) |
| West Virginia | $ 149.22 | $ 146.03 | $ 3.19 | $ 158.64 | $ 156.65 | $ 1.99 |
| Wisconsin | $ 122.68 | $ 142.72 | $ (20.04) | $ 128.22 | $ 146.93 | $ (18.71) |

[1]The analysis for 2003 and 2004 was prepared by the Medicaid state agency's contractor and does not include the rate and cost impact of provider tax, approved retroactive to July 1, 2003. The revised rates and costs by provider were unavailable as of the completion date of our study.

National Foundation
of Dentistry
for the Handicapped

An affiliate of the
American Dental Association

Iowa Donated Dental
Services (DDS) Program
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# TESTIMONY FOR IOWA COUNCIL ON HUMAN SERVICES

July 12, 2006

Members of the Council:

My name is Dr. Jay Davidson and I am representing the Iowa Donated Dental Services program of the National Foundation of Dentistry for the Handicapped. Joining me is Naomi Johnson, the Referral Coordinator for the program and the person who makes it work.

Last year when we testified before you, we were just starting this program to help disabled or elderly people who cannot afford comprehensive treatment, nor get public aid. Along with our partners, the Iowa Dental Association and Delta Dental of Iowa, we have recruited 100 dentists who each donate comprehensive treatment for one or two disabled or aged people every year. Fifteen laboratories also participate and donate some of the fabrications such as dentures and crowns.

The Iowa DDS program is part of a national network that operates in 35 other states. Over 12,000 dentists and 2,600 labs participate and will collectively donate $15 million in services this year. Though the dentists and many labs donate their services, some monies are needed to support the volunteers; to pay for a referral coordinator, for printing, telephone, postage and other administrative expenses. In most of these other states, their state governments provide this funding. In Minnesota, for example, the health department grants $56,000 per year,

# Donated Dental Services (DDS)
## a national humanitarian program

developed and coordinated by NFDH

in collaboration with

12,000 volunteer dentists

2,900 volunteer laboratories

American Dental Association

Academy of General Dentistry

American Academy of Periodontology

American College of Dentists

American Association of Endodontists

American Association of Oral and Maxillofacial Surgeons

American College of Prosthodontists

American Academy of Implant Dentistry

American Association of Women Dentists

Hispanic Dental Association

American Dental Assistants Association

National Association of Dental Laboratories

American Association of Orthodontists

### Financial support provided by

- xélan Foundation
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  - John F. Philips Foundation
  - Michael L. Quick Foundation
- The Daniels Fund
- Delta Dental
- Great-West Life and Annuity Insurance Company

### with assistance from

- Dentsply
- Argen
- Heraeus Kulzer
- Ivoclar
- Implant Innovations Inc.
- Nobel Biocare
- Patterson Dental Company
- Sullivan-Schein Dental

*The inherent dignity of every person is reflected through a happy and healthy smile*

Delta Dental of Iowa provided a grant to start the Iowa program. These monies expire next June and we are here to ask your support for the $35,643 we will need in the 07/08 fiscal year for the DDS program, hopefully through the health department. Let me tell you why our request is so important.

**Many aged or disabled Iowans have seriously-neglected dental problems because they cannot afford needed treatment and public assistance is generally unavailable.**

With limited incomes and restricted government help, hundreds of elderly or disabled people suffer from neglected dental problems. They cannot afford food and rent, let alone hundreds of dollars worth of dental care. Though many are eligible for Medicaid, Iowa's Medicaid program only provides emergency and basic dental benefits for adult recipients. And numerous disabled or elderly individuals do not qualify for Medicaid, yet are still indigent and cannot afford care. Several clinics help, but focus on emergency services, not extensive treatment. As a result, dental diseases fester though they cause pain, suffering, and a host of related health problems.

I am one of the 100 dentists who volunteers and one of the patients I am treating exemplifies why DDS is needed. Jill is 37 years old and has debilitating health problems that include Lupus and serious, persistent mental illness. As a result, she cannot work and subsists on $557 per month in social security and disability income and receives some food stamps. When she applied to the DDS program, she could not chew on one side of her mouth and had seriously neglected the problem because she had no money to get care.

**DONATED DENTAL SERVICES (DDS) PROGRAM**

DDS targets indigent adults who are also mentally or physically disabled, mentally or chronically ill (including the homeless), or aged. The program is a last resort for people with seriously neglected problems who have no where else to turn to for needed care.

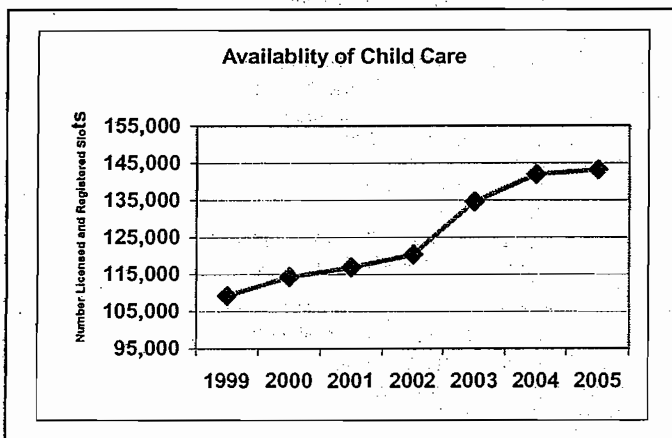
We just finished the first year of the DDS program and our volunteers contributed $111,823 in services for 45 disabled or elderly people who had no other way of getting care. In the current 06/07 fiscal year that began July 1st, we are planning to generate at least $140,000 in services for 75 people. And in the following 07/08 fiscal year, we plan to help 100 people receive $200,000 in services at a cost of $35,643. In other words, for each dollar we are requesting for 07/08, DDS will generate almost $6 in services.

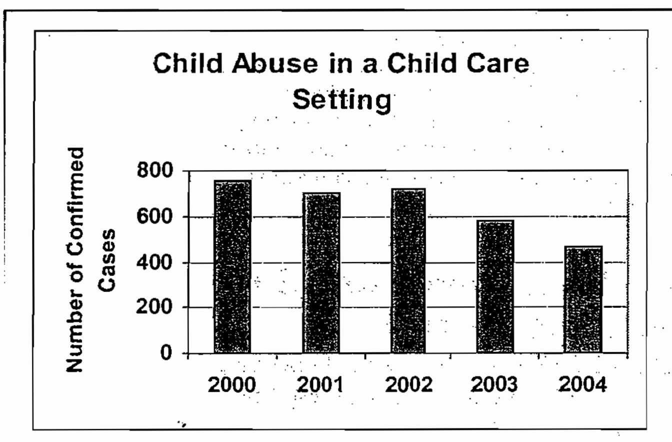
**We dentists are willing to help some of our state's most vulnerable people. Dentists alone, however, cannot shoulder the burden of treating indigent disabled or aged people with severely neglected problems.** We know government cannot afford to pay for all of our diverse and complex problems, including health care for all elderly or disabled individuals. But government can help enormously by allocating its limited funds to support private sector partnerships, such as the DDS Program. We hope this Council will help us find the $35,643 next year to support these vital services.

# Secure and Nurturing Child Care Environments

## State Indicators

- Child Abuse in a Child Care Setting
- Availability of Child Care
- Quality Child Care Ratings




### *Also Note:*

- Iowa ranks 3rd in the nation at 71% for the percent of children under age 6 with all parents in the workforce. (UC Census – 2004 Community Survey)
- 19.66% of Iowa's 3 and 4 year olds attended an accredited preschool or one meeting Head Start performance standards in 2004-2005. This was in increase from 18.55% the previous year. (Iowa Department of Education)

Research shows that high quality early care environments are positively related to children's later language, math, and behavior skills. Empowerment early childhood funds are targeted for specific quality enhancement activities. Technical assistance through training and mentoring helps child care providers deliver better care and education. Through Community Empowerment efforts, the numbers of centers, teachers, and family child care providers who participate in quality improvement activities have increased.

### *A Local Example of Quality Improvement*

**Audubon, Carroll, Guthrie, Greene Empowerment Area - Quality Child Care**

The Partnerships 4 Families (P4F) Empowerment Area - Audubon, Carroll, Guthrie & Greene Counties - identified the improvement of quality childcare as one of their priorities based on their community plan. With the support of a Child Care Consultant, Child Care Home Evaluation Specialist, and incentives to home child care providers, P4F has been able to produce the following outcomes in FY'05:

- 15% increase of child care slots in registered homes or centers
- 100% of registered child development homes receive spot checks to determine compliance with DHS registration requirements. 43 providers were 95-100% compliant with the DHS checklist
- 1092 children are being cared for in homes that are meeting 85% or more of the DHS Child Development Home Registration requirements
- 236 additional registered slots were available for families to access quality child care.

## *A partnership between communities and the state to improve the well-being of families with young children.*

## *Purpose*

Community Empowerment is to empower individuals and their communities to achieve desired results to improve the quality of life for children, 0-5, and their families.

## *Achieving Results and Key Indicators*

Every Empowerment Area in Iowa will have the capacity and commitment for achieving these results as measured by these indicators:

***Healthy Children***

- Low Birth Weight
- Rate of Immunization by age 2

***Children Ready for School***

- Pre-literacy skills
- Children in Quality Preschools

***Safe and Nurturing Families***

- Incidence of Child Abuse
- Teen Birth Rate

***Safe and Supportive Communities***

- Serious Crime
- Juvenile Arrests
- Employment Rate

***Secure and Nurturing Child Care Environments***

- Child Abuse in a Child Care Setting
- Availability of Child Care
- Quality Child Care Ratings

## *Statewide Collaborations*

- Early Care, Health and Education Congress
- Early Childhood Iowa Stakeholders
- Promoting Early Learning Standards and Quality Child Care Rating System
- Collaborative training opportunities with Prevent Child Abuse Iowa and Community Partnerships to Protect Children

## *DHS Investments*

***(Early Childhood Grants)***

| | |
|---|---|
| FY 2003 | $6,279,725 |
| FY 2004 | $7,261,647 |
| FY 2005 | $7,259,000 |
| FY 2006 | $7,250,000 |
| FY 2007 | $7,246,000 |

## *How it works*

- State Empowerment Board supports state and community partnerships and promotes collaboration between education, health and human services
- 58 community Empowerment Boards representing all 99 counties
- ***Early Childhood Grants*** enhance the quality and capacity of child care through:
  - Regular child care and provider recruitment
  - Child care for mildly ill children
  - 2nd and 3rd shift child care
  - Provider training and professional development
  - Support child care registration and licensure
  - Child care home consultants and nurse consultants
  - Support providers to improve quality rating system ranking or seeking accreditation
- ***School Ready Grants*** provide comprehensive services for:
  - Preschool and child care
  - Parent support
  - Home visitation
  - Parent education
  - Professional Development
- An interagency team from the Departments of Economic Development, Workforce Development, Education, Human Rights, Human Services, Management and Public Health supports the state and community boards

## *Local Investments with Early Childhood Grants* *(FY 2006)*

- $2,223,790 child care capacity building
- $2,194,970 QRS/QPPS accreditation support
- $393,124 Infant/ext. hour care
- $1,108,024 Home/Health Consultants
- $185,596 Head Start support
- $832,608 Professional Development including TEACH and PITC support
- ($3,021,209 for CC R&R Support)

# STATE OF IOWA

THOMAS J. VILSACK
GOVERNOR
SALLY J. PEDERSON
LT. GOVERNOR

OFFICE OF DRUG CONTROL POLICY
MARVIN L. VAN HAAFTEN, DIRECTOR

**Presentation to the Iowa Council on Human Services (7-12-06)**
**Dale Woolery—Associate director, Governor's Office of Drug Control Policy**

The Governor's Office of Drug Control Policy (ODCP) wishes to bring three issues to your attention, as they address Iowa's Drug Control Strategy and involve the Iowa Department of Human Services:

1. ODCP continues to provide federal grant funding ($185,000 in SFY 2007) to the State Training School and Iowa Juvenile Home for longer-term substance abuse treatment at both facilities. Due to significant cuts in the federal programs that provide the funding, ODCP likewise has been forced to reduce grant funding to STS and IJH in recent years. Little change is expected next year, although Congress is still debating those funding levels. It's our understanding that state funds have also been appropriated for treatment. The need for treatment is clear. The grant-supported treatment provider tells us that assessments show 70%-90% of all youth admitted to STS and IJH are in need of substance abuse treatment, while only about one-third receive it. On a related note, meth is a growing concern among these youth. In 1996, fewer than 20% of STS and IJH youth reported meth use. Now, it's in the 30%-50% range.
2. ODCP last year, with the support of its Drug Policy Advisory Council, asked the Iowa Legislature for an additional $7 million in substance abuse treatment funding. We also supported the Attorney General's proposal for an additional $7 million in treatment resources. Very little of either proposal was passed. While I don't have details yet, ODCP is again preparing to support additional drug treatment resources next year...with an emphasis on "family-focused" treatment that considers the welfare of children of drug users. We will be coordinating closely with the Department of Human Services, which is represented on our Drug Policy Advisory Council and other state agencies in the weeks and months ahead. According to data from DHS and the Iowa Department of Public Health, there is a strong need for additional substance abuse treatment.
3. ODCP, thanks to a $500,000 federal grant, continues to award mini-grants to support local Drug Endangered Children (DEC) teams. These are collaborations involving DHS personnel, law enforcement officers, prosecutors, medical professionals and others in a rapid response to rescue, assess and treat children in drug endangered environments. Nine such teams exist now, and we anticipate that growing to 12 by the end of this fiscal year. Additional federal grant funds are anticipated to continue the program next year. The funding also supports the DEC Coordinator, housed in the Attorney General's office.

LUCAS STATE OFFICE BLD., 1ST FLOOR
321 EAST 12TH STREET • DES MOINES, IOWA 50319 • 515-242-6391 • FAX 515-242-6390

*Maja Rater*

702 Baker Street
Casey, Iowa 50048
Phone/Fax: 641-746-2692
Email: children@netins.net

For years I raised 7 children by myself—on and off welfare. When I received my court ordered child support I was off welfare. When it stopped coming I turned to welfare. Contrary to common belief I believe that children need a parent at home. This was denied my children after the *Welfare Reform Bill* was signed into law and the part of the bill that dealt with child support enforcement was ignored. As a nation we went gung-ho after mothers sending them into the work force while we ignored the promise of the *Welfare Reform Bill* which dealt with dads' responsibilities to his children. While my former husband was sitting at home meditating/watching television, living off his girlfriend or working for cash this mother was at work while the children came home to an empty house—something I had sworn never would happen. Well, I had not taken into account that I lived in a state/nations which ignored the laws of the land when it comes to the welfare of children. We gladly pay for daycare as long as mom is not the "daycare provider." Anything to keep moms away from her children. Raising children is not work in this culture unless we are raising someone else's children—not our own!! I have come to believe that the *Welfare Reform Bill* was not about holding both parents economically accountable for their children but a way to provide cheap labor!!

Finally after years of fighting for the court ordered child support, the fight of my life, I am now receiving it every month—my youngest daughter is graduating from ISU this year. Articles in the Des Moines Register reminds me of how tough life was for us before and how nothing has changed for women in my situation depending on their court ordered child support. "Homelessness up in Iowa for mothers and children in Iowa." No mentioning of nonsupport in the article though. I still think it is a miracle that we didn't end up homeless. Electricity shut off up in Iowa. I know all about that—again because of not receiving our court ordered child support.. One day I came home from work and found my kids hiding behind the couch as they had come home to a house with no electricity. It had been shut off although I know the bill had been paid as I had gotten an overdraft. Apparently it had something to do with their bookkeeping. All that has ended for us now that I receive the court ordered child support. It took the fight of my life to get to this point and nothing appears to have changed for thousands of families in Iowa. Over one billion dollars are owed in court ordered child support to families in Iowa. It has become a cultural norm that moms do it on their own with crumbs from the rich man's table which is meant to keep her and her children in poverty and dependency—job security for the employees of DHS and CSRU.

For us depending on our court ordered child support for economic survival receiving it is our first line of defense against poverty and dependency which robs us of the liberty and human dignity to live our lives according to our values in a society which constantly tries to remind us that we are worthless and without human value because of our dependency – which is caused by this society's unwillingness to uphold the laws of the land in regards to parental responsibilities to their children.

I constantly hear from parents who are dealing with this contempt against us:

Laura has been fighting for years to get her child support order modified for her two sons now teens, as well as her medical order enforced, dealing with the humiliation of sending her children on HAWK-I. Finally CSRU got tired of our demands and went to court asking the judge to rule that Iowa didn't have to enforce the order.

Well, since we brought a copy of the Full faith and credit for child support orders (Title 28 § 1738B) the judge ruled as he should: Iowa has to enforce the order. However CSRU has not given up yet. Every chance they get they tell her "you are not giving us what we are asking for so we don't have to enforce the order." We are having a meeting next week with CSRU so we will see what happens. We might have to go back to court and ask the judge to rule on it again!!

Shannon who had given up on the system contacted me because she is exhausted working full time as well as raising 3 children without the support she is awarded. She is now owed over $26,000 in unpaid child support. Dad is supposed to pay $693 plus $138 on the arrears a month and all she receives is from $3.95 to $60 a month while dad is taking care of his girlfriend's children. Of course no medical either so her children are on Medicaid. That is of course willful non-support and qualifies for criminal nonsupport. But who cares? Try to rob a bank for $5 and see what happens?

Mary told me that she was glad to see someone fight the system. She had followed my case. She had given up herself. After having gone to court several times she had given up and raised her 2 children without support. It was now too late for her she said... Her case was in Wisconsin but she lived in Iowa. Wisconsin is the state of Governor Tommy Thompson. The governor of welfare reform fame? For whom there is a standing ovation whenever he shows up anywhere because of his welfare reform?

I told her that it was not too late as Wisconsin has a 20 year statue of limitation and she still had a year or so left. She contacted Wisconsin Child Support Agency and was told that her case was still active. Huh? Her case was still active and while dad was driving new cars, building new houses, she had not received a dime in support! To make a long story short, after several month of fighting her former husband handed her a check for $43,000 to cover the back child support owed.

Carol contacted me telling me that her case was being closed by CSRU. She is fighting breast cancer. We put a stop to that. However, no child support is forthcoming. He went to Great Britton and although we have reciprocity with Great Britton the order is not

being enforced. She is too embarrassed to ask for any help so I don't know what I can do for her at the moment. Hopefully I will think of something. It is very hard for me to stand by and see women suffer like these moms are in a country which claims to be decent and law abiding. Moms call me crying telling me "we didn't sign up to raise our children by ourselves." Neither do the laws of the land demand that. I am even being told that many families are cheated out of child support payments because there is no automatic check off for owed child support when dad signs up for Social Security Benefits.

Decent people should be shocked by this state sponsored child neglect to the tune of over one billion dollars. CSRU needs to be overhauled. The child support collections need to be transferred to the Department of Revenue and Finance. They know how to collect and are willing to do it. I found that out years ago when I could not pay a traffic ticket. CSRU is ignoring its obligations to these families as well as thousands of other families and children in Iowa—besides the tax payers who are left holding the bill for many of these families. Sure did for me for many years while my former husband with two Master's Degrees was sitting at home watching television while the nation sent mothers into the workforce leaving their children to come home to empty homes!!.

**In Des Moines:** This encampment, seen from the Southwest Ninth Street bridge, is along the Raccoon River. Those who work with homeless populations say several economic and social factors have combined to worsen living conditions for many people.

| | COUNTY | MAJOR CITY | NUMBER | PERCEN |
|---|---|---|---|---|
| 1 | Polk | Des Moines | 6,008 | 1 |
| 2 | Scott | Davenport | 2,298 | 1 |
| 3 | Linn | Cedar Rapids | 1,875 | 1 |
| 4 | Clinton | Clinton | 1,678 | [illegible] |
| 5 | Pottawattamie | Council Bluffs | 1,594 | 1 |
| 6 | Johnson | Iowa City | 1,257 | |
| 7 | Story | Ames | 966 | |
| 8 | Black Hawk | Waterloo Cedar Falls | 957 | |
| 9 | Woodbury | Sioux City | 656 | |
| 10 | Marshall | Marshalltown | 646 | |
| 11 | Dubuque | Dubuque | 552 | |
| 12 | Webster | Fort Dodge | 516 | |

COUNTIES WITH MORE THAN 500 HOMELESS

Note: Population estimates as of July 1, 2004

Source: 2005 Iowa Statewide Homeless Survey, U.S. Census

# Homelessness up in Iowa for poor mothers, children

HOMELESS, from Page 1A

lost jobs.

"I think it's really hard to put a firm picture on any homeless community because they're invisible," said Mike Peterson, outreach coordinator for Iowa Homeless Youth Centers in Des Moines, an agency that helps homeless people ages 16 to 22. "But it's clear we are seeing more females than males now."

Like other nonprofit groups, Iowa Homeless Youth Centers is seeing many more new faces in its fluid population. Thirty to 40 people each month seek help at its downtown Des Moines service center for the first time; there they can get food from a pantry and hot meals. The agency serves 400 to 500 people a month. In coming weeks, the pantry may have to further ration food — the current limit is 16 items a month — to meet greater demand.

A policy team from around the state met Thursday and today at the Des Moines Botanical Center to use the new research to hone a two-year-old statewide plan to deal with homelessness, said Lyle Schwery, homeless programs coordinator for the Iowa Finance Authority.

That group is expected to make recommendations to the homeless council, a group with 30 voting members representing nonprofit agencies, businesses, religious groups, and homeless or formerly homeless adults.

"We just got the study last Friday," Schwery said. "We are struggling to get it analyzed ourselves."

The research by the Iowa Policy Project in Mount Vernon suggests that more people are being turned away from shelters, while homelessness is increasing at a greater rate among some groups.

## Homeless numbers

A new study shows that the number of homeless in Iowa has increased. A look at some of the study's findings

**21,280**
The number of Iowans who were homeless in 2005, a 14.5 percent increase from 1995 when 18,592 were homeless

**61%**
The percentage of homeless households that were made up of women and children

**44%**
The percentage of homeless who were uninsured

**56%**
The percentage of homeless who were women

**17%**
The percentage of homeless men who were veterans

**24%**
The percentage of homeless who were African-Americans

**32%**
The percentage of homeless who were employed

Source: 2005 Iowa Statewide Homeless Study

African-Americans make up 2 percent of the population, but they now make up 24 percent of the homeless population.

Ninety-four percent of homeless households with children are headed by single women.

Williams-Moore    Weston-Knauer

Linda Williams-Moore, executive director of the YWCA in Des Moines, and staff members said the growing number of women and children seeking assistance are in more desperate situations than in years past.

Some have reached the federal government's five-year limit on welfare benefits but show no hope of ever being able to hold a job that pays enough to support their children. Others are victims of domestic violence. Some come out of prison and have nowhere to go. Many made their way through school systems but are barely literate.

"One of our moms here has four kids and an IQ of 58," said Cathi VaNote, a YWCA residence hall director.

Said Williams-Moore: "For a segment of our population, the standards are unreachable. It's not that they don't want out of here. But for some, this is going to be it."

Shuianda Ross, a 30-year-old YWCA resident, is typical of some of Iowa's new homeless.

A former nursing student in Louisiana, she was forced to quit school last year after learning she was pregnant with her fourth child. Her relationship with her boyfriend failed. Her welfare checks amounted to $250 a month.

Deciding Louisiana had nothing to offer her, Ross packed up her children last June and took a train to Iowa. Here, she receives more welfare money from the state — $495 a month plus food stamps. Most of that money — $310 — goes toward the small, low-income apartment she rents at the YWCA; the rest goes for food.

After giving birth a month ago, Ross said, she is already looking for work.

"I want to be independent — to work, buy a car, eventually get a bigger place and set an example for my children," she said. "I just want to have a simple life and be happy. That's all."

But it's not easy.

Those who determine public policy should walk in a single mother's shoes to understand her need for job training and a better-paying job, she said.

"I think they need to see the things we go through," she said.

While the 2005 homeless study excluded individuals who live temporarily with relatives and friends, it did include some families who were living together, according to one school that officials surveyed.

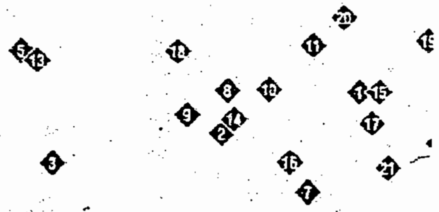
That's why the West Sioux Community School District, on the western edge of the state between Sioux City and Sioux Falls, S.D., was found to have the highest proportion of homeless schoolchildren in the state — 12.8 percent. Superintendent Paul Olson said many Hispanic families there make the most of lower-paying jobs by "doubling up."

In Olson's opinion, many are poor, but they are not necessarily desperate.

"In some cases, we have four to five families living in one place," he said. "Part of this is cultural, but every once in a while it concerns us. We had one family living in another family's garage with no insulation."

## Homeless students in Iowa

More than 4,657 students in Iowa schools are homeless, according to a 2005 study of the homeless in Iowa. Of districts with more than 50 homeless students, West Sioux is the district with the highest percentage of its enrollment, nearly 13 percent, homeless or without permanent housing.



DISTRICTS WITH MORE THAN 50 HOMELESS STUDENTS

| | DISTRICT | TOTAL | PERCENT OF ENR |
|---|---|---|---|
| 1 | Cedar Rapids | 550 | 3.2% |
| 2 | Des Moines | 523 | 1.6% |
| 3 | Council Bluffs | 447 | 4.8% |
| 4 | Davenport | 317 | 2.0% |
| 5 | Sioux City | 223 | 1.7% |
| 6 | Clinton | 206 | 4.8% |
| 7 | Ottumwa | 177 | 3.8% |
| 8 | Ames | 147 | 3.3% |
| 9 | Perry | 118 | 6.6 |
| 10 | Marshalltown | 112 | 2.3% |
| 11 | Waterloo | 107 | 1.0% |
| 12 | Bettendorf | 98 | 2.3% |
| 13 | West Sioux | 88 | [illegible] |
| 14 | Southeast Polk | 83 | 1.7% |
| 15 | College | 79 | 2.8% |
| 16 | Oskaloosa | 70 | 3.0% |
| 17 | Iowa City | 69 | 0.6% |
| 18 | Fort Dodge | 64 | 1.6% |
| 19 | Dubuque | 61 | 0.6% |
| 20 | Oelwein | 61 | 4.6% |
| 21 | Columbus | 51 | 4.9% |

Note: Figures include students who meet the Department of Housing and Urban Development definition of homeless, as well as those who meet the Department of Education definition of homeless, which includes students living temporarily with relatives or friends. Includes Pre-K students.

Source: 2005 Iowa Statewide Homeless Survey, U.S. Census

GAMES AUTOGRAPHS MEMORABILIA SILENT AUCTION MEET THE I-CUBS COACHING STA

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January 20-21, 200

The Des Moines Register

The Newspaper Iowa Depends Upon ■ DesMoinesRegister.com ■ Price 50 Cents in Stores and Coin Racks

# Survey finds spike in Iowa homelessness

## Problem has hit poor moms with kids especially hard since '99

RODNEY WHITE THE REGISTER

**Struggling:** Shuianda Ross, 30, shown with three of her four children, is living at the Des Moines YWCA, but she hopes to find a job and a new home for her family. African-Americans make up 2 percent of Iowa's population but 24 percent of its homeless population.

By LEE ROOD
REGISTER STAFF WRITER

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Homelessness among poor women with children in Iowa rose dramatically from 1999 to 2005, with that group now making up more than three out of five of all homeless households, a new study has found.

The study shows a 14.5 percent overall leap in homelessness, an increase based on "conservative" reporting by public and private agencies.

The yearlong study commissioned by the Iowa Council on Homelessness cost $76,000 and paints the most accurate demographic picture ever of the estimated 21,280 Iowans believed to be without permanent homes in 2005. It includes the first specific information about public school children who are homeless.

The findings are stark: 550 schoolchildren lived on the streets or "doubled up" with others in Cedar Rapids, 523 in Des Moines, 447 in Council Bluffs, 317 in Davenport and 223 in Sioux City.

"It has gone from bad to worse, it really has," said Kittie Weston-Knauer, principal of Scavo Alternative School in Des Moines. "And the thing is, if we really wanted to stop this, we could find a way."

Those who work with homeless populations say several factors — a lackluster economy, growing family dysfunction and drug problems, demographic shifts and less government help — have collided to worsen living conditions, especially for single mothers. Affordable housing and employment were two top concerns among homeless people surveyed for the research, as 32 percent could not find an affordable place to live, 26 percent had been evicted or foreclosed upon, and 20 percent had

See HOMELESS, Page 6A

### IOWA'S HOMELESS POPULATION

The 2005 Iowa Statewide Homeless Survey is based on "conservative" reporting by 1,675 agencies and schools statewide that served people who were homeless at some time during 2005. The numbers exclude individuals who were temporarily living with relatives or friends. The numbers include people living on the streets, in pup tents or in their cars, as well as those living in shelters and transitional housing.

**21,280** The number of Iowans who were homeless in 2005, a 14.5 percent increase from 1995.

**523** The number of homeless students in the Des Moines school district, which is 1.6% of total enrollment.

### HOW YOU CAN HELP THE HOMELESS

Call the Des Moines Area Religious Council, (515) 277-6969, to find out how and what you can contribute to area pantries. In Des Moines, three main shelters are Churches United Shelter, (515) 284-5719; Bethel Mission, (515) 244-5445; and Door of Faith, (515) 974-0545. The YWCA constantly needs towels, blankets and sheets. For more information, call (515) 244-8961.

### EVERY SCHOOL DISTRICT IN IOWA

See how many homeless children were reported in each Iowa school district at DesMoinesRegister.com.

# Critics: ( exposes to gamb

The Iowa Lottery's TouchPlay machines are in open view in stores and restaurants.

By WILLIAM PETROSKI

Angry Iowans are complaining about children being exposed to the Iowa Lottery's new TouchPlay gambling machines, even if kids aren't being caught illegally playing the games, which closely resemble slot machines.

Unlike state laws that strictly prohibit Iowa's riverboats and racetracks from allowing people younger than 21 from being on a casino floor, children cannot be kept out of groceries, convenience stores and other retailers offering TouchPlay games.

George Antolik of Urbandale said he was shocked recently when he and his 10-year-old twins went into a suburban Kum & Go convenience store

# Stampede kills 345 p

Officials say 289 people were hurt in the rush to complete a Muslim ritual before sunset.

By SALAH NASRAWI

Mina, Saudi Arabia — Thousands of Muslims surging to complete a stoning ritual before sunset stampeded Thursday after some pilgrims tripped over dropped luggage, causing a pileup that killed at least 345 people in the second tragedy to hit this year's hajj.

Saudi authorities have sought for years to ease the flow of increasingly mammoth crowds during the annual Islamic pilgrimage, but the deaths on the final day of the stoning of the devil ritual underlined the difficulty in managing one of the world's biggest religious events.

# Blame poverty, not racism, for achievement gap in scl

As citizens who gave serious consideration to Jonathan Narcisse's 2005 Des Moines school board candidacy, we were disturbed by his comments in the June 19 Register implying that public schoolteachers are participants in the genocide of the black race in Iowa ("Citizens Must Act; System Fails Black Kids").

It was just nine months ago that Narcisse was extolling the virtues of public education for all our citizens. He called for the empowerment of teachers in education decision-making. Now, he says that vouchers and home schooling are the last, best hope.

The "achievement gap" measured by the test scores of minority children against non-minority kids is the only evidence Narcisse submits regarding the role of public schools in this "genocide." That's simplistic, unfair and harsh.

The "minority achievement gap" is, in reality, a poverty gap. One education expert calls the link between poverty and student learning "every bit as strong as the connection between cigarettes and cancer." Another study found that the cognitive scores of children in poverty are 60 percent lower than the highest socioeconomic groups before they enter kindergarten.

Narcisse reports that "80 percent of Iowa's black students live in poverty, as do more than 90 percent of Iowa's black children under age 5." Poverty is the heart of this issue, not a racist public school system.

Despite this, it appears that our state has abandoned the notion that government can — and should — play a role in eliminating poverty. In 2004, Iowa was the only state in the nation to cut taxes by more

## IOWA VIEW

Alan YOUNG

Dave O'CONNOR

than 1 percent of state revenues, (cuts that primarily benefited Iowa's wealthiest individuals), while 93,000 Iowa children (13.4 percent) lived in poverty and another 21 percent lived in low-income households. How many additional teachers of English language learners could that lost revenue have provided? What could that money have done for children in poverty at a time when service providers are experiencing budget cuts?

We'll never know.

Nationwide, income inequality is at an all-time high. Poverty continues to affect persons of color disproportionately. Yet, it is our nation's public school system that is continually singled out and taken to task by critics whose agenda is the privatization of education.

Narcisse's mischaracterization of the problem plays into the hands of these critics and what education writer Stan Karp has called "...a calculated political campaign to use achievement gaps to label schools as failures, without providing the resources and strategies needed to overcome them."

The Register's series on educating minority and English language learners showed how capital- and labor-intensive the process of really leaving no child behind is.

To provide the personal level of instruction that low-performing students need, far more human and financial resources are necessary. Among the most important needs:

- Universal preschool, taught by qualified instructors.
- Smaller class sizes.
- Improved and targeted professional development.
- Far more resources for tutoring and after-school programs.
- Higher teacher salaries to attract and retain the best and the brightest.
- Freedom for teachers to engage low-performing students with meaningful, authentic curriculum, unshackled from the mandates currently dictated by the so-called "No Child Left Behind Act."

However, without society's commitment to leveling the economic playing field, "Attempting t schools with is like tryin on one side according t economist.

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ALAN YOUNG an are both teachers, of the Des Mo Association a secr

# poverty, not racism, for achievement gap in schools

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- Higher teacher salaries to attract and retain the best and the brightest.
- Freedom for teachers to engage low-performing students with meaningful, authentic curriculum, unshackled from the mandates currently dictated by the so-called "No Child Left Behind Act."

However, without society's commitment to leveling the economic playing field, "Attempting to fix inner-city schools without fixing the city is like trying to clean the air on one side of a screen door," according to one political economist.

We admire and share Narcisse's passion to improve education. We suggest he work alongside educators instead of against them. Teachers work hard every day in their classrooms to overcome the challenges of poverty. Instead of suggesting blacks abandon public education, Narcisse and others should look to those who wield governmental power to help level the economic playing field, so teachers have a better chance to provide the best education for all students.

**ALAN YOUNG and DAVE O'CONNOR are both teachers. Young is president of the Des Moines Education Association and O'Connor is secretary.**

# CLASP

CENTER FOR LAW AND SOCIAL POLICY

## Child Support Substantially Increases Economic Well-Being of Low- And Moderate-Income Families

*Research Fact Sheet*

Research clearly demonstrates that child support payments are a critical source of economic stability for both moderate- and low-income families, including families leaving welfare. Child support makes up a substantial portion of household income for many families, helping them out of deep poverty and adding income that contributes to child well-being.

**For All Families**

- Child support constitutes 16 percent of family income for households that receive it.[1] In 2001, on average, $4,300 a year came to eligible families through this source.[2]
- For divorced families, the economic impact of child support is even greater—constituting 26 to 29 percent of income. In fact, child support reduces the poverty rate in this population by 7-11 percentage points.[3]
- For poverty-level families entitled to child support, the money is an extremely important source of financial help. About 66 percent of custodial parents with incomes below poverty who were due child support in 2001 received at least some payment. The average amount received for the year was $3,000. This accounted for 40 percent of their total family income.[4]
- Child support lifts about half a million children out of poverty and reduces the poverty gap by about 8 percent.[5]

**For Families Leaving Welfare**

- Child support is also a significant income source for families who leave welfare. About 42 percent of poor children with a non-resident parent whose families have left welfare receive child support. Child support makes up 30 percent of the income of these families. On average, $2,562 per year comes to eligible families through this source.[6]
- Child support is an important source of income for families affected by welfare time limits. The percentage of these families receiving child support and the amounts these families receive increase once public assistance is terminated.[7]

- Child support is also an important income source to families leaving the Temporary Assistance for Needy Families (TANF) program for work. Between one-quarter and one-third of those leaving welfare for work receive child support—averaging between $250 and $400 per month.[8]

- A Washington State study of families leaving welfare with regular child support payments found that these families had a slower rate of welfare reentry, a faster rate of finding work, and a slower rate of job loss compared to similar families who did not have steady child support income.[9]

- According to one study, an overwhelming majority of former TANF recipients (78 percent) who have child support orders characterize child support payments as making a "very big difference" in their family finances. Another 8 percent say such payments make a "pretty big difference."[10]

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[1] Sorensen, E., & Zibman, C. (2000a). *To What Extent Do Children Benefit From Child Support?* Discussion Paper 99-11. Washington, DC: Urban Institute. Available at www.urban.org.
[2] U.S. Census Bureau. (2003). *Custodial Mothers and Fathers and Their Child Support; 2001.* P60-225. Washington, DC: U.S. Department of Commerce.
[3] Bartfield, J. (2000). "Child Support and the Post-divorce Economic Well-being of Mothers, Fathers and Children." *Demography, 37*(2): 203-213.
[4] U.S. Census Bureau, 2003.
[5] Sorensen, E., & Zibman, C. (2000b). *Child Support Offers Some Protection Against Poverty.* Series B, No. B-10. Washington, DC: Urban Institute. Available at www.urban.org.
[6] Sorensen & Zibman, 2000a.
[7] Gordon, A., Kuhns, C., Loeffler, R., & Agodini, R. (2000). *Experiences of Virginia Time Limit Families in the Six Months after Case Closure: Results of an Early Cohort.* Report submitted to the Virginia Department of Social Services. Princeton, NJ: Mathematica Policy Research, Inc.
[8] Minnesota Department of Human Services, Program Assessment and Integrity Division. (2000). *Minnesota Family Investment Program Longitudinal Study: One Year after Baseline.* Minneapolis, MN: Author; Macro International and the Ohio Department of Job and Family Services. (2000). *Ohio Job and Family Services Legislative Outcome Study.* Columbus, OH: Authors; Formoso, C. (2003). *Child Support Impacts on Custodial Family Outcomes.* Olympia, WA: Division of Child Support. Available at www.dshs.wa.gov/dcs.
[9] Formoso, 2003 (note 8).
[10] Pearson, J., & Thoennes, N. (2000). *A Profile of Former TANF Clients in the IVD Caseload.* Denver, CO: Center for Policy Research.

## OFFICE OF CHILD SUPPORT ENFORCEMENT



Prev: Table 4 List of Tables Next: Table 6

**Table 5**

**CURRENT AND ARREARS COLLECTIONS DUE AND DISTRIBUTED, FY 2005**

| STATES | Total Amount of Current Support Due | Amount of Support Collected and Distributed as Current Support | Total Amount of Arrearages Due | Amount of Support Collected and Distributed as Arrears |
|---|---|---|---|---|
| ALABAMA | $354,584,897 | $183,467,681 | $2,529,997,733 | $88,278,703 |
| ALASKA | 100,640,806 | 55,310,350 | 631,176,511 | 38,633,110 |
| ARIZONA | 395,339,188 | 175,358,750 | 1,914,636,900 | 105,670,891 |
| ARKANSAS | 210,449,522 | 120,146,515 | 716,595,496 | 50,305,300 |
| CALIFORNIA | 2,679,235,029 | 1,320,030,508 | 19,629,453,563 | 1,027,653,212 |
| COLORADO | 310,063,476 | 178,862,355 | 1,168,648,239 | 89,229,023 |
| CONNECTICUT | 318,026,507 | 176,125,845 | 1,600,456,947 | 78,089,742 |
| DELAWARE | 90,006,068 | 54,374,589 | 250,545,167 | 18,829,298 |
| DIST. OF COL. | 74,729,773 | 39,526,064 | 378,610,272 | 14,880,008 |
| FLORIDA | 1,467,212,937 | 832,230,395 | 4,622,132,652 | 358,888,103 |
| GEORGIA | 761,188,225 | 400,074,122 | 3,154,680,695 | 159,104,255 |
| GUAM | 13,405,456 | 6,344,608 | 94,840,747 | 2,778,679 |
| HAWAII | 116,637,898 | 64,505,589 | 573,980,671 | 24,290,534 |
| IDAHO | 164,214,984 | 91,646,311 | 426,080,944 | 34,647,599 |
| ILLINOIS | 770,104,519 | 410,383,067 | 2,822,462,771 | 229,012,230 |
| INDIANA | 657,154,762 | 347,084,033 | 3,764,641,627 | 137,722,036 |
| IOWA | 337,812,577 | 218,690,681 | 1,041,654,377 | 83,561,799 |
| KANSAS | 180,591,954 | 98,458,671 | 597,441,645 | 51,068,235 |
| KENTUCKY | 452,764,578 | 250,420,325 | 1,404,497,255 | 101,648,687 |
| LOUISIANA | 398,348,602 | 220,899,174 | 1,007,210,889 | 88,785,262 |
| MAINE | 116,736,223 | 70,393,744 | 454,315,790 | 34,017,127 |
| MARYLAND | 575,085,470 | 362,739,058 | 1,491,329,405 | 110,284,348 |
| MASSACHUSETTS | 587,418,333 | 374,706,227 | 2,185,617,134 | 112,214,576 |
| MICHIGAN | 1,711,264,603 | 1,035,679,989 | 8,924,400,354 | 382,253,410 |
| MINNESOTA | 665,453,454 | 461,252,956 | 1,522,665,309 | 129,431,250 |
| MISSISSIPPI | 278,015,699 | 148,664,157 | 776,535,692 | 58,325,076 |
| MISSOURI | 651,763,971 | 356,466,590 | 2,038,883,693 | 174,212,961 |
| MONTANA | 60,137,253 | 36,493,643 | 195,374,467 | 17,293,134 |
| NEBRASKA | 191,345,289 | 129,811,445 | 630,786,333 | 46,091,436 |

| | | | | |
|---|---|---|---|---|
| NEVADA | 209,666,823 | 95,778,001 | 940,399,320 | 47,375,391 |
| NEW HAMPSHIRE | 97,995,185 | 63,333,814 | 188,359,297 | 21,391,660 |
| NEW JERSEY | 1,198,358,162 | 782,141,523 | 2,350,162,013 | 180,942,884 |
| NEW MEXICO | 93,702,759 | 46,853,275 | 673,826,953 | 27,988,020 |
| NEW YORK | 1,747,599,275 | 1,138,281,691 | 3,996,083,285 | 385,570,516 |
| NORTH CAROLINA | 718,561,829 | 463,648,295 | 1,714,678,945 | 149,787,925 |
| NORTH DAKOTA | 69,570,693 | 50,579,586 | 179,230,645 | 18,104,005 |
| OHIO | 1,935,658,459 | 1,335,190,881 | 4,196,327,455 | 346,513,331 |
| OKLAHOMA | 242,934,081 | 121,745,973 | 1,507,916,466 | 73,082,104 |
| OREGON | 397,653,000 | 238,960,025 | 1,212,291,371 | 86,810,794 |
| PENNSYLVANIA | 1,532,470,733 | 1,145,051,057 | 2,107,133,349 | 279,871,103 |
| PUERTO RICO | 391,132,349 | 216,225,376 | 935,193,689 | 53,300,725 |
| RHODE ISLAND | 72,407,156 | 43,898,404 | 186,442,389 | 14,947,932 |
| SOUTH CAROLINA | 371,139,802 | 175,958,935 | 1,201,833,328 | 72,773,869 |
| SOUTH DAKOTA | 68,595,558 | 47,357,258 | 139,437,644 | 15,533,338 |
| TENNESSEE | 573,374,148 | 317,807,300 | 1,959,289,661 | 132,599,718 |
| TEXAS | 2,074,412,422 | 1,255,309,848 | 8,742,468,805 | 625,233,977 |
| UTAH | 186,945,288 | 114,772,680 | 324,972,172 | 44,142,945 |
| VERMONT | 53,765,540 | 36,013,238 | 101,349,565 | 12,850,554 |
| VIRGIN ISLANDS | 13,015,224 | 7,244,166 | 53,207,735 | 2,804,339 |
| VIRGINIA | 662,944,278 | 403,826,092 | 2,134,641,217 | 163,501,904 |
| WASHINGTON | 732,909,233 | 464,028,767 | 1,964,240,264 | 183,365,439 |
| WEST VIRGINIA | 197,294,587 | 125,657,768 | 798,540,927 | 52,354,970 |
| WISCONSIN | 677,159,466 | 467,294,640 | 2,197,567,317 | 128,950,481 |
| WYOMING | 57,396,985 | 36,544,867 | 214,765,719 | 20,431,266 |
| TOTALS | $29,066,395,088 | $17,413,650,902 | $106,570,012,809 | $6,987,429,214 |
| **Source: Form OCSE-157** | **line 24** | **line 25** | **line 26** | **line 27** |

**Note: No assumption is made regarding data reliability.**

**FY 2005 CHILD SUPPORT ENFORCEMENT PRELIMINARY DATA REPORT**

Laja RATER
102 BAKER St
CASEY, IA 50048
h 641-746-2692

# Increa$ing the Collection Rate: In Search of Successful Techniques

**By Eileen Brooks**
*Director, State, Tribal and Local Assistance Division, OCSE*

What do Pennsylvania, North Dakota, Minnesota, South Dakota, Ohio, Wisconsin, Nebraska, Vermont, New Jersey, and New York have in common? They are the FY 2004 top 10 performers on the current support collection measure, with rates ranging from 74.4 percent to 64.7 percent. The national rate was 59.9 percent that year, the most recent for which data are available.

While performance varies among states, the national rate, just short of the 60 percent national target for 2004, continues to increase each year. The national annual current collection rate target is determined by factoring in historical actual performance with consideration given to ongoing activities and new strategies in the Child Support Enforcement Program. Although the continued increase in performance is a good sign, we should strive to do better.

In fact, improving our current collection rate is a national performance goal. Why? Consider these words from the National Child Support Enforcement Strategic Plan for FY 2005–2009 (available online at *www.acf.dhhs.gov/programs/cse)*:

> ***Families come first. Child support should be a reliable source of income for families. Parents must meet their financial and emotional responsibilities to their children and we will help those who are struggling to do so. Reliable child support and medical coverage are particularly crucial for families striving for self-sufficiency.***

OCSE used the Logic Model to plan activities intended to increase the national current support collection rate. Go to *www.acf.hhs.gov/programs/cse/grants/* and look under Grants Resources for an "Instructional Guide – Creating and Using the Logic Model for Performance Management" for help in planning activities in your own state, tribe, or local jurisdiction. Remember that the full incentive amount on the current collection performance measure for an individual state can be achieved with a rate of 80 percent or more!

The recent passage of the Deficit Reduction Act of 2005 (Public Law 109-171) contributes a sense of urgency to our task and a need for partnering among CSE, TANF and work programs. In TANF reauthorization, both work participation requirements and work supports are strengthened for families on assistance. The aim is for more families to enter the economic mainstream and fewer children to grow up in poverty. Increased unding to encourage responsible fatherhood is also authorized in this Act. The CSE program received new and expanded enforcement tools and distribution options that will allow states to provide more support directly to families, especially families who formerly received assistance.

*See* **RATE**, *next page*

**Des Moines Register**

Estimated printed pages: 5

January 13, 2006
**Section:** Main News
**Page:** 1A

## Survey finds spike in Iowa homelessness

*Rood Lee*
*Staff*

Problem has hit poor moms with kids especially hard since `99

## Child Support Automated Enforcement Tools
## Delinquency Triggers

| Enforcement Tool | Statute | Administrative Rules | Triggers |
|---|---|---|---|
| Income Withholding (IWO) | 252D—effective date of order; amount equal to payment of one month | 98.21 - same as 252D | Mandatory IWO—delinquency of at least one mo.; Immediate IWO—establishment of support obligation |
| Administrative Levy | 252I – delinquency in an amount equal to the support payment for one month | 98.91 – same as 252I | Delinquency of at least one month |
| License Sanctions | 252J – delinquent in an amt. equal to the support payment for 3 months | 98.101 – same as 252J | 3 months delinquent; no seek employment order; no income withholding in place |
| Seek Employment | 252B.21 – obligor failed to make support payments | 98.71 – same as 252B.21 | 3 months delinquent; no income withholding in place |
| Contempt | 598.23 – willingly fails to make support payments as provided in the order | None | Failure to comply with seek employment; worker/attorney assessment |
| State Tax | 252B.5 Revenue 421.17(21) | 95.6 – $50 delinquency & no payment on current & delinq. support in each of past 12 mos. | $50 delinquency & no payment on current & delinq. support in each of past 12 mos. |
| Federal Tax and Non-tax Offset | 252B.5 | 95.7 – PA $150 delinq. & delinquent for three months; NPA - $500. | PA $150 delinq. & delinquent for three months; NPA - $500 & per federal regulations, child must be a minor |
| Vendor Offset | 252B.5 and 421.17(29) | 98.81 refers to 421.17(29)—delinq. at least $50 | Same as state tax |
| Credit Reporting | 252B 42 USC 666(a)(7) | 95.12 – overdue support exceeds $1,000 | Overdue support exceeds $1,000 (IV-D) |
| Passport Sanctions | 252B.5 – over $5,000 delinquency | None | Over $5,000 delinquency |

07/12/02

**"The duty of parents to provide for the maintenance of their children, is a principle of natural law: an obligation... laid on them not only by nature herself but by their own proper acts, in bringing them into the world; for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish.**

***Sir Williams Blackstone***
***Commentaries on the Law of England in Four Books***

726.5 Nonsupport.

**A person, who being able to do so, fails or refuses to provide support for the person's child or ward under the age of eighteen years commits nonsupport; provided that no person shall be held to have violated this section who fails to support any child or ward under the age of eighteen who has left the home of the parent or other person having legal custody of the child or ward without the consent of that parent or person having legal custody of the child or ward. Support, for the purposes of this section, means any support which has been fixed by court order, or, in the absence of any such order or decree, the minimal requirements of food, clothing or shelter. Nonsupport is a class "D" felony.**
**Section History: Early form**

**[S13, § 4775-a; C24, 27, 31, 35, 39, § 13230; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, § 731.1; C79, 81, § 726.5]**

# EIGHT MAJOR FEDERAL CHILD SUPPORT LAWS

*

**1975 - Social Security Act, Title IV, Section D**
*

**1984 - Child Support Amendments - Public Law 98-378**
*

**1988 - Family Support Act - Public Law 100-485**
*

**1992 - Child Support Recovery Act, P.L. 102-521, 18 USC Chapter 11A**
*

**1993 - Omnibus Budget Reconciliation Act**
*

**1994 - Full Faith and Credit Act P. L. 103-383**
*

**1996 - Personal Responsibility and Work Opportunities Reconciliation Act of 1996, PRA**
*

**1998 - Dead Beat Parents Punishment Act**

**www.childsupport-aces.**

# Education, licensure, and Regulation of Chiropractic in the State of Iowa

## IOWA CHIROPRACTIC SOCIETY

**1605 N. Ankeny Blvd.**
**Suite 100**
**Ankeny, IA 50021-4163**
**515-963-9460**

**Web Site – www.iowadcs.org**

12 July, 2006

Outline:

I. Education, Licensure, and Regulation of Chiropractic in Iowa
II. Safety and Effectiveness of Chiropractic
III. Chiropractic Patient Satisfaction
IV. Cost-Effectiveness of Chiropractic
V. Conclusion

## I. Education, Licensure, and Regulation of Chiropractic in Iowa

The educational training of medical and chiropractic doctors has much in common, despite what those in either program would acknowledge or what would be expected from prevailing stereotypes in the health care delivery system. (1)

A recent study described U.S. chiropractic curricula as an average of **4820** classroom and clinical hours, with about 30% spent in the basic sciences and 70% in clinical sciences internship. Medical school curricula average about **4670** hours with a similar breakdown. (2)

Applicants for chiropractic licensure in Iowa must first successfully complete all 4 parts of national board examinations. These examinations are administered by the National Board of Chiropractic Examiners (NBCE), which is a division of the Council for Chiropractic Education (CCE). The CCE reports to the US Department of Education and provides accreditation to chiropractic colleges.

The Iowa Board of Chiropractic Examiners functions under the Iowa Department of Public Health to oversee and regulate the chiropractic profession in this state. Once licensed, chiropractors in Iowa are required to obtain 60 hours of continuing education every biennium.

## II. Safety and Effectiveness of Chiropractic

The practice of chiropractic has proven to be one of the safest forms of treatment for many conditions. Clinical research has shown that serious complications from spinal manipulation are extremely rare, and are estimated to be 1 case per 100 million manipulations. To date, no serious complication has been noted in more than 73 controlled clinical trials or in any prospectively evaluated case. (2)

Adding weight to chiropractic's important role in Iowa's health care system is the clinical effectiveness of spinal manipulation. One research article found that in a clinical trial comparing medication, acupuncture, and spinal manipulation for chronic spinal pain, spinal manipulation provided the best overall short-term results, despite the fact that the spinal manipulation group had experienced the longest pretreatment duration of pain. (3)

Many medical research journals have published articles that support the effectiveness of chiropractic care. One such article was published in the *Annals of Internal Medicine* in 2002. This study found that when comparing chiropractic care (manual therapy), physical therapy, or continued care by a general medical provider the success rate at 7 weeks was twice as high for the chiropractic group (68.3%) as for the group who were provided continued care by a medical provider. Additionally chiropractic care scored better than physical therapy on all outcome measures, and patients receiving chiropractic care had fewer absences from work and reported less analgesic use than the other groups. (4)

## III. Patient Satisfaction of Chiropractic Care

Patient satisfaction has always been a strength of the chiropractic profession. As reported in *Spine* in 2002, 87.4% of surveyed chiropractic patients were "very satisfied" with their chiropractic care. (5) This finding has been consistently demonstrated.

Also published in 2002, was a study from the University of California – Los Angeles (UCLA) comparing the satisfaction of low back pain patients who received medical care, physical therapy, or chiropractic care. The researchers found that patients were more satisfied with chiropractic care than with physical therapy or medical care. (6)

It is important to note that this information should not reflect any perceived animosity between chiropractic physicians, physical therapist, or medical doctors. Rather, it should be interpreted as a reflection of the patients' response to treatment.

Further clinical research regarding patient satisfaction levels were published in the *Journal of Manipulative and Physiological Therapeutics*. This study concluded that "…a significant percentage of patients (84%) felt that the care they received (from their chiropractor) was 'just about perfect' and 97% either strongly agreed or agreed with the statement, 'I would recommend this doctor to a friend or relative'." (7)

## IV. Cost-Effectiveness of Chiropractic Care

In an environment of ever increasing concerns over the escalating cost of health care, the chiropractic profession possesses a unique and valuable characteristic – when chiropractic utilization increases, overall cost of treatment decreases.

The most recent scientific evidence of this trend was demonstrated in a California study. ***A comparison of over 1.7 million insured patients seeking care for back pain showed that when chiropractic care was utilized the cost of treatment was reduced by 28%, hospitalizations were reduced by 41%, back surgery was reduced by 32%, and the cost of medical imaging (x-ray, MRI) was reduced by 37%. Additionally, 95% of those receiving chiropractic care stated they were satisfied with their treatment***. The authors

of this study estimated that utilizing chiropractic care as a first treatment option for back pain may reduce annual U.S. health care costs by more than $28 billion. (8)

Research published in the British Medical Journal in 2003 also found that the total costs of those patients treated in the chiropractic group were around 1/3 the costs of those treated by the physical therapist or general medical doctor. The researchers cited faster recovery times as a likely reason for the decreased cost in the chiropractic group. (9)

Yet another scientific study put actual dollar figures associated with these differences. This research found that chiropractic was substantially more cost-effective ($593.33 average cost per patient) than conventional care ($774.06 average cost per patient). (10) Though these findings are significant, the U.S. government has reported even greater savings when chiropractic is utilized under the Medicare program.

A report compiled in July 2001 found that:

1. Medicare beneficiaries who received chiropractic care had lower average Medicare payment for all Medicare services than those who did not ($4,426 vs. $8,103)
2. Medicare beneficiaries who received chiropractic care average fewer Medicare claims per capita than those who did not
3. Medicare beneficiaries who received chiropractic care had lower average Medicare payments per claim than those who did not. (11)

## V. Conclusion

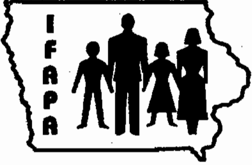
For this reason, proper utilization of chiropractic care should be encouraged in order to minimize health care costs, maximize patient outcomes, and achieve higher patient satisfaction levels.

As stated in the Journal of Manipulative and Physiological Therapeutics, February 2000, there is solid and impressive economic and related justification for the integration of chiropractic. Chiropractic care is a cost-effective alternative to the management of neuromusculoskeletal conditions by other professions. There is much repeated evidence that patients prefer chiropractic care over other forms of care for common musculoskeletal conditions. The public interest will be well served by this transformation. (12)

Reference:


1. Coulter, Ian; et al. A Comparative Study of Chiropractic and Medical Education. Alternative Therapies. September 1998. 4:5.
2. Meeker, W., Haldeman, S. Chiropractic: A Profession at the Crossroads of Mainstream and Alternative Medicine. Annals of Internal Medicine. 2002; 136: 216-227.
3. Giles, L., Reinhold, M. Chronic Spinal Pain: A Randomized Clinical Trial Comparing Medication, Acupuncture, and Spinal Manipulation. Spine. 2003. 28, 14:1490-1503.
4. Hoving, J.L., et. al. Manual Therapy, Physical Therapy, or Continued Care by a General Practitioner for Patients with Neck Pain. Annals of Internal Medicine. 2002; 136:713-722.
5. Coulter, I., et. al. Patients Using Chiropractors in North America – Who are They, and Why Are The in Chiropractic Care? Spine. 2002. 27;3:291-298.
6. Hertz-Miller, R.P., et. al. Comparing the Satisfaction of Low Back Pain Patients Randomized to Receive Medical or Chiropractic Care: Results from the UCLA Low-Back Pain Study. American Journal of Public Health. Oct. 2002. 92:10.
7. (*) Sawyer CE, Kassak K. Patient Satisfaction with Chiropractic Care. Journal of Manipulative and Physiological Therapeutics 1993; 16(1): 25-32.(*)
8. (*) Legorreta, A.P. "Comparative Analysis of Individuals With and Without Chiropractic Coverage." Archives of Internal Medicine, Oct. 11, 2004; vol. 164: pp 1985-1992. (*)
9. Ingeborg, B.C., et. al. Primary Care – Cost Effectiveness of Physiotherapy, Manual Therapy, and General Practitioner Care for Neck Pain: Economic Evaluation Alongside a Randomized Controlled Trial. British Medical Journal. April 26, 2003.
10. Mosley, C.D., et. al. Cost-Effectiveness of Chiropractic Care in a Managed Care Setting. American Journal of Managed Care. March 1996. Vol. 2.
11. Muse & Associates. Utilization, Cost, and Effects of Chiropractic Care on Medicare Program Costs. July 2001.
12. Manga, P. Economic Case for the Integration of Chiropractic Services Into the Health Care System. Journal of Manipulative and Physiological Therapeutics. Feb. 2002. 23(2).


(*) –Check with publications for details




# Iowa Foster and Adoptive Parents Association

*6864 Northeast 14th Street, Suite 5 • Ankeny, IA 50023-9525 • 1-800-277-8145 • 515-289-4567 • fax 515-289-2080 • e-mail IFAPA@ifapa.org*


**Council on Human Service Presentation**
July 12, 2006

The Iowa Foster and Adoptive Parent Association's mission is "To recruit and retain quality foster and adoptive families by promoting support, training and public awareness in conjunction with other public and private organizations. The Iowa Foster and Adoptive Parents Association (IFAPA) advocates for foster and adoptive children and families."

IFAPA appreciates the support and cooperation shown by the Department of Human Services towards the foster and adoptive parents of Iowa and the special needs children for whom they provide a home.

Some major changes and challenges in the Child Welfare System began last year and will continue this next year, especially in the foster and adoptive care system. *The Better Results for Children* has caused major issues for the subsidized adoptive families and their access to services. There are over 2,700 subsidized adoptive families. These families adopted feeling they had a safety net with the adoption subsidy and availability of services from DHS as their children progress through the stages of development. During this progression, unresolved issues surface and many of these children will need in-patient treatment to allow them to maintain in a family setting. With the Better Results for Children, these families have found they no longer meet the service criteria to access services through DHS. We are also aware that the Adoption Subsidy payments will only increase with the numbers of adoptions and the needs of these adoptive families to meet the children's needs. This is an issue of concern for the legislators, but is needed by the families so they can adopt these children.

*The Request for Proposal for Foster and Adoptive Recruitment and Retention* that will be published soon, will make changes in how the system recruits, retains, and supports the foster and adoptive parents. IFAPA has provided this service for the last 4 years with our involvement ending December 31, 2006. With this contract including licensing duties, IFAPA will not bid as we are not a licensed child placing agency. It is hoped that this new statewide contract will create better cooperation between the Department of Human Services, private agencies, our association, and current foster and adoptive parents.
There are two major issues of concern. The first is the difficulty to recruit qualified foster and adoptive families to care for the difficult level of care these children require. Families are struggling to meet the needs of these children. They need a lot of support and services to be able to provide for these children. There has not been sufficient funding for DHS staff to meet the Child Welfare League of America's ratio of cases to workers. (1 caseworker for every 17 active

cases.) In Iowa, the workers have case loads reaching 55-70 cases per worker, as reported to us by DHS field offices.

The second area of concern is in the area of retention of foster/adoptive parents. Greater and more consistent access to workers and the services that the children need is required. Adequate funding needs to be directed to workers and services to support the foster and adoptive parents, which in turn will lead to greater retention of foster/adoptive parents and less disrupted placements.

The proposed *Dual Licensing –Resource Family Model* will have a major affect on the families who are interested in providing foster and adoptive services. This model has been used in other states with success. It will require new rules, regulations, significant changes within the system, and training for workers, agencies and foster/adoptive parents. If this model is well designed in Iowa, it could be an effective means of providing services to foster and adoptive families.

The issue of *Medicaid – RTSS* services has recently included changes that impact both foster and adoptive parents. For adoptive parents, the changes may provide increased access to services for the subsidized adoptive parents so that their children receive the services they need. For foster parents, the concern is the limited amount of state dollars to provide these services. As we indicated earlier, families will need these services to continue to parent the children and meet their needs. If there is a reduction in services to the families and children, there will be a reduction in the number of families willing to become foster and adoptive parents.

The *IV-E Waiver for funding of subsidized guardianship* is seen as a positive option for many youth to have permanency in their living arrangement. We are looking forward to the implementation of this program.

The establishment of the *Mental Health Division* is another positive step in Iowa. This has been an area where leadership, creativity, planning, and coordination with all partners has been sorely lacking. IFAPA strongly supports a children's mental health system. Most of the children who come into foster care/adoptive care have mental health issues that require outpatient therapy for child and family, medications, and many times hospitalization, PMIC, or residential treatment.

The *Foster Parent Bill of Rights* is seen as a positive legislative action to show the support and respect of the families who provide care for Iowa's children. Even though the content in the Bill of Rights is manualized and required of staff, it allows the families to advocate and be included as part of the team.

As requested from the invitation, the fiscal needs for the services and support of the foster and adoptive parents is being shared in this document. We realize next year will continue to require extensive planning with limited resources. Our association is asking for the following:

- At a minimum, maintain the foster family and adoption subsidy maintenance rates at 65% of the USDA standard for raising a child in the Midwest. Ideally the rates should be increased to 70%. Iowa completed 993 adoptions for children in the child welfare system. This has substantially increased the adoption subsidy assistance payments, while allowing for a reduction in the costs for these children in foster care and also providing them with a permanent home.
- Medicaid to continue to fund the health, mental health and dental services needed by the foster/adoptive children. Families have been reporting that they have limited access to dentists who will accept Title XIX payment. We are now hearing that many doctors are also not accepting Title XIX patients.
- Development and payment of Post-Adoption Supports who have limited access to services through DHS.
- Develop a post-secondary educational tuition payment program for foster and adoptive children.
- Adequate numbers of DHS social workers to provide services and supports to a manageable size caseload, allow planning time, allow workers to be trained and have time to put in place best practices for foster and adoptive services, and time for Family Team Conferencing for each child in care.

The foster parents in the *2000 Iowa Foster Family Satisfaction Survey – Retention Analysis* and in additional limited services identified several areas of concern that would assist with retention of foster parents. Those include:

1. Being valued as a member of the team, by joint training opportunities, by regular contact with the workers (calls being returned), being listened to as they have the children 24/7, having their ideas and their recommendations considered in the planning for the children, and having accurate information on the children shared with the families.
2. Increased training in the area of specific behavior disorders and how to parent children with them, more information on how the system works and the teamwork approach, plus working with birth families.
3. Joint training of social workers and foster parents.

4. Better representation by the GAL's in meeting the mandated requirements.

These are other issues that are of major concern to the foster and adoptive parents:

- Working with the schools on the special needs of these children. Our publications and Building Bridges program are working with individual teachers and groups in the schools for a better understanding of the needs and issues with the foster and adoptive parents.

Within IFAPA's Personal Service Contract with DHS, the association has accomplished the following:

Publications

- Newest publication *"Navigating Iowa's Adoption Subsidy Program."*
- Publication of *The Child Abuse Assessment: A Guide for Foster Parents*
- Publication of *Confidentiality: A Guide for Foster Parents*
- Publication: *Foster Parents and the Courts*
- *Adoption Basics for Educators: How Adoption Impacts Children and How Educators Can Help*
- *Helping Your Adopted Child Succeed in School* – parents' booklet
- *Raising Relative's Children*
- *News and Views of Iowa* – bi-monthly newsletter for foster and adoptive parents

Trainings

- IFAPA offered 120 six-hour trainings to foster and adoptive parents from July 2005 – June 2006. (Teens Transitioning; Foster Parents and the Courts; Five Love Languages and Anger De-Escalation; Skin Care, Hair Care, and Cultural Heritage; Preventative Practices; Managing your Risks; Drug Awareness; Teaching Life Skills; Stress of Fostering on the Marriage; Working with Birth Families; Life Long Connections; Fostering Positive Relationships; Discipline in Foster Care and Adoption; Parenting from the Trenches; Advanced Topics in Transracial Foster and Adoptive Families; Attachment Issues in Foster Care & Adoption).
- IFAPA offered Mandatory Child Abuse Reporting to foster parents over the ICN to sites across the state in November 2005 and June 2006. This was also offered in March, 2006, at our conference.
- State Conference held March 3 - 5, 2006

- Support Groups for foster and adoptive parents were offered training opportunities of: Aging Out; Meth-Exposed Children; 10 DVD topics specific to parenting children in foster and adoptive families; 9 Preventative Practice Modules; Confidentiality; Public Policy Training; and Working with the Courts

Events

- Foster Care and Adoption Month Event at Adventureland in September.
- Adoption Saturday
- Spring Fling
- Legislative Breakfast in March 2006, where 70+ Legislators attended to learn about foster and adoptive care issues.

Supports

- Through the FAIR (Foster Allegation Information Resource) Program, foster parents who had an allegation of abuse were provided information of the assessment process, time frames, and appeal rights.
- The 18 Independent Contractors of Foster and Adoptive Parent Liaisons provided peer support to foster and adoptive parents in their assigned areas. They contact newly licensed foster homes to provide information and contact foster homes exiting foster care to determine the reasons for the families leaving.
- The IFAPA part-time Adoption Information Specialists have contacted the new adoptive subsidized families to provide support, information and referral, resources.
- Subsidized Adoption Respite – IFAPA completes mailings to adoptive families on the respite program and pays providers for up to 5 days of respite.
- "Building Bridges" – Training of trainers to go into the schools systems and provide training for staff on the dynamics of foster and adoptive care.

We continue to serve on committees for Dual Licensing, Transitioning Youth from foster care to independence, Iowa Youth Development, Supreme Court Improvement Project, Iowa Plan Advisory Committee, Mental Health Forum, Merit Roundtable for Consumers, Families, and Advocates, and Healthy and Safe Families.

As you can see, the Iowa Foster and Adoptive Parents Association collaborates and is in a partnership with the Iowa Department of Human Services and the other child-welfare agencies and associations to meet the needs of the foster and adoptive parents who are providing a home to Iowa's special needs children.

**Iowa Foster and Adoptive Parents Association**

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# Orchard Place

Public Hearing Testimony
Brock Wolff
Chief Executive Officer, Orchard Place

**Chief Executive Officer**
Brock Wolff

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Robert Thomson
Sumner Worth

I want to thank the Council on Human Services and Director Concannon for the opportunity to provide input into budget deliberations for State Fiscal Year 2008. The transition to a new Governor and new General Assembly the Department and the Council will be facing in the coming months make this year's budget process especially challenging. I want to thank you for your hard work on behalf of Iowa's most vulnerable citizens.

In your letter inviting testimony you asked for information regarding current areas of collaboration and ways in which that collaboration could be improved. Orchard Place has a budget of nearly $16 million and we rely on state and federal revenue for approximately 2/3 of our budget. I appreciate the opportunity to share some of the non-governmental sources our organization relies upon in our service to children struggling with mental health and juvenile justice issues.

Orchard Place works closely with the United Way for a significant amount of funding for a number of programs; namely Project Turnaround which provides structure and support to children who have been suspended from school, placement of mental health professionals in schools in high risk communities and a therapeutic child care….

You may be aware that Orchard Place operates a 103 bed psychiatric medical institution for children (PMIC). Education for children at the residential campus and through our Phoenix day treatment program is provided by the Des Moines public schools. However, the schools do not fund summer programming. Orchard Place submitted a grant application to the Anonymous Funder for summer school on the residential campus and Phoenix program, which has been approved for two years. As you all know, school is the work of childhood and many of the young people in our care through these two programs have had their education interrupted due to their mental illness and associated behaviors. We are pleased to be able to provide the educational structure and the opportunity to allow these children to catch up educationally, providing them with a better transition into their home schools when their time with us has concluded.

Each year Orchard Place hosts an adult Spelling Bee which raises over $120,000 to pay for recreational activities for children in our programs. These activities not typically covered by state/federal reimbursement we rely upon for treatment activities. Additionally, we hold a school supply drive each fall and collect Christmas presents in the winter for families associated with all of our programs who may not be able to afford to purchase supplies and gifts for their children. Businesses like Bankers Trust, Kum and Go, the Iowa Clinic, Hy-Vee, Iowa Realty and Sticks as well as a large number of individual business leaders contribute to these and other programs at Orchard Place, making it possible to offer a wider array of services and activities for the children and families we serve.

A United Way Agency

*Accredited by the Joint Commission on Accreditation of Healthcare Organizations*

808 5th Avenue, Des Moines, Iowa 50309-1315
Phone: 515/244-2267 Fax: 515/246-3599

*Developing Strong Futures*

Legislatively this year we partnered with Tanager Place to bring forward a foster care transition proposal for children leaving care at PMIC who are not attached to a family. We are looking forward to working with you as we move toward implementation of that project and other initiatives that address the system of care needs for children with mental health issues. Orchard Place has also aggressively pursued funding for insurance reimbursement for care at our PMIC. Historically PMIC care has largely been covered through the Medicaid program.

We will continue to look for ways to partner with DHS and the business community to better serve vulnerable Iowans. We appreciate the Department's willingness to work with us on areas of mutual concern.

I did want to touch briefly on a budget area as you consider your priorities for FY 2008. State funding associated with juvenile justice has gone down during tight budget times of the past several years. In an effort to leverage federal resources, the RTSS program has funded an increasing amount of the work done in juvenile justice through our PACE program. Statewide the state dollars associated with juvenile justice funding have dropped by nearly 40% in the past five years. Federal dollars have offset much of the decline, but those dollars come with strings attached that can make serving children in the juvenile justice system more difficult.

We are concern that pending RTSS rule changes, driven by the federal government, will leave a gap in services for children without a mental health diagnosis who have juvenile justice issues. We would like to encourage the Council and the Director to consider a request for additional state monies in juvenile justice during this time of transition.

STATEMENT TO THE IOWA COUNCIL ON HUMAN SERVICES
Fiscal Year 2008 Budget Recommendations and Legislative Package

July 12, 2006

1. **Improve recognition of Advanced Registered Nurse Practitioners to sign documents of the Department of Human Services.**
   A member has identified that she has been unable to sign the following Department of Human Services documents, even though the Department has provided for reimbursement of services provided by an ARNP to Medicaid clients in the following areas:
   a. Adult Rehabilitation Option
   b. Targeted Case Management (Iowa Code 234, IAC 441-83)
   c. State Waiver programs
   d. Psychiatric rehab practitioner definition does not include an ARNP (Iowa Code 225C; IAC 441-24.1 and 441.24.4 (9).

2. **Evaluate time devoted to certify and recertify changes in dosages for psych-mental health clients.**

This requirement adds to the cost of doing business for private practitioners and is a deterrent to provision of services to Medicaid clients. We encourage an analysis of the time spent and the administrative costs of such requirements.

3. **Accurate Identification and Analysis of Medicaid Claims Data submitted by ARNPs**
It has been three years since our request of Commissioner Concannon for programming the computer software to collect claims data submitted by advanced registered nurse practitioners (ARNPs) pursuant to implementation of House File 479 passed in 2003. **We believe it would be innovative for the Iowa Medicaid program to implement the data collection technology to follow the episode of care rather than just paying units of services.**

With all the changes of the Medicaid program in structuring of the Iowa Medicaid Enterprise into one location, we hope that our request is being taken into consideration. Until such data is compiled in such a manner that it can be analyzed and compared, it is difficult to demonstrate that cost savings can occur with the use of advanced registered nurse practitioners.

As we have noted in past years, a 1992 study in the *Yale Journal of Medicine* looked at two decades of research and evidence was that advanced registered nurse practitioners (ARNPs) provide care of comparable quality and at a lower cost than physicians since ARNPs prescribe fewer drugs, use less expensive tests and select lower cost treatments than physicians do. In the findings, it was determined that patients of nurse practitioners experienced fewer hospitalizations than patients of physicians, and the average cost per visit for patients of nurse practitioners was $12.36 compared to $20.11 for physician patients. (These results are impacted by NP and physician salary differentials.) NP ordered more laboratory tests than physicians; although the laboratory cost per NP patient was less than for the physician patient (likely less costly tests are ordered with greater frequency).

The Office of Technology Assessment (OTA) Study (1979) published in MEDICAL CARE, February 1982 noted that "...the episode is a "more appropriate unit for measuring differences in effectiveness of care, since the outcome of the care process may be causally related not only to a service received at a single visit, but to any services received over the course of the episode." Measured this way, costs-per-episode were found to be at least 20% less when nurse practitioners provided the initial care than when physicians did.

The Iowa Nurses Association lobbied this issue 2001 to 2003 by stating that that the Association believed that utilizing ARNPs could save the Medicaid program dollars, both from the already established reduction in payment as compared to physicians, for their monitoring an "episode of care" and for deferring or delaying hospitalizations and nursing home stays. We would very much like to see with your Medicaid data, a replication of the professional literature that demonstrated that patients of nurse practitioners experienced fewer hospitalizations than patients of physicians and the average cost per visit was lower adjusting for salary differentials.

There would be the added benefit of ensuring that ARNPs are billing under their own number and being reimbursed at the ARNP rate for Medicaid services. We continue to have concerns that many physician offices continue to bill ARNP services under the physician billing rate for Medicaid which under represents the care and services ARNPs are providing to the Medicaid population already.

**4. Placement for aggressive and abusive individuals.**
Admitting aggressive and abusive patients to long term care facilities is not appropriate. Long term care regulations will not allow for certain medications to be used under certain conditions that in an alternate setting would be able to be used. The association membership believes there has been an increase in the use of expensive emergency services and an increased number of acute hospitalizations. The lack of long-term housing and services cause unnecessary suffering and stress on clients, families and an increase in direct and indirect costs for society.

**We recommend consideration of community based congregate housing with on-site professional services for those who are severely ill and continued policy work to develop a cost-effective alternative solution.**

**5. Dental care access**
Dental health is an important aspect of total physical health. The payment levels are so low that it is de facto non-provision of dental care.

It is our understanding that for adults, the only service Medicaid will pay for is to pull the tooth, rather than to restore health to the tooth. This is extremely unfortunate for the patient and the dentist to be limited to this option. We also understand that while there are 1000 dentists that continue to see children who are Medicaid recipients, there are challenges to accommodate the increased volume of new patients. Preventive care is important to preserving total physical health.

**We strongly encourage improvement of both payment and service availability since these services are a preventive health measure.**

chsc
Child Health
Specialty Clinics
Serving diverse needs

Iowa's Title V Program for Children with Special Health Care Needs

CHSC – Iowa City
100 Hawkins Drive
Iowa City, IA 52242
Phone: (319) 356-1117
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CHSC Director
Jeffrey G. Lobas, M.D.

Regional Centers

Burlington

Carroll

Council Bluffs

Creston

Davenport

Des Moines

Fort Dodge

Iowa City

Mason City

Oelwein

Ottumwa

Sioux City

Spencer

July 11, 2006

Kevin W Concannon, Director
Ruth L Mosher, Chair
Council on Human Services
State of Iowa
1305 E Walnut St
Des Moines IA 50319

Dear Mr. Concannon, Ms. Mosher, and Members of the Council for Human Services:

As a pediatrician I have dedicated my life and career to improving the health and well-being of children. As a physician that has cared for patients for some 25 years I have significant concerns about our children and I would like to share some of this perspective. The Department of Human Services has an enormous potential and responsibility to help our children and that is why I am addressing you today.

I am the Director of Child Health Specialty Clinics (CHSC). CHSC is the state of Iowa's program for Children with Special Health Care Needs (CSHCN) and as the Title V program for the state is charged with assuring the health of these children. These are children with chronic behavioral and physical disorders and disabilities. With 12 sites we are well positioned in the state to be a platform for developing a statewide system for children. On a regular basis we conduct formal needs assessments and I would like to share with you some of the trends which we have discovered.

It is estimated that 15% of the children in Iowa have special health care needs. This is consistent with national estimates. It is of note that studies have shown that these 15% of children likely make up 80% of the costs in the pediatric arena. This is clearly a high leverage group.

*Medical Home and Primary Care*

A medical home provides care which is comprehensive and coordinated. It implies planned care, communication, and connection to community resources. It is an essential component of our primary care system for anyone with chronic disease or disability. It is estimated that only 57% of CSHCN are enrolled in a medical home.

**Pediatric Specialty Care**

Although 60% of CSHCN need a specialist, 25% of them have significant difficulty in obtaining and accessing that care.

**Pediatric Behavioral Health Services**

12% of CSHCN who need behavioral health services were not able to access them.

These are just a few of the concerning trends which we have identified. CHSC is a safety net and we feel the impact of a system that is strained and struggling. We have developed a system of care for CSHCN working with primary care physicians and the behavioral health system. We provide this care through our regional centers, our Birth to Five clinics and our Integrated Evaluation and Planning Clinics. Our waiting lists for clinics are steadily increasing in spite of our efforts to improve efficiency. The access problems that we have noted create a multitude of problems – longer waiting times to be seen, increased hospitalizations, and ultimately an increase in the use of emergency rooms and the like.

**CHSC Response**

We have addressed these issues as best we can given the resources available. We have partnered with Magellan Behavioral Health to provide psychiatric services via telehealth network. We provide a standardized approach to care coordination for these complex and difficult children. We have introduced innovative approaches to our clinic systems.

***Iowa Medical Home Initiative***

In response we have developed a program called the Iowa Medical Home Initiative where we are working with primary care practices to provide them the tools to improve their systems of care for adults and children with chronic disease. We are completing our first learning collaborative with 35 practices throughout the state to improve care.

***Behavioral Health Program***

Working with Magellan Behavioral Health we have pioneered telepsychiatry and using our clinic system have provided care for some 3000 of the most difficult and complex cases each year. We provided psychiatric services to over 1500 children via the telehealth network. We have developed guidelines, standardized approaches to triage, evaluation, care coordination, and treatment.

The results have been dramatic. Using standardized instruments we know the children we care for improve clinically. Over 100 of the children that we have cared for over the last two years have been discharged from psychiatric hospitals or residential treatment centers. Historically 25-30% of these children are rehospitalized within a very small window of time. In our system all of these children have remained in the community and are receiving community-based services.

*Chronic Disease and Care Coordination*

We have reconfigured our approach within our clinic system. Through our clinic system we have increased the numbers of patients seen by 25% and served almost 5500 children last year in clinic and provided over 32,000 care coordination visits.

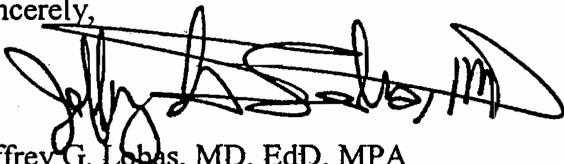
*CHSC Needs Your Help*

CHSC is an invaluable resource with an enormous potential that is providing the best of care with outstanding results. By preventing hospitalizations we save the state hundreds of thousands of dollars. Although we have been innovative and successful we are in fact a safety net that is being stretched beyond its limits. Our funding now allows us to be open only 4 days a week at most of our centers. If we do not find a way to support this system the Iowa Medical Initiative will not be sustained, centers will close, services and innovative approaches will no longer be available.

The need seems insurmountable but there is reason to hope as we have developed some successful innovative approaches. I need the Department of Human Services as a committed partner working with me collaboratively to develop innovative solutions for these children at risk. The issues are immense and we can no longer look for the answers in the traditional practice of medicine. We need to develop innovative approaches improving systems using the principles and strategies of planned care. This means an investment in projects like the Iowa Medical Home Initiative. It means investments in telepsychiatry, and care coordination. It means funding research in developing evidence-based practices and their effectiveness. What I am asking you to consider today is an investment in this system of care for children with special health care needs.

I would ask this Council, Mr. Concannon, and the Department of Human Services to begin this dialogue, this planning, and this work of creation in developing innovative approaches to care for this most vulnerable population.

Sincerely,



Jeffrey G. Lobas, MD, EdD, MPA
Professor and Director
Child Health Specialty Clinics
Medical Director
Division of Health Promotion and Chronic Disease Prevention

JGL:ne

Attachment: CHSC Data Highlights

**Child Health Specialty Clinics**

**Data Highlights for Report to the Human Services Council**

**July 11, 2006**

## Access to a Medical Home

The *National Survey of Children with Special Health Care Needs* (2001) estimated that only 57% of Iowa children and youth with special health care needs (CYSHCN) are enrolled in a medical home. In making the estimate, the survey asked families about the following major attributes of a medical home:

- Professional care coordination is available when needed
- Child's doctors communicated well with each other
- Child's doctors communicated well with other programs
- No problems obtaining referrals when needed

The national goal specified by the federal Maternal and Child Health Bureau is that by 2010, 100% of all CYSHCN should be enrolled in a medical home, so Iowa has much work to do.

## Need for and Access to Specialty Care

The *Iowa Child and Family Household Health Survey* (2000) asked families of CYSHCN and families without CYSHCN about need for specialty care. Also, if specialty care was needed, the survey asked how much of a problem in the previous year, if any, it was to get needed specialty care. Here are the results:

**Table 1**

| Child needed care from specialist? | Families of CYSHCN | Families of Children without a Special Need |
|---|---|---|
| Yes | 60% | 23% |
| No | 40% | 77% |

**Table 2**

| If specialist care needed, was there a problem getting specialty care? | Families of CYSHCN | Families of Children without a Special Need |
|---|---|---|
| Yes, there was a problem | 23% | 10% |
| No, there wasn't a problem | 77% | 90% |

Table 1 demonstrates that families with CYSHCN report greater need for specialty care than families without CYSHCN. Table 2 further shows that of families who needed specialty care for their children, those with CYSHCN report over twice the problem obtaining needed specialty care than reported by families without CYSHCN. These data together suggest that CYSHCN have increased need for specialty care and a greater problem obtaining that specialty care.

## Need for and Access to Behavioral Health Services

The *Iowa Child and Family Household Health Survey* (2000) also asked families of CYSHCN and families without CYSHCN specifically about need for care for their children's behavioral or emotional problems. If behavioral care was needed, the survey also asked if there were any times during the previous year when the needed care couldn't be obtained.

**Table 3**

| Child needed care for behavioral or emotional problems? | Families of CYSHCN | Families of Children without a Special Need |
|---|---|---|
| Yes | 30% | 4% |
| No | 70% | 96% |

**Table 4**

| If behavioral care needed, was there any time you could not get it? | Families of CYSHCN | Families of Children without a Special Need |
|---|---|---|
| Yes, couldn't get needed care at some time | 12% | 7% |
| No, could always get needed care | 88% | 93% |

Table 3 demonstrates one of the most dramatic differences in this survey between families of CYSHCN and families that don't have a child with special needs. Families with CYSHCN report a more than seven-fold greater need for behavioral or emotional care for their children than reported by families without CYSHCN. Table 4 further shows that of families who needed behavioral care for their children, those with CYSHCN report nearly twice the problem obtaining needed behavioral care than reported by those without CYSHCN.

## For Further Information

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**The Iowa Council on Human Services**
**Testimony submitted by FutureNet**
**The Iowa Network for Adolescent Pregnancy Prevention, Parenting, and Sexual Health**

## Community Adolescent Pregnancy Prevention

Although the United States has the highest rate of teen pregnancy in the industrialized world, the teen pregnancy rate in the United States declined markedly in the decade between 1990 and 2000. In Iowa, the teen pregnancy rate also declined during these years.

Iowa's Community Adolescent Pregnancy Prevention programs (CAPP), funded by the Department of Human Services, have made an important impact on preventing teen pregnancy and improving the sexual health of teens in our state. Since 1988, CAPP grantees have worked collaboratively in their communities to design and deliver teen pregnancy prevention programs and services. In 2004-2005, over 50,800 teens were served in 54 counties. Further, sixteen years of program evaluation by the University of Iowa consistently show evidence of a decline in teen pregnancy rates in those counties served by CAPP programs. Still, nearly half of Iowa counties continue to go un-served by the CAPP grant program. In these counties, teens may receive little if any medically accurate information to help them to make informed, healthy decisions that prevent pregnancy. Clearly, the State of Iowa can still improve its commitment to adolescent pregnancy prevention and thus further reduce the social, educational, and economic impact of teen pregnancy.

Across the United States, the growing emphasis on medically accurate, science-based prevention practices has transformed our expectations for prevention strategies. We now know that the greatest return on our investment into adolescent pregnancy prevention comes when teens participate in programs that have a proven effective impact based on accepted standards of evaluation. By adopting science-based practices in all adolescent pregnancy prevention efforts, the State of Iowa can further reduce its teen pregnancy rate and improve related sexual health outcomes for its teens.

With this in mind, FutureNet requests your support to allow the Community Adolescent Pregnancy Prevention Grant program to have a greater impact in reducing and eventually eliminating teen pregnancy in our state.

1. **Support an increase in funding to the Community Adolescent Pregnancy Prevention Grant program so that proven effective prevention and intervention programs can serve teens in all 99 Iowa counties.**
2. **Participate in a consortium of key players in our state's field of adolescent sexual health, convened by FutureNet, who will establish reasonable basic standards of science-based practices that can be accomplished by all providers of sexual health education in Iowa, including CAPP grantees and Iowa schools.**
3. **Support legislation requiring Iowa's schools to provide youth with age appropriate, medically accurate, science-based instruction related to health, human growth and development and family life education.**

*For further information, contact Rhonda Chittenden, Executive Director, FutureNet*
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*rchittenden@iowafuturenet.org*

**Presentation to the**
## Iowa Human Services Council
**By**
**The Iowa Association of Community Providers**

Ladies and gentlemen of the Iowa Human Service council: I am here today representing the Iowa Association of Community Providers (IACP). IACP is an association that represents providers for persons with disabilities and mental illness. Specifically the mission of the association is to promote quality services in Iowa's communities by strengthening association members.

The association is committed to promoting healthy and secure communities in which people have access to services and supports that enable them to be a part of the community of their choice. Many of the individuals served by IACP members are eligible for Medicaid and subsequently benefit from the provisions of the Iowa Medicaid Plan. It is within this context that I come before you today.

IACP members seek to be the best possible stewards of the public resources dedicated to individuals supported by the Iowa Medicaid Plan. The following are several suggestions to enhance the delivery of the service system:

1. This first comment is not a budget issue, rather relates to improved effectiveness and efficiency. The members of IACP recommend a common approach to regulatory oversight be pursued, that is reflective of the intent of the legislation and leadership within the Department. Currently our members often receive conflicting interpretation from within the Department based upon the individual with whom they have conversation. Clarity and consistent application of rules must be demonstrated. IACP strongly urges IACP members and CPC's be key participants in the development of final rules for the application of legislation; including eligibility, funding and time limits for each service.

2. Rate setting for ICF/MR providers based upon 80% cap does not address the rising cost of doing business (increased wages for staff to meet cost of living, double digit insurance premiums, inflationary increases of supplies and equipment). Providers have had rates reduced with this cap while costs that are not within their direct control continue to increase. Staff of these services are paid wages that are at or below the poverty level. ICF/MR provides one component necessary in the continuum of care for individuals.

   The acuity of individuals served in ICF/MR settings requires focus of care 24 hours a day/seven days a week. This need does not align with the effort to move to a case-mix reimbursement based upon a menu of services as found in HCBS.

3. HCBS allows providers a 2 ½% "profit margin". However, the rate is set retrospectively and does not take into considerations increased costs throughout the year, such as those mentioned above (cost of living, staff raises, insurance, etc.). Further, if a provider does in fact see a small profit, the rate for the next fiscal year is cut by that amount, essentially penalizing the provider for the allowed profit. The claims payment system lags behind several months, forcing providers into difficulties with cash flow, at times being forced to take loans to continue daily operations. Payment of net 30 is requested to improve cash flow rather than continuing the practice of "lending" to the state. Unlike the corporate business world, throughout this period of "floating loans," our members do not suspend service, rather continue to provide services to individuals with disabilities and mental illness.

4. The BI Waiver funding must be increased by $1000 from $2650 to $3650, and allow for timely exceptions to policy for person's who require 24 hour residential service and support through a day program. Currently $2650 includes cost for case management services (~$200), day program services (~$1000) leaves $1400, less than $45/day for residential training and supervision, less if cognitive skills training and/or social skills training are also necessary.

5. The 3% increase agreed upon by CMS to go into effect July 1, 2006 and retro to July 1, 2005 has yet to be implemented, and providers are receiving conflicting information regarding this increase, although it was finalized between DHS and CMS early 2006. IACP requests this increase be effective immediately with process in place for retroactive payment to July, 2005.

Iowa can no longer afford a system that lacks consistency and fails to appreciate the business of serving and supporting individuals with disabilities and special needs. As providers, the members of IACP have long known the capacity of individuals the state and nation witnessed at the First National Special Olympics this past week. We must refine and improve the system to fund and equip these individuals for a life that is productive and fulfilling in all areas of their life.

Thank you for this opportunity to provide comment to the Iowa Human Services Council to assist in the continued improvement of system care for individuals with disabilities and mental illness.

COUNCIL ON HUMAN SERVICES

Ruth L. Mosher, Chair Kevin Concannon, Director

The eight Chief Juvenile Court Officers appreciate this opportunity to review with the Council the status of the graduated sanction programs and Court Ordered Services. We are grateful for the Council's and Director's support for the 4% increase in funding for graduated sanctions and the 5% increase for Court Ordered Services for FY07. These increases were vitally needed due to increased cost in services and federal reductions in funding for delinquent youth, which hampered early prevention programs. Federal monies for prevention grants were zeroed out and other federal delinquency dollars were reduced from $6,000,000 (1998) to $1,642,000 (2005).

GRADUATED SANCTIONS

Funding for the four graduated sanction programs experienced reductions of 35.4% from 2001 to 2005 (see attachment #1). Thus, the number of juveniles who could be provided with services was negatively impacted.

However, of the youth served in the four programs, data from CJJP in a March 2006 report highlights positive outcomes for those youth served (see attachment #2). The following statistics are for each of the four graduated sanction programs from 2001 to 2005. Shown is a yearly average for that five year time period.

A. Life Skills - 1336
B. School Based Supervision - 52,583
C. Tracking, Monitoring & Outreach - 14,332
D. Supervised Community Treatment - 2,284

In summary, the graduated sanction programs, because of the reduced funds and increased provider costs, have not been able to maximize their potential in developing programs in rural areas. Nor were they able to create outreach programs through the tracking funding. The outreach component could be mentoring, gender-specific programs, recreational or parental involvement with the assistance of funding from other sources.

We would recommend to the Council that it consider a 10%increase in the graduated sanction programs. We foresee the purpose of these programs to be the development of more proactive, rather than reactive, programs. The increased funding would also make it possible to develop after-care programs for juveniles returning from residential or institutional placements. The objective of these programs would be to develop solid community-based programs and prevent the costly out of home placements for Iowa's children.

COURT ORDERED SERVICES

In attachment #1, you can see that this fund has had a 13% reduction over the years from 2001 to 2005. At the same time, the cost for the following components has increased at a percentage greater than that.

- *Transportation*: Costs have increased from .29/mile to the federal limit of over .40/mile. This cost constitutes the highest percentage of most Districts' Court Ordered Services budget.

- *Drug Testing/Evaluations*: Costs vary from $30.00 to over $300.00 for testing, depending on what type of test is requested and the distance a provider must travel. Evaluations (psychological, psychiatric and substance abuse) range from $600.00 to $1,500.00, depending on what is ordered.

- *HF619*: With the sexual offender law, we may have to use Court Ordered Services funds to provide electronic monitoring for juveniles as the Legislature did not appropriate adequate funds for both adult and juvenile offenders. The estimate for this potential expenditure would be between $58,400.00 and $233,600.00, depending on what type of device is used and how long that device is used.

The Juvenile Court, in its place and purpose in the Juvenile Justice System, has had to rely on programs after a child's entry into the system, thereby becoming more of a reactive force that depends on programs and services to rehabilitate juveniles. The introduction of graduated sanction programs has made it possible for Juvenile Court Services to formulate proactive programs. We believe in early intervention and as we see younger children (elementary age) entering the system, we have experimented with programs that involve the family in intensive short term treatment. Functional Family Treatment, as this program is called, involves one worker with multiple families for three to four months. The objective is to prevent out of home placement. The cost, at the outset, for training purposes is high, but cost effective in the long-run. This program is presently taking place in the Sixth Judicial District. Ms. Bennett will briefly discuss the program currently being used in the Sixth District.

Multi-Systemic Therapy has been experimented with in two counties in the Eighth Judicial District. MST has been praised as one of the top programs for providing community-based programs for juveniles that were considered serious and chronic offenders. Funding, at the outset, was provided by Department of Human Services but unfortunately, the program was high in cost and no other funds could be found to maintain it. Research data has indicated that when MST

could be sustained, it was successful in working with the most serious type of juvenile offender.

These types of programs in particular are needed if we wish to contain the increasing number of delinquent juveniles being placed out of the home. The intimidating factor is the fiscal consideration in implementing such programs. The cost savings of early prevention programs to prevent placement out of the home is worth the effort it takes to look more closely at such programs.

On a positive note, data now available on recidivism of delinquents in Iowa indicates that, state-wide, 67% of our juveniles do not re-offend. We can do better and we will, if we have the tools and resources to work with our delinquent youth and their families. Iowa is one of the leaders in providing resources and programs for the Child Welfare and Juvenile Justice System. This is a frequent statement heard from those who have attended national conferences.

Those of us in the field know we have a better system than some of our neighboring states. We need to continue building on that and never be content with what we are presently doing. As the Council has stated in its letter of invitation, let us look for creative ways to meet the needs of our Iowa youth.

Reduction in Funding from 2001 to 2005

| Year | Tracking and Monitoring | Life Skills | Supervised Community Treatment | School-Based Supervision | Total Delinquency Funding | Court Ordered Care and Treatment |
|---|---|---|---|---|---|---|
| 2001 | $ 4,151,673 | $ 537,500 | $ 5,494,197 | $ 3,528,000 | $ 13,711,370 | $ 3,290,000 |
| 2005 | $ 3,063,905 | $ 396,673 | $ 3,775,466 | $ 1,615,597 | $ 8,851,641 | $ 2,859,851 |
| Reduction | $ 1,087,768 | $ 140,827 | $ 1,718,731 | $ 1,912,403 | $ 4,859,729 | $ 430,149 |
| Percent | 26.2% | 26.2% | 31.3% | 54.2% | 35.4% | 13.1% |

ATTACHMENT #1

**Section II. Highlights**

- Almost 75% of the cases discharged from JCS programs were discharged successfully;
- Less than 30% of the cases successfully discharged from a JCS program had a subsequent complaint / out-of-home placement;
- Cases that were successfully discharged from a JCS program service (19%) had a smaller percentage of subsequent complaints/out-of-home placements than cases that were unsuccessfully discharged (34%);
- The average number of subsequent complaints/out-of-home placements for cases that were successfully discharged (2.38) was lower than the average number of subsequent complaints/out-of-home placements for the cases that were unsuccessfully discharged (3.24);
- The number of cases successfully discharged (1,952) was almost three times as great as the number of cases unsuccessfully discharged (663); however, both groups accounts for similar numbers of subsequent complaints/out-of-home placements – 1,331 for youth successfully discharged and 1,327 for youth unsuccessfully discharged;
- Cases that were successfully discharged only accounted for 38% of the out-of-home placements while the unsuccessfully discharged cases accounted for 62% of the out-of-home placements;
- The average age of the youth involved with the JCS program services is 15.8 years old;
- The average number of days of JCS program services is 149.6 days for Community-Based Day Treatment, 30.6 days for Life Skills and 110.9 day for Tracking & Monitoring.

ATTACHMENT #2

IOWA STATEWIDE RECIDIVISM
Juvenile Court Services Cases Initiated in 2003
Subsequent Complaints in 2003 - 2005

| | Juveniles New to the Systen Who Were Referred in 2003 | Juveniles with 0 Subsequent Complaints | Juveniles with 1 Subsequent Complaint | Juveniles with 2 Subsequent Complaints | Juveniles with 3/More Subsequent Complaints | Percentage of Chronic Reoffenders (3/More Sub complaints) | Percentage of All Reoffenders | Percentage of Those who Did NOT Reoffend |
|---|---|---|---|---|---|---|---|---|
| DISTRICT 1 | 1,814 | 1,219 | 311 | 132 | 150 | 8% | 33% | 67% |
| DISTRICT 2 | 2,275 | 1,601 | 384 | 148 | 142 | 6% | 30% | 70% |
| DISTRICT 3 | 1,756 | 1,081 | 303 | 149 | 153 | 9% | 34% | 62% |
| DISTRICT 4 | 1,138 | 762 | 192 | 92 | 90 | 8% | 33% | 67% |
| POLK COUNTY | 1,897 | 1,207 | 373 | 155 | 159 | 8% | 36% | 64% |
| DISTRICT 6 | 1,724 | 1,183 | 298 | 126 | 117 | 7% | 31% | 69% |
| DISTRICT 7 | 1,673 | 1,142 | 246 | 104 | 175 | 10% | 31% | 68% |
| DISTRICT 8 | 1,383 | 878 | 272 | 114 | 108 | 8% | 36% | 63% |
| **TOTALS** | **13,660** | **9,073** | **2,379** | **1,020** | **1,094** | **8%** | **33%** | **67%** |

*Provides positive family strengthening resources to youth at risk*

# FFT Functional Family Therapy

::Home
::What is FFT?
Clinical Model
::CSS- Clinical Service System
::Contact

## Welcome to Functional Family Therapy Online

FFT is an empirically grounded, well-documented and highly successful family intervention for at-risk and juvenile justice involved youth. Its high rates of effectiveness have been recognized by:

- The Office of Juvenile Justice and Delinquency Prevention
- The Center for Substance Abuse Prevention
- The Center for Disease Control and Prevention
- The U.S. Surgeon General's Report on Youth Violence.

FFT is one of the nationally recognized Blueprints programs. It is also one of the only interventions named by the US Surgeon Genera as a model program for seriously delinquent youths.

**Who benefits from FFT?**

Youth ages 10-18, and their families, whose problems range from acting out to conduct disorder to alcohol/substance abuse. Often these families tend to have limited resources, histories of failure, a range of diagnoses and exposure to multiple systems. FFT can be provided in a variety of contexts, including schools, child welfare, probation, parole/aftercare, mental health, and as an alternative to incarceration or out-of-home placement.

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*Provides positive family strengthening resources to youth at risk*

Functional Family Therapy

Home
What is FFT?
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Contact

## What is FFT?

- Empirically grounded, well-documented and highly successful family intervention program for dysfunctional youth
- Applied to a wide range of at-risk youth aged 11-18 and their families, including youth with problems such as conduct disorder, violent acting-out, and substance abuse
- Intervention ranges from, on average, 8 to 12 one-hour sessions up to 30 sessions of direct service for more difficult situations
- Conducted both in clinic settings as an outpatient therapy and as a home-based model
- A treatment technique that is appealing because of its clear identification of specific phases, which organize intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption
- Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success

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# Aggression Replacement Training: A Comprehensive, Research-based Intervention for Aggressive, Impulsive and Delinquent Youth

*(Arnold Goldstein Ph.D., Barry Glick Ph.D., and John Gibbs Ph.D.)*

Overview and Training Provided by:
Darin Carver, M.S.W.
(801) 644-1022
darincmet@juno.com

**Introduction to ART:**

Aggression Replacement Training (ART) was originally introduced in 1987 by Dr. Arnold Goldstein and colleagues. It was hailed as a multi-channel intervention aimed at the complex emotional, behavioral and moral developmental delays common to behaviorally disruptive and delinquent youth. Since its introduction, ART has accrued a strong research-base and has been *identified by the U.S. Department of Justice as a "model program."* ART views delinquent youth as skill-deficient and in need of new prosocial skills to improve internal control rather than relying solely on external force and consequences. ART is a cognitive-behavioral, teaching/coaching model and lends itself well to use by probation and correction staff members. It is composed of three distinct methods of intervention:

- Anger Control Training – without the capacity to control strong emotions young people find themselves unable to make clear decisions and utilize basic "people" skills in everyday situations. Through a 10-week intervention, juveniles learn powerful methods for decreasing physiological arousal and the defeating cognitions that sustain aggressive and impulsive behavior.

- Skillstreaming – a structured skill learning process that in and of itself has been demonstrated to increase the prosocial responses of its participants. Through a series of behavioral procedures and steps, juveniles acquire new methods for problem solving, dealing with peer pressure and managing previously difficult social situations.

- Moral Reasoning Training – enhancing the moral reasoning level of delinquent youth is a daunting task. Simply pointing out thinking errors or giving moral rationale from an adult point of view is not very effective. Young people need to develop their own reasons for making good decisions. This model requires the facilitator to skillfully build mature moral reasoning with delinquent juveniles by using a series of carefully planned dilemmas and moral questions. Not only will this method work, but young people like it.

**Statement of Tonya Diehn**

**before the**

**Iowa Department of Human Services**

**Public Hearing on: SFY 2008 budget process**

**July 12, 2006**

Mr. Chairman, I am Tonya Diehn, the chairwoman of the State Program Services & Public Affairs Committee for the Iowa Chapter of the March of Dimes Birth Defects Foundation. I am pleased to submit testimony for the record as you and your colleagues from the Council on Human Services move through the SFY 2008 budget process.

The mission of the March of Dimes is to improve the health of children by preventing birth defects, premature birth and infant mortality. As you might expect, providing adequate health care coverage to women of childbearing age and infants and children is one of our primary advocacy priorities and is especially pertinent to the advancement of our mission.

As you all are aware, Iowa is a fairly large, mostly rural state. Based on the latest information from the Iowa Department of Public Health, 63 of the state's 99 counties have been designated by the Governor's office as health professional shortage areas. When rural geography is combined with shortage areas, access to good quality health care can become an issue.

March of Dimes has long been interested in finding ways to reach out to our state's widely dispersed population of women and children. The vision has been to provide much needed maternal health information to families that do not live in urban areas with readily accessible health care professionals and services. To achieve this mission, the March of Dimes, Zeta Phi Beta Sorority and many local health organizations have worked over fifteen years to expand the Stork's Nest program into a strong network of diverse yet cohesive sites.

The Stork's Nest program is a prenatal incentive program for high risk, low income pregnant women. Women earn points by fostering a healthy lifestyle during and up to the child's first birthday. Those points are then redeemed at the Nest store where there are new and like new maternal and layette items, such as diapers, clothes, strollers and cribs. The Iowa Stork's Nest program is now offered at approximately 40 sites (see map enclosed). Each location is different. While all sites offer the basic program concepts of education classes, referrals and incentive items, many go a step or two further.

Here are just a few examples: **Clay County**—Here the Nest is working in partnership with Early Head Start, so the women served are at 100% of the federal poverty level. Through this partnership, expectant Nest moms receive home visits from a nurse on a monthly basis. A home visitor is available for weekly visits if more frequent contact is needed. Educational classes and incentives, along with social opportunities for families provide additional support

and information. **Page/Fremont Counties**—A mobile Nest travels to the farthest corners of these counties to take the program to women who would otherwise be unable to participate. A volunteer driver takes a van out to give education and incentive items; the travel is usually coordinated with WIC clinic days. **Story County**— When the Story County Nest expanded services into Nevada, Iowa, they began offering an incentive catalog so that women could see ahead of time what they would be purchasing with their points. A binder with photographs is the catalog. Women can order the incentive item one month and pick it up the next or if they are working with a case manger, arrangements can be made for them to deliver the item during a scheduled visit. They also can make arrangements to schedule a time to come to the Stork Nest store in Ames. **Wapello County**—This Nest distributes food baskets in addition to incentives. They encourage their moms to gather with monthly theme nights such as *"spaghetti nite"* or *"breakfast for dinner nite."* **Poweshiek County**—Nest moms are encouraged to read as well as watch for the signs of preterm labor through Mother Goose time at the library and participation in the annual baby fair (in partnership with March of Dimes). **Marshall County**---Local churches participate in an annual Nest diaper drive with a goal of 200 bags of diapers. **Lee County**—Educational classes are followed by support groups. Nest staff work with local agencies to offer parents the opportunity to participate in group activities with their children (county fair, zoo). Social skills are encouraged with occasional restaurant outings. **Polk County**—In order to eliminate as many barriers as

possible, this Nest offers Interpretation for Spanish, Vietnamese, Arabic and Nuer speakers, as well as transportation and childcare for classes.

One of the strongest pieces of the Iowa Stork's Nest program is the collaboration with other agencies. Through local Nests, the March of Dimes and Zeta Phi Beta are able to partner with county health departments, WIC, Visiting Nurse Association, community clinics, community action programs and many others. Collaboration strengthens fund raising activities and expedites a system of cross referrals—a win/win situation for everyone involved.

How can the Iowa Department of Human Services and the March of Dimes continue to outreach good quality maternal and infant care? The March of Dimes provides three year startup grants for the Stork's Nest. Due to the large number of Stork's Nests in Iowa, our organization is unable to provide continued grant funding for all of them. Although there has been some attrition, most programs have been in place for a reasonable amount of time, primarily due to assistance from "umbrella" organizations like health departments and social service agencies.

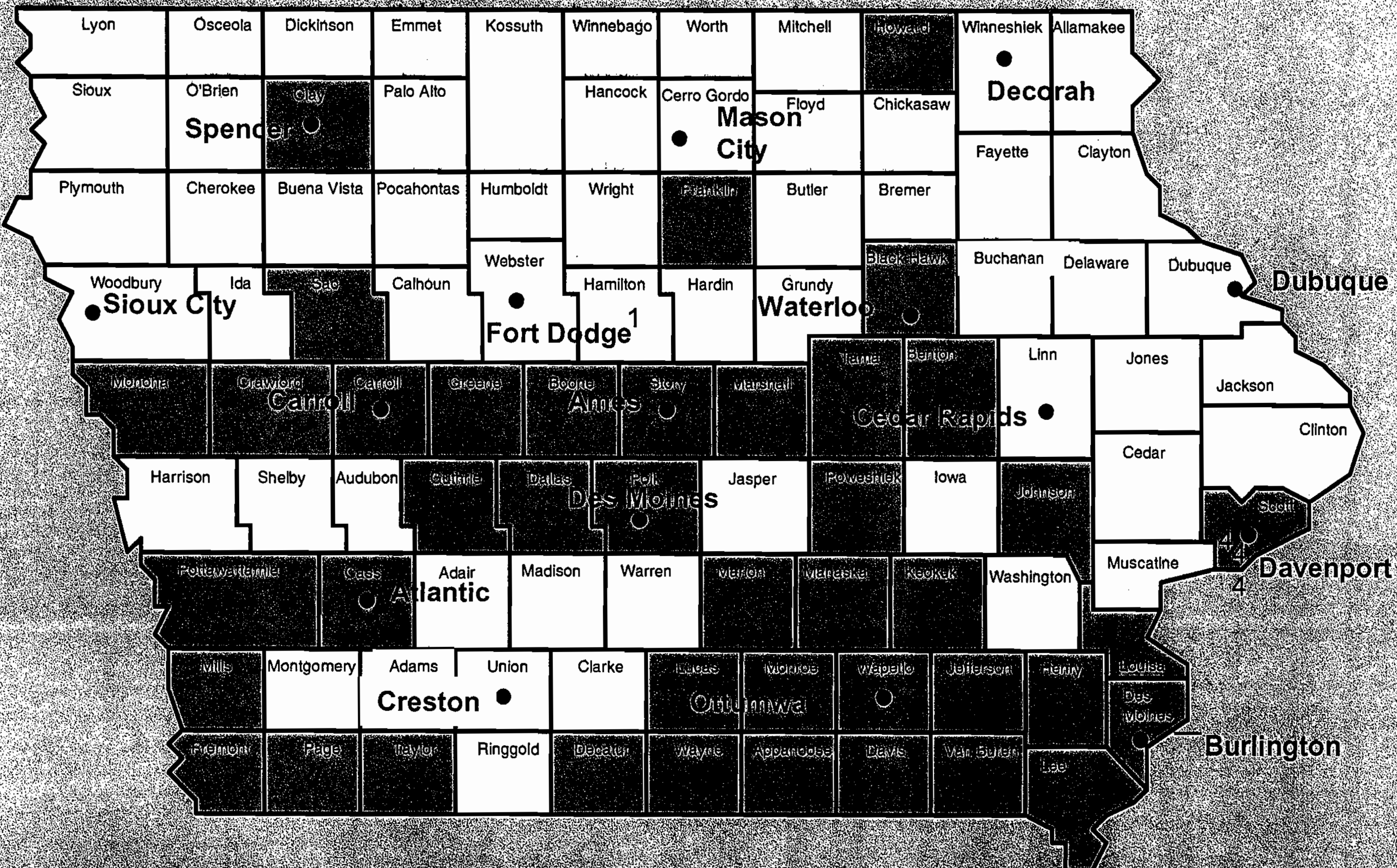
We are asking the Department of Human Services to look at opportunities that would be available through Medicaid to provide ongoing support of this program. The Stork's Nest program is an excellent vehicle for target case management. This program is a tried and true program that services thousands

of pregnant women yearly for healthier birth outcomes. It's simply a great example of what can be accomplished when limited resources are successfully leveraged among agencies.

On behalf of the Iowa Chapter of the March of Dimes, thank you for your leadership on Medicaid, the State Children's Health Insurance Program (*hawk-i*), IowaCares Act and other health benefits for mothers and children who often have difficulty obtaining the care they need when they need it.

Again, thank you for your time and for your commitment to Iowa families and their children.

# IOWA Stork's Nest Program Sites




Source: Iowa Midwest Nest Coalition
website, 2006

#16

Good Morning,

I am Suzanne Overton. Thanks for letting me speak to you this morning, and thanks more for actually listening.

For the last thirteen years I have been among the 25-30% of custodial parents who get little or no support payment from the other responsible parent.

Sometimes both parents are negligent and family, friends and the state must step in to provide for the children.

Sometimes I wonder how our lives could have been different if the child support ~~who~~ would have been <u>enforced</u> before he owed $26,000.!

Maybe I wouldn't have needed to work two jobs just to keep a roof over our heads.

I have been fortunate to have two great sisters and my father and friends. Not everyone has this.

It always seemed for me that only one wolf howls at the door at a time.

Literally families not getting this vita support are one step from <u>Castropl</u>

Choices become limited when you have children and less financial means.
As the government depletes available funds to state/federal programs Child Support is even more VITAL!
There are not income poverty guideline for child support.
No book length forms to fill out or vouchers that specify what certain food items your allowed.
I believe most receiving their support payments wouldn't apply or even qualify for state aid.
How much funds would that put in the budget for other state obligations.
We have a Vital Choice to make for our children that are solely dependent on us.
If its more enforcement so be it.
More strict guidelines lets do it.
I believe ~~as~~ some of the people I have worked at the Child Suppo Recovery Unit will know many ideas to get this done. Especially if funds are available to do it.
Ask Mrs. Nesbit or Mrs. Eaton.
Or does my choice ~~[illegible]~~ only matter when the child is to be ~~killed~~ aborted.

Thanks
Suzanne Overton

MEMORANDUM

To: Council on Human Service
From: State Child Care Advisory Council
Re: Child Care Issues
Date: July 12, 2006

We wish to express our appreciation to you for your approval of our recommendations concerning the Child Care Subsidy Co-Payment Schedule and reaffirm our willingness to work with you and your staff on its implementation.

Today, we bring to you another recommendation:

We recommend that child care rates be based on the most recent market survey.

As you know, the state is required to conduct a market rate survey every two years. It is not required to use this survey in determining the rates. Unfortunately, Iowa has not always used the most current survey in setting this rate. The result has been that the rates have been so low that many quality providers have not accepted children for whom the state makes such low payment.

We believe that the child care rate should always reflect the most recent survey.

Therefore we recommend you request the DHS staff:

1. Include in the 2007 DHS legislative package, legislation that sets the child care provider rates based on the most recent market rate survey.

2. Include in the DHS budget proposal the funds necessary to fund the bi-annual increase.

Thank you for your consideration and hopefully approval of these recommendations.

IOWA HOSPITAL ASSOCIATION

# Council on Human Services
# SFY 2008 Public Hearing
# July 12, 2006

Looking back on the 2006 Legislative Session, advocates for Health & Human Services programs can claim identify several significant accomplishments. In particular, the Iowa Hospital Association (IHA) thanks the Council and the Department for their contributions on the mental health redesign bill that we believe has the potential to provide the most significant improvements to Iowa's behavioral healthcare system in well over a decade.

Iowa's community hospitals have played a much larger role in Iowa's behavioral health delivery system over the past decade with the reduction of beds at the state's Mental Health Institutes (MHIs). However, this line of service has been very resource intensive without adequate reimbursement forcing many hospitals to reduce behavioral health services or eliminate them all together. The legislative change this session to cost-based reimbursement for Medicaid mental health inpatient hospitalization was a very strategic method to help retain the amount of services available in the state. IHA is aware of one hospital strongly considering closing their mental health services until this legislative change.

While IHA is very supportive of the movement away from legal settlement and the mental health payment changes made during the 2006 legislative session, but Iowa cannot be satisfied with that progress and must continue to strive for additional improvement. One area in particular need of improvement is reimbursement for home health services. It is common knowledge that home and community-based treatment is a more cost-effective type of treatment, but the home health reimbursement rates are beginning to preclude providers from taking Medicaid patients or in the case of some hospitals, having to make the difficult decision to stop providing the service all together.

Much of the dialogue on low home health rates in the Medicaid program has been for services provided for mental health patients under the Iowa Plan. Now that targeted reimbursement has been focused on inpatient and community mental health center treatment, Iowa Medicaid needs to ensure that the home health rates are adequate to allow for access to care provided at home in a more cost-effective way, when possible.

Another area of mental health reimbursement that needs further attention is an expansion of the cost-based reimbursement for outpatient treatment. Although the Department targeted community mental health centers in the 2006 legislation to help solidify the outpatient treatment centers in the state, community mental health centers do not reach all Iowans. The

Iowa Department of Inspections and Appeals' web site lists 7 community mental health centers in the state of Iowa. They are located in the following counties: Scott, Jackson, Dubuque, Bremer, Linn, Wappello, and Clay; 6 of the 7 are on the Eastern part of the state with 5 located in the North East Quadrant. Spencer is the only location of a community mental health center west of Waverly and Ottumwa, and not a single community mental health center is located in the Southwest Quadrant of the state.

Hospitals provide outpatient mental health services across the entire state with many rural facilities specifically offering outpatient services to serve a need not offered in their area. Iowa Medicaid should expand the cost-based reimbursement to hospital outpatient mental health services to ensure adequate access across the state.

An additional benefit of targeting cost-based reimbursement to hospital outpatient mental health services is the substance abuse treatment offered there as well. Varying national statistics and research estimate that between 60 to 70 percent of people suffering from a mental health or substance abuse disorder actually have a co-occuring disorder and suffer from both. A hospital can better handle those co-occuring disorder patients by providing both types of outpatient treatment services under one roof, which national research has demonstrated to provide better outcomes when compared to separate treatments at separate locations.

Also with these co-occuring disorders, an Iowa administrative simplification would to change the Medicaid billing procedure to allow for one bill of a treatment session for behavioral health treatment of the co-occuring disorder instead of requiring separate bills for mental health services and substance abuse services.

Like medical services for the chronically ill and disabled, effective and well coordinated behavioral health services are often the pathway from a life marginalized to a life of productivity and improved value. IHA applauds the efforts taken this past session and look forward to working with the Council and the Department on further behavioral health improvements during the upcoming legislative session.

While IHA has spent much of its time discussing pressing behavioral health needs, the need to adequately pay providers for the provision of services under the traditional Medicaid program still exists. IHA appreciates the Iowa General Assembly's approval of a three percent payment increase for Medicaid providers for FY 2006 and FY 2007, but these actions represent two payment increases in seven years. They fall far short of the growing gap that was created first by setting payment levels below the actual cost of providing care, and then by not recognizing the annual cost increases that have occurred in salaries, pharmaceuticals, technology, utilities, and other factors essential to hospital operations.

All of you are well familiar with Iowa's low Medicare reimbursement, and Medicaid continues to reimburse hospitals at a lower rate than Medicare, further compounding the problem. Statewide, about 60 percent of all hospital revenue in Iowa is from Medicare and Medicaid. In 2005, Iowa Hospitals lost more than $110 million providing services to patients covered by these programs. These losses impact hospitals' ability to provide competitive

wages and benefits, the amount businesses and individuals who purchase insurance pay, and the scope of community benefits offered by hospitals.

Community benefits are activities designed to improve health status and increase access to health care. Along with uncompensated care, which is made up of both charity care and bad debt, community benefits include such services and programs as health screenings, support groups, counseling, immunizations, nutritional services, and transportation programs. An IHA statewide survey released earlier this year shows that Iowa hospitals provided more than $393 million in community benefits in 2005. That figure includes $217 million in uncompensated care and over $59 million in free or discounted programs and services that hospitals offered to help the communities they serve.

The programs and services identified in the community benefits survey were implemented in direct response to the needs of individual communities, as well as entire counties and regions. When community benefit programs are threatened, then so is the access to health care for thousands of Iowans since these kinds of programs are not likely to be offered by any entity other than the community hospital.

Ultimately, the Iowa Medicaid program needs to improve hospital Medicaid payments to Medicare levels. Given increasing numbers of Medicaid patients, it is the responsibility of Iowa government to pay at least Medicare rates to prevent a further cost shift to Iowa's employers and businesses, help hospitals provide adequate salaries and benefits for the nearly 70,000 hospital employees across the state, and ensure access to care and community benefits for Iowa's citizens.

IHA and Iowa's hospitals remain committed to seeking collaborative solutions toward maintaining quality health care services for all Iowans. The goals in this regard are no different than legislators who are elected to serve their districts, DHS staff who are employed to respond to Medicaid members, and hospitals that exist to serve their patients and community. In the end, it's the same population.

Thank you for the opportunity to participate in the FY 2008 budget process.

Presented by:

Shannon Strickler
Director, Government Relations
Staff Legal Counsel
Iowa Hospital Association

Presentation of
Kim D. Schmett
Executive Director
Coalition for Family and Children's Services in Iowa
To the
Iowa Department of Human Services
July 12, 2006

The coming year should be a milestone for residential care programs in the Iowa child welfare system. The current outdated RTS funding system will be replaced by a Medicaid based system. For too many years the RTS system has been too rigid and unable to adequately meet the needs of Iowa's children and their families. Coalition agencies welcome the challenge to work with the Department of Human Services to create a new and hopefully more flexible system; a system which encourages innovation and working with both children and their families to create individual solutions to individual problems.

The transition will not be easy, but its potential certainly warrants our efforts. This is intended to be a revenue neutral process. However, we need to maintain a constant vigilance to assure that needed resources are not inadvertently lost during this process.

This coming year will also mark the second year of the current contract system for children's emergency shelters. Just two short years ago Iowa's system of children's shelters was on the verge of immediate collapse. Several shelters closed for lack of adequate funding. Numerous others were about to close. Entire regions of the state were facing the loss of their shelter safety net systems.

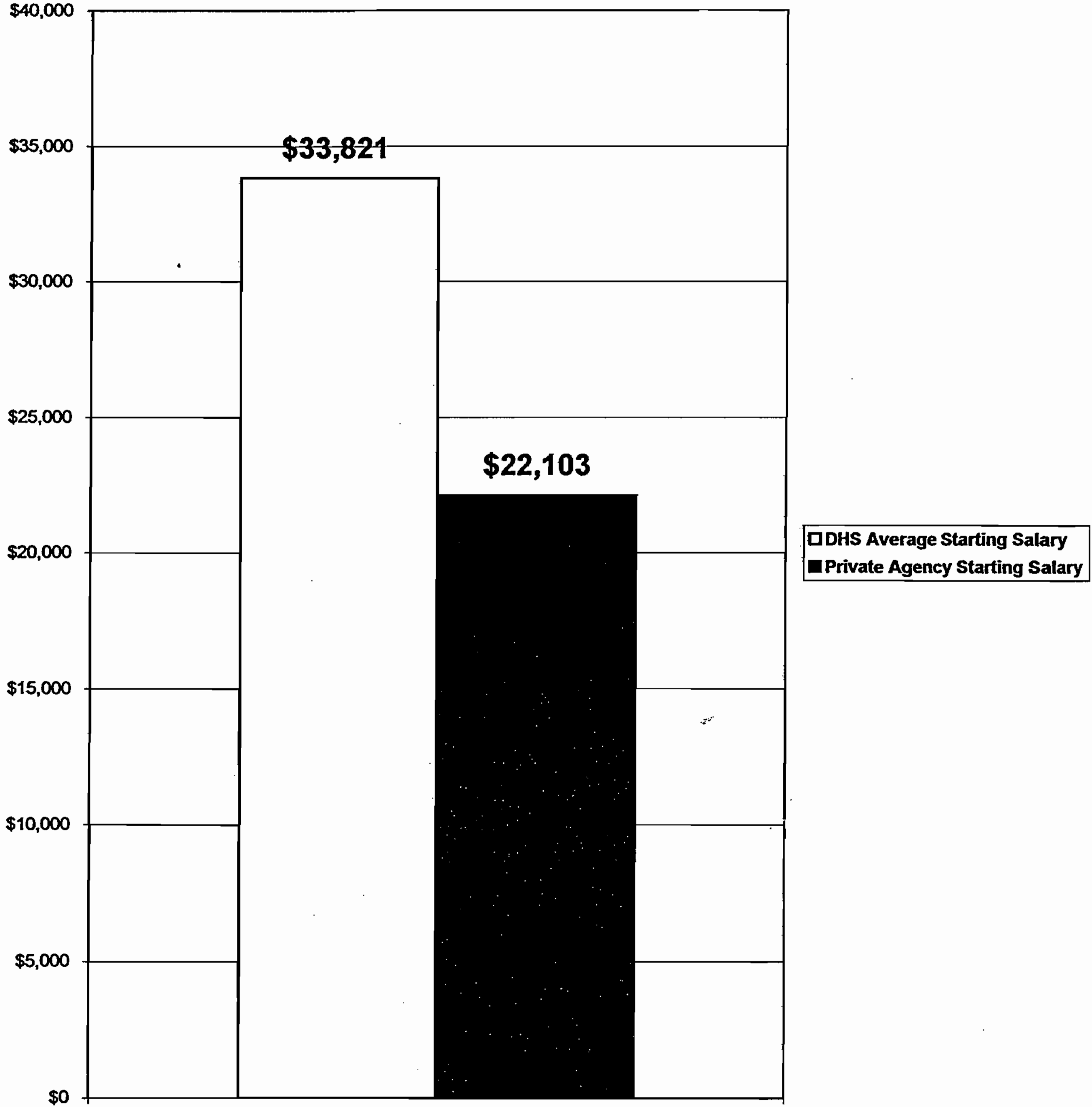
The Department responded with a proposal where it agreed to purchase a state-wide shelter system by contracting for a minimal number of beds that was adequate to preserve shelter services. These contracts stabilized the shelter system. Shelters stopped closing and today shelter services are reasonably available in most areas of our state.

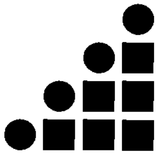
The contract system has worked admirably and its projected usage has proven remarkably accurate on a state-wide basis. However, this contract has also exposed an unfair and unreasonable practice which unnecessarily costs both shelters and the department money. This occurs because shelters are not paid for the last day of service they provide to children. Its obviously unreasonable and unfair not to pay for services that were both requested and used. Its even more unreasonable because the Department loses federal money that it could be receiving if it purchased the last day. This loss of federal revenue is not offset by savings because under the current contract system the Department usually guarantees payment for the state portion of the bed. This presents an excellent opportunity to bring additional federal money into Iowa's child welfare system.

Finally, it is time Iowa begins to address a problem which has a tremendous impact on the quality of care we can provide for our at risk children. This is a problem which was created by year after year of little or no increases for provider services in the child welfare budgets. This problem is created by the resulting discrepancy in pay rates for child welfare workers employed by private agencies whose rates have been capped by the State and for public employees who have regularly received both pay raises and "step" increases in their salaries.

This pay difference has become so great that it is becoming difficult, if not impossible for the private agencies who work most directly with our at risk children to retain experienced staff. Today a newly hired DHS Youth Counselor will start working for a $34,000 annual salary. A similar position in a private agency can only pay about $22,000 per year. This doesn't take into account the excellent benefit package provided to Iowa state employees. Most private agencies can only afford limited, if any employee benefits.

This extreme difference in pay discourages child welfare workers from accepting the positions where they would have the most personal contact with at risk children, and the most potential to have a positive impact on that child's life. They shouldn't be penalized for wanting to work closely with our kids. We need the Department's help to rectify this problem.


Starting Salaries for DHS and Private Agency Social Workers - 2006
$40,000
$35,000
$30,000
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$33,821
$22,103
DHS Average Starting Salary
Private Agency Starting Salary
DHS SW 2
DHS Social Worker 2 Position and Private Family Centered Skill Worker



Governor's
Developmental
Disabilities Council

People, Possibilities, Progress

June 29, 2006

TO: Iowa Council on Human Services Members

FROM: Becky Harker, Executive Director

RE: SFY 2008 Budget Testimony

Thank you for this opportunity to offer suggestions as you develop your budget recommendations for FY 2008. The Governor's DD Council is a federally funded state agency with a responsibility to work to influence systems change that promotes the independence, productivity and inclusion of the more than 450,000 Iowans with disabilities. The Council works with direction from the federal Administration on Developmental Disabilities (ADD) to identify needs and to plan initiatives that address outcomes in specific emphasis areas for people with disabilities. The focus of the Iowa DD Council has been in the areas of self-determination and community inclusion, areas in which success will be determined, in a large part, by the extent of efforts to develop systems of service delivery that promote empowerment, choice and inclusion in natural community settings.

If our testimony sounds all too familiar it's most likely because it has changed very little in recent years. While we recognize that meaningful and sustainable systems change is incremental in nature, that change has been slow to occur in Iowa. Despite recent efforts to expand access to home and community-based services, the state's Medicaid program retains a distinct "institutional bias" that too often serves seniors and individuals with disabilities in higher-cost institutions, instead of in lower cost and often more desirable home- and community- settings. In 2004 Iowa's per capita utilization of state operated 16+bed MR/DD institutions ranked Iowa, at 48th, among the most institutionally reliant in the country. By contrast, only 30% of total MR/DD spending in 2004 was in Home and Community-Based Waiver programming. Those figures do not mean Iowa is choosing not to fund less restrictive services for persons with disabilities but it does suggest that, rather than shifting away from funding institutions as many states have, Iowa is continuing to fund a dual system that supports both institutional and community-based services at a higher cost to the state.

Thomas J. Vilsack
GOVERNOR
Sally J. Pederson
LT. GOVERNOR

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617 East Second Street
Des Moines, IA 50309
**VOICE & TTY**
515/281-9082
800/452-1936
**FACSIMILE**
515/281-9087
**WEB SITE**
www.state.ia.us/
government/ddcouncil

The DD Council continues to support the development of policy and budgeting that reduces that institutional bias and rebalances the long-term care system by creating choices for and access to community-based service alternatives. The Iowa General Assembly made progress in that area in 2006 and we applaud your part in that effort. The implementation of key elements of MH/MR/DD/BI redesign represent a step forward as does the re-establishment of a Division of Mental Health and Disability Services that can serve as a central point of accountability and a catalyst for systems change that addresses the funding and policy barriers to access to community-based services. The increase in the state's commitment to MH/MR/DD/BI allowed growth funding to counties helped to ease the impact on service consumers but the remaining shortfall is still resulting in reductions in services and growing waiting lists in many counties.

We hope that your budget recommendations will attempt to address the state's commitment to those individuals as well as to the growing number of Iowans with disabilities who are waiting for state funded Medicaid waiver services. We also encourage you to explore the means available to Iowa to implement provisions of the Family Opportunity and Money Follows the Person Acts, opportunities created by the Deficit Reduction Act to increase choice and flexibility for individuals and families and promote community living. Governor Vilsack acknowledged the importance of such initiatives when he said, following the 2005 legislative session, "Without in-home assistance, individuals who otherwise would be able to thrive in the community could be forced to seek institutionalization in order to receive the care and services they need. Folks who need assistance should have options to stay in their own home." We agree and look forward to budget and policy decisions that build our state's capacity to offer options that use our limited resources wisely and enhance the quality of life for all Iowans with disabilities and their families. Thank you for your time and attention and your consideration of the Governor's DD Council as a resource as you move forward.

**THE IOWA COUNCIL ON HUMAN SERVICES**
**FY 2008 Budget Hearing**
*Submitted July 2006 by Jill June*
*Representing the Iowa Planned Parenthood Affiliate League*

The Iowa Planned Parenthood Affiliate League (IPPAL) is a coalition of reproductive health care providers advocating for access to voluntary family planning services and adolescent pregnancy prevention programs as key components of public policy to protect the health and well-being of women and children in Iowa.

**Family Planning Services**
IPPAL wants to take this opportunity to thank the Department of Human Services for diligently pursuing the Iowa Family Planning Waiver and working to see that the program is a success.

The Iowa Family Planning Waiver went into effect in February, 2006 with the primary goal of reducing the number of unintended pregnancies and the number of births paid by the Iowa Medicaid Program.

As stated in the waiver application, "Family planning has far-reaching benefits for women and their families. Women who can plan the number and timing of their births enjoy improved health, experience fewer unwanted pregnancies and births, and have lower rates of induced abortion. In addition, women who have control over their fertility have a chance to get more schooling and find paid employment-achievements that enhance their social and economic status and improve the well-being of their families."

**IPPAL recommends continued support for this critical program.**

**Community Adolescent Pregnancy Prevention**
Another important component of preventing unintended pregnancy among adolescents is through the Community Adolescent Pregnancy Prevention programs (CAPP). Although the rate of teenage pregnancy in the United States has been declining, it still remains the highest in the developed world.

CAPP programs are currently funded through TANF and fund efforts to strengthen families and prevent negative outcomes for children. In 2005 approximately 50,800 teens were served by programs in 54 counties.

**IPPAL recommends increasing these vital programs to cover additional counties.**

In addition, regardless of strategies used to reduce the incidence of teen pregnancy in the state, we urge your support of age-appropriate, medically accurate, science-based sexuality education in the schools.

*For additional information contact: Planned Parenthood of Greater Iowa, Jill June, President/CEO, 515-235-0400 or jjune@ppgi.org*

*"Enhancing the quality of care by providing education, recognition, advocacy, and research in support of direct care workers."*

July 5, 2006

Ruth L. Mosher, Chair
Council on Human Services &
Kevin W. Concannon, Director
Iowa Department of Human Services
Hoover State Office Building
1305 East Walnut Street
Des Moines, Iowa 50319-0114

RE: Iowa CareGivers Association
Written Testimony – FY 2008 Budget

Dear Ms. Mosher and Director Concannon:

Thank you for the opportunity to submit written testimony to the Council on Human Services with recommendations on ways to address the human needs of Iowans.

More specifically: How can we partner to ensure that persons with disabilities, children with special needs, and older Iowans have access to the care and services they need in times when the population needing services continues to grow at a rate far greater than the number of well educated and skilled direct care workers (DCWs) to provide the services?

As you know, the Iowa CareGivers Association (ICA), was founded in 1992 as the first direct care worker association in the country. Its mission is to provide education, recognition, advocacy, and research in support of DCWs such as Certified Nurse Aides (CNAs) and Home Care Aides (HCAs) in response to the shortages and high rates of turnover among these frontline caregivers.

In its leadership role, the ICA established a Coalition of twenty agencies representing long term care workers, providers, and advocates dedicated to shaping policy and practice related to DCW recruitment and retention. As a result, The Robert Wood Johnson Foundation and The Atlantic Philanthropies awarded the Coalition, with the ICA serving as the lead agency, a 3 ½ year, $1.3 million demonstration grant. That grant ends in December 2006.

It is from that context that we submit:

*1117 Pleasant Street Suite 221 Des Moines, Iowa 50309*
*phone: (515) 241-8697 fax: (515) 241-8587 e-mail: information@iowacaregivers.org www.iowacaregivers.org*

- Assistance to the Department to maintain and advance services to Iowans
- Request for funding to expand the great work of the Iowa CareGivers Association and the Iowa Better Jobs Better Care program
- Recommendations on systemic changes that will better serve Iowans

In addition, we thank the Department for its financial support in providing scholarships for DCWs to attend the ICA's two-day annual educational conference.

Please call or email if you have any questions or concerns. We look forward to working with you.

Sincerely,

Di Findley, Executive Director
Iowa CareGivers Association
515-241-8697

**Iowa Council on Human Services Budget Hearing**
**Submitted by**
**Iowa CareGivers Association**
**Fiscal Year 2008**

## IOWA CAREGIVERS ASSOCIATION FISCAL NEEDS

**History:** The Iowa CareGivers Association (ICA), founded in 1992, is the first direct care worker association in the country. The ICA's mission is to enhance the quality of care by providing education, recognition, advocacy and research in support of DCWs. Its sole purpose is the recruitment and retention of Certified Nurse Aides (CNAs), Home Care Aides (HCAs), and other DCWs in response to the DCW shortage and high turnover rates that compromise the quality of and limit access to care and supportive services.

**Problem:** Without DCWs children with special needs, persons with disabilities and older Iowans are placed at great risk for not having their most basic care needs met. Many DCWs leave the field due to: 1) short staffing; 2) poor wages and benefits (25% of CNAs in Iowa's nursing homes have no health care coverage from any source); 3) lack of respect/status; and 4) lack of adequate education, training, and opportunities for advancement within the field of direct care. It is incumbent upon us to invest in an infrastructure that will ensure a stable direct care workforce to meet the growing demand for services resulting from the increasing number of Iowans reaching retirement age and in need of care or services, and the movement toward more home and community based services.

**What ICA Brings to the Partnership:**
Many strides have been made in addressing these very important and complex issues but more must be done. The ICA is eager to partner with the IDHS and other state entities to build upon the incredible momentum that currently exists.

The ICA has been a leader at the state and national levels in the areas of DCW recruitment and retention and the DCW Association movement.

- DCW Leadership Program has provided a venue for DCWs to share their voices and bring visibility to their issues and concerns. One hundred twenty-two DCWs have successfully completed the course to date
- DCW Leadership Program is being used as the model by other DCW Associations
- ICA created a Coalition of 20 Iowa organizations that resulted in our being one of only five states in the country to be awarded a 3 ½ year $1.3 million Better Jobs Better Care grant funded by The Robert Wood Johnson Foundation and The Atlantic Philanthropies. The Coalition has been instrumental in some of the following changes:

over

state's system for accurate and consistent tracking of DCW or other long term care worker rates of turnover. In addition, there is no standardized formula for measuring turnover in our state or the country for that matter.

Iowa's nursing homes, through the case mix payment system are eligible for an incentive payment if they meet certain accountability measures, one of which is staff retention. Unfortunately, the turnover of ALL staff is lumped together (administrators, maintenance staff, accountant, CNAs, Directors of Nursing, Social Workers, etc.). One would assume that the turnover of those providing the most basic hands on care might have a greater direct impact on the "quality" of care being delivered than the turnover of the accountant or lawn maintenance crew.

The system should contain a mechanism for tracking turnover of staff by worker classification using **one standard formula.** With better turnover data we can in partnership: 1) more accurately assess the costs associated with staff turnover; 2) provide important information to consumers and family members making decisions about nursing home or other forms of long term care; and 3) identify program and education gaps.

**Recommendations:**

- Assess the effectiveness of the case mix payment system and accountability measures
- Re-evaluate the accountability measures
- Collect staff retention measures from nursing facilities by worker classification
- Correlate the staff retention of various worker classifications to the facilities' standing with the state/citations/inspections.
- Make the turnover information public
- Provide incentives for providers to encourage DCW involvement in the ICA programs and services

May 31, 2006

Lt. Governor Sally Pederson
State Capitol
Des Moines, Iowa

Dear Lt. Governor Pederson:

Three years ago you joined us as we greeted members of the National Better Jobs Better Care (BJBC) grant selection committee during their site visit to determine whether we would be awarded one of five state BJBC demonstration grants. Thanks to your help and that of others, we were awarded the $1.3 million grant from The Robert Wood Johnson Foundation and The Atlantic Philanthropies. Ours was a very ambitious grant proposal, typical of Iowans, but the ambitious nature of the grant's goals and objectives was paled only by the ambition and commitment of the twenty-two member BJBC Coalition.

State department representatives have been supportive and involved in the BJBC Coalition and ICA activities in a number of ways:

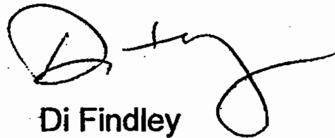
- DIA has developed an incredible product in the expansion of the Iowa Nurse Aide Registry to the Direct Care Worker Registry capable of including all direct care workers.
- DPH is administering the Direct Care Worker Education Task Force that resulted from the BJBC Coalition's legislative efforts. The Department has also sponsored scholarships for Home Care Aides (HCA) employed in public health entities to attend the HCA Mentor program. ICA was also the recipient of a grant to develop and pilot a direct care worker leadership program that has proven to be one of our most popular programs.
- DEA has provided ongoing support that enables us to manage the BJBC grant, produce our newsletter, host Iowa Caregivers Month and other events and forums, and advocacy.
- DHS provides financial support for direct care workers to receive scholarships to attend our annual conference and other educational programs

I recently met with Josh Mandelbaum to seek advice on strategies to assist us in our transition from the BJBC grant that ends December 2006 and sustain the excellent work that has been accomplished. Josh advised us to schedule meetings with the caucus staff and key legislators over the summer. Several of those meetings have already been scheduled. We have had preliminary meetings and discussions with Directors Concannon, Hansen, and Haverland over the past several months. Director Concannon, in a meeting with Betty Grandquist and myself, expressed an interest in providing some funding to help us maintain certain aspects of the BJBC project.

over

We will follow up with a call in the near future to schedule a meeting with you and your staff if you are willing to discuss this and other strategies we are exploring. Thank you very much for giving this your consideration. Please call if you have any questions or concerns.

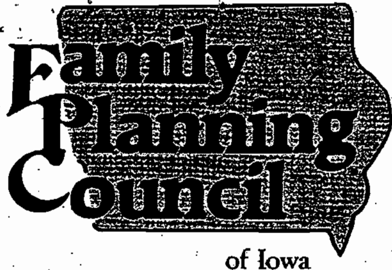
Sincerely,



Di Findley
Executive Director
Iowa CareGivers Association

p.s. On another note, we are very happy to hear that you will be joining us on June 5, 2006. We're looking forward to the event, though a bitter-sweet sentiment, as it will be your last Caregivers Month event as our Lt. Governor.

cc:KConcannon
MHansen
MHaverland
JMandelbaum




108 3rd Street, Suite 220
Des Moines, Iowa 50309
(515) 288-9028
Fax (515) 288-4048
email: FPCI@fpcouncil.com

July 5, 2006

Ruth L. Mosher, Chair
Council on Human Services
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319

Dear Ms. Mosher:

Thank you for the opportunity to provide input to the Council on Human Services regarding the SFY 2008 budget for the Department of Human Services.

I am submitting comments and recommendations on behalf of the Family Planning Council of Iowa. Twenty copies of the comments are enclosed.

Thank you again. If you need additional information please contact me at (515) 288-9028 or jtomlonovic@fpcouncil.com.

Sincerely,

Jodi Tomlonovic

Jodi Tomlonovic
Executive Director

**FAMILY PLANNING COUNCIL OF IOWA**
**TESTIMONY TO THE**
**COUNCIL ON HUMAN SERVICES**
**JULY 2006**

*The Family Planning Council of Iowa is a private non-profit organization dedicated to promoting access to family planning and reproductive health care for all Iowans through direct services, public education and advocacy, professional training, and collaboration.*

Thank you for the opportunity to provide testimony to the Council on Human Services regarding the FY2008 budget process.

First, I would like to thank the Council on Human Services and the Department of Human Services for the Medicaid Family Planning Waiver. The waiver went into effect February 1, 2006. Women in Iowa are already seeing the benefits of the program. The clinics have received very positive comments from women who have enrolled in this program. Women are expressing their thanks for the program and appreciation for how it is helping them with their health care.

This waiver project helps Iowa capitalize on the value of voluntary family planning services. DHS's investment in a family planning waiver project will provide the anticipated results and savings only if all DHS programs support the project. This means that other programs provide their clients with information about and access to the Iowa Family Planning Network. The cooperation of other DHS programs is important to the success of the waiver project.

Overall, family planning is a vital component of the Medicaid program. Recent changes to the federal laws overseeing Medicaid appear to have made it easier for states to choose to eliminate family planning as a required service for optional coverage groups. We realize that the IA Medicaid Program is not discussing such a move, but we do ask that the Council affirm its understanding of the value of family planning services and its support in assuring family planning services are included in all Medicaid programs.

Providing clinical services is one mechanism for helping avert unintended pregnancies. Another important mechanism is to provide good, factual information and education about preventing unintended pregnancies. It is especially important that teens receive honest, age appropriate, medically accurate, evidence based information about preventing pregnancies. It is also important that teens are provided with the lessons and life skills to enable them to make good decisions regarding avoiding unintended pregnancies. Over the years, the Department of Human Services has funded the Community Adolescent Pregnancy Prevention Program (CAPPP). This program, using Temporary Assistance to Needy Families (TANF) funds, requires that communities come together to develop programs for their area to work with teens on preventing pregnancy. This required collaboration of various types of providers assures that the funded programs reflect the needs of the community.

## Recommendations:

*Continued Support of Funding for the Community Adolescent Pregnancy Prevention Programs:*

Education and information to young people is an additional means of helping avoid unintended pregnancies. The Community Adolescent Pregnancy Prevention funds community developed programs focusing on this issue. We ask the Council to continue to support this program and to increase the funding level.

*Encourage Information about Voluntary Family Planning Services:*

Having state and private agencies that provide human services programs furnish information about voluntary family planning services to their interested clients helps clients avoid unintended pregnancies and the attendant future costs. We ask the Council to encourage the provision of information and the provision of referrals to the Iowa Family Planning Network for interested clients.

For more information contact: Jodi Tomlonovic, Executive Director
Family Planning Council of Iowa
(515) 288-9028
jtomlonovic@fpcouncil.com

**FAMILY PLANNING COUNCIL OF IOWA**
**TESTIMONY TO THE**
**COUNCIL ON HUMAN SERVICES**
**JULY 2006**

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For more information contact: Jodi Tomlonovic, Executive Director
Family Planning Council of Iowa
(515) 288-9028
jtomlonovic@fpcouncil.com

# IOWA STATE ASSOCIATION OF COUNTIES

Budget and Legislative Recommendations for
Department of Human Services

Fiscal Year 2007-2008

***ISAC's Mission Statement:***
*To promote effective and responsible county government for the people of Iowa.*

The Iowa State Association of Counties (ISAC) would like to thank the Council on Human Services for the invitation to provide input into the development of the FY 2007–2008 DHS budget and legislative package. This effort toward cooperation is greatly appreciated. Counties understand that the under funding of DHS programs creates major issues that must be addressed by county resources if an acceptable quality-of-life is going to be maintained for local citizens. Our recommendations are broken into the following categories:

## MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES FUNDING AND SERVICES

In order for the State of Iowa to realize the system redesign proposed by the MH/DD Commission, there must be adequate state funding to support this system change. ISAC supports the following improvements to the disability service system:

- Restoration of allowed growth that takes into account inflation, growth in the numbers served and investments in improvements in the service delivery system;
- A state-county cooperative effort to manage increased Medicaid costs;
- Maintenance of Medicaid-funded case management services for persons with disabilities;
- Adequate funding of the state payment program to allow the county of residence to provide the same services at the same reimbursement rate without jeopardizing services for persons with legal settlement in that county;
- Develop a timeline for moving the management of Medicaid and institutional state cases along with the associated funding to the county of residence; and
- Adequate funding of technical assistance and oversight of the Medicaid program, most critically the Adult Rehabilitation Option (ARO) and Home and Community Based Services (HCBS) in congregate living settings.

ISAC has aggressively pursued redesign of the Iowa MH/DD/BI system. This pursuit is an attempt to create a quality system for Iowans with disabilities by enhancing their quality of life and self-sufficiency. To help facilitate this system redesign, ISAC adopted a proposal that includes the following interdependent components:

- Standardization of clinical and financial eligibility;

- A defined set of core community-based services;
- Transition from the concept of legal settlement to one of residency;
- Increased utilization of federal funding for disability services;
- Creation of a funding formula that is directly linked to the individual receiving services;
- Expansion of the state-operated risk pool and creation of local risk pools; and
- Define/redefine roles of the state and counties in the management of the system

## DISPUTED BILLINGS

For many services provided to persons with disabilities, the Department charges all or part of the cost back to the county. DHS does not have an adequate system to resolve bills which a county disputes. In 2001, the Legislature ordered DHS to forgive all bills for services prior to July 1, 1997, if the county had properly disputed the bill. Unless dramatic improvements are made in the DHS processes, ISAC supports the development of a process to move the date for writing off bills from July 1, 1997, to July 1, 2002. In addition, ISAC supports legislative changes which would require DHS to respond to disputed billings in a timely manner, to allow credits from one institution to be used against charges at another institution, and to clarify that any offset process only be used within a specific county fund (e.g. MH/DD Services Fund, General Fund, etc.).

ISAC has offered to work with the Department to improve the accuracy of the Adult Rehabilitation Option billings, just as was done with the HCBS Waiver services several years ago.

## CHAPTER 812 COMMITMENTS

The lack of clarity as to responsibility for the costs of Chapter 812 commitments continue to add to the disputed billings concerns. ISAC supports legislation clarifying that the cost of evaluation and restoration of competence to stand trial pursuant to Iowa Code chapter 812 is a state funding responsibility. Many counties refuse to pay these costs out of their MH/DD funds and the state is collecting less than $1M per year while the rest remains on the books in dispute.

## INSTITUTIONAL PLACEMENT OF CHILDREN

The placement by the Department of Human Services of children in institutional settings creates problems for counties when those children reach majority. Since they are already placed and families are comfortable with those placements, moving to more community-based options is problematic. It would be very helpful if the department used those placements much more sparingly and encouraged more use of home and community based services for children.

# COUNCIL ON HUMAN SERVICES
# IOWA DEPARTMENT OF HUMAN SERVICES
# BUDGET HEARING

Iowa Protection and Advocacy Services, Inc. appreciates the opportunity to offer recommendations for the Iowa Department of Human Services Budget. In years previous, our agency has been repetitious in its recommendations focusing on a common theme --- fiscal responsibility to shift the service system for Iowans living with a disability from a congregate, institutional system to a community based system. This shift will not only create a more cost-effective system of services, but also begin to address the quality of life issues desired by all citizens residing in our state.

For the first time in many decades, Iowa Protection and Advocacy Services, Inc. has witnessed positive movement by the Iowa Department of Human Services which reflects the potential for a community-based system of services. A vision appears to be emerging that may enable Iowans living with disabilities to have choice and control over their lives. Much remains to be accomplished, but working together collaboratively within a common vision will enable Iowans with disabilities to participate fully as citizens of our state.

Iowa P&A offers the following recommendations:

1. Increase waivers and the use of waiver services;
2. Shift funding for disability services from county to state funding;
3. Reduce Iowa's ICF/MRs by 20%, moving residents into smaller, community programs (Iowa has 137 ICF/MRs);

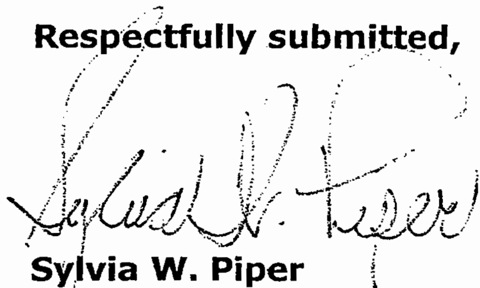
4. Increase the reimbursement rate for community providers;
5. Expand the use of in-home, family support so that parents do not have to place their children outside of the home to receive assistance and care;
6. Utilize the principles of self-determination enabling people with disabilities to control their lives and determine their individual services;
7. Pass "Money Follows the Person" legislation similar to that which others states in the Midwest have done, e.g., Nebraska;
8. Upgrade Iowa's restraint and seclusion laws, particularly for children;
9. Make sure that HF 2780 is amended to reflect a renewed service system designed for the delivery of contemporary services rather than the continuation of the current antiquated system which it currently reflects.

** Further: It is essential that a Director for MH/MR/DD/BI be hired and provided with appropriations and freedom to fulfill a direction to shift the Iowa service system from institution to community-based --- from ICF facilities to the utilization of existing community services.

Iowa Protection and Advocacy Services, Inc. applauds the headway which the Iowa Department of Human Services has made under the leadership of Director Concannon. It has been our pleasure to work collaboratively with him and his staff on several issues during the course of this past year. Iowa P&A desires to be a part of the solution to achieve a quality system of services for Iowans with disabilities. At this juncture we have hoped that the progress we have seen will continue. It must!

**Iowa P&A appreciates the opportunity for input into the DHS budget process and your positive consideration of our recommendations.**

**Respectfully submitted,**



**Sylvia W. Piper**
**Executive Director**
**July 12, 2006**

**cc: Board of Directors**
**Iowa Protection and Advocacy Services, Inc.**